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Original Article

Mental Health Laws, Incarceration, and the Cost of Reoffending: A Review of Secondary Evidence

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ABSTRACT: *People with mental illness are over-represented in prisons in every region where this has been measured, and many leave custody without the care they need and later return. This paper reviews secondary evidence on how mental health law and service provision relate to incarceration and recidivism, and what these outcomes cost. Using a qualitative, comparative approach, it draws on fifteen sources published between 1939 and 2024: systematic reviews, a randomized trial, cross-national studies, a cost analysis, a study protocol, an economics preprint and one advocacy report. The evidence shows that prisoners carry a much higher burden of psychosis, depression and substance use than the general population. The link between falling psychiatric bed numbers and rising imprisonment is supported in South America but not across Europe. Psychological programs delivered inside prisons have modest effects on reoffending once small-study bias is accounted for. In contrast, models that connect treatment to the community and the courts, including therapeutic communities with aftercare, forensic assertive community treatment, mental health courts and mandated treatment on probation, show more promising but uneven results. Economic evidence is thin yet consistent in direction: completing a mental health court was associated with 12-month costs about 57% lower than for a comparison group. The paper argues that continuity of care around release matters more than any single legal provision, and it identifies gaps in direct tests of legal reform, cost-effectiveness research and evidence from low- and middle-income countries.*

KEYWORDS: *Mental Health Law, Incarceration, Recidivism, Diversion, Forensic Assertive Community Treatment, Cost-Effectiveness.*

1. INTRODUCTION

Prisons were not built to treat mental illness, yet they now hold very large numbers of people who have one. Fazel et al. (2016) found that the prevalence of every mental disorder examined was higher in prisoners than in the general population. Surveys suggest that around one in seven prisoners has psychosis or major depression, and about one in five enters prison with a substance misuse problem. The gap is wide in low- and middle-income countries too: the prevalence of non-affective psychosis among prisoners there was, on average, about 16 times the general population figure (Baranyi et al., 2019).

Two explanations are usually offered. The first, associated with the Penrose hypothesis, holds that people with serious mental illness are drawn into the criminal justice system when hospital and community care shrink (Mundt et al., 2015; Penrose, 1939). The second holds that prison itself produces or worsens illness. Researchers describe these as the importation and deprivation models, and both probably contribute (Cunha et al., 2023). Whichever carries more weight in a given country, the practical result is the same: the criminal justice system ends up managing health problems that it has neither the mandate nor the resources to treat.

The consequences are financial and human. Between a third and a half of people released from prison reoffend within two years, and the annual social and economic cost of reoffending has been estimated at more than £18.1 billion in the United Kingdom and US$13 billion in Illinois alone (Beaudry et al., 2021). In Portugal, each prisoner costs the state an average of €49 a day, a figure that international data suggest roughly doubles once mental health care is added (Cunha et al., 2023).

This paper asks three questions. How do mental health law and the capacity of mental health services relate to incarceration? What does the evidence say about interventions that aim to reduce reoffending among people with mental illness, inside prison and in the community? Moreover, what is known about the cost of the current approach and the savings that alternatives might bring? The paper argues that the evidence points less to any single legal provision than to a recurring weak spot: the lack of continuity in care around arrest, imprisonment and release.

2. LITERATURE REVIEW

2.1. MENTAL ILLNESS IN PRISON POPULATION

Prevalence estimates vary by country and diagnosis, but the direction is consistent. Baranyi et al. (2019) pooled 23 publications covering 14,527 prisoners in 13 low- and middle-income countries and estimated one-year prevalence at 16.0% for major

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depression, 6.2% for psychosis, 5.1% for drug use disorders and 3.8% for alcohol use disorders (Figure 1). Fazel et al. (2016) reached the same conclusion about serious mental disorder in their wider review of prison surveys. They stressed that few of these disorders are identified or treated in custody. The two reviews agree on the scale of need, and Fazel et al. add that most of it goes unrecognized and untreated.

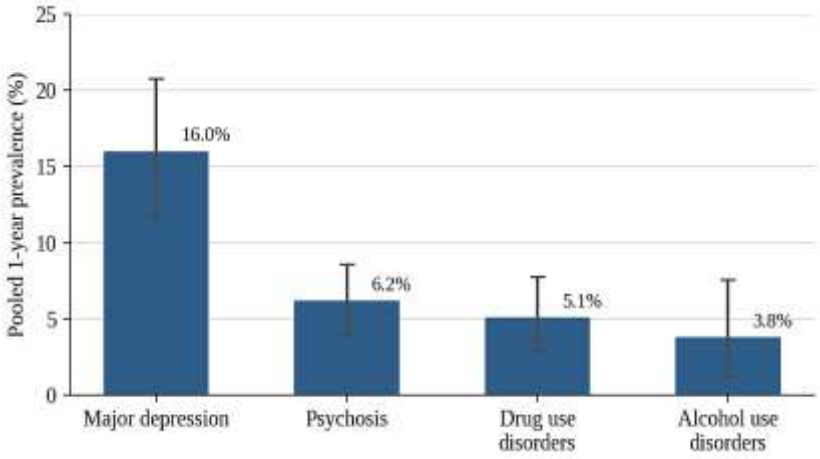


FIGURE 1 Pooled One-Year Prevalence of Mental Disorders in Prisoners in Low- and Middle-Income Countries

Note: *Data from Baranyi et al. (2019): 23 publications, 14,527 prisoners, 13 countries. Error bars show 95% confidence intervals.*

Whether prison causes illness is less settled. Cunha et al. (2023) set out two competing accounts. Under importation, adversity before prison, such as abuse, homelessness and earlier mental illness, explains most of the disorder found there. Under deprivation, the prison environment itself does the damage through overcrowding, isolation, loss of autonomy, fear of victimization and violence. They describe the direction of causality as one of the main open questions in the field, and note that the first weeks of a sentence and the period after release carry a higher risk of suicide (Bukten & Stavseth, 2021, as cited in Cunha et al., 2023). Rowlandson et al. (2024) add that suicide among prisoners in the United Kingdom has been reported at 3.9 times the general population rate. Because Cunha et al. present a protocol and not results, their account is best read as a research agenda built on earlier studies rather than as new evidence.

2.2. MENTAL HEALTH LAWS, HOSPITAL CAPACITY AND INCARCERATION

The idea that mental health provision and imprisonment are linked is old. Penrose (1939) compared European statistics and reported an inverse relationship between psychiatric hospital beds and prison populations, and the pattern has carried his name since (Blüml et al., 2015). Later tests have given mixed answers. Mundt et al. (2015) followed South American countries from 1990, when they committed to community-based care, and found that bed numbers fell most where and when prison populations grew most. Blüml et al. (2015) used data from 26 European countries between 1993 and 2011 and found no general support for the hypothesis; the size and direction of the association differed significantly between countries, and socioeconomic indicators did not explain the variation. They suggest that national welfare and health systems, traditions and resources shape what happens after hospital beds are cut.

Evidence from the United States fits the more pessimistic reading. A joint report by the Treatment Advocacy Center and the National Sheriffs' Association noted that, by its 2010 count, there were more than three times as many people with serious mental illness in jails and prisons as in hospitals, with the worst states close to ten times, and that the number in prisons and jails now exceeds the number in state psychiatric hospitals tenfold (Torrey et al., 2014). The report was produced by an advocacy organization and a law enforcement body, and it describes stocks of people rather than causes, so it illustrates the

2.3. RECIDIVISM AND TREATMENT INSIDE PRISONS

If prison fails to treat mental illness, treatment inside prison should reduce reoffending. The best available test is the meta-analysis by Beaudry et al. (2021), which pooled 29 randomized controlled trials with 9,443 participants. Across all trials, psychological interventions were associated with lower odds of reoffending (OR = 0.72, 95% CI [0.56, 0.92]). The authors also found evidence of publication bias and small-study effects. After removing trials with fewer than 50 participants in the intervention group, the reduction was no longer statistically significant (OR = 0.87, 95% CI [0.68, 1.11]; Figure 2).

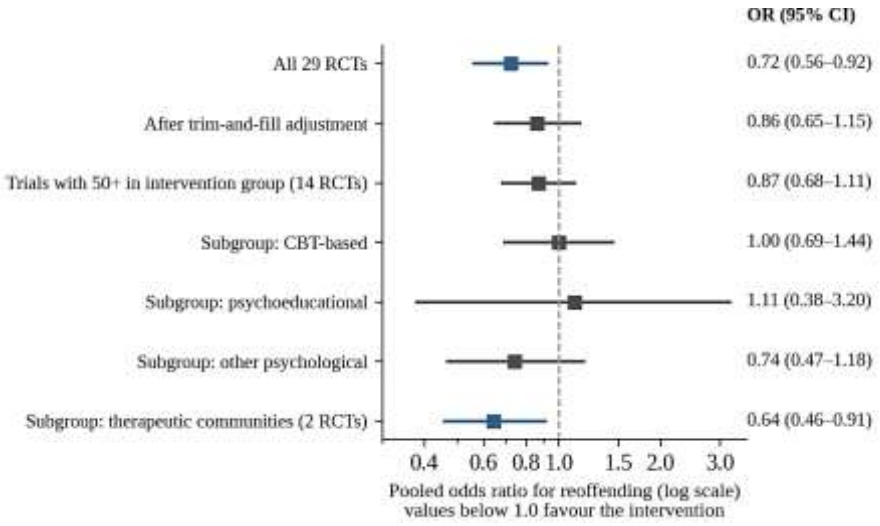


FIGURE 2 Effect of Prison-Based Psychological Interventions on Reoffending

Note: *Data from Beaudry et al. (2021). Subgroup estimates come from trials with at least 50 participants in the intervention group. Blue markers show 95% confidence intervals that exclude 1.0. CBT = cognitive behavioral therapy; RCT = randomized controlled trial.*

These results are weaker than earlier syntheses. Beaudry et al. point to a 2007 review that reported risk reductions of 20–30% for cognitive behavioral programs (Lipsey et al., 2007, as cited in Beaudry et al., 2021), whereas the randomized trials showed no clear effect for CBT-based programs (OR = 1.00, 95% CI [0.69, 1.44]). They attribute the gap partly to earlier reviews that included weaker, non-randomized designs. Knapp and Wong (2023), in a narrative review of economic evidence, still found some support for the cost-effectiveness of CBT and therapeutic communities at the point of incarceration. The two sets of findings are not strictly contradictory, since cost-effectiveness can rest on outcomes other than reoffending. However, they complicate any claim that CBT is a reliable way to cut reoffending in prison.

One subgroup stood out. Therapeutic communities were associated with lower reoffending (OR = 0.64, 95% CI [0.46, 0.91]), but this rests on only two trials, and both connected participants to voluntary services after release (Beaudry et al., 2021). In one of them, 42% (33 of 79) of participants with links to community services returned to custody, against 86% (137 of 159) of those without. Participants were not randomly assigned to have those links, so the comparison is suggestive only. This fits the authors' wider conclusion that in-prison treatment may not work unless it is tied to support after release. Cunha et al. (2023) reach a similar view from the other direction, summarising research that finds imprisonment has a null or even criminogenic effect on reoffending and can undermine reintegration through its harm to mental health.

2.4. DIVERSION AND COMMUNITY BASED MODELS

Forensic assertive community treatment (FACT) adapts an intensive community team model for people with serious mental illness who are involved with the justice system. Cusack et al. (2010) ran a randomized trial in California among frequent jail users with serious mental illness. At 12 months, FACT participants had fewer jail bookings, more outpatient contacts and fewer hospital days than those receiving treatment as usual, and the 24-month results followed the same pattern. FACT participants were more likely to avoid jail altogether, although once jailed the number of jail days did not differ between groups. Goulet et al. (2022) are more cautious. Their review covered 16 studies, six of which (1,246 participants) could be pooled, and found mixed results: apart from higher use of outpatient services, comparisons with control groups produced no significant differences. They link the inconsistency in the literature to non-randomized designs, short follow-up and differences in how FACT programs are built. Taken together, the two studies suggest that FACT reliably changes how people use health services, while its effect on criminal justice outcomes is less certain. One trial found fewer bookings, but the pooled evidence did not confirm it.

Mental health courts take a different route, diverting defendants into supervised treatment. Lowder et al. (2018) meta-analyzed 17 studies (N = 16,129) and found a small reduction in recidivism compared with traditional court processing, and they called for research on why effectiveness varies between courts. A third model works at sentencing. Nesbit (2022) used random allocation of cases to judges in North Carolina between 1994 and 2009 to compare probationers required to attend weekly mental health counseling with those who were not. In the revised version of the paper, mandated treatment lowered three-year recidivism by about 12 percentage points, or 36%; the first version had estimated 5.6 percentage points, or 17%. The effect was strongest among more financially advantaged probationers, in a system where probationers pay for their own treatment.

Table 1 sets these studies side by side. What the community models share, and what most in-prison programs in Beaudry et al. lack, is a link between treatment and a setting outside the prison, backed by a legal lever such as a court order, a probation condition or a team that works with the courts. This is an observation about patterns across studies, not a finding any of them tested directly. Note. RCT = randomized controlled trial; OR = odds ratio.

TABLE 1 Summary of the Main Studies Reviewed

Study	Design and setting	Main finding	Key limitation
Beaudry et al. (2021)	Meta-analysis of 29 RCTs (9,443 participants) of psychological programmes delivered in prison	Pooled OR 0.72 across all trials; 0.87 (not significant) in trials with 50 or more per intervention group; therapeutic communities OR 0.64	Only 2 of 29 trials at low risk of bias; all trials from high-income countries
Cusack et al. (2010)	RCT of forensic assertive community treatment (FACT) versus treatment as usual; frequent jail users with serious mental illness, California	Fewer jail bookings, more outpatient contact and fewer hospital days at 12 months; same pattern at 24 months; jail days once jailed did not differ	Single site; no difference in length of jail stays
Goulet et al. (2022)	Systematic review of 16 FACT studies; meta-analysis of 6 (1,246 participants)	Mixed results; no significant differences from controls apart from higher outpatient service use	Non-randomized designs, short follow-up and variable programme structure in the primary studies
Lowder et al. (2018)	Meta-analysis of 17 studies (N = 16,129) of adult mental health courts	Small reduction in recidivism compared with traditional court processing	Sources of variation between studies not explained
Kubiak et al. (2015)	Retrospective cost analysis of one urban mental health court; 105 participants and 45 eligible non-participants	12-month costs of $16,964 (completers), $32,258 (non-completers) and $39,870 (comparison)	Groups not randomized; small samples; completers may differ from others
Nesbit (2022)	Judge-assignment analysis of North Carolina probation cases, 1994–2009	Mandated counseling cut three-year recidivism by about 12 percentage points (36%) in the revised version; benefit–cost ratio about 5:1	Preprint; probationers pay for treatment; estimate differed between versions
Rowlandson et al. (2024)	Systematic review of full economic evaluations of mental health interventions in prison	One eligible study (group interpersonal psychotherapy for depression), which found the therapy cost-effective	One small study with 3-month follow-up
Cunha et al. (2023)	Study protocol for cross-sectional and longitudinal research on imprisonment and mental health, Portugal	No findings yet; sets out how effects during and after prison will be measured	Protocol only

Note: *RCT = randomized controlled trial; OR = odds ratio.*

2.5. DIVERSION AND COMMUNITY BASED MODELS

The cost of the current approach shows up in several places. Beaudry et al. (2021) cite the UK and Illinois estimates of the cost of reoffending given earlier. Cunha et al. (2023) report an average of €49 per prisoner per day in Portugal, and Rowlandson et al. (2024) note that in 2021– 22 a secure mental health bed in the United Kingdom cost £739 a day, against an average of £86 a day in public sector and contracted prisons. Rowlandson et al. also point out that reoffending adds to overcrowding, which is itself a known risk factor for poor mental health among prisoners.

On the other side, Kubiak et al. (2015) compared 12-month outcome costs covering treatment, arrest and confinement for people who had left an urban mental health court more than a year earlier. Total costs were $16,964 for those who completed the program, $32,258 for those who did not, and $39,870 for eligible people who were never enrolled; completers' costs differed significantly from both other groups (Figure 3). Most of the difference came from arrests. Cusack et al. (2010) found that FACT's extra outpatient costs were partly offset by lower inpatient and jail costs, and Nesbit (2022) estimated a benefit–cost ratio of about 5:1 for mandated treatment, meaning the crime avoided was worth more than the treatment cost.

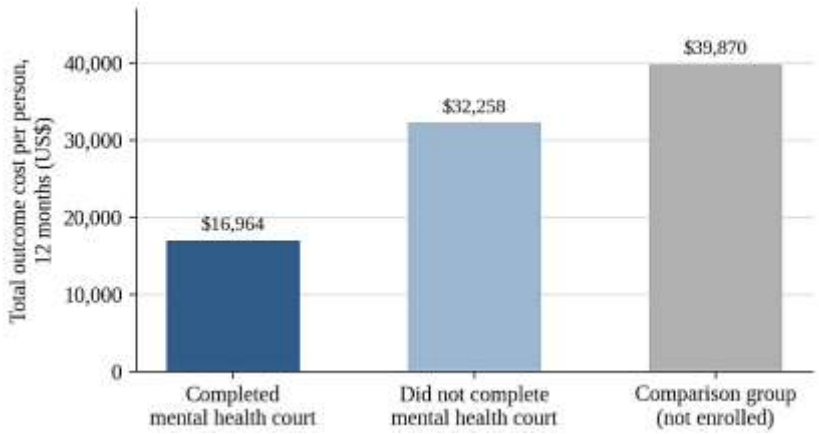


FIGURE 3 Twelve-Month Outcome Costs by Mental Health Court Completion Status

Note: *Data from Kubiak et al. (2015). Costs cover treatment, arrest and confinement in the 12 months after leaving the court. The comparison group had 45 people; the mental health court groups totaled 105.*

The strength of this evidence should not be overstated. Rowlandson et al. (2024) searched for full economic evaluations of mental health interventions for adult prisoners. They found only one, a trial of group interpersonal psychotherapy for depression among 181 prisoners in the United States. It found the therapy cost-effective, but the sample was small, follow-up lasted three months, and the groups differed at baseline. Knapp and Wong (2023) reach a similar verdict across the wider criminal justice system, noting a shortage of high-quality economic evidence, especially cost–benefit analyses, though with some support for CBT, therapeutic communities and, after release, assertive community treatment.

2.6. SUMMARY OF GAPS

Reading across the studies, four gaps recur. First, almost none of them test a legal change directly; they measure hospital beds, court programs or sentencing conditions. Second, the randomized evidence comes from high-income countries (Beaudry et al., 2021), although Baranyi et al. (2019) show the burden of illness in prisons in poorer countries is heavy. Third, economic evaluations are rare and mostly small. Fourth, outcomes are almost always reoffending or service use, so wellbeing, housing and employment after release are largely unmeasured.

3. METHODOLOGY

This study uses a qualitative and analytical design based entirely on secondary data. No new data were collected. The aim was to compare what published studies and reviews report about mental health law and services, incarceration, recidivism and cost, and not to pool their results statistically.

Fifteen sources were used. Most are peer-reviewed journal articles from outlets such as The Lancet Psychiatry, JAMA Psychiatry, Psychiatric Services and Community Mental Health Journal. They include five systematic reviews or meta-analyses, two narrative reviews, one randomized controlled trial, two cross-national ecological studies, a cost analysis and a study protocol. Two sources are not peer-reviewed: an economics preprint posted to arXiv (Nesbit, 2022) and a survey report by an advocacy organization and a sheriffs' association (Torrey et al., 2014). One historical paper (Penrose, 1939) was included because later studies build on it. Sources were located through targeted searches of PubMed and PubMed Central, ScienceDirect, SpringerLink, SAGE Journals and arXiv, and by following the reference lists of key reviews. Priority was given to systematic reviews, randomized or quasi-experimental designs, and work published since 2010.

Findings were compared along three dimensions: setting (prison or community), study design (randomized or not) and outcome (incarceration, reoffending or cost). Where studies agreed, this is noted; where estimates differed, the Analysis section considers why. Effect sizes are reported as the original authors gave them. Currency figures are quoted in the original currency and year and were not adjusted or converted.

The approach has limits. It is not a systematic review; no formal quality appraisal was carried out, and relevant studies may have been missed. The search was in English, and the strongest evidence comes from high-income countries. The cost figures come from different countries and years, so they are treated as illustrations of scale rather than directly comparable estimates.

4. RESULTS AND DISCUSSION

4.1. LAW IS ONE CHANNEL AMONG SEVERAL

This paper argues that mental health law shapes who ends up in prison. The evidence reviewed supports a narrower version of that claim. Most studies on incarceration measure service capacity, chiefly hospital beds, not the wording of statutes such as civil commitment criteria. Legal rules matter in principle, because they decide when a person can be treated without consent and what a court may order. However, no study reviewed here compares incarceration before and after a specific change in mental health legislation. The idea that restrictive laws push people towards the criminal justice system is plausible and consistent with the bed data, but it has not been tested directly.

The bed data are also not uniform. Mundt et al. (2015) found the Penrose pattern in South America, while Blüml et al. (2015) found no general pattern in Europe and a wide spread between countries. A reasonable reading is that cutting hospital beds is not harmful in itself and becomes harmful when nothing replaces them. South American countries that reduced beds after 1990 may not have built the community services that were meant to take their place, whereas some European systems may have. The reviewed studies cannot settle that, but it helps explain why the same policy produces different results, and it shifts the useful question from how many beds a country has to what happens to someone turned away from one. The US figures in Torrey et al. (2014) fit this reading, though for the reasons given earlier, they describe the problem rather than test it.

4.2. WHY CARE AFTER RELEASE SEEMS TO MATTER MORE THAN CARE INSIDE

The most consistent thread across the studies is timing. The programs with the weakest results in Beaudry et al. (2021) were delivered entirely inside prison, and the two therapeutic communities that did better linked participants to services after release. FACT, mental health courts and mandated treatment on probation are all community-based. The estimates are not directly comparable, since a judge-assignment study in one US state and a meta-analysis of prison trials measure different things in different populations, but the contrast is informative.

Several explanations are possible, and the studies do not allow us to separate them. The first is continuity. A prison program ends at the gate at the moment risk is highest, and suicide risk is raised in the weeks after release (Bukten & Stavseth, 2021, as cited in Cunha et al., 2023). The second is content. Beaudry et al. suggest that therapies designed for mental disorders do not address the housing, employment and money problems that follow release and contribute to reoffending. The third is study design. Prison trials suffer from attrition because people are transferred or released unexpectedly (Beaudry et al., 2021), while judge-assignment designs estimate the effect only for people whose treatment depends on which judge they happen to draw. The fourth is selection: people who complete a court program, as in Kubiak et al. (2015), may differ from those who drop out in ways that also predict lower costs.

Two further points temper the enthusiasm. The change in Nesbit's (2022) headline estimate between versions, from 17% to 36%, shows how sensitive quasi-experimental results can be to specification, so neither figure should be treated as settled. The finding that benefits were greatest for financially better-off probationers also raises an equity problem. If people must pay for court-ordered treatment themselves, those with the fewest resources, who are likely to have the greatest need, may benefit least.

4.3. READING THE COST EVIDENCE WITH CARE

Using the figures Kubiak et al. (2015) report, completing the mental health court was associated with 12-month costs about 57% lower than the comparison group ($16,964 against $39,870; author's calculation). Non-completers, however, cost only about 19% less than the comparison group ($32,258 against $39,870). Most of the saving therefore sits with completers, who are unlikely to be a random subset of participants. The 57% figure is better read as an upper bound on what a well-run court might save than as an expected saving for everyone referred.

The international figures give a sense of scale. At €49 a day, a year in custody in Portugal costs about €17,900 per prisoner before any mental health care (49 × 365 = €17,885), and roughly double that if the international estimate cited by Cunha et al. (2023) holds. In the United Kingdom, a secure mental health bed at £739 a day costs about 8.6 times the average prison day of £86 (Rowlandson et al., 2024; author's calculation). These figures come from different countries and years and should not be compared with each other or with the US court figures. What they share is the message that untreated mental illness is expensive wherever the bill lands.

The case for savings from treatment is therefore plausible and partly supported, but not proven. The 5:1 ratio in Nesbit (2022) counts avoided crime, and Cusack et al. (2010) found offsetting only in part. Against that, Rowlandson et al. (2024) could locate just one full economic evaluation of an in-prison mental health intervention. A policy maker relying on current evidence would be right to expect savings from community-linked treatment but wrong to budget for a specific amount.

4.4. BENEFITS AND LIMITS OF ALTERNATIVE APPROACHES

Community-based and diversion approaches are usually credited with four gains: fewer people in custody, lower reoffending, lower costs and better lives for those affected. The evidence reviewed supports the first three in part. Cusack et al. (2010) found fewer jail bookings, Lowder et al. (2018) and Nesbit (2022) found lower recidivism, and Kubiak et al. (2015) and Cusack et al. (2010) found lower costs in some categories. However, each study measures outcomes for participants, not for prison populations as a whole, so a fall in system-wide incarceration is assumed but not shown. Improved quality of life is also assumed. None of the studies reviewed measured wellbeing as a main outcome, and Rowlandson et al. (2024) note that quality-adjusted life years, the standard measure for comparing health interventions, are rarely collected in this field. No study showed all four gains at once, and their size varies from small (Lowder et al., 2018) to large (Nesbit, 2022).

Two cautions apply across the evidence base. Even among randomized trials of prison programs, only two of 29 were at low risk of bias, and all were run in high-income countries (Beaudry et al., 2021). Conclusions about what works therefore rest on limited, geographically narrow evidence and should be applied in other health and legal systems only with local testing.

5. CONCLUSION

This paper set out to examine how mental health law and services relate to incarceration, what works to reduce reoffending among people with mental illness, and what the current approach costs. Four findings stand out. First, mental disorder is far more common in prisons than outside them, and low rates of identification and treatment are widely reported (Baranyi et al., 2019; Fazel et al., 2016). Second, the link between fewer psychiatric beds and more imprisonment holds in some regions and not others, and no study reviewed tests a change in the law itself (Blüml et al., 2015; Mundt et al., 2015). Third, psychological programs delivered only inside prison have modest effects on reoffending, while models that connect treatment to the community and the courts show more promising, though uneven, results (Beaudry et al., 2021; Cusack et al., 2010; Lowder et al., 2018; Nesbit, 2022). Fourth, the economic case for treatment is consistent in direction but thinly evidenced (Knapp & Wong, 2023; Rowlandson et al., 2024).

The practical significance is mainly for how services are joined up. Treatment that begins in custody needs a planned handover to community services at release, with appointments and support arranged in advance. Diversion at the court and probation stages deserves funding alongside, and not instead of, community capacity. Policy makers who reduce hospital beds or change commitment rules should track incarceration and community service use at the same time so they notice harm early. Moreover, any new program should build economic evaluation into its design from the start, so that cost evidence is not collected after the fact.

Future research could usefully do six things. It could exploit natural experiments, such as before-and-after studies of changes to mental health legislation, to test the legal claim directly. It could run randomized trials in low- and middle-income countries, where the burden is heavy, and the trial evidence is almost absent. It could compare the same treatment delivered in prison and in the community, as Beaudry et al. (2021) suggest, to separate the treatment effect from the setting effect. It could collect quality-adjusted life years and other wellbeing outcomes alongside reoffending. It could examine who benefits when treatment is court-ordered and paid for by the individual. It could also follow people longer, since most of the studies reviewed here report results at one to three years.

CONFLICTS OF INTEREST

The author declares that there is no conflict of interest concerning the publishing of this paper. However, one of the fifteen sources reviewed, Torrey et al. (2014), was produced jointly by the Treatment Advocacy Center and the National Sheriffs' Association, organizations with a stated policy interest in expanding involuntary and assisted outpatient treatment. This source is treated throughout the review as a description of the scale of the problem rather than as independent evidence of cause.

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