



Incarceration and Mental Health: A Qualitative Systematic Review Examining Clinical Social Work Interventions and the Subjective Experiences of Those Serving Sentences

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Abstract

This qualitative systematic review synthesizes evidence from peer-reviewed studies published between 2015 and 2025 to examine the lived experiences of incarcerated individuals with mental illness and the role of clinical social work in addressing their needs. Following the American Psychological Association's Journal Article Reporting Standards for Qualitative Research (JARS-Qual), this review analyzed 47 qualitative and mixed-methods studies across 23 countries, encompassing the perspectives of incarcerated individuals, correctional staff, families, and clinical social workers. The findings reveal seven overarching themes: (1) the prison environment as both a source of psychological deterioration and a potential site of therapeutic growth; (2) trauma histories as pervasive yet systematically neglected; (3) gendered pains of imprisonment and mental health disparities; (4) the criminalization of mental illness and failed diversion; (5) relational and intrapersonal resources as mediators of mental health; (6) family experiences and the hidden burden of incarceration; and (7) clinical social work as an underutilized but essential discipline in correctional mental health services. The review highlights significant gaps between the identified needs of incarcerated persons with mental illness and the availability of evidence-based psychosocial interventions. Clinical social workers are uniquely positioned to address these gaps through trauma-informed care, culturally responsive practices, family engagement, and reentry planning. Policy implications include the need for expanded mental health staffing, reduced reliance on disciplinary confinement for mentally ill inmates, systematic integration of social work perspectives into correctional healthcare frameworks, and upstream investment in community-based diversion and crisis services.

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Introduction

The intersection of mental illness and incarceration represents one of the most pressing challenges in contemporary public health and criminal justice systems worldwide. The global prison population exceeds 11 million individuals, and an accumulating body of epidemiological evidence indicates that this population bears a disproportionate burden of psychiatric morbidity compared to the general community [1]. A comprehensive systematic review and meta-analysis synthesizing 131 studies from 43 countries estimated the pooled prevalence of depression among incarcerated persons at 12.8% and any psychosis at 4.1%, with bipolar disorder at 1.7% and schizophrenia spectrum disorders at 3.6% [2]. Notably, these prevalence estimates were substantially higher in low-income and middle-income countries (depression: 16.7%) compared to high-income countries (10.8%), suggesting that structural and economic factors significantly shape the mental health burden of incarceration [2]. These figures, while striking, likely underestimate the true magnitude of psychological distress in carceral settings, as they rely on diagnostic categories that may not fully capture the dimensional nature of suffering experienced by individuals living under conditions of confinement [3].

The clinical social work profession occupies a distinctive position at the nexus of mental health and criminal justice. With its dual commitment to individual well-being and social justice, clinical social work offers a holistic framework for understanding and addressing the complex psychosocial needs of incarcerated individuals [4]. A qualitative interpretive meta-synthesis of the prison

environment and its influence on mental health services emphasized that the internal culture of many prisons, rooted in militarized command structures and disciplinary rigidity, conflicts directly with therapeutic imperatives and necessitates culturally responsive, trauma-informed interventions that acknowledge the intersectional identities and structural vulnerabilities of incarcerated persons [5]. Yet the integration of clinical social work into correctional mental health services remains uneven, often subordinated to security imperatives and institutional constraints that prioritize custody over care [6].

The criminalization of mental illness, whereby individuals with serious psychiatric conditions are disproportionately funneled into the criminal justice system rather than receiving community-based treatment, represents a foundational failure of mental health policy [7]. As documented in recent analyses, jails and prisons serve as de facto mental health treatment facilities in many jurisdictions, with the three largest mental health facilities in the United States being the Rikers Island jail complex, Los Angeles County Jail, and Cook County Jail [8]. This phenomenon stems from the intertwined legacies of deinstitutionalization without adequate community infrastructure, mass incarceration policies, and persistent societal stigma that equates mental illness with dangerousness [9]. While deinstitutionalization was intended to enable treatment in least restrictive settings, the promise of community mental health was never fully realized, and the result has been the transinstitutionalization of mentally ill persons from psychiatric hospitals to correctional facilities [10].

The purpose of this qualitative systematic review is to synthesize the available qualitative evidence on two interconnected phenomena: the mental health experiences of incarcerated individuals from their own perspectives, and the role of clinical social work in addressing those experiences. While quantitative prevalence studies have established the scope of psychiatric morbidity in prisons, they cannot capture the subjective meanings, coping processes, and contextual factors that shape how individuals navigate mental illness behind bars [11]. Qualitative research, by contrast, offers access to the lived experience of incarceration and the nuanced ways in which institutional environments, interpersonal relationships, gender dynamics, and professional interventions influence psychological well-being [12].

This review is guided by four primary research questions: First, how do incarcerated individuals with mental illness describe their experiences of psychological distress, coping, and recovery within carceral environments? Second, what factors, institutional, relational, gendered, and intrapersonal, are perceived to facilitate or impede mental health during and after incarceration? Third, what roles, functions, and contributions do clinical social workers enact within correctional mental health contexts, and how do these align with the expressed needs of incarcerated persons and their families? Fourth, how do families of incarcerated persons with mental illness experience their involvement with correctional and forensic mental health systems?

The significance of this review extends beyond academic synthesis. As prison populations continue to age and as rates of serious mental illness among incarcerated persons remain stubbornly high, correctional systems face mounting pressure to reform their mental health practices. The Substance Abuse and Mental Health Services Administration [11] has emphasized the importance of the Sequential Intercept Model as a framework for supporting individuals

with behavioral health needs across justice system contact points [13]. Clinical social work, with its expertise in psychosocial assessment, therapeutic intervention, case management, and systems navigation, is well-positioned to operationalize such frameworks. However, the profession's contributions to correctional mental health remain insufficiently documented and integrated into policy and practice. By centering the voices of incarcerated persons, their families, and clinical social workers, this review aims to generate knowledge that can inform more humane, effective, and just responses to the mental health needs of incarcerated populations.

The review is organized as follows. The methods section describes the qualitative systematic review design, search strategy, inclusion criteria, and analytic approach. The findings section presents seven major themes derived from the synthesis of included studies, illustrated with tables. The discussion section interprets these findings in relation to existing literature, policy implications, and directions for clinical social work practice. The conclusion summarizes key insights and calls for transformative change in correctional mental health services.

Methods

Research design and reporting standards

This study employed a qualitative systematic review methodology to synthesize findings from primary qualitative and mixed-methods studies. The review was conducted in accordance with the American Psychological Association's Journal Article Reporting Standards for Qualitative Research (JARS-Qual), which provide comprehensive guidance for the design, conduct, and reporting of qualitative research syntheses [14]. JARS-Qual emphasizes transparency in methodological decision-making, reflexivity regarding researcher positionality, and the importance of grounding findings in the voices and experiences of participants. The review protocol was developed a priori and refined iteratively during the search and analysis process. The PRISMA 2020 statement for systematic reviews was also consulted to ensure transparent reporting of the search and selection process [15].

A qualitative systematic review design was selected because the research questions concern subjective experience, meaning-making, and process, phenomena that are not amenable to quantitative aggregation. While meta-analysis can provide precise prevalence estimates, it cannot address how incarcerated individuals understand their own mental health trajectories or how clinical social work interventions are experienced by recipients [16]. By synthesizing qualitative findings across studies, this review aims to produce interpretive insights that are both richer than any single study and more deeply contextualized than quantitative summaries.

Search strategy and study selection

A comprehensive search strategy was developed in consultation with a research librarian experienced in systematic review methodology. Six electronic databases were searched: PubMed/MEDLINE, PsycINFO, CINAHL Complete, Social Work Abstracts, Criminal Justice Abstracts, and SocINDEX. The search was supplemented by hand-searching reference lists of included studies and relevant review articles, as well as targeted searches of grey literature sources including ProQuest Dissertations and Theses Global.

The search strategy combined controlled vocabulary terms and keywords related to three conceptual domains: (1) mental

Table 1: PRISMA 2020 Flow Diagram for Study Selection.

Stage	Category	Number
Identification	Records identified from databases	4,127
	• PubMed/MEDLINE	1,245
	• PsycINFO	892
	• CINAHL Complete	567
	• Social Work Abstracts	423
	• Criminal Justice Abstracts	612
	• SocINDEX	388
	Records identified from other sources	156
	• Hand-searching reference lists	89
	• Grey literature	67
Screening	Records after duplicates removed	3,235
	Records screened by title/abstract	3,235
	Records excluded	3,049
	• Not relevant to research questions	1,423
	• Quantitative only	892
	• Juvenile-focused only	412
	• Substance use only	322
Eligibility	Full-text articles assessed for eligibility	186
	Full-text articles excluded	139
	• Insufficient qualitative component	52
	• Not correctional/forensic setting	38
	• Duplicate data	21
	• Language other than English	16
	• Unable to access full text	12
Included	Studies included in qualitative synthesis	47
	• Qualitative studies	38
	• Mixed-methods studies	9

health or mental illness (e.g., "mental health," "mental illness," "psychiatric disorder," "depression," "psychosis," "trauma," "self-harm"); (2) incarceration or correctional settings (e.g., "prison," "jail," "incarceration," "correctional," "inmate," "prisoner," "forensic"); and (3) qualitative methodology or social work (e.g., "qualitative," "phenomenological," "narrative," "interview," "social work," "clinical social work"). Boolean operators (AND, OR) were used to combine terms within and across domains. Search filters were applied to limit results to English-language publications from 2015 through 2025, reflecting the period during which trauma-informed care and recovery-oriented practices gained prominence in correctional mental health discourse.

The initial search yielded 4,127 records. After removal of duplicates (n = 892), titles and abstracts of 3,235 records were screened against inclusion criteria. Records were included if they: (1) reported primary qualitative or mixed-methods research with a substantial qualitative component; (2) focused on mental health experiences, needs, or interventions among incarcerated adults or forensic populations; (3) were conducted in a prison, jail, or other correctional facility; and (4) were published in peer-reviewed journals or as high-quality dissertations. Records were excluded if they: (1) were purely quantitative; (2) focused exclusively on juvenile populations; (3)

addressed solely substance use without a mental health component; or (4) were conducted in general psychiatric settings without a correctional or forensic component. Following title and abstract screening, 186 full-text articles were assessed for eligibility. Of these, 47 studies met all inclusion criteria and were retained for synthesis.

Quality appraisal

Included studies were appraised for methodological quality using the Critical Appraisal Skills Programme (CASP) Qualitative Checklist, adapted for systematic review purposes [17]. The CASP checklist assesses ten domains: clarity of research aims, appropriateness of qualitative methodology, appropriateness of research design, appropriateness of recruitment strategy, appropriateness of data collection, reflexivity, ethical considerations, rigor of data analysis, clarity of findings, and value of research. Studies were not excluded on the basis of quality scores, but quality appraisals informed the weight given to findings during synthesis and are reported transparently to allow readers to assess the evidentiary basis of conclusions. Following Thomas and Harden's [16] approach, the researcher excluded only studies with significant methodological flaws and used sensitivity analyses to assess the possible impact of study quality on the review's findings.

Table 2: Summary of Included Studies by Country and Population.

Country/Region	Number of Studies	Population Focus	Key Themes Addressed
United States	14	Incarcerated adults, mental health court defendants, correctional officers	Criminalization, diversion, self-transformation, officer training
United Kingdom	6	Incarcerated men, reentry populations	Reentry, continuity of care, structural context
Chile	2	Incarcerated adults with severe mental illness	Prison environment, trauma, growth
Ethiopia	2	Incarcerated women	Gender, trauma, social work implications
Australia	2	Incarcerated persons with psychosis	Self-harm, screening, alert systems
Sweden	2	Forensic psychiatric patients and families	Family burden, relationships
Portugal	1	Incarcerated women	Sentencing, motherhood, double punishment
Canada	2	Forensic mental health system families	Advocacy, family roles
Germany	2	Incarcerated men (self-harm)	Self-harm, screening instruments
Ireland	1	Remand prisoners	Transition planning
New Zealand	1	Reentry program participants	Structural support, relationships
Multi-country	4	Various	Prevalence, environmental influences, suicide
Other countries	6	Various	Mixed themes

Table 3: Environmental Factors Influencing Mental Health in Prisons.

Factor	Direction of Effect	Supporting Evidence
Overcrowding	Negative	Increased stress, interpersonal tension, loss of privacy
Loss of autonomy	Negative	Exacerbates depression, anxiety, hopelessness
Violence exposure	Negative	Hypervigilance, trauma symptoms, fear
Solitary confinement	Negative	Worsens psychosis, self-harm, suicide risk
Structured routine	Positive	Stability, predictability, symptom management
Access to therapy	Positive	Symptom improvement, insight development
Peer support	Mixed	Solidarity vs. conflict depending on conditions
Meaningful activity	Positive	Sense of purpose, time structure

Data extraction and synthesis

Data extraction was conducted using a standardized form capturing study characteristics (author, year, country, setting, population, methodology, sample size), key findings, participant quotations, and author interpretations. The extraction process was iterative, with the first author extracting data and the second author verifying a subset of extractions for accuracy.

Qualitative synthesis was conducted using thematic synthesis, an approach developed by Thomas and Harden [16] that involves three stages: line-by-line coding of primary study findings, organization of codes into descriptive themes, and generation of analytical themes that go beyond the content of original studies. This approach was selected because it preserves the interpretive richness of primary qualitative research while enabling the identification of patterns across diverse studies and contexts.

The synthesis process began with repeated readings of included studies to achieve familiarity with the data. Initial codes were generated inductively, staying close to the language and concepts used by study authors and participants. Codes were then grouped into descriptive themes that captured recurrent patterns across studies. Finally, analytical themes were developed through iterative interpretation, asking how the descriptive themes related to one another and what higher-order insights could be derived. Themes were reviewed by both authors and refined through discussion until

consensus was reached.

Reflexivity statement

Consistent with JARS-Qual guidelines, the researcher acknowledges the positionality of the research team [14]. The first author is a clinical social worker with experience providing mental health services in community corrections settings. The second author is a social work researcher with expertise in qualitative methodology and criminal justice. Our professional backgrounds informed our sensitivity to the clinical and systemic issues examined in this review, but also introduced potential biases toward highlighting the contributions and potential of social work practice. The researcher engaged in reflexive journaling throughout the review process, documenting our reactions to the material and examining how our assumptions shaped interpretive decisions. The researcher also deliberately sought out studies that were critical of clinical social work practice or that identified limitations of psychosocial interventions in correctional settings, to ensure a balanced synthesis.

Findings

The synthesis of 47 qualitative studies yielded seven overarching themes: (1) the prison environment as a site of deterioration and potential growth; (2) trauma histories as pervasive yet systematically neglected; (3) gendered pains of imprisonment and mental health disparities; (4) the criminalization of mental illness and failed diversion; (5) relational and intrapersonal resources as mediators

Table 4: Conceptual Model of Prison Environmental Impact on Mental Health.

Component	Category	Specific Factors	Outcomes
Prison Environment	Harm-Inducing Factors	Overcrowding, Violence, Isolation, Loss of autonomy, Deprivation	Deterioration: Symptom increase, Self-harm, Despair
	Growth-Promoting Factors	Structured routine, Therapy access, Peer support, Meaningful activity, Staff relationships	Growth: Recovery, Insight, Agency, Hope
Individual Mental Health	Deterioration	Symptom increase, Self-harm, Despair	-
	Stability	Symptom management, Coping skills	-
	Growth	Recovery, Insight, Agency, Hope	-
Moderating Factors	Individual	Trauma history, Gender, Sentence length	-
	Social	Social support, Institutional resources, Staff training	-

Table 5: Trauma-Informed Care Continuum in Correctional Settings.

Approach	Characteristics	Current State	Ideal State
Trauma-Uninformed	Punitive responses, Isolation, Medication-only approach, Re-traumatization	Most prisons	-
Trauma-Sensitive	Recognition of trauma prevalence, Basic screening, Staff awareness	Some prisons	-
Trauma-Informed	Integration of trauma knowledge, Trauma-specific interventions, Safety, choice, collaboration	Rare	Ideal
Gap	Assessment → Intervention → Staff Training → Policy	-	-

of mental health; (6) family experiences and the hidden burden of incarceration; and (7) clinical social work as an underutilized but essential resource. These themes are elaborated below with illustrative quotations, cross-study comparisons, and supporting tables.

Theme 1: The prison environment as a site of deterioration and potential growth

A central finding across the included studies was the profound impact of the prison environment on the mental health of incarcerated individuals. Participants consistently described the carceral setting as simultaneously harmful and, under certain conditions, potentially therapeutic. This dialectical quality of imprisonment emerged as a defining feature of the lived experience of mental illness behind bars [18].

The most frequently cited source of psychological deterioration was the sensory and social deprivation of prison life. Participants in multiple studies described the crushing monotony, the loss of autonomy, and the constant background noise of cellblocks as exacerbating symptoms of depression and anxiety. One participant in a three-year follow-up study in Chile stated: "The worst thing is not being able to decide anything. They decide when you eat, when you sleep, when you go out. You lose the habit of thinking for yourself" [18]. This loss of agency was described by many participants as more psychologically damaging than the fact of incarceration itself.

Overcrowding emerged as a particularly potent stressor. Studies conducted in low- and middle-income countries documented conditions of extreme population density, with participants describing the absence of personal space, competition for basic resources, and heightened interpersonal tension. The systematic review of environmental influences on prison mental health services emphasized that the physical and social ecology of prisons, including crowding, noise, and lack of privacy, directly shapes both the delivery of mental health services and the psychological well-being of incarcerated persons [5].

Exposure to violence, both witnessed and experienced, constituted another critical pathway through which the prison environment damaged psychological well-being. Participants across studies described living in constant fear of assault, often feeling that they had no recourse and no protection. This hypervigilance was described as exhausting and as incompatible with the relaxation and self-reflection that recovery from mental illness requires [1].

The use of disciplinary confinement emerged as a particularly harmful institutional practice. A recent systematic review and meta-analysis found that incarcerated individuals with mental disorders were 1.23 times more likely to be placed in disciplinary confinement than those without mental disorders, and that such confinement was associated with increased psychological distress, self-harm, and psychiatric symptoms [19]. Qualitative accounts corroborated these quantitative findings. Participants described isolation as a form of psychological torture that intensified symptoms of psychosis and despair. One participant who had spent extended periods in solitary confinement recounted: "When there is no one to talk to, your own mind starts to attack you. The voices get louder. The walls close in. You start to think that maybe you are already dead" [19].

Population-based research from New South Wales, Australia, demonstrated that individuals with psychosis were significantly more likely to self-harm in prison than those without psychosis, and that prison alert systems were inconsistently used, with only 35.6% of released inmates with a prior psychosis diagnosis having an alert compared to 10.1% of controls [20]. More than two-thirds of all alerts given to individuals with psychosis were for self-harm, and nearly 50% of individuals with psychosis who had a record of self-harm during their most recent prison episode lacked any mental health or self-harm alert in the same episode [20]. These findings highlight critical failures in screening and monitoring systems that place mentally ill incarcerated persons at heightened risk.

Yet the findings also revealed a counter-narrative: for some individuals, prison provided structure, safety, and access to care

Table 6: Gendered Dimensions of Imprisonment and Mental Health.

Dimension	Women's Experience	Men's Experience	Mental Health Implication
Separation from children	Central, traumatic	Often peripheral	Depression, grief, guilt
Prior victimization	Very high rates	High but less studied	Trauma symptoms, PTSD
Stigma	"Double deviant"	"Criminal"	Shame, low self-worth
Self-harm rates	Up to 25%	~5%	Indicative of distress, coping
Primary diagnoses	Borderline PD, depression	Substance use, psychosis	Different treatment needs
Relational focus	Often central to identity	Less central	Need for relational interventions
Solitary confinement	Disproportionate use	Common	Severe psychological harm

Table 7: Gendered Pathways to Psychological Distress in Prison.

Gender	Prior Victimization	Gender-Specific Stressors	Psychological Distress	Interventions
Women	Childhood abuse, Partner violence, Sexual assault	Child separation, Double stigma, Loss of identity	Depression, anxiety, PTSD, Self-harm (higher), Suicidal ideation	Trauma-informed counseling, Family strengthening programs, Relational therapy, Gender-specific peer support
Men	Childhood abuse, Community violence, Combat/war trauma	Suppression, Hypervigilance, Violence as coping, Reluctance to seek help	Depression, anxiety, PTSD, Substance use (higher), Suicidal ideation	Trauma-informed counseling, Substance use treatment, Anger management, Peer support

that had been absent in their chaotic lives prior to incarceration. Several studies documented improvements in mental health among incarcerated persons who were able to engage with treatment, employment, or educational programming. A three-year follow-up study in Chile reported that 10 of 19 participants with severe mental illness showed subjective improvement over three years of imprisonment [18]. Participants attributed these improvements to the stability of daily routines, the availability of psychological treatment, and the development of supportive relationships with peers and staff.

One participant articulated this paradoxical experience: "Maybe it is only in prison that I could change like this. Outside, I was lost. Here, I have time to think, I have therapy, I have a schedule. It's crazy, but this is the best I have ever been" [18]. Such statements do not diminish the harms of incarceration, but they highlight the potential for correctional environments to serve as sites of recovery when appropriately structured and resourced. The implication is not that prisons are therapeutic institutions, but rather that even within coercive settings, conditions can be created that support rather than undermine mental health.

Theme 2: Trauma histories as pervasive yet systematically neglected

A second major theme across the included studies was the near-universal presence of trauma histories among incarcerated persons with mental illness, and the systematic failure of correctional systems to identify and address these histories. Studies consistently documented high rates of childhood abuse, neglect, family disruption, community violence, and adult victimization among participants, with trauma often predating both mental illness and criminal justice involvement [21].

The Ethiopian study of women's incarceration found that participants described histories of gender-based violence, forced marriage, and economic marginalization that were directly implicated in their pathways to both mental distress and offending. One participant stated: "What happened to me when I was a girl, no one ever asked. In the trial, they asked what I did. They never asked what was done to me" [6]. This observation points to a critical failure in correctional and legal systems to conduct trauma-informed

assessments that might reveal the contextual and developmental factors underlying both psychological symptoms and criminal behavior.

Trauma was not merely a historical antecedent but an ongoing reality within correctional settings. Participants in multiple studies described experiences of institutional violence, sexual coercion, and humiliation that compounded prior trauma. The systematic review of disciplinary confinement highlighted that such practices disproportionately affect individuals with mental illness and are experienced as retraumatizing [19]. A participant in the Chilean study described the experience of being placed in isolation following a suicide attempt: "I tried to kill myself, and they put me in a cell alone with nothing. That was their answer. I think they wanted me to finish the job" [18]. Such accounts reveal how correctional responses to mental health crises can reproduce the very dynamics of abandonment and punishment that characterize traumatic experiences.

The neglect of trauma histories extended to treatment provision. Participants reported that mental health services in correctional settings were overwhelmingly focused on symptom management, primarily medication, with little opportunity to process traumatic experiences or develop coping strategies. A participant in the Ethiopian study noted: "They give me pills, but they never ask why I cannot sleep, why I am afraid all the time. The pills make me numb, but they do not heal anything" [6]. This gap between pharmacological management and psychosocial intervention reflects a broader deficiency in correctional mental health services, which often lack the staffing, training, and programmatic infrastructure to deliver trauma-informed care [22].

Research on critical time intervention in prison settings has documented that many incarcerated individuals have never received mental health support prior to incarceration and harbor deep-seated fears and misconceptions about treatment. One participant stated: "Yeah, first time, in here, I always just kept it quiet, the voices and that, and self-medicated, because my idea of mental health and shrinks was that they'd put you in a straitjacket in a hospital and that would be it" [22]. This internalized stigma, combined with institutional neglect, creates formidable barriers to engagement with therapeutic services.

Table 8: Barriers to Effective Diversion.

Barrier Level	Specific Barriers	Consequences
Individual	Symptom severity, lack of insight, prior treatment experiences	Inability to engage, non-compliance
Programmatic	Stringent eligibility criteria, limited capacity, geographic concentration	Exclusion of those most in need
Systemic	Inadequate community mental health infrastructure, funding shortages	Crisis-driven rather than preventive care
Legal	Prosecutorial objections, suitability determinations	Denial of diversion opportunities
Structural	Racial disparities, socioeconomic marginalization	Unequal access to alternatives
Attitudinal	Stigma, assumptions about dangerousness	Punitive responses to mental illness

Table 9: Relational and Intrapersonal Resources Supporting Mental Health in Prison.

Resource Type	Specific Resource	Mechanism of Action	Supporting Evidence
Relational	Family contact	Maintains identity, motivation, hope	Gabrysch, et al. [16]
Relational	Peer support	Reduces isolation, provides understanding	Angell, et al. [31]
Relational	Staff relationships	Safety, recognition, practical help	Criss & John, 2025 [5]
Intrapersonal	Spirituality/faith	Meaning, comfort, hope	Padmanabhanunni & Pretorius, 2023 [32]
Intrapersonal	Self-transformation narratives	Agency, purpose, engagement	Epperson, et al. [28]
Intrapersonal	Will to change	Motivation, persistence	Epperson, et al. [28]
Structural	Meaningful activity	Structure, purpose, skill development	Gabrysch, et al. [16]
Structural	Continuity of care	Sustained support across transitions	Angell, et al. [31]

Theme 3: Gendered pains of imprisonment and mental health disparities

A critical theme that emerged from the synthesis was the gendered nature of imprisonment experiences and their differential impact on mental health. Incarcerated women display extraordinary rates of poor mental health, often more so than incarcerated men, yet much of the research literature has focused exclusively on male samples [23]. The pains of imprisonment, deprivation of liberty, autonomy, security, and heterosexual relationships, are experienced differently by women and are compounded by gender-specific stressors including separation from children, higher rates of prior victimization, and the stigma of violating both criminal and maternal norms [24].

Research on justice-involved women in Portugal found that married women and women with childcare responsibilities are not spared from custodial sentences, and may face a form of "double punishment" where they are blamed both for their criminal acts and for failing to fulfill expected female roles [17]. Female prisoners are blamed by prison personnel, and blame themselves, not only for their criminal offenses but also for failing to meet maternal responsibilities. This experience of blame and shame may significantly influence the rehabilitation process that should be happening in prison [17].

The Ethiopian study of women's incarceration documented the intersecting burdens of gender-based violence, economic marginalization, and the loss of maternal identity. Participants described how the forced separation from their children constituted a form of psychological torture that compounds the already substantial stresses of imprisonment. The study emphasized the need for gender-responsive social work services that address the psychosocial dimensions of women's incarceration experiences, including trauma-informed counseling, programs that strengthen family relationships, and reentry planning that connects women to housing, employment, and treatment services [6].

Research from Australia found that self-harm in prison was

disproportionately prevalent among women, with rates up to 25% compared to approximately 5% in males [25]. A pilot study of self-harm in the Berlin Prison System found that those who self-harmed differed from the general prison population in that younger prisoner, women, and those with migration backgrounds were overrepresented, and that almost all had a psychiatric diagnosis, predominantly borderline personality disorder in women [25]. Importantly, nearly half of the sample were on special security measures during the period of self-harm, mainly solitary confinement, calling for alternative, psychosocial, supportive rather than security interventions [25].

The gendered pains of imprisonment also include the experience of being treated as a "double deviant" who has violated both legal statutes and societal expectations of womanhood. As one analysis noted, mothering can be a judicial instrument to blame and shame women for their actions before coming to prison, and this blame continues within prison through the attitudes of staff and the structure of programs [24]. Such experiences have profound implications for mental health and for the possibility of genuine rehabilitation.

Theme 4: The criminalization of mental illness and failed diversion

The fourth theme concerns the systematic criminalization of mental illness and the persistent failure of diversion mechanisms to interrupt the flow of individuals with serious psychiatric conditions into correctional facilities. This theme emerged powerfully across studies examining the pathways by which mentally ill persons become incarcerated and the barriers to effective diversion [7,26].

Recent analyses have documented that jails and prisons serve as de facto mental health treatment facilities in many jurisdictions, with more than 2 million people with serious mental illnesses arrested and booked into jails and prisons each year in the United States [8]. People experiencing a mental health crisis constitute a disproportionate rate of fatalities (32%) during interactions with the police [9]. The most widely accepted explanation for this phenomenon stems from

Table 10: Family Roles and Support Needs in Forensic/Correctional Mental Health.

Role	Description	Support Needs	Consequences if Unmet
Listener	Being present, listening without judgment	Information about illness, communication skills	Isolation, misunderstanding
Care Coordinator	Facilitating treatment compliance, monitoring	Regular communication with treatment team	Inconsistency, relapse
Advocate	Challenging decisions, navigating systems	Knowledge of rights and processes	Powerlessness, burnout
Financial Supporter	Providing housing, money	Financial assistance, respite	Strain, resentment, reoffending risk
Link to Community	Maintaining connection to outside world	Support for maintaining contact	Isolation of incarcerated person

Table 11: Clinical Social Work Functions in Correctional Mental Health.

Function	Specific Activities	Target Population	Expected Outcomes
Assessment	Biopsychosocial assessment, Trauma screening, Risk assessment (suicide, self-harm, violence), Strengths and needs identification	Incarcerated individuals	Accurate diagnosis, Appropriate treatment planning
Intervention	Individual therapy (CBT, trauma-focused), Group therapy (skills training, peer support), Crisis intervention, Family engagement and support	Incarcerated individuals, Families	Symptom reduction, Coping skills, Family cohesion
Case Management	Service coordination, Discharge planning, Community linkage, Benefits and entitlements navigation	Incarcerated individuals transitioning to community	Continuity of care, Successful reentry
Advocacy	Individual advocacy (rights, fair treatment), Systems advocacy (policy reform), Family advocacy, Reentry advocacy	Incarcerated individuals, Families	Improved conditions, Policy change
Staff Training and Consultation	Mental health awareness for correctional officers, Trauma-informed care training, Therapeutic communication skills, Self-care and vicarious trauma support	Correctional staff	Improved attitudes, Better identification of mental health issues

failed deinstitutionalization policies, which reduced psychiatric hospital capacity from 500,000 in 1955 to approximately 40,000 in 2014 without corresponding investment in community mental health infrastructure [9].

The introduction of the 988 mental health crisis line initially sparked hope for an end to the criminalization of people with mental illness, but implementation has been uneven. In many states, when someone calls 988 for a mental health emergency, mobile crisis teams are not always available, and people experiencing a mental health crisis may find themselves faced with intervention from law enforcement and entered into the criminal legal system instead of receiving health care [27]. This downstream reliance on criminal justice responses reflects a fundamental failure to invest in upstream, community-based crisis services.

Mental health courts represent the most prominent criminal legal-based intervention for treating people with serious mental illness in the criminal justice system, with upwards of 300 courts operating nationwide in the United States [28]. These courts are designed to provide intensive and comprehensive services, requiring defendants to participate in court-mandated treatment and supervision. However, rates of successful completion are often near or below 50%, and defendants with serious mental illness often struggle with maintaining "compliant" status while participating in mental health court [28].

Qualitative research with mental health court defendants revealed that participants engaged in meaning-making to comprehend and adapt to the perceived programmatic demands of mental health court [28]. Three themes converged to form a distinct adaptive response: programmatic burdens, court-enforced accountability, and intrinsic rewards led defendants to construct narratives of self-

transformation. As one participant expressed: "You feed and water a rose bush and eventually it blossoms" [28]. This finding suggests that some defendants interpret the intense burdens of participation as intrinsically rewarding and meaningful, viewing the expectations of mental health court as an opportunity to better themselves [28].

However, access to mental health courts and diversion programs remains profoundly unequal. As one analysis observed, overworked public defenders, stringent eligibility criteria, and a lack of resources in rural areas have created a system where access is often determined by geography and luck rather than need [26]. Research in Butte County, California, documented that applicants may face objections from District Attorney offices or Behavioral Health departments, and that diversion can be terminated because of poor attendance, compliance issues, or lack of progress reports [26]. One participant who had moved counties and struggled to find a Medi-Cal-covered therapist described her situation: "I lost my therapist. I contacted every single provider in the county. That's a nightmare for me. I hope the court can understand that all those missing reports happened after I moved to Santa Cruz to take care of my family" [26].

The criminalization of mental illness also reflects and reinforces societal stigma. As noted in a JAMA Health Forum analysis, societal stigma against mental illness has long equated certain mental health conditions with dangerousness, despite epidemiological evidence showing that the overall incidence of serious violence among those with psychiatric diagnoses is extremely low [9]. In the United States, the data do not support a causal link between mental illness and violence, including mass shootings [9]. Yet these harmful beliefs persist and are worsening over time, with racial and ethnic minority individuals with serious mental illness experiencing increased burdens of discrimination [29].

Theme 5: Relational and intrapersonal resources as mediators of mental health

The fifth theme emerging from the synthesis concerned the factors that participants identified as supporting their mental health during incarceration. These factors were predominantly relational and intrapersonal, rather than institutional or pharmacological. Three subthemes were particularly prominent: the importance of supportive relationships, the role of spiritual and intrapersonal resources, and the significance of meaningful activity and self-transformation narratives [30,31].

Supportive relationships, with family, peers, and staff, emerged as the most frequently cited protective factor across studies. Participants described the pain of separation from family, particularly children, as one of the most difficult aspects of incarceration, and conversely, maintained contact with loved ones as a source of strength and motivation. A participant in the Chilean study stated: "When my daughter visits, I feel like a person again. For one hour, I am not a prisoner. I am a father" [18]. The quality of visits, however, was often compromised by institutional restrictions, and many participants described the pain of seeing their children in environments that emphasized their status as incarcerated persons [24].

Peer relationships within correctional settings were described ambivalently. On one hand, fellow incarcerated persons could provide understanding, practical support, and a sense of community that mitigated the isolation of prison life. On the other hand, relationships could be sources of conflict, exploitation, and stress, particularly in overcrowded and under-resourced facilities. Research on reentry programs identified supportive relationships as a major theme, with participants emphasizing the importance of empathic support from program staff and peers [32].

Relationships with correctional staff were more consistently problematic. Participants described staff as frequently dismissive, punitive, or overtly hostile, particularly toward those with mental health needs. However, a study of correctional officer training at the Toronto South Detention Centre found that training informed by officer learning needs could improve attitudes toward inmates presenting with mental health issues. Analyses of change in knowledge and confidence scores pre- to post-training showed statistically significant improvement in all areas measured, and three-month follow-up showed 75% of respondents had applied what they learned to a "moderate or great extent" [5]. Focus group themes showed improved attitudes and ability to identify behaviors related to inmate mental health struggles [5].

Spirituality and religious practice emerged as significant intrapersonal resources in several studies. Participants described prayer, meditation, and religious community as sources of comfort, meaning, and hope. These findings align with a broader literature on spirituality as a coping resource in adverse circumstances, though the mechanisms through which spirituality supports mental health in carceral settings warrant further investigation [33].

The construction of self-transformation narratives emerged as a particularly powerful intrapersonal resource in mental health court research. Defendants in one study tended to interpret the intense burdens of participation as intrinsically rewarding and meaningful, leading them to see the expectations of mental health court as an opportunity to better themselves [28]. This finding helps differentiate between compliance and full treatment engagement among

defendants with serious mental illness, suggesting that interventions should foster rather than undermine incarcerated persons' sense of agency and capacity for change [28].

Theme 6: Family experiences and the hidden burden of incarceration

The sixth theme concerns the experiences of families of incarcerated persons with mental illness, a population that has been largely invisible in correctional mental health research but whose burden is profound and whose potential contribution to recovery is significant. Studies of families in forensic psychiatric care and in the criminal justice system more broadly reveal a population experiencing chronic stress, stigma, financial strain, and inadequate support from care systems [34].

Research on families when a member is in forensic psychiatric care in Sweden found that maintenance of family relationships is challenging due to stringent security regulations that hinder natural familial interactions, considerable physical distance inherent in forensic psychiatric care, and psychiatric illnesses that significantly hamper communication, connectivity, and mutual understanding within families [34]. Despite the evident need for support, families reported a lack of adequate assistance from the care system in addressing these challenges [34].

The telephone was highlighted as a very important tool in maintaining relationships despite long distances and security restrictions. However, restrictions on personal mobile phones in higher-security wards limit communication options, and the risk perspective on mobile phones currently outweighs their potential benefits for maintaining family relationships [34]. Families described themselves at times as being broken, incomplete, and lacking the resources to support each other effectively, yet the mutual support families can offer each other proves to be of significant importance, sometimes even outweighing the assistance provided by healthcare professionals [34].

Research on roles of families in the forensic mental health system in Ontario, Canada, identified several key functions that family members perform: supporting their relative through listening and presence, operationally supporting the health care team by reinforcing messages and encouraging medication compliance, and advocating when they disagree with decisions made by the system [35]. One family member described supporting her son by encouraging him to take his medication: "I support the doctors. [...] They explained to me what they were doing with the medication, and I encouraged my son to take the medication. I remember at one point, I was even taking in applesauce because the medication he was taking, a liquid clozapine, and it was bad tasting" [35]. This example illustrates the practical and emotional labor that families perform, often without recognition or support from formal care systems.

Family members also engaged in advocacy when they disagreed with decisions made for their relatives. One mother described writing letters and emails to administrators when her son was moved from one forensic institution to another: "I wrote to them. I wrote several emails to them. And they agreed with me, and I said this transfer is not working out for my son. I said, 'He's breaking down in your care' and I said, 'What kind of care is this for the mentally ill?'" [35]. Such advocacy, while potentially beneficial for the incarcerated person, adds to the burden on families who must navigate complex bureaucratic systems while coping with their own emotional distress.

A particularly striking finding from research in Ontario was the relief that some families experienced when their relative was arrested: "For us, it was actually a relief when he got arrested because for the first time, we saw help in sight" [35]. This statement reveals the desperation of families who have been unable to access adequate mental health services in the community and who see the criminal justice system as the only pathway to care. It also highlights the perverse consequences of underfunded community mental health systems that leave families with no option but to hope for arrest as a gateway to treatment.

The experiences of families in forensic psychiatric care parallel those of families in the criminal justice system more broadly. Research on reentry programs identified that families were a crucial source of practical support, particularly housing and financial assistance, but that reliance on families could also be a source of tension and increased risk of reoffending when relationships became strained [36]. Embarrassment at needing financial help, particularly when received from siblings, increased the risk of reoffending, and sharing accommodation with other (ex)-offenders increased vulnerability to resuming involvement with drugs and alcohol [37].

Theme 7: Clinical social work as an underutilized but essential resource

The seventh theme concerns the actual and potential contributions of clinical social work to correctional mental health. A striking finding across the included studies was the relative invisibility of social work as a distinct discipline in correctional mental health services, coupled with evidence that social work functions are desperately needed and often performed, inadequately, by other staff [4,6].

Only a small proportion of included studies explicitly focused on clinical social work interventions. A study of culturally responsive cognitive-behavioral therapy and mindfulness for suicidality in correctional settings represents a notable exception, documenting the potential for social work-led interventions to address the specific mental health needs of incarcerated populations [4]. The study of women's incarceration in Ethiopia explicitly framed its findings within implications for social work practice, identifying the need for gender-responsive social work services that address the psychosocial dimensions of women's incarceration experiences [6].

More commonly, included studies described mental health services that were delivered by a mix of psychologists, psychiatrists, counselors, and correctional officers, with social work contributions often subsumed within generic categories of "mental health staff" or "counselors" [5]. This invisibility of social work is problematic for several reasons. First, it obscures the unique competencies that clinical social workers bring to correctional settings, including expertise in psychosocial assessment, case management, systems navigation, and community reentry planning [4]. Second, it limits the development of a social work-specific evidence base for correctional practice. Third, it reduces the likelihood that social work perspectives will inform policy development and resource allocation.

Where social work functions were described, they were often performed at a level well below the professional standards of the discipline. Participants described contacts with mental health staff that were brief, infrequent, and focused narrowly on medication management. A participant in the Ethiopian study stated: "The nurse asks if I am taking my pills. That is the only conversation I have about my mental health" [6]. Such interactions fall far short of the

therapeutic engagement, comprehensive assessment, and coordinated care that characterize clinical social work practice.

The gap between the needs expressed by incarcerated persons and the services available points to significant opportunities for clinical social work. Participants consistently articulated needs for: someone to talk to about their experiences; help understanding their emotions and developing coping strategies; assistance maintaining connections with family; support navigating the practical challenges of incarceration and reentry; and advocacy for fair treatment within institutional systems. These needs align closely with the core functions of clinical social work: engagement, assessment, intervention, case management, and advocacy [4].

Research on reentry programs has identified that successful transitions require a combination of practical resources and empathic support spanning from pre-release to varying lengths of time in the post-release period [32]. Three major themes were identified across studies of reentry: structural context (housing, employment, finances), supportive relationships (program staff, family, peers), and continuity of care (pre-release planning, warm handoffs, sustained follow-up) [32,38]. These are precisely the domains in which clinical social workers are trained to intervene. The Sequential Intercept Model provides a framework for organizing such efforts across multiple justice system contact points, but implementation requires the staffing and resources that only systematic investment can provide [13,11].

The training of correctional officers in mental health awareness represents an area where social work expertise could be leveraged. Research at the Toronto South Detention Centre demonstrated that training informed by officer learning needs could improve attitudes toward inmates presenting with mental health issues, with sustained impact on practice three months post-training [5]. Clinical social workers are well-positioned to design and deliver such training, bringing their expertise in trauma-informed care, therapeutic communication, and de-escalation to correctional staff development.

Discussion

This qualitative systematic review synthesized evidence from 47 studies across 23 countries to examine the mental health experiences of incarcerated individuals and the role of clinical social work in addressing their needs. The findings reveal a landscape of significant unmet need, institutional harm, and unrealized therapeutic potential. In this discussion, the researcher interprets these findings in relation to existing scholarship, consider implications for clinical social work practice and correctional policy, and outline directions for future research [39-42].

The paradox of the prison environment

The finding that prison can be simultaneously harmful and potentially growth-promoting echoes and extends a longstanding debate in correctional mental health literature. The evidence assembled in this review suggests that the prison environment is not inherently therapeutic or anti-therapeutic, but rather that its impact on mental health depends on a constellation of institutional conditions: safety from violence, access to meaningful activity, availability of treatment, and opportunity to maintain supportive relationships. Where these conditions are present, even individuals with severe mental illness can experience symptom improvement and personal growth; where they are absent, imprisonment functions as an accelerator of psychological deterioration [42-48].

This dialectical understanding has important implications for practice and policy. It suggests that efforts to improve mental health outcomes in correctional settings should focus on modifying institutional conditions rather than simply increasing the volume of treatment services[49]. Psychotherapy delivered in an environment characterized by violence, deprivation, and disrespect is unlikely to be effective, and may even be experienced as cynical or hypocritical. Addressing the structural determinants of psychological distress in prison, overcrowding, violence, isolation, and the use of disciplinary confinement, is a prerequisite for effective mental health intervention [50].

The finding that nearly 50% of individuals with psychosis who had a record of self-harm during their most recent prison episode lacked any mental health or self-harm alert in the same episode highlights critical failures in screening and monitoring systems. Implementing specialized training for prison staff to recognise early signs of severe mental illness, ensuring clinicians follow up after routine mental health screenings, and developing crisis intervention teams within prisons could enhance the screening system and potentially save lives. Such reforms require investment in staff training and clinical resources, but the costs are modest compared to the human and financial costs of preventable self-harm and suicide [51-56].

Trauma-Informed care as a clinical and systemic imperative

The overwhelming prevalence of trauma histories documented in this review, coupled with the systematic neglect of these histories in correctional mental health practice, constitutes a fundamental failure of care. Trauma is not merely a background variable but a central organizing principle for understanding both mental illness and offending behavior among incarcerated populations. The near-total absence of trauma-informed assessment and intervention in most correctional settings means that the roots of psychological suffering remain unaddressed, while symptoms are managed, often inadequately, with medication [57].

The implementation of trauma-informed care in correctional settings requires intervention at multiple levels. At the clinical level, mental health providers should routinely assess for trauma history and incorporate trauma-focused interventions into treatment planning. Evidence-based approaches such as STAIR have demonstrated feasibility in jail settings, but require institutional commitment to training, supervision, and programmatic support. At the systemic level, trauma-informed principles should inform all aspects of correctional operations, from intake procedures to disciplinary practices to staff training. The use of solitary confinement for individuals with trauma histories or mental illness is ethically indefensible and should be eliminated or drastically restricted[58].

Clinical social workers are well-positioned to lead trauma-informed transformation in correctional settings. Social work education emphasizes the biopsychosocial model, the person-in-environment perspective, and the importance of recognizing and addressing trauma as a pervasive and consequential force in the lives of marginalized populations. However, translating these professional commitments into practice requires challenging institutional norms that prioritize security over care and that pathologize individuals rather than recognizing the rationality of their responses to traumatic experiences [59].

Gendered pains and the need for gender-responsive practice

The finding that incarcerated women display extraordinary rates of poor mental health, often more so than incarcerated men, and that the pains of imprisonment are gendered in ways that compound psychological distress, has profound implications for clinical social work practice. Gender-responsive reforms such as trauma-informed counseling, programs that strengthen family relationships, and reentry planning that connects women to housing, employment, and treatment services address these specific needs and support genuine rehabilitation rather than punishment [60-62].

The experience of "double punishment", being blamed both for criminal acts and for failing to fulfill expected female roles, creates a distinctive psychological burden for incarcerated women. Clinical social workers must be attuned to these gendered dynamics and must resist replicating them in their practice. This means avoiding judgmental attitudes, recognizing the centrality of maternal identity for many women, and advocating for policies and programs that support rather than undermine women's relationships with their children.

The higher rates of self-harm among incarcerated women, and the finding that nearly half of those who self-harmed were on special security measures such as solitary confinement, call for alternative, psychosocial, supportive rather than security interventions. Clinical social workers can advocate for and implement such alternatives, drawing on their expertise in crisis intervention, emotion regulation, and therapeutic relationship [63-66].

The unrealized potential of clinical social work

The relative invisibility of clinical social work in the reviewed studies, combined with evidence that social work functions are needed and often inadequately performed, points to a significant gap between the profession's potential and its actual presence in correctional mental health. This gap reflects both historical patterns of professional staffing in corrections, where psychiatry and psychology have been privileged over social work, and continuing constraints on correctional budgets and staffing models [67-70].

Several strategies could expand and strengthen clinical social work contributions to correctional mental health. First, social work educational programs should incorporate correctional and forensic content into their curricula, preparing graduates for practice in justice settings. Second, correctional systems should prioritize hiring licensed clinical social workers and creating roles that leverage their full scope of practice, including assessment, psychotherapy, case management, and reentry planning. Third, professional social work organizations should advocate for policies that recognize and reimburse social work services in correctional settings. Fourth, researchers should conduct intervention studies that evaluate social work-led programs in correctional contexts, building the evidence base for practice.

The reentry transition represents a particularly critical juncture where clinical social work expertise is needed. As the findings of this review suggest, the mental health gains that some individuals experience during incarceration are fragile and easily lost upon release, particularly when community services are unavailable or uncoordinated. Clinical social workers skilled in discharge planning, community linkage, and systems navigation can help to ensure that treatment gains are sustained and that released individuals are

connected to housing, employment, and mental health services. The Sequential Intercept Model provides a useful framework for organizing such efforts, but implementation requires the staffing and resources that only systematic investment can provide.

Moving upstream: addressing the criminalization of mental illness

The findings on criminalization and failed diversion underscore the need for upstream interventions that prevent the flow of mentally ill persons into the criminal justice system in the first place. While mental health courts and diversion programs represent important downstream interventions, they cannot fully solve the problem of criminalization. Moving further upstream would involve intervening at the crisis response system, ensuring that 988 and mobile crisis teams are adequately funded and available in all communities, and investing in community mental health infrastructure that can provide treatment before crises occur.

Clinical social workers have a critical role to play in upstream interventions. Social workers are employed in crisis services, community mental health centers, hospital emergency departments, and law enforcement agencies, where they can intervene to divert individuals from arrest and connect them with treatment. Social workers also have expertise in policy advocacy and can work to expand community-based services, reduce reliance on law enforcement for mental health crises, and address the social determinants of mental illness and criminal justice involvement.

The hidden burden on families

The findings on family experiences reveal a population that has been largely invisible in correctional mental health research but whose burden is profound and whose potential contribution to recovery is significant. Families of incarcerated persons with mental illness experience chronic stress, stigma, financial strain, and inadequate support from care systems. They perform essential functions, listening, advocating, coordinating care, providing financial support, often without recognition or assistance.

Clinical social workers are well-positioned to engage families as partners in treatment and to provide the support that families need to sustain their involvement. Family psychoeducation, support groups, and family therapy can help families understand mental illness, develop coping strategies, and maintain relationships with their incarcerated relatives. Social workers can also advocate for policies that facilitate family contact, including flexible visiting arrangements, affordable communication options, and support for transportation to distant facilities [71-74].

Limitations

This review has several limitations that warrant acknowledgment. First, the inclusion criteria restricted the sample to English-language publications, potentially excluding relevant research from non-English-speaking countries. Second, the search period was limited to 2015-2025, meaning that earlier foundational qualitative work was not included. Third, the quality of included studies varied, and some studies provided limited methodological detail, constraining the depth of synthesis possible. Fourth, the synthesis combined studies from diverse cultural and institutional contexts, and the transferability of findings across these contexts requires careful consideration. Fifth, the relatively small number of studies explicitly focused on clinical social work interventions limits the specificity of conclusions regarding social work practice. Sixth, the inclusion

of studies from forensic psychiatric settings, while relevant to the broader question of mental health and incarceration, may introduce differences in institutional context that affect comparability.

Conclusion

This qualitative systematic review has synthesized evidence from 47 studies across 23 countries to illuminate the mental health experiences of incarcerated individuals and the role of clinical social work in addressing their needs. The findings reveal a landscape of profound psychological suffering, pervasive trauma, gendered disparities, failed diversion, and institutional conditions that often exacerbate rather than ameliorate mental illness. At the same time, the evidence documents the capacity of incarcerated persons to experience growth and recovery when supportive conditions are present, the critical role of families and relationships in mediating mental health, and the unrealized potential of clinical social work as a discipline uniquely positioned to address these complex needs.

The implications of these findings are both clinical and political. Clinically, they call for the integration of trauma-informed care, the expansion of psychosocial interventions beyond medication management, the adoption of gender-responsive practices, and the strengthening of relational and intrapersonal resources that incarcerated persons themselves identify as central to their mental health. Politically, they call for challenging institutional practices, overcrowding, violence, solitary confinement, and the subordination of care to custody, that damage psychological well-being and undermine the possibility of recovery. They also call for upstream investment in community mental health services, crisis response systems, and diversion programs that can prevent the criminalization of mental illness in the first place.

Clinical social workers have a professional mandate and a distinctive set of competencies that position them to lead both clinical and political responses to this crisis. With expertise in psychosocial assessment, therapeutic intervention, case management, family engagement, and systems advocacy, social workers can address the complex, multi-level needs of incarcerated persons with mental illness and their families. Realizing this potential requires not only individual practice excellence but also collective advocacy for the resources, policies, and professional recognition necessary to make correctional mental health care truly therapeutic.

Future research should prioritize intervention studies that evaluate social work-led programs in correctional settings, qualitative longitudinal studies that track mental health trajectories from incarceration through reentry, implementation science research that identifies strategies for embedding trauma-informed care in correctional institutions, and studies that examine the experiences and needs of families of incarcerated persons with mental illness. Such research should center the voices and experiences of incarcerated persons and their families, whose perspectives are too often excluded from the production of knowledge about their own lives and care. As this review has demonstrated, listening to those voices reveals both the magnitude of the challenge and the possibilities for transformation.

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