Peer support on the "inside and outside": building lives and reducing recidivism for people with mental illness returning from jail

Article *in* Journal of Public Mental Health · July 2019

DOI: 10.1108/JPMH-02-2019-0028

CITATIONS
3

READS
718

10 authors, including:

Chyrell D. Bellamy
Yale University
43 PUBLICATIONS **1,154** CITATIONS
SEE PROFILE

Mark Costa
Yale University
15 PUBLICATIONS **58** CITATIONS
SEE PROFILE

Larry Nulton
Bowling Green State University
1 PUBLICATION **3** CITATIONS
SEE PROFILE

Nathan Aguilar
Columbia University
1 PUBLICATION **3** CITATIONS
SEE PROFILE

Peer support on the "inside and outside": building lives and reducing recidivism for people with mental illness returning from jail

Chyrell Bellamy, James Kimmel, Mark N. Costa, Jack Tsai, Larry Nulton, Elissa Nulton, Alexandra Kimmel, Nathan J. Aguilar, Ashley Clayton and Maria O'Connell

Chyrell Bellamy, James Kimmel and Mark N. Costa are all based at Department of Psychiatry, Yale School of Medicine, Yale University, New Haven, Connecticut, USA.
Jack Tsai is based at Department of Psychiatry, Yale School of Medicine, New Haven, Connecticut, USA and New England Mental Illness Research, Education, and Clinical Center, US Department of Veterans Affairs, Darien, Georgia, USA.
Larry Nulton and Elissa Nulton are both based at Peerstar LLC, Altoona, Pennsylvania, USA.
Alexandra Kimmel and Nathan J. Aguilar are both based at Yale School of Medicine, New Haven, Connecticut, USA.
Ashley Clayton and Maria O'Connell are both based at Department of Psychiatry, Yale School of Medicine, New Haven, Connecticut, USA.

Received 22 February 2019
Revised 1 May 2019
Accepted 1 June 2019

The authors thank Lori W. Schiltz and the peer support specialists for making the connections.

Abstract

Purpose – *The purpose of this paper is to gain understanding about the effectiveness of a forensic peer support program's impact on reducing criminal recidivism. People with histories of mental illness returning to the community following incarceration face tremendous challenges in jails and prisons and in successful reentry to community. Transitioning from jails and prisons is fraught with additional challenges such as reconnecting or connecting with mental health and substance abuse treatment, finding adequate housing, finding employment, reuniting with family and friends, etc. Unfortunately, recidivism remains high, principally because of these challenges. Many state and local authorities have supported the development of the forensic peer specialist.*

Design/methodology/approach – *Kaplan–Meier survival analyses were conducted to examine time to re-incarceration.*

Findings – *The population served was determined to be a particularly high risk of re-incarceration population, when released from prison. All had a mental illness diagnosis, with 80 percent diagnosed with at least one serious mental illness, and more than 50 percent had three or more anterior incarcerations. Utilizing Kaplan–Meyer survival analysis, the chance of re-incarceration for participants after one year was of 21.7 percent. Surprisingly, in the first year after release from prison, participants did much better than those in the general US prison population when in terms of re-incarceration rates (21.7 percent vs 43.4 percent).*

Originality/value – *While preliminary findings of this approach, this study reaffirms the idea that forensic peer support programs are beneficial in reducing recidivism rates for people diagnosed with a mental illness coming out of prison, offering individuals supports to maintain their lives in the community.*

Keywords *Incarceration, Forensic, Recidivism, Mental illness, Peer support, Community reentry*

Paper type *Research paper*

The imprisonment of people with mental illness in the USA is a direct result of mass incarceration and unfair sentencing laws that primarily targeted African Americans and people from lower socioeconomic backgrounds and communities. According to scholars, "mass incarceration has become the perceived default option for long-term care of serious mental illnesses (SMI) in the USA, partly because it is less expensive for US states than providing a full range of community programs, supported accommodation, and rehabilitation beds" (Allison *et al.*, 2017, p. 25). Each year it is estimated that a large portion of those returning home from jails and prisons have mental illness and co-occurring addictions. For people with mental illness, transitioning from jails and prisons is fraught with challenges such as reconnecting or connecting with mental health and substance abuse treatment, finding adequate housing, finding employment, reuniting with family and friends, etc. (Portillo *et al.*, 2017; Draine *et al.*, 2005; Davidson and Rowe, 2008; Rowe *et al.*, 2007). Unfortunately, recidivism remains high for many people with mental illness because of these challenges. In research by Cloyes *et al.* (2010), people with mental illness returned to prison 358 days sooner than those without a mental illness (385 days vs 743 days). The use of peer supporters (those that have lived experience of incarceration) in community settings has demonstrated some effectiveness in reducing recidivism and other health factors (Rowe *et al.*, 2007).

However, little research has been done to evaluate the use of forensic peer support services that is offered in jails for individuals with mental illnesses and co-occurring addictions and works with them upon return to their communities. Data were examined of individuals that received these services with a primary focus on recidivism rates.

Incarceration and reentry

In the USA, in general, jails are short-term facilities that hold people awaiting trial or sentencing or those with stays less than two years, and usually house individuals facing misdemeanor charges. Prisons are longer-term facilities run by the state or the federal government for individuals with felony charges and serving longer terms. However, these definitions are not consistent across states.

The USA has the highest rate of incarceration (more than five times higher when compared to other industrialized countries) (Mauer, 2016). Mass incarceration in the USA started in 1970 and can be attributed to policy changes and changes in practices. There is a huge racial and ethnic disparity with African Americans and Latinos presenting a much higher chance of being incarcerated when compared with white Americans (Saperstein and Penner, 2010); and a large disparity for those from poor communities (Mauer, 2016). Policy changes resulted in increased likelihood of a prison sentence upon arrest and increase in time served in prison. Changes in practices have resulted in increased parole or probation revocation (one in three people admitted to prison are due to parole or probation revocation) (Mauer, 2016).

There were 6,613,500 persons under the supervision of the US adult correction system, by the end of the year 2016 (2.7 percent of all adults), of which almost 2,162,400 were inside prison (Kaeble and Cowhig, 2018). A consequence of mass incarceration is that every year there is a vast number of people re-entering society and undergoing the process of social and economic reintegration (Morenoff and Harding, 2014). In total, 85 percent of sentenced prisoners are released within three years of admission (Stahler *et al.*, 2013). In 2015, 641,027 sentenced prisoners were released from state or federal prison (Kaeble and Cowhig, 2018).

People released from prison reenter their communities with a considerable chance of being re-incarcerated (Stahler *et al.*, 2013). In their 2018 Update on Prison Recidivism, the Bureau of Justice Statistics has estimated that within one year after release from state prison, 43 percent were arrested; 68 percent by the end of the third year; and, ultimately, 83 percent had been arrested at least one time by the end of a nine-year follow-up period after being released from prison (Alper *et al.*, 2018). By the end of this nine-year follow-up period, on average each released prisoner had been arrested five times (Alper *et al.*, 2018). The risk of recidivating also increases as the number of prior arrests increases (Bell *et al.*, 2013).

Mental illness and co-occurring drug use: recidivism and reentry

Persons with mental illness are overrepresented in the jails and prisons across the USA The estimates have varied over the past few years, with one report citing 64 percent of jail inmates, 56 percent of state prison inmates and 45 percent of federal prison inmates, reporting symptoms of SMI (James and Glaze, 2006). In prisons and jails, roughly 4 in 10 men and 6 in 10 women reported a combination of physical health, mental health, and substance abuse conditions, including an estimated one-tenth of men and one-quarter of women with co-occurring substance abuse and mental health conditions (Mallik-Kane and Visher, 2008). People with mental health issues face a vast number of difficulties when trying to reintegrate back into their community. They tend to experience more difficulty obtaining housing and employment and reported higher levels of criminal involvement than those without mental health issues (Portillo *et al.*, 2017; Mallik-Kane and Visher, 2008; Draine *et al.*, 2005). There is also a strong association between mental illness and incarceration and recidivism (Hirschtritt and Binder, 2017), with people coming out of prison with a mental illness being more likely to return to custody than those without a mental illness (Louden and Skeem, 2011).

Drug involvement and continued drug use has also been strongly associated with incarceration and increased chance of recidivism after being released from prison (Stahler *et al.*, 2013). In total,

68 percent of state prison inmates have reported history of regular use of illegal drugs (Stahler *et al.*, 2013). Eight to ten months after release, about one-third of returning individuals reported recent substance use (Mallik-Kane and Visher, 2008). Men and women with pre-prison substance abuse problems were more likely to use again after release (Mallik-Kane and Visher, 2008). Substance use puts these individuals at risk for a number of adverse outcomes. The possession of illegal drugs puts individuals at an additional risk for arrests and parole violations, ultimately placing them back into the correctional system (Mallik-Kane and Visher, 2008).

For people with mental illness coming out of prison, if these challenges can be addressed, they are less likely to recidivate (Mallik-Kane and Visher, 2008). Institutional actors can play an important role in all aspects of the dynamic process involving incarceration, communities, and reentry (Morenoff and Harding, 2014). On the other side, the lack of such programs has recently prompted the call for the coordination of case management services for people with SMI to continue mental health treatment after being released from prison (Hirschtritt and Binder, 2017). However, it has also been demonstrated that implementing such structural programs may not necessarily result in a sound reduction of recidivism rates for those with a mental illness coming out of prison (Louden and Skeem, 2011). Forensic peer specialists (FPS) can be an additional strategy to augment services and supports for people with mental illness transitioning from jails to the community.

Forensic peer support: the (name omitted for the reviewing process) program

Many state and local authorities have supported the development of the FPS. FPS assist people through a variety of services and roles, but perhaps one of the most important functions of FPS is to give hope and serve as an inspirational example to the possibility of recovery (Davidson and Rowe, 2008) because they are individuals that have their own experiences with navigating the criminal justice system as people with their own lived experiences of mental illness and/or addictions. More tangible roles provided by FPSs include helping individuals to connect with their communities, access treatment and support services as well as to assist with any common reentry difficulties such as psychological, social and financial challenges (Davidson and Rowe, 2008). The FPS field is still very new, with job qualifications and job responsibilities varying from site to site. Little research exists on its effects in assisting people with SMI returning from jails and prisons.

The Peerstar, LLC program description

Since 2009, Peerstar, LLC has been a licensed provider of peer support mentoring services to individuals in the state of Pennsylvania with SMI and/or co-occurring substance abuse disorders. Peerstar primarily receives funding from the Medicaid reimbursements, with additional funding from other state and county sources. The program works with county jails in Pennsylvania. In PA, jails are run by counties and serve individuals for shorter time periods. Although Peerstar has recently expanded into the metro region, most of its services are rendered in semi-rural areas of central and west-central Pennsylvania. As of the time of this study, Peerstar employed 77 peer specialists who provided peer support services to an active caseload of 429 individuals. All peer specialists self-disclosed as present or former consumers of behavioral health services with a minimum education level of high school diploma or equivalent. They received 80 h of peer specialist certification training from one of two training vendors approved by the state. They also receive weekly supervision from individuals who have received state-approved peer support supervisor training.

All peer specialists working in the FPSS received an additional 16 h of specialized forensic peer support training. Peerstar's own trainers provide this supplemental forensic training, utilizing a curriculum designed in collaboration with the Yale Program for Recovery and Community Health. The training for the FPSs incorporates a citizenship oriented care perspective (Rowe *et al.*, 2007). FPSs were prepared to utilize the 5Rs of citizenship: roles, rights, resources, responsibilities and relationships as a way to better connect and transition individuals from jail to the community. The additional training also included a special emphasis on supporting individuals who may be struggling with compulsive justice/revenge-seeking behaviors (e.g. retaliation-driven interpersonal conflicts and violence. In this regard, Peerstar trains FPS in utilizing the nonjustice system ("Miracle Court") role-playing tool designed to help individuals overcome justice/revenge (See Rowe *et al.*, 2018 for a review of the nonjustice system components).

Peerstar has largely operated as a one-on-one peer support mentoring program that incorporates the following components:

- 30–90 days prior to release – eligible and enrolled re-entering inmates are paired with in-jail-based FPS mentors.
- Criminogenic risk screen – (PA DOC risk tool + Wisconsin risk assessment as indicated): FPS administer one or more risk screens to determine recidivism risk and service level intensity.
- Recovery-based reentry/transition planning – the FPS and the re-entering citizen develop a recovery-based "Intake & Reentry/Transition Plan." This document identifies intervention needs such as mental health/physical health treatment, drug and alcohol treatment, anger/revenge management, housing, employment, IDs, public benefits and transportation. The document also identifies recovery and reentry goals such as crisis management, development of community roles/natural supports, individual advocacy, self-help/self-improvement, wellness/recovery, social networks, trauma management (PTSD) and probation/parole compliance. Jail and community-based supports are also identified.
- Recovery-based reentry/transition plan implementation – the forensic peer support specialist engages with the re-entering citizen as a mentor and role model, guiding and supporting implementation of the various elements of the intake and reentry/transition plan. The FPS's role is to: "Do with, not for." in-jail activities at this point may include accessing in-jail behavioral health and drug and alcohol treatment programs/supports, applying for public benefits, arranging for day of release housing, arranging for community-based behavioral health and drug and alcohol treatment, overcoming justice/revenge cravings (utilizing the nonjustice system/Miracle Court), establishing linkages with community supports, identifying appropriate and desired faith-based connections, identifying and planning to fulfill probation/parole requirements, providing PTSD support, and providing dual-stigma (mental illness/criminal history) support.
- Inmate release into community – upon release, re-entering citizens are paired with community-based forensic peer support mentors (who are not typically the same FPS who worked with the individuals inside the jail).
- Recovery-based individual services planning – the community-based forensic peer support specialist, his or her supervisor, and the re-entering citizen create a recovery-based "Individual Service Plan" ("ISP") that meets PA requirements for PA medical assistance (Medicaid) funding. The ISP incorporates an adults needs and strengths assessment and includes one or more of the following mental health and/or co-occurring substance abuse recovery goals: wellness and recovery, education and employment, crisis support, housing, social networking, self-determination and individual advocacy. In addition, the ISP includes a specific forensic emphasis of reducing the risk of recidivism and re-incarceration and probation/parole compliance.
- Recovery-based ISP implementation – the forensic peer support specialist engages with the re-entering citizen as a mentor and role model, guiding and supporting implementation of the various elements of the ISP, again "Doing with, not for." Activities are geared toward achieving the recovery goals identified in the ISP and reducing risk of recidivism and re-incarceration and maintaining probation/parole compliance. These activities may include such things as assisting the individual to: develop a wellness recovery action plan or psychiatric advance directive, recognize the early signs of relapse and crises, gain information about returning to school or work, seek reasonable accommodations for psychiatric disabilities, access and maintain stable housing, become an active and contributing community member, take a proactive role in mental health and drug and alcohol treatment, develop anger/revenge management skills and overcome justice/revenge cravings (utilizing the nonjustice system/Miracle Court), make independent choices, develop a network of supports, increase self-worth, improve or eliminate unhealthy personal relationships, start new relationships, and improve communications with family members and others.
- ISP review/modification – at least every six months, the community-based forensic peer support specialist, his or her supervisor and the re-entering citizen meet to review the ISP,

assess progress and modify the ISP to add or subtract goals and determine whether continued peer support services are indicated and will be beneficial.

- Program discharge – an individual is discharged from the FPSP upon request or disengagement, or when he or she has achieved the goals in the ISP and there is a reasonable expectation that discharge from the program will not result in loss of gains or goals attained and that services are not expected to provide additional benefits to the individual.

The Peerstar program gathered several narratives from the forensic peer support staff as anecdotal evidence to demonstrate some of the benefits of forensic peer support staff. Of particular salience were stories of how the forensic peer support staff connected to the people they were assigned to serve. Below are narratives told by Forensic peer support staff to their project directors (authors on this paper) to provide examples of working with individuals on the inside and outside (names and specific details were disguised).

Melissa (pseudonym)

M is a 41-year-old female who has spent much of her life struggling to keep her home, deal with her bipolar disorder, depression, anger, intellectual disability and verbally and physically abusive family members. While incarcerated for disturbing the peace, M enrolled in FPSS.

Communication with M during in-jail forensic peer support sessions was difficult, at first. She only gave one-word answers and would only tolerate brief, 15-min sessions. It was very clear that M needed help with relating socially with people, and in maintaining her hygiene. Because of these issues and her mental illness symptoms, M was separated from the general inmate population, in part for her own safety. M would bang her cell door late at night, refuse showers and not eat.

Gradually, the forensic peer support staff inside the jail worked with M to understand the importance of being clean and socially appropriate. Staff also worked with M to develop concrete recovery goals, including: decreasing the frequency of crises, managing her anger, increasing her personal wellness and increasing her self-esteem. Upon release, community-based forensic peer support staff supported M in achieving these same goals.

According to the peer support staff, supporting M in her recovery in the community was at first challenging because of her mental health symptoms, her inability to manage her anger and her lack of social skills. With the help of her forensic peer specialist, however, M was able to learn to advocate for herself with her treatment providers and obtain the proper medication, which has helped her to develop social skills, start new relationships and stop unwanted and unhealthy relationships. M was also able to extricate herself from an abusive living situation and move to a personal care home, where she continues to thrive and her personal hygiene issues have been resolved.

Recently, M's forensic peer support specialist observed just how far M has come in her recovery journey. When M's roommate lost her brother, M was able to provide comfort in an open, socially appropriate manner, both physically and verbally. M told her forensic peer specialist that this was not something that she was able to do when she started the program.

Ronnie (pseudonym)

R is a 25-year-old male who entered the program while incarcerated. R informed his forensic peer specialist that he is transgender and had been struggling over the years with major depression and attention deficit disorder/attention deficit hyperactive disorder (ADD/ADHD). During his incarceration, R had been physically assaulted and, during forensic peer support sessions, expressed anger and shame over the altercation. For his own protection, R was placed into a restrictive housing unit while incarcerated, but this had the undesirable effect of limiting opportunities for him to receive forensic peer support services.

When R and the forensic peer specialist were able to meet, they brainstormed community goals that R would like to work on upon release. These goals included obtaining a job, continuing his schooling, building relationships with his family, improving self-esteem and becoming comfortable with his identity as a possible transgender individual. While incarcerated, R and his forensic peer specialist began working on these goals.

Upon release, R and his forensic peer specialist continued working on these goals in the community. During this process, R has experienced much success with his recovery. R has been able to hold

several jobs, has his own apartment, and now owns car. He has also been able to work through his self-identity concerns. R currently has a girlfriend and that is working out very well for him.

These stories demonstrate how FPSs assist individuals with mental illness transitioning from jail. The program wanted to understand whether and how these interactions between the forensic peer support staff and the individuals they served influenced recidivism rates.

Methods

The purpose of this evaluation study was to gain understanding about the effectiveness of a forensic peer support program's impact on reducing criminal recidivism. In 2010, we trained Peerstar's staff as forensic peer support specialists. The study was considered exempt by Yale's institutional review board because all the information was collected from the Peerstar file, de-identified and entered in a database created for this study. At no point did the researchers have access to any records from jails or prisons. We did not record any identifiers; except that which was named in a limited data agreement (the county of the jail; dates of admission and discharge).

Information was collected from participants that were within 90 days of being released from jails in PA and had been contacted by the Peerstar program to initiate contact and follow through until after incarceration. The individuals had to have a history of mental illness or co-occurring substance use to be referred to Peerstar. The data were collected over a two-year plus time frame so that recidivism rates could be examined. They received referrals for FPSs from five jails located in rural counties. Of note, referrals were made by different staff at different jails but typically the referral came from jail staff such as a counselor, jail case manager, warden, sometimes a corrections officer and in some jails, inmates could sign up and self-refer. A forensic coordinator, who is like a case manager, received all the referrals, reviewed and assigned them to the FPSSs and kept track of inmates receiving services. Upon release, the Forensic coordinator oversaw the transition to Peerstar's community program.

Data collection instruments

The following instruments were collected by the agency on each client over a two-year period: intake and client record forms (included demographic data; mental illness and drug use history; criminal charges, criminogenic/risk scores; behavioral health services obtained before, during and after jail and FPSS provided).

Data analysis

First, descriptive statistics were used to summarize socio-demographic characteristics of the participants, their intake characteristics, their risk level, risk assessment and needs assessment, the in-jail programs they were enrolled, the post-release referrals, the number of participants who were able to maintain FPS contacts after release, the number of participants who were re-incarcerated after release into the community, the average amount of time participants were followed and, for those who were re-incarcerated the average amount of time before re-incarceration. Then bivariate analyses were conducted to examine the association between all categorical variables. Emphasis was given for variables significantly associated with gender, diagnosis of a SMI, history of drug use prior to incarceration, and with association with re-incarceration. Point bi-serial correlations were conducted for continuous independent variables and Phi correlations for dichotomous independent variables. Correlations that were significant at the $\alpha = 0.05$ level were flagged.

Survival analyses were then conducted to examine time to re-incarceration. Kaplan–Meier Survival curves were constructed to describe the number of days from jail release to re-incarceration during the period of the study. Even though there were participants who were followed for more than 1,000 days after release from jail, for purpose of the survival analysis we decided to consider only the first 360 days, as the majority of the population was followed for 360 days or less, and those who were followed for a longer period of time, coincided with difficulties in the first years of the program where Peerstar reported challenges with connecting with project participants after release from jail (but since improved their follow-up procedures).

Results

The average age of participants in the program was of 32.5 years and 52 percent were male. The majority self-identified as white (97 percent). No participant self-reported as Latino. In terms of education, 80 percent had completed 12th grade, 15 percent had not; and 4 percent had post-secondary education. Most participants had three or more anterior incarcerations (51 percent). Reasons for incarceration were drug possession (6 percent), drug distribution (7 percent), DUI (4 percent), violent crime (11 percent), theft (16 percent), parole violation (43 percent), and others (12 percent). In total, 38 percent of participants had been sentenced. Regarding risk level, 47 percent had their risk level assessed, with 39 percent of these being considered low risk, 40 percent medium risk and 20.7 percent high risk. All participants were considered to have a mental illness. In relation to the diagnosis, 9 percent of participants had been diagnosed with schizophrenia, 53 percent with bipolar disorder and 48 percent had been diagnosed with major depression, meaning that 79 percent had been diagnosed with a SMI (schizophrenia, bipolar disorder or major depression). Also, 46 percent had been diagnosed with anxiety. When it comes to the medical history in the year prior to their incarceration, 31 percent had been hospitalized, 55 percent had received mental health treatment, and 30 percent had received psychiatric medication. About drug use in the year prior to incarceration, 70 percent had a history of drug use. About employment and benefits, 33 percent had been employed prior to incarceration and 61 percent were eligible to receive benefits. Regarding housing in the year prior to incarceration, 38 percent rented a house, 30 percent were living with family members, 9 percent owned their house, 9 percent were living with friends, and 8 percent were homeless or living in shelters. Relating to child custody, 18 percent had the custody of a child (see Table I).

Participants received one program on average, when in jail, varying from a minimum of 0 to a maximum of 8. 54 percent of participants received 0 services when in jail. In jail, participants were part of AA/NA meetings (31 percent), anger management (10 percent), cognitive behavioral therapy (15 percent), domestic violence program (13 percent), education (22 percent), employment skill (19 percent), individual work (15 percent), parenting program (18 percent), religious study (31 percent) and substance abuse program (36 percent).

Regarding needs upon release from jail, 38 percent of participants needed primary care, 14 percent needed a specialist, 47 percent needed a mental health provider, 43 percent needed medication, 22 percent needed treatment for alcoholism, 32 percent needed treatment for substance use and 21 percent had other needs. In total, 20 percent needed continued education, 21 percent needed job skills training, and 30 percent needed a job placement. In total, 22 percent had court fine obligations. On average, participants received 2.2 referrals when leaving jail, with a minimum of 0 referrals to a maximum of 14 referrals. In total, 58 percent of participants received no referrals when leaving jail.

On average participants had 4.8 contacts with the FPS (minimum of 0 contacts to a maximum of 28 contacts – four participants had no contact with the FPSS). Overall, 24 percent of participants were re-incarcerated in the follow-up period after release from jail. On average, people were followed 392 days in the community after release (minimum of 0 days and maximum of 1,050).

If we consider the first 360 days of follow-up after release from jail, 62 participants (1 percent) were re-incarcerated in this period. On average, in this time frame, those who were re-incarcerated stayed out of jail for 118 days (95–142 days – 95% confidence interval). Those who were not re-incarcerated were followed for a mean of 325 days (317–333 days – 95% confidence interval).

Utilizing Kaplan–Meyer survival analysis, the chance of re-incarceration for participants after one year was of 22 percent (see Figure 1).

At the level of significance of $p < 0.05$, re-incarceration was associated with being younger (30 vs 33 years old), substance abuse program referral, other program referral, community corrections referral, drug treatment referral, alcohol probation and past violation of probation. At the level of significance of $p < 0.01$, re-incarceration was associated with drug use in the prior year to re-incarceration, participation in drug services in the past year, need of alcohol treatment, not having completed high school, history of domestic violence, higher final score of the PA DOC assessment and higher risk level determined by this same assessment.

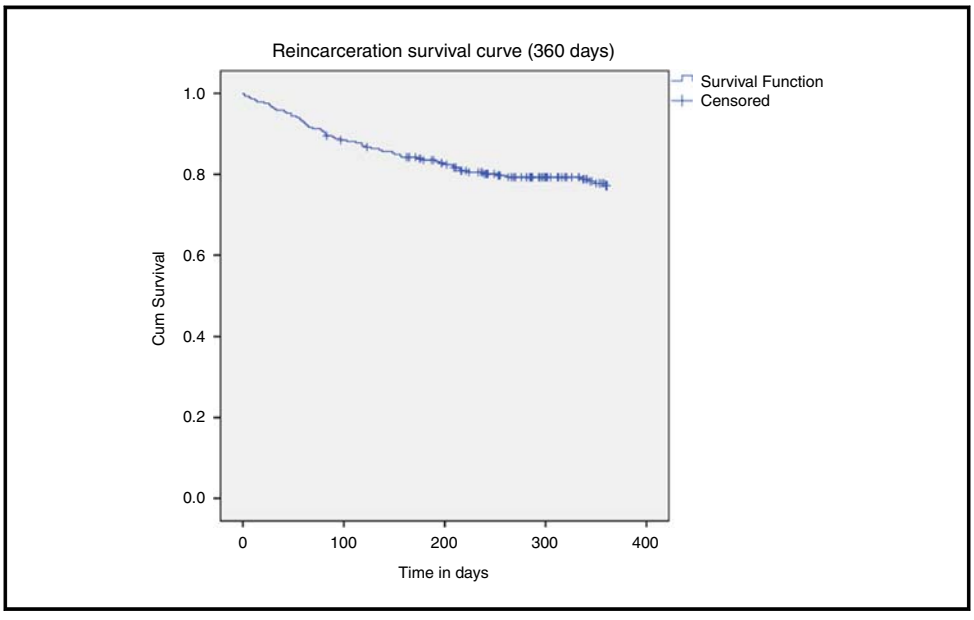
Table I Socio-demographics, psychiatric diagnoses and current incarceration crimes of _____ participants

Variable	*M (SD)/n (%)*
Age	32.54 (9.40)
Gender	
Male	153 (51.9%)
Female	142 (48.1%)
Race	
White	216 (96.0%)
African American	8 (3.6%)
Highest grade completed	
Less than 12th grade	36 (15.4%)
12th grade	188 (80.3%)
More than 12th grade	10 (4.3%)
Previous incarcerations	
0	38 (14.7%)
1	50 (19.3%)
2	38 (14.7%)
3–4	50 (19.3%)
5–7	48 (18.5%)
8 or more	35 (13.5%)
Currently incarcerated for	
Drug possession	16 (5.6%)
Drug distribution	19 (6.6%)
DUI	13 (4.5%)
Violent crime	33 (11.5%)
Theft	47 (16.4%)
Parole violation	123 (42.8%)
Other crimes	36 (12.5%)
Sentenced individual	115 (38.3%)
Risk level	
Low	108 (39.3%)
Medium	110 (40.0%)
High	57 (20.7%)
Mental illness	
At least 1 serious mental illness[a]	240 (78.9%)
Psychiatric diagnoses	
Schizophrenia	27 (9.0%)
Bipolar disorder	160 (53.3%)
Major depression	143 (47.7%)
Anxiety disorder	137 (45.7%)
Other disorder	65 (21.7%)
Hospitalized in past year	92 (30.7%)
Received mental health treatment in past year	166 (55.3%)
Received psychiatric medication in the past year	91 (30.3%)
Substance use in past year	209 (69.7%)
Received substance abuse services in past year	123 (41.0%)
Employed in past year	99 (33.0%)
Benefit eligibility	183 (61%)
Housing in past year	
Own	26 (8.7%)
Rent	114 (38%)
Live with family	89 (29.7%)
Lived with friends	26 (8,7%)
Homeless/shelter	24 (8.0%)
Child custody	53 (17.7%)

Notes: $n = 300$. [a]Serious mental illness was defined as Schizophrenia, bipolar disorder and major depression disorder

Drug use in the year prior to incarceration and risk level were the two variables with strongest association with re-incarceration (Pearson's correlation 0.194, $p = 0.001$ and 0.177, $p = 0.003$, respectively). We used Kaplan–Meyer survival analysis to compare re-incarceration results along the first year after being released from jail, using these two variables as predictors and different

Figure 1 Survival curve: time to re-incarceration



variables as strata. We found that none of the 25 participants who did not have a diagnosis of SMI nor had a history of substance use in the year prior to incarceration went back to jail in the first year after being released from jail. We also found differences in the association between risk level and re-incarceration having gender as a stratum. For men, there were no major differences in chance of re-incarceration between medium and high-risk participants (24 percent with medium risk assessment and 25 percent with high risk assessment went back to jail after one year), but those assessed as low risk did much better (11 percent went back to jail in the first year). For women, those with low or medium risk assessment presented similar risk of re-incarceration (18 percent and 26 percent, respectively), but those assessed as high risk presented a much higher chance of going back to jail in the first year (67 percent).

Discussion and conclusion

The Peerstar population was a particularly high risk of re-incarceration population when released from jail. Almost 80 percent were diagnosed with at least one SMI and more than 50 percent had a history of three or more prior incarcerations. Surprisingly, in the first year after release from jail, Peerstar participants did much better than the general US jail/prison population when it comes to re-incarceration (22 percent vs 43 percent). This strongly points to the need of randomize control trials to determine the influence of in jail/prison peer support programs on recidivism outcomes.

Drug use in the prior year was strongly associated with re-incarceration in the Peerstar population. Also, women assessed as high risk was the subpopulation with the worse outcome when it comes to re-incarceration in the first year after release from jail. One could think that peer-based program in jails/prisons are very promising; however, this study also suggests that there needs to be specific programs outside jails/prisons for women with SMI, and drug use issues. Even though this study did not aim at understanding the reason of different subpopulation outcomes regarding re-incarceration, one could speculate that specific policies to address the needs of these subpopulations, if changed, could decrease even more their recidivism rate.

In conclusion, while preliminary findings, this study demonstrates that forensic peer support programs can be a promising intervention to reduce recidivism rates and increase community tenure for people living with mental illness and co-occurring addictions. There are several limitations that must be noted; primarily, we received the data as secondary rather than collecting as part of a larger study. This was done purposefully as not to impact the natural setting of a new program. A future

study utilizing this approach to FPS could provide data to further test the benefits of this program on the lives of individuals returning with mental illness back to their communities. This will also allow for the collection of additional psychosocial measures to further test the target mechanisms of this FPS compared to other reentry programs. In addition, because of the large impact of mass incarceration in the USA, it will be important to test the effectiveness of FPS programs in more racial/ethnic diverse cities to assess intersectional and social dynamics that might influence community reentry and recidivism rates. Working in state vs county jails may present challenges such as whether FPSs can enter jails and prisons to provide these services. These implementation challenges would need to be explored prior to introducing FPS programs in these areas.

References

Allison, S., Bastiampillai, T. and Fuller, D.A. (2017), "Mass incarceration and severe mental illness in the USA", *The Lancet*, Vol. 390 No. 10089, p. 25.

Alper, M., Durose, M.R. and Markman, J. (2018), "2018 update on prisoner recidivism: a 9-year follow-up period (2005-2014). Update", available at: www.bjs.gov/index.cfm?ty=pbdetail&iid=6266 (accessed February 2, 2019).

Bell, N., Bucklen, K.B., Nakamura, K., Tomkiel, J., Santore, A., Russell, L. and Orth, R. (2013), "Pennsylvania department of corrections recidivism report 2013", available at: www.ncjrs.gov/App/publications/abstract.aspx?ID=263525 (accessed February 12, 2019).

Cloyes, K.G., Wong, B., Latimer, S. and Abarca, J. (2010), "Time to prison return for offenders with serious mental illness released from prison: a survival analysis", *Criminal Justice and Behavior*, Vol. 37 No. 2, pp. 175-87.

Davidson, L. and Rowe, M. (2008), *Peer Support Within Criminal Justice Settings: The Role of Forensic Peer Specialists*, CMHS National GAINS Center, Delmar, NY.

Draine, J., Wolff, N., Jacoby, J.E., Hartwell, S. and Duclos, C. (2005), "Understanding community re-entry of former prisoners with mental illness: a conceptual model to guide new research", *Behavioral Sciences & the Law*, Vol. 23 No. 5, pp. 689-707.

Hirschtritt, M.E. and Binder, R.L. (2017), "Interrupting the mental illness–incarceration-recidivism cycle", *JAMA*, Vol. 317 No. 7, pp. 695-6.

James, D.J. and Glaze, L.E. (2006), "Highlights mental health problems of prison and jail inmates", available at: http://citeseerx.ist.psu.edu/viewdoc/summary?doi=10.1.1.694.3355 (accessed February 12, 2019).

Kaeble, D. and Cowhig, M. (2018), "Correctional populations in the United States, 2016", *Bureau of Justice Statistics*, pp. 1-14, available at: www.bjs.gov/content/pub/pdf/cpus16.pdf

Louden, J. and Skeem, J. (2011), "Parolees with mental disorder: toward evidence-based practice", *Bulletin of the Center for Evidence-Based Corrections*, Vol. 7 No. 1, pp. 1-9.

Mallik-Kane, K. and Visher, C.A. (2008), *Health and Prisoner Reentry: How Physical, Mental, and Substance Abuse Conditions Shape the Process of Reintegration*, Urban Institute Justice Policy Center, Washington, DC.

Mauer, M. (2016), "Race to incarcerate: the causes and consequences of mass incarceration", *Roger Williams University Law Review*, Vol. 21 No. 2, pp. 447-70.

Morenoff, J. and Harding, D. (2014), "Incarceration, prisoner reentry, and communities", *Annual Review of Sociology*, Vol. 40, pp. 411-29.

Portillo, S., Goldberg, V. and Taxman, F. (2017), "Mental health peer navigators: working with criminal justice-involved populations", *Prison Journal*, Vol. 97 No. 3, pp. 318-41.

Rowe, M., Bellamy, C., Baranoski, M., Wieland, M., O'Connell, M.J., Benedict, P. , Davidson, L., Buchanan, B.A. and Sells, D. (2007), "A peer-support, group intervention to reduce substance use and criminality among persons with severe mental illness", *Psychiatric Services*, Vol. 58 No. 7, pp. 955-61.

Rowe, M., Kimmel, J., Pavlo, A., Antunes, K., Bellamy, C., O'Connell, M.J., Ocasio, L., Desai, M., Bal, J. and Flanagan, E.H. (2018), "A pilot study of motive control to reduce vengeance cravings", *Journal of the American Academy of Psychiatry and the Law*, Vol. 6 No. 4, pp. 486-97.

Saperstein, A. and Penner, A.M. (2010), "The race of a criminal record: how incarceration colors racial perceptions", *Social Problems*, Vol. 57 No. 1, pp. 92-113.

Stahler, G.J., Mennis, J., Belenko, S., Welsh, W.N., Hiller, M.L. and Zajac, G. (2013), "Predicting recidivism for released state prison offenders: examining the influence of individual and neighborhood characteristics and spatial contagion on the likelihood of reincarceration", *Criminal Justice and Behavior*, Vol. 40 No. 6, pp. 690-711.

Further reading

Corrigan, P.W., Larson, J.E., Smelson, D. and Andra, M. (2019), "Recovery, peer support and confrontation in services for people with mental illness and/or substance use disorder", *The British Journal of Psychiatry*, Vol. 214 No. 3, pp. 130-2.

Durose, M.R., Cooper, A.D. and Snyder, H.N. (2014), *Recidivism of Prisoners Released in 30 States in 2005: Patterns from 2005 to 2010*, US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, Washington, DC.

Schinkel, M. and Whyte, B. (2012), "Routes out of prison using life coaches to assist resettlement", *The Howard Journal of Criminal Justice*, Vol. 51 No. 4, pp. 359-71.

USDOJ, OJP and BJS (2019), "Terms and definitions", The US Department of Justice, Office of Justice Programs and Bureau of Justice Statistics, Washington, DC, available at: www.bjs.gov/index.cfm?ty=tdtp&tid=13 (accessed July 18, 2019).

Corresponding author

Mark N. Costa can be contacted at: mark.costa@yale.edu