The Prison Journal
1–24
© 2017 SAGE Publications
Reprints and permissions:
sagepub.com/journalsPermissions.nav
DOI: 10.1177/0032885517704001
journals.sagepub.com/home/tpj
SAGE

Mental Health Peer Navigators: Working With Criminal Justice–Involved Populations

Shannon Portillo[1], Victoria Goldberg[2], and Faye S. Taxman[2]

Abstract

Although peer navigators have gained traction within health care, they are still a relatively new feature of criminal justice–involved organizations. Based on data gathered from interviews, nonparticipant observations, and focus groups from a nonprofit that employs peer navigators to assist clients returning from prison with diagnosed mental illnesses, we argue that peer navigators play multiple roles that extend beyond the client level by influencing the organization and its interaction with the community. Importantly, we discuss these implications for the organization and suggest structure and socialization issues for the integration of criminal justice–involved peer navigators.

Keywords

reentry, mental health, peer navigators, organizational change

Introduction

Peer navigators[1] have recently gained increased prominence in health care, particularly within mental health organizations (see Dohan & Schrag, 2005; Griswold, Pastore, Homish, & Henke, 2010; Onken, Dumont, Ridgway,

[1]University of Kansas, Lawrence, USA
[2]George Mason University, Fairfax, VA, USA

Corresponding Author:
Shannon Portillo, School of Public Affairs & Administration, University of Kansas, 1445 Jayhawk Blvd., Lawrence, KS 66045, USA.
Email: sportillo@ku.edu

Dornan, & Ralph, 2002). Peer navigators are individuals who work in various capacities to support and assist clients with whom they share life and/or treatment experiences. They have been shown to improve client outcomes and client engagement with their care and treatment plan (Dohan & Schrag 2005; Onken et al., 2002). Peer navigators work in a variety of health care fields. However, our focus here is specifically on individuals with mental health diagnoses (Onken et al., 2002). In this article, we explore the transportability of mental health peer navigators into organizations working with criminal justice–involved clients. The use of peer navigators as a formal part of the reentry process is a new innovation. Although there are limited organizations across the country exploring the use of peer navigators in the reentry process,[2] this organizational innovation has yet to receive much empirical attention. Here, we discuss the use of peer navigators in a nonprofit organization working with individuals with mental health diagnoses in Washington, D.C.

Individuals with mental illness diagnoses are overrepresented within the criminal justice system (James & Glaze, 2006; Steadman et al., 2009; Teplin, 1990). As the criminal justice system is increasingly called upon to deliver mental health services, there is an increased need to coordinate with other human service systems (Sauber, 2013). Particularly during periods of transition, such as reentry from correctional institutions, individuals are vulnerable, and coordination of care is critical for a successful transition. As individuals reenter communities, they face a number of obstacles, including unstable housing, lack of employment, and so on (see, for a more complete discussion on reentry, Lattimore & Visher, 2013; Visher & Bakken, 2014). A large number of individuals also have a mental health diagnosis, compounding potential challenges they face when reentering communities. Nonprofits and community services have attempted to bridge gaps in services and assist individuals reentering communities, particularly those diagnosed with mental health challenges.

In this article, we present an in-depth case study of peer navigators employed in a nonprofit focused on assisting formerly incarcerated individuals with mental health diagnoses reenter their community. DC-RISES (DC-Reentering Individual Service Enhancement and Support, a pseudonym for a program based in a Washington, D.C., nonprofit) piloted a program from 2011 to 2013 to assist individuals with mental health diagnoses reentering the community from correctional institutions. They employ two peer navigators within their program. Here, we explore how peer navigators operate within their organization and community. Although much of the scholarship on peer navigators focuses on client outcomes, we consider the process of working with peer navigators within organizations and how clients respond to the work of peer navigators. We first discuss the rise of peer navigators in health care. We then discuss the potential of peer navigators working with

criminal justice–involved populations. Next, we present data on DC-RISES. Based on 75 hr of observations and interviews, 69 client files, and two focus groups with clients, we discuss the role of peer navigators within DC-RISES and the ways in which organizational structure and process influence the successful integration of peer navigators within the organization. We conclude with a discussion of the implications of using peer navigators with criminal justice–involved individuals with mental health diagnoses, specifically focusing on the how peer navigators may fit into reentry processes.

Peer Navigators

Peer navigators are individuals who have a unique background or experience that can provide support, guidance, or care for an individual with a similar experience (Mead, 2003). For example, health care providers have used peer navigators to support cancer patients. Patients who have fought the disease and are in remission may work with a newly diagnosed patient to connect them to community support, health care services, mentors, and so on (Dohan & Schrag, 2005). Peer navigators are also becoming increasingly common in mental health care (Solomon, 2004). Peers in the mental health field grew out of self-help and psychiatric survivor movements, where people connected to each other around their mental health treatment experiences (Campbell, 2005; Chamberlin, 1978; Mead & MacNeil, 2005). One compelling reason for the use of peer navigators in health care is "authentic empathy." Mead and MacNeil (2005) argued that peer navigators can relate better to clients than traditional service providers, because of their lived experiences. In 2002, there were 1.6 times as many peer-supported organizations as traditional professional-run organizations, and this number is growing (Goldstrom et al., 2006). This may be due to the a large body of evidence that shows that services provided by peers were as effective, if not more effective, than traditional service providers (Clarke et al., 2000; Davidson et al., 1999; Davidson, Chinman, Sells, & Rowe, 2006; Felton et al., 1995; Rivera, Sullivan, & Valenti, 2007; Solomon & Draine, 1995). Based on a thorough review of current literature on peer navigators in mental health services, Repper and Carter (2011) argued that professional mental health care providers who integrate peer supports are more successful at promoting hope and belief in the possibility of recovery; empowering clients and increasing their self-esteem, self-efficacy, and self-management of difficulties; and social inclusion, engagement, and increased social networks than professional staff working on their own.

While peer navigators have worked in a variety of settings (Chinman, Young, Hassell, & Davidson, 2006), most peer navigators work for or with

professional health care staff (Solomon, 2004). Peers who are employees typically work alongside traditional mental health workers, acting as auxiliary case managers, advocates, counselors, and so forth. While there is a large body of evidence supporting the efficacy of peer navigators, organizations integrating peer navigators into their practices face potential challenges. A recent review by Miyamoto and Sono (2012) identified challenges such as role conflict, boundary conflicts, disclosing status, role ambiguity, low compensation, and limited hours of work. As organizations integrate peer navigators, issues of fit, organizational processes, and organizational structure arise.

While the use of peer navigators is becoming increasingly common in a variety of health care fields, particularly mental health, it is still a relatively rare occurrence in criminal justice settings. There is a small but growing call for peer navigators within the criminal justice system with dual challenges, those with justice involvement and other challenges such as mental illness and substance use problems (Davidson & Rowe, 2008; Rowe et al., 2007). Scholars argue the dual shared background would help clients navigate both criminal justice and health care systems simultaneously, providing stronger and more relevant support for clients (Rowe et al., 2007). There are many challenges to adopting practices from one field to another, particularly when it comes to fit and alignment (Portillo, Rudes, & Taxman, 2016; Schoenwald & Hoagwood, 2001; Taxman & Belenko, 2011). A practice or program that works well in one field and seems like it would work well in another field may face difficulties that are not always obvious. There are potential institutional or organizational challenges when integrating criminal justice–involved mental health peer navigators into organizations. For example, if peer navigators are criminal justice–involved themselves, in particular, on probation or parole, there may be policies preventing them from associating with other individuals currently on probation or parole. With or without policies preventing peer navigators in criminal justice–involved organizations from interacting with clients, there may be hesitancy from probation or parole officers to accept peer navigators as legitimate. While peers in the health care fields may work as volunteers, this may be more difficult for peer navigators in criminal justice settings who might be more reliant on their work for an income. These, and other, criminal justice specific issues related to peer navigators are explored through our work with DC-RISES presented below.

Reentry and Mental Health

Although prior scholarship has established that individuals with mental illnesses are overrepresented in the criminal justice system (James & Glaze, 2006; Steadman et al., 2009; Teplin, 1990), the criminal justice system is still

struggling to find interventions that meaningfully reduce recidivism as this population reenters communities. Reentering individuals with mental health diagnoses return to incarceration more quickly compared with reentering offenders without mental illnesses. Cloyes, Wong, Latimer, and Abarca (2010) found that offenders with a serious mental illness returned to prison 358 days sooner than those without a serious mental illness (385 days vs. 743 days). Offenders with a diagnosed mental illness are also more likely to fail under community supervision (Dauphinot, 1997; Messina, Burdon, Hagopian, & Prendergast, 2004).

When reentering communities, formerly incarcerated offenders are often placed on community supervision. The standard conditions of community corrections are often difficult for offenders without mental illness diagnoses to comply with (Lehman, 1995; Wahl, 1999), and may provide significant hurdles for offenders with mental diagnoses. Often offenders with mental health diagnoses are given additional "special conditions." Special conditions are often related to their diagnosis. For example, offenders with mental health diagnoses may be required to attend treatment and comply with prescriptions and treatment plans given by a health professional. While these additional requirements may be in the interests of the offender, they add additional burdens (Ditton, 1999; Orlando-Morningstar, Skoler, & Holliday, 1999; Skeem, Emke-Francis, & Louden, 2006). For example, offenders may have to pay out of pocket for medications and have additional obligations on their time. Special conditions related to mental health also mean that offenders must coordinate with an additional set of service providers.

Offenders with mental illnesses may recidivate more frequently because of greater unmet needs at their time of release (Draine, Wolff, Jacoby, Hartwell, Duclos, 2005; Lovell, Gagliardi, & Peterson, 2002). For example, similar to offenders returning to the community, they have needs for housing, substance abuse treatment, financial assistance, and personal support (Draine & Herman, 2007). Probation and parole officers' high caseloads, lack of training, and lack of resources are detrimental to providing adequate supervision and support for mentally ill offenders in their caseloads (Louden, Skeem, Camp, & Christensen, 2008). These structural factors combine with overwhelming challenges for offenders with mental illness as they reenter the community—increased likelihood of homelessness, substance abuse, physical and sexual victimization, and inadequate mental health care upon release (Ditton, 1999; Greenberg & Rosenheck, 2008; Grob, 1991; Lurigio, Rollins, & Fallon, 2004; Mueser, Bennett, & Kushner, 1995).

Given the increased reentry obstacles individuals with mental illness diagnoses face, they often have an immediate need for services upon release. Coordinating the transition of medical services, in particular, is a challenge,

as most individuals leave correctional institutions with limited or no medication (Byrne & Taxman, 1995; Wormith & McKeague, 1996). Coordination of care and client advocacy is one area where nonprofits may step in to assist criminal justice–involved individuals. DC-RISES is one such organization. We highlight the role they play in assisting reentering offenders with mental health diagnoses further. We are particularly interested in the role that peer navigators play within the organization.

Setting

DC-RISES is a pseudonym for a working group within a nonprofit in the District of Columbia. The larger nonprofit that houses DC-RISES works on a variety of issues related to low income communities, specifically access to affordable housing and interactions with the legal system. DC-RISES received foundation funding in 2010 to conduct a pilot project focused on helping inmates with mental illness reenter the community. The mission of their project is as follows: (a) remove the barriers that people with mental illnesses face as they return to the community, (b) provide direct advocacy and education to the public, and (c) influence local government to adopt a public health model. While there is no formal relationship between the working group and the criminal justice system, the staff tries to work closely with probation and parole officers, public defenders, and correctional institutions. To accomplish their mission, the nonprofit established DC-RISES, a work group consisting of a staff attorney, a social worker, two peer navigators, and a legal intern. According to organizational documents, each member of the work group has a unique role. The role of the staff attorney/project administrator is to advise correctional administrators on disability law compliance and effective best practices, present self-directed treatment plans at hearings as an alternative to incarceration, and provide legal representation to redress discrimination, abuse, or neglect. The social worker conducts assessments, advises on identifying effective therapeutic supports, develops person-centered transition plans, and coordinates and monitors implementation of such plans by community providers. The peer navigators each have unique roles: one acts as a client advocate by providing outreach to support deinstitutionalization and independence; providing navigational and hands-on guidance securing identification, benefits, transportation, and self-directed health care; and encouraging supportive relationships and social engagement. The other acts as a community organizer, performing tasks such as convening self-help groups, empowerment ,and skill-building trainings for criminal justice/mental health system survivors,[3] family members, and allies, and ensuring those with direct experience inform systemic policy reform and decision making.

The legal intern works with both clients and staff on clients' legal issues and works with clients before they are released back to the community on Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) applications.

Clients receive services from DC-RISES for a variety of reasons including assistance with various applications (e.g., SSI, Medicaid), assistance obtaining housing, assistance getting linked to appropriate mental health services, and referrals to other services (e.g., Assertive Community Treatment [ACT],[4] Veteran's Affairs). Local probation or parole officers may refer clients. Clients may hear about DC-RISES while incarcerated via their outreach to prisons and jails or word of mouth. Past clients may also refer individuals. While there is no formal connection between DC-RISES and the criminal justice system, staff works closely with criminal justice contacts, which regularly leads to additional client referrals. Once a staff member is assigned to a client, they become their case manager. Depending on client needs and requests, some clients work with multiple staff members. DC-RISES overarching goal is to create stable reentry into the community from a correctional institution. Staff work with clients to create goals and objectives they hope to achieve while they are receiving services. While there are no formal case plans, each client has a file where staff note goals and objectives and track applications and meeting notes.

Research Design

This study examined the processes of the work group. Data were collected from January 2011 through May 2013, the duration of the initial pilot project. This project uses a multiple method approach to triangulate data collection and provide robust data and greater reliability (Lofland & Lofland, 2006; Morrill, 1995; Snow & Anderson, 1993). We rely on three main qualitative methodologies. First, we conducted a review of available case files of each client. Second, we completed 75 hr of observation and interviews with members of the DC-RISES staff. Finally, we conducted focus groups with current and former DC-RISES clients.

DC-RISES accepted clients based on three criteria. Clients must be a DC resident who (a) has a significant mental illness or emotional impairment as determined by a mental health professional; (b) are or were incarcerated at the DC Jail, Correctional Treatment Facility, or within the Federal Bureau of Prisons (including Residential Reentry Centers, that is, "halfway houses") *and* (c) are within 90 days of discharge back to DC and request assistance for problems that fall within the priorities listed above. During this time, there were 94 unique client intakes into the program. Of these cases, 25 cases were

Table 1. Client Characteristics.

Descriptive	*N* = 69	Percent
Sex		
Male	61	88.40
Female	6	8.70
Not specified	2	2.90
Race		
Black	68	98.55
Not specified	1	1.45
Age		
20-29	11	15.94
30-39	19	27.54
40-49	13	18.84
50-59	23	33.33
60+	3	4.35
Re-incarceration during contact with DC-RISES		
No	44	63.77
Yes	8	11.59
Not specified	17	24.64

Note. DC-RISES = DC-Reentering Individual Service Enhancement and Support.

closed before services were provided because they did not meet the program's criteria for acceptance. Sixty-nine cases were identified as "open" during the pilot period. See Table 1 for a breakdown of client characteristics. Most clients were male (88.40%), identified as Black (98.55%), and were above the age of 40 (56.62%).

Although it is not formally called a case plan, each client has a file that includes information and any documents relevant to their progress (e.g., copies of applications, notes from meetings). While case planning includes a discussion of client objectives, there is limited accessible and consistent record keeping with regard to goals and outcomes for clients. DC-RISES does not have a common set of objectives or measures of success for clients. Staff members who are assigned to a client are responsible for updating the client file; although with multiple staff on a case, this process is not always consistent. Our data included all de-identified client information that was input into DC-RISES's computerized client management system. These data provided an overview of type of services clients received, the length of services provided, diagnoses of clients, and general background information on clients.

Table 2. Staff Characteristics.

Descriptive	*N* = 6	Percent
Gender		
Male	2	33.33
Female	4	66.67
Race		
Black	3	50
White or Caucasian	2	33.33
Asian (Indian)	1	16.67
Staff role		
Project director/attorney	1	16.67
Staff attorney	1	16.67
Law fellow	1	16.67
Peer advocate	2	33.33
Social worker	1	16.67
Approximate age		
20-30	1	16.67
30-40	2	33.33
40-50	2	33.33
50+	1	16.67

Observations and Interviews

We were primarily interested in the processes and structures of the organization. To understand the role of peer navigators within DC-RISES, we interviewed all organizational staff and spent significant time in the field observing their day-to-day activities. In total, we spent 75 hr over 10 months in the field with DC-RISES. See Table 2 for a description of staff characteristics.[5] All professional staff are female, while the peer navigators are male. Half of the staff identified as Black. Professional staff and one peer advocate were middle-aged, one peer advocate was older, and the legal intern was a young professional completing her law degree.

Researchers observed interactions between organizational staff, and with organizational staff and clients. We spent a total of 75 hr with staff, primarily within the DC-RISES offices. All staff agreed to be observed, and allowed researchers to sit in on client meetings, outreach presentations, intakes, and organizational meetings. The goals of these observations were (a) to provide background on the program and staff, (b) to allow researchers to better understand program processes, (c) to observe interactions between program staff and clients, and (d) to better understand their organizational goals and

day-to-day work environment. During observations, researchers had the opportunity to conduct informal, conversational interviews with all of the organizational staff. Interviews fleshed out information on staff background and provided staff perceptions of (a) organizational processes, (b) procedures, and (c) organizational culture. While interacting with the staff, note taking was kept to a minimum as to not disrupt rapport or the flow of work. As a result, most formal note taking occurred after exiting the field each day.

Focus Groups

DC-RISES provided the research team with a client list that included all available contact information for all closed and current case files from the duration of the pilot study to recruit for focus groups (69 case files). The research team employed a recruiter with experience signing up difficult-to-find populations to assist in tracking down and inviting clients to participate in the focus groups. Participation in the focus groups was voluntary, and all comments made by participants were confidential. Participation did not affect current services, and although the focus groups were held at the DC-RISES office, staff at DC-RISES were not given names or identifying information of anyone who participated. We did provide a meal for each group as well as an incentive for their time. Each participant received a US$10 metro card to aid in transportation to and from the focus group, and a US$40 stipend for their time. The three groups took place in March 2013, and each lasted approximately 2 hr. Groups were held at lunch and late afternoon to accommodate a variety of schedules. We had scheduled an evening group, but did not receive interest in participation at that time.

The goal of the focus groups was to explore the interactions between DC-RISES and the clients they have served. We were primarily interested in the following themes: (a) their experiences with the criminal justice system, (b) interactions with DC-RISES (in particular, the peer navigator staff), and (c) challenges clients faced during the reentry process. The groups were not audio recorded as the team felt this might disrupt rapport with the participants. Instead, one team member took notes, while the other took lead on facilitating each group. Fifteen past (no longer receiving services) and present (still receiving services) clients participated in the groups and are representative of the clients during the pilot period. Of the 15 total participants, 13 are male, all are Black, and we estimate that 11 are above the age of 40.

Coding Procedures and Analysis

All observation, interview, and focus group notes were linked to Atlas.ti (a qualitative software package) for coding and analysis. We began with a

semigrounded theory framework (Charmaz, 2011; Glaser & Strauss, 1967), reading through all notes, building off of broad study themes and inductively coding, and noting emerging themes and categories. Throughout the processes, we developed analytic memos, grouping raw descriptive data with subsequent themes and analytic interpretations. We were particularly focused on behavioral and/or attitudinal patterns that shed light on how organizational workers and clients understood the work environment and processes. This concentrated approach to coding and analysis is a well respected form of qualitative data analysis (suggested by Charmaz, 1995; Emerson, 2001). Throughout our "Findings" section, we use pseudonyms to protect the confidentiality of workers and clients involved in this project.

Findings

Based on data gathered from staff during observations and interviews and data gathered from clients during focus groups, peer navigators played an important role in the organization. Clients, in particular, discussed the role of peer navigators in three distinct ways: role model, legitimizer, and resource broker. While discussions with staff largely mirrored the language and framework used by clients, the organizational processes and structure did not support these roles for peer navigators. Instead, the organizational processes and structures relied on peer navigators as part of a professional team, ready to respond to crisis situations from clients and capable of interacting with organizational and government bureaucracy, community partners, and correctional institutions. Here, we first present the client-centered perceptions of peer navigators, fleshing out their roles as role model, legitimizer, and resource broker. We then discuss how these roles jibe and clash with organizational processes and structures.

Peer Navigators at DC-RISES

Peer navigators operate within and seamlessly move between three main roles: role model, legitimizer, and resource broker. Each role manifests itself at different levels of interaction between peer navigators and others (clients, co-workers, community partners, etc.). The level of interaction is dependent upon the goal of the role. For example, working with clients one-on-one as a role model is an example of peers working at the individual level. The interaction takes place only between the peer and the client, and client perceptions are based on interactions at this level. Table 3 illustrates each role, the level of interaction, a brief description of each role, and an exemplar from our fieldwork.

Table 3. Peers Roles.

Role	Level of interaction	Description	Specific exemplars
Role model	Individual	Provides clients with an example of someone who has successfully reentered the community after a period of incarceration who also has a mental illness.	Clients describe peer advocates as "inspirational," "a mentor," "someone to look up to," and "lifelong friends."
Legitimizer	Organizational	Increases client's trust in DC-RISES as an organization. Criminal justice/mental health backgrounds provide a level of legitimacy to the organization and other staff members.	Walter says that Paul "advocates thoroughly." He gets the DC-RISES name out and reassures folks. People trust that DC-RISES will follow through because of Paul.
Resource broker	Community	Interacts with and connects clients with other service providers, organizations, and agencies. Acts as "face" of DC-RISES to other agencies.	Paul spoke at a public defenders conference about his experiences in the criminal justice system as well as the mental health system. He spoke to an audience of attorneys, service providers, and other returning citizens.

Note. DC-RISES = DC-Reentering Individual Service Enhancement and Support.

Paul is a middle-aged Black man who had been with DC-RISES for 3 years at the start of our project. He is employed as a client advocate. According to his job description, his focus is one-on-one work with clients, and his role is most closely aligned with classic views of peer navigators in health care. He works to connect clients to service providers and counsels clients as they move through and engage with the system. Paul was incarcerated for 25 years, and considers himself a survivor of the mental health and criminal justice systems. He takes pride in helping his clients with issues that he himself faced as he returned home from his incarceration (e.g., homelessness, lack of support and resources in the community).

Eric's official title is peer community organizer. While he also works with clients, his main focus is community outreach activities. According to his job description, he is meant to engage with potential community partners and connect the operations of the organization to community development efforts. Eric is an older Black man who joined DC-RISES around the same time as Paul. He was in and out of the criminal justice system as he was a juvenile, and although he acknowledges that he has been diagnosed with a mental illness, he does not think that he was diagnosed accurately. No peer navigator shared many details about his mental health status currently or in the past, but each shared his criminal justice experiences. Both peer navigators first engaged with DC-RISES as clients, then volunteered for the organization. Both are now on payroll, as part-time employees. Their positions are "soft money funded" and are only guaranteed for the duration of the current grant cycle.

Role Model

The most common role that peer advocates enacted for clients was that of a role model. Here, they modeled what an individual in their client's situation, one with a mental illness diagnosis and criminal justice record, can do to be successful upon reentry to the community. This aligns with the traditional view of the role of peer navigator—a person to look to as an example who shares some unique aspect of one's identity. What is unique about the peers in DC-RISES, however, is that they share dual identities—a mental illness diagnosis and experience in the criminal justice system. Clients discussed realizing this quickly, looking to the peers as role models of where they saw themselves in the future, with some clients even expressing an interest in becoming peer navigators themselves at some point. Clients saw both peer navigators as role models, but because they worked primarily one-on-one with Paul, they spoke specifically about how they looked up to him. One example of this is Jamal, a middle-aged Black male who has been with DC-RISES for a year at the point we talked. He discusses working with Paul:

> He gives basic life skills and mentors . . . He's been out there and done that and he can walk you through the way you're supposed to live to stay out of the system and he understands the mental health part and that's needed. Being in and out, in and out.

Jamal recognized that Paul has similar experiences in the criminal justice system. To Jamal, Paul knows "the way you're supposed to live to stay out of the system," and Jamal sees Paul as an example of what he should be doing to

stay out of the criminal justice system. Throughout our conversation with Jamal in the focus group, he noted that he looked up to Paul and found him "inspirational." Jamal also emphasized Paul's experience in the mental health system. "You don't need to rely on the system. There are people who have mental illnesses greater than us who can function in the community and he showed me that." Paul provides an example of someone who has managed to be successful on their own, without relying heavily on a system that clients discuss as ineffective. It is evident that Jamal sees Paul as someone he can look up to and someone who has navigated both the criminal justice system and the mental health system successfully. Jamal's discussions are representative of a number of clients with similar feedback and represent a consistent example from our data. Paul functions as an example of what could be and gives hope to clients that they too can get a job and have a stable life once they return home.

Organizational Legitimizer

Clients also ascribed a level of legitimacy to DC-RISES because of the peer navigators' experience in both the criminal justice and mental health systems. Similar to their role as role models, peer navigators legitimated the usefulness of DC-RISES as an organization to potential and current clients. Clients looked up to the peers because they shared their background, had worked with DC-RISES, and became successful. This transferred to greater legitimacy for the organization, as the organization was now perceived as an entity that can really help individuals who have a major mental health diagnosis and criminal justice system involvement. The mental health and criminal justice backgrounds of the peers came up in other capacities as well—specifically related to how clients perceived DC-RISES as an organization and how they viewed the services they received from the peers. Chris, an older Black male of late, middle age described how he built trust with Paul.

> Speaking for me, that's when I opened up and trusted Paul because of his background, has he told you his story? [yes]. I'd be lying if I said that didn't make a difference. He told me his background and I knew I could trust him because he had been through it. He was in a halfway house and he built a better life. He built that rapport with me, because we kinda already knew each other.

Throughout the focus group, Chris repeated that one of the biggest reasons he enjoys working with DC-RISES is the opportunity to work with someone he could relate to and who could relate to him. There are not many organizations where individuals with a criminal justice–involved background get to work with staff who also has a criminal justice–involved background. Our conversations with clients illustrate their appreciation for working with

people like Paul, who could relate to them on different, more personal levels, than traditional criminal justice actors and other types of service providers. It is through this shared identity of "criminal justice system survivor" that clients grew closer to Paul and increased trust in DC-RISES as a whole. In fact, some clients were more frank in their admission that their perception of DC-RISES was grounded in their perceptions of the peer navigators.

One client, a middle-aged Black male named Kenny, explained that he was aware of Paul's history in the criminal justice system and the story of how he became successful after leaving a halfway house. He stated enthusiastically, "This program is all right because they have Paul." This is an example of how peer advocates provide credibility to the organization. As role models, they inspire clients on the individual level. As legitimizers, they provide an example of how the organization can help people in their situations be successful. By hiring Paul and Eric, DC-RISES shows clients that they are committed to supporting people with criminal justice–involved backgrounds and mental illness diagnoses. It is unclear whether participants would have been less interested in the DC-RISES program if there were no peer navigators. However, it is clear that their presence enhanced the experience of many of the clients we talked to.

Resource Broker

Clients also described peer navigators as resource brokers. Traditionally, case managers play the role of "resource broker" for individuals who need assistance. If the person is on probation or parole, their probation or parole officer may act in that role (Storm, 1997; Trusty 1997). The role of resource brokers is to connect clients to services, as they provide limited services themselves. In the case of Paul, the peer navigator whose role was client advocate, much of his actual duties were more resource-broker-oriented than advocacy-oriented. Clients noted that Paul connected them with mental health services, housing services, and employment services. He also helped them get transportation assistance and with smaller tasks such as getting an ID, opening a bank account, and taking them to appointments. Paul reported that most of his responsibilities are around connecting clients with core service agencies such as the Department of Mental Health, the Department of Housing, the Department of Human Services, The Social Security Administration, and so on. He is proud of his relationships with many of these organizations, knowing many contacts by name, especially in local organizations such as homeless shelters, food pantries, and halfway houses. Paul sees most of his clients as wanting a "hand-up not a hand-out." He, thus, focuses on networking for services that will help them achieve their goals.

While Eric does not work one-on-one with clients with the same frequency as Paul, the work he does indirectly benefits clients and DC-RISES as a whole. Eric acts as a liaison between DC-RISES and members of the community who are interested in policy reform, reentry, education, and empowerment as they relate to individuals reentering the community. Eric builds connections with community organizations and individuals that can ultimately benefit clients. For example, through the DC-RISES mentoring program, past and present clients meet with community representatives to discuss currently relevant issues, focusing around reentry and advocacy for people in the criminal justice system. The group also provide peer advocate training opportunities to its members to learn mentoring and advocacy skills. It is important to note that none of the focus group members reported participating in the mentoring group. However, many described it in detail, giving specifics on the groups and expressing interest in becoming peer navigators in the future.

Through their work with other organizations and community members, Paul and Eric network interaction between DC-RISES and the rest of the community. DC-RISES (knowingly or unknowingly) offer Paul and Eric as exemplars of individuals with criminal justice system involvement and mental illness diagnoses. Both men are employed full time and are trusted to work with clients who are also struggling with very serious issues such as homelessness, substance abuse, and mental health disorders. Through their interactions with service providers, government and criminal justice agencies, and health providers, Paul and Eric represent DC-RISES as an organization engaged in a mission to support individuals with criminal justice and mental health system backgrounds.

Organizational Processes and Structure

In addition to the two peer navigators, DC-RISES employs a work group consisting of a staff attorney/program director, social worker, and legal intern. Each person has a distinct job description. The staff attorney manages the program while also advocating for the clients' legal needs and representing them in court when necessary. The social worker focuses on diagnosis, therapy, and case management. The legal intern assists with client legal work and engages with probation and parole officers on the clients' behalf. Ideally, each member of the work group should be able to focus on their role and play to their strengths. However, in our observations and interviews, it became clear that job descriptions are idealized, and actual functions are more needs-based for the organization.

In particular, the staff attorney/program director spends significant time focusing on grant reporting and funding development. Furthermore, the

social worker and legal intern expend significant time on immediate crisis management. For example, clients are released from federal correctional institutions with 72 hr worth of medication. For many clients, this means they need immediate help connecting with community mental health care providers. Lack of stable housing is another immediate need for many clients. The social worker and legal intern discussed spending significant time handling landlord–tenant disputes and locating stable housing for clients.

The work group itself operates as a team. When one member of the team is pulled into handling a crisis or performing work outside of their traditional scope, others pitch in to assist. This often results in one or both of the peer navigators working as case managers for clients. Within client records, every member of the work group was listed as responsible for some number of clients as their primary case manager. In the role of case manager, the work group member is responsible for creating a plan for the individual, meeting with them regularly, and inputting all of their notes and information into the computerized system. While this is a role for which the social worker has training and professional background, other members of the team learn "as they go" This is also a role that, at times, requires prerelease meetings with clients wherever they are being incarcerated. This can be difficult for the peer navigators, as they are often not allowed to visit inmates as care providers because of their criminal records.

In observations of the work group at a pre-release meeting, the social worker and staff attorney/program director made no mention of the peer navigators employed at DC-RISES (who were not at the meeting due to their criminal justice background). Instead, the staff attorney and social worker focused on their professional and legal services responsibilities. As noted above, peer navigators are just one of the potential benefits for clients working with DC-RISES, bringing legitimacy and trust to the organization. Without knowledge of the peer navigators, potential clients may lump DC-RISES with traditional service providers, resulting in skepticism of DC-RISES or lack of interest in their services.

In addition, peer navigators face challenges outside of correctional institutions. Namely, it is difficult for peer navigators to interact with probation and parole officers on a client's behalf, as both peer navigators have been on probation in the jurisdiction. Paul noted he is currently still on probation, resulting in sometimes-awkward conversations with probation and parole officers. These officers knew Paul was on probation in their office, and Paul perceived them to be skeptical of the work he was doing with clients. Some officers seemed to stigmatize Paul, uncomfortable with the fact that they were peers working together for a client. Furthermore, many jurisdictions (including Washington, D.C.) have probation conditions that include the

prohibition of probationers, "associate[-ing] with any person convicted of a felony, unless granted permission to do so by the probation officer" (U.S. District Court, 2011). This means that a probation officer can forbid an offender from working with a peer at DC-RISES. Our project is limited to data from the peer navigators and their colleagues at DC-RISES. It would be an important follow up to this study to explore how criminal justice actors perceive peer navigators and their work.

Clients noted that the social worker was able to "get things done" and "be taken seriously" when interacting with local service agencies and probation and parole officers. She brought professional legitimacy to their advocacy. While peer navigators bring legitimacy to DC-RISES as an organization that works with and for people reentering society from correctional institutions with a mental health diagnosis, the social worker provides legitimacy for the organization when working with other agencies and a professional peer. The organizational structure itself allows for clear roles and particular job descriptions. However, role ambiguity comes with the pressure the organization faces seeking continued funding and assisting clients in crisis situations. The criminal justice context further complicates the role of peer navigators working within this setting.

Discussion and Conclusion

With the passage of the Affordable Care Act (2010), there is a growing use of peer navigators in the health care system. Organizations working with criminal justice–involved clients are also expanding the use of peer navigators within their organizations (see Note 2). In this project, we set out to empirically explore how peer navigators are integrated into an organization working with criminal justice–involved clients. Our project found that peer navigators play three distinct roles within the organization: role model, legitimizer, and resource broker. As role models, peer navigators exemplified the successful navigation of reentry from correctional institutions with a mental illness diagnosis. As legitimizer, the peer navigator provided evidence that the organization had clout within the community it served. As resource brokers, the peer navigators connected clients and the organization with other organizations and individuals who may be valuable for their success. Peer navigators had an impact on the individual, organizational, and community level.

While these roles are consistent with peer navigators working with other disciplines, within DC-RISES, peer navigators also face organizational structure and process challenges. Given the small nonprofit environment, peer navigators were often pulled to work across roles with others in their work group. Given their criminal background and lack of traditional professional

training, this was, at times, a difficult role for them to fulfill. This is not to say that the use of peer navigators will not work with criminal justice–involved populations. Rather, organizations must carefully consider what roles peer navigators can and should occupy, and how to prepare and train them for work within these roles. Given the movement of peer navigators from traditional health care settings to criminal justice settings, organizations must consider carefully how the context will affect the work of peer navigators and train their staff accordingly.

With a growing body of evidence that shows positive outcomes for organizations and individuals who work with peer navigators, it is an ideal time to consider expanding the use of peer navigators to criminal justice–involved individuals and organizations (Clarke et al., 2000; Davidson et al., 1999; Davidson, Chinman, Sells, & Rowe, 2006; Felton et al., 1995; Rivera et al., 2007; Solomon & Draine, 1995). The use of peer navigators integrates well into organizations that work with individuals within the criminal justice system for numerous reasons. First, criminal justice–involved individuals experience many of the same challenges as individuals who are dealing with mental illnesses (the primary user of peer navigators)—such as homelessness, employment challenges, and a mental illness diagnosis. In addition, the criminal justice system is currently overburdened and largely undertrained to deal with mentally disordered offenders, especially as they transition back to the community from extended stays in prison or jail facilities. Peer navigators provide valuable knowledge and support for these individuals, having been through the process themselves and possessing insights that can help clients succeed. Similarly, probation and parole officers or those who are closely associated with the criminal justice system can be seen as adversarial to one who has spent time in the system and does not trust it. In contrast, peer navigators provide organizations with legitimacy because they employ individuals with criminal justice system experience. Finally, peer navigators are successful exemplars of individuals who survived the experience, offering clients hope that they too can be successful.

The peer navigators we studied reported facing unique challenges that peer navigators in traditional health settings may not face. Most importantly, their criminal justice offender background may limit their legitimacy with service providers and probation officers, and limit their ability to meet with potential clients before they are released to the community. Organizations also face challenges integrating peer navigators into their structures and processes, given limitations in professionalism and training.

As a case study, this project has limitations. Here, we analyze and report on data from a working group within a single nonprofit, with a small number of staff, limited clientele, and recent pilot funding. DC-RISES has employed

peer navigators for 3 years, and the two we focused on here are their first. Additional research is needed to investigate if peer navigators with criminal justice–involved backgrounds can be effective when working with clients who also have this background. How do criminal justice actors perceive the use of peer navigators with this population? While much of the literature on peer navigators in general is positive, it rarely focuses on the criminal justice–involved population. So, we have begun to explore how organizations integrate peer navigators into their processes and structure. While there is significant research on peer navigator outcomes, there is limited research regarding peer navigators from an organizational perspective. Regardless of the limitations of this small study, overall the findings support the argument that peer navigators can play a role for clients with mental health diagnoses and criminal justice involvement and the explores the potential challenges organizations may face when integrating peers into their work. The role of peer navigators in justice settings has not been thoroughly investigated, but appears to be promising.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: The authors were funded by the nonprofit studied here to conduct independent focus groups and observations. The authors are grateful for the funding, but cannot disclose the name of the nonprofit while maintaining their anonymity.

Notes

1. The role of peer navigators is still relatively new within health care and criminal justice, and has gone by a variety of names, including peer supports, peer mentors, or peer service providers. Here, we use the general term *peer navigators*, as inclusive of alternative terms in this growing area.
2. See, for example, The Center for Returning Citizens in Philadelphia (http://tcrcphilly.org/) or The Fortune Society in New York City (http://fortunesociety.org/).
3. Peer navigators within the mental health field often discuss clients involved in the mental health system as survivors rather than patients or clients. This is the language that DC-RISES (DC-Reentering Individual Service Enhancement and Support) staff use as well, extending the use to individuals from criminal justice and/or mental health system. They emphasize that individuals have survived these systems and prefer to recognize that in their language choice rather than referring to individuals as clients or patients.

4. Assertive Community Treatment (ACT) was developed for people in the community with severe and persistent mental illnesses who are disengaged from mental health treatment. The multidisciplinary team consists of psychiatrists, nurses, addiction counselors, vocational specialists, social workers, and peer specialists. Someone from the ACT team is on call 24/7 to handle client needs.
5. The project director changed in February 2013; most data reported refer to the original staff attorney/project director, as the new director's time was limited during the project pilot phase.

References

Byrne, J., & Taxman, F. (1995). Mentally ill offenders: An overview of issues. *Perspectives*, *19*, 41-44.

Campbell, J. (2005). The historical and philosophical development of peer-run support programs. In S. Clay (Ed.), *On our own, together: Peer programs for people with mental illness* (pp. 17-64). Nashville, TN: Vanderbilt University Press.

Chamberlin, J. (1978). *On our own: Patient-controlled alternatives to the mental health system*. New York, NY: Hawthorn Books.

Charmaz, K. (1995). The body, identity, and self: Adapting to impairment. *The Sociological Quarterly*, *36*, 657-680.

Charmaz, K. (2011). *Grounded theory methods in social justice research*. Thousand Oaks, CA: SAGE.

Chinman, M., Young, A. S., Hassell, J., & Davidson, L. (2006). Toward the implementation of mental health consumer provider services. *The Journal of Behavioral Health Services & Research*, *33*, 176-195.

Clarke, G. N., Herinckx, H. A., Kinney, R. F., Paulson, R. I., Cutler, D. L., Lewis, K., & Oxman, E. (2000). Psychiatric hospitalizations, arrests, emergency room visits, and homelessness of clients with serious and persistent mental illness: Findings from a randomized trial of two ACT programs vs. usual care. *Mental Health Services Research*, *2*, 155-164.

Cloyes, K. G., Wong, B., Latimer, S., & Abarca, J. (2010). Time to prison return for offenders with serious mental illness released from prison: A survival analysis. *Criminal Justice and Behavior*, *37*, 175-187.

Dauphinot, L. L. (1997). The efficacy of community correctional supervision for offenders with severe mental illness (Doctoral dissertation). Available from ProQuest Information & Learning.

Davidson, L., Chinman, M., Kloos, B., Weingarten, R., Stayner, D., & Tebes, J. K. (1999). Peer support among individuals with severe mental illness: A review of the evidence. *Clinical Psychology: Science and Practice*, *6*, 165-187.

Davidson, L., Chinman, M., Sells, D., & Rowe, M. (2006). Peer support among adults with serious mental illness: A report from the field. *Schizophrenia Bulletin*, *32*, 443-450.

Davidson, L., & Rowe, M. (2008). *Peer support within criminal justice settings: The role of forensic peer specialists*. Delmar, NY: CMHS National GAINS Center.

Ditton, P. M. (1999). *Special report: Mental health and treatment of inmates and probationers*. Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics.

Dohan, D., & Schrag, D. (2005). Using navigators to improve care of underserved patients. *Cancer*, *104*, 848-855.

Draine, J., & Herman, D. (2007). Critical time intervention for reentry from prison for persons with mental illness. *Psychiatric Services*, *58*, 1577-1581.

Draine, J., Wolff, N., Jacoby, J. E., Hartwell, S., & Duclos, C. (2005). Understanding community re-entry of former prisoners with mental illness: A conceptual model to guide new research. *Behavioral Sciences and the Law*, *23*, 689-707.

Emerson, R. M. (2001). *Contemporary field research: Perspectives and formulations*. Prospect Heights, IL: Waveland Press.

Felton, C. J., Stastny, P., Shern, D. L., Blanch, A., Donahue, S. A., Knight, E., & Brown, C. (1995). Consumers as peer specialists on intensive case management teams: Impact on client outcomes. *Psychiatric Services*, *46*, 1037-1044.

Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory*. London, England: Weidenfield & Nicolson.

Goldstrom, I. D., Campbell, J., Rogers, J. A., Lambert, D. B., Blacklow, B., Henderson, M. J., & Manderscheid, R. W. (2006). National estimates for mental health mutual support groups, self-help organizations, and consumer-operated services. *Administration and Policy in Mental Health and Mental Health Services Research*, *33*(1), 92-103.

Greenberg, G., & Rosenheck, R. (2008). Jail incarceration, homelessness, and mental health: A national study. *Psychiatric Services*, *59*, 170-177.

Griswold, K. S., Pastore, P. A., Homish, G. G., & Henke, A. (2010). Access to primary care: Are mental health peers effective in helping patients after a psychiatric emergency? *Primary Psychiatry*, *17*(6), 42-45.

Grob, G. N. (1991). *From asylum to community*. Princeton, NJ: Princeton University Press.

James, D. J., & Glaze, L. E. (2006). Mental health problems of prison and jail inmates. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

Lattimore, P. K., & Visher, C. A. (2013). The impact of prison reentry services on short-term outcomes evidence from a multisite evaluation. *Evaluation review*, *37*, 274-313.

Lehman, A. F. (1995). Vocational rehabilitation in schizophrenia. *Schizophr Bull*, *21*, 645-656.

Lofland, J., & Lofland, L. H. (2006). *Analyzing social settings*. Belmont, CA: Wadsworth Publishing Company.

Louden, J. E., Skeem, J. L., Camp, J., & Christensen, E. (2008). Supervising probationers with mental disorder: How do agencies respond to violations? *Criminal Justice and Behavior*, *35*, 832-847.

Lovell, D., Gagliardi, G. J., & Peterson, P. D. (2002). Recidivism and use of services among persons with mental illness after release from prison. *Psychiatric Services*, *53*, 1290-1296.

Lurigio, A. J., Rollins, A., & Fallon, J. (2004). The effects of serious mental illness on offender reentry. *Federal Probation*, *68*, 45-52.

Mead, S. (2003). Defining peer support. *Intentional peer support: An alternative approach*. Retrieved from: http://www.intentionalpeersupport.org (accessed 5 May 2015).

Mead, S., & MacNeil, C. (2005). Peer support: What makes it unique? *International Journal of Psychosocial Rehabilitation*, *10*(2), 29-37.

Messina, N., Burdon, W., Hagopian, G., & Prendergast, M. (2004). One year return to custody rates among co-disordered offenders. *Behavioral Sciences & the Law*, *22*, 503-518.

Miyamoto, Y., & Sono, T. (2012). Lessons from peer support among individuals with mental health difficulties: A review of the literature. *Clinical Practice & Epidemiology in Mental Health*, *8*, 22-29.

Morrill, C. (1995). *The executive way: Conflict management in corporations*. Chicago, IL: University of Chicago Press.

Mueser, K. T., Bennett, M., & Kushner, M. G. (1995). Epidemiology of substance use disorders among persons with chronic mental illnesses. In A. F. Lehman (Ed.); L. B. Dixon (Ed.). (1995). *Double jeopardy: Chronic mental illness and substance use disorders* (pp. 9-25). Langhorne, England, PA: Harwood Academic Publishers, Gordon, xi, 306 pp.

Onken, S. J., Dumont, J. M., Ridgway, P., Dornan, D. H., & Ralph, R. O. (2002). *Mental health recovery: What helps and what hinders?* (A national research project for the development of recovery facilitating system performance indicators). Alexandria, VA: Prepared for National Technical Assistance Center for State Mental Health Planning, National Association of State Mental Health Program Directors.

Orlando-Morningstar, D., Skoler, G., & Holliday. (1999). *Handbook for working with mentally disordered defendants and offenders*. Washington, DC: Federal Judicial Center.

Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 *et seq*. (2010).

Portillo, S., Rudes, D. S., & Taxman, F. S. (2016). The transportability of contingency management in problem-solving courts. *Justice Quarterly*, *33*, 267-290.

Repper, J., & Carter, T. (2011). A review of the literature on peer support in mental health services. *Journal of Mental Health*, *20*, 392-411.

Rivera, J., Sullivan, A., & Valenti, S. S. (2007). Adding consumer-providers to intensive case management: Does it improve outcome? *Psychiatric Services*, *58*, 802-809.

Rowe, M., Bellamy, C., Baranoski, M., Wieland, M., O'Connell, M., Benedict, P., . . . Sells, D. (2007). A peer-support, group intervention to reduce substance use and criminality among persons with severe mental illness. *Psychiatric Services*, *58*, 955-961.

Sauber, S. R. (2013). *The human services delivery system: Mental health, criminal justice, social welfare, education, health services*. New York, NY: Columbia University Press.

Schoenwald, S. K., & Hoagwood, K. (2001). Effectiveness, transportability, and dissemination of interventions: What matters when? *Psychiatric Services*, *52*, 1190-1197.

Skeem, J. L., Emke-Francis, P., & Louden, J. E. (2006). Probation, mental health, and mandated treatment: A national survey. *Criminal Justice and Behavior*, *33*, 158-184.

Snow, D. A., & Anderson, L. (1993). *Down on their luck: A study of homeless street people*. Berkeley, CA: University of California Press.
Solomon, P. (2004). Peer support/peer provided services underlying processes, benefits, and critical ingredients. *Psychiatric Rehabilitation Journal*, *27*, 392-401.
Solomon, P., & Draine, J. (1995). The efficacy of a consumer case management team: 2-year outcomes of a randomized trial. *The Journal of Mental Health Administration*, *22*, 135-146.
Steadman, H., Osher, F., Robbins, P. C., Case, B., & Samuels, S. (2009). Prevalence of serious mental illness among jail inmates. *Psychiatric Services*, *60*, 761-765.
Storm, J. P. (1997). What United States probation officers do. *Federal Probation*, *61*, 13-18.
Taxman, F. S., & Belenko, S. (2011). *Implementing evidence-based practices in community corrections and addiction treatment*. Boulder, CO: Springer.
Teplin, L. A. (1990). The prevalence of severe mental disorder among male urban jail detainees: Comparison with the Epidemiologic Catchment Area Program. *American Journal of Public Health*, *80*, 663-669.
Trusty, M. L. (1997). Three types of case management for homeless mentally ill persons. *Psychiatric Services*, *48*, 497-503.
U.S. District Court. (2011). *Conditional of probation and supervised release*. Retrieved from http://www.dcp.uscourts.gov/Supervision/Conditions_English.pdf
Visher, C. A., & Bakken, N. W. (2014). Reentry challenges facing women with mental health problems. *Women & Health*, *54*, 768-780.
Wahl, O. F. (1999). Mental health consumers' experience of stigma. *Schizophrenia Bulletin*, *25*, 467-478.
Wormith, J. S., & McKeague, F. (1996). A mental health survey of community correctional clients in Canada. *Criminal Behaviour and Mental Health*, *6*, 49-72.

Author Biographies

Shannon Portillo is an associate professor at the University of Kansas School of Public Affairs and Administration. She takes an interdisciplinary approach to her work exploring how rules and policies are carried out within public organizations.

Victoria Goldberg is a doctoral student in the Criminology, Law & Society Department at George Mason University. Her research and teaching focuses on mental health in community corrections and reentering population.

Faye S. Taxman is a university professor in the Criminology, Law & Society Department at George Mason University. Her work covers the breadth of the correctional system from jails and prisons to community corrections and adult and juvenile offenders.

The author has requested enhancement of the downloaded file. All in-text references underlined ir