RECOVERY AND REENTRY:
PROFESSIONALIZING AND RESISTING STIGMAS IN FORENSIC PEER SUPPORT

A dissertation presented

By

Wallis Adams

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ABSTRACT OF DISSERTATION

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Abstract

This dissertation examines multiple stigmas and the professionalization of peer support work through a mixed-methods study of Forensic Peer Support (FPS) in Pennsylvania. FPS workers are part of the growing peer workforce in recovery-oriented mental healthcare. They draw on their own lived experience with mental illness and criminal justice system involvement to provide individualized support to peer clients with similar histories. Drawing on data from Pennsylvania, including online surveys and in-person qualitative interviews with peer support workers, and supplemented by interviews with FPS stakeholders, this research addresses how peer support workers experience, manage, and resist interpersonal, structural, and occupational stigmas. This dissertation reveals gaps between the conceptualization and implementation of FPS, while providing insight on the composition of the workforce and nature of the work itself. I find that the experiential salience of multiple stigmas depends on the sociopolitical, regional, and social contexts in which individuals are situated. While peers highlight the impact of mental illness stigma within familial and other social contexts, stigma related to criminal justice system exposure is perceived as structural in nature and deeply embedded in the contemporary U.S. sociopolitical framework. Respondents engage in a number of stigma resistance and management techniques, including situational avoidance techniques, that have broader implications for social integration, stigma power, and citizenship. Findings from this study indicate that the peer support field is undergoing sweeping change, and these findings resonate with observations that international peer support scholars and activists have made. The introduction of Certified Peer Specialists as a Medicaid-reimbursable service greatly expanded the number of individuals employed in and receiving peer services throughout Pennsylvania. However, I find that these processes are having additional unanticipated consequences, including changes to the nature of peer work, heightened concern over occupational stigma and jurisdictional threat, and dilemmas
over professional peer identity. Despite broad support, high rates of training, and initial evidence of effectiveness, there are major constraints on the implementation and expansion of FPS programming from barriers related to the criminal justice system and structural stigma. Taken together, this project demonstrates the way that multiple stigmas limit the occupational status of peer workers, while simultaneously highlighting the ways in which peer work and workers deflect and resist stigma. This research also has critical implications for policy and practice to support the increased inclusion of peer support workers within traditional mental healthcare settings, as well as the integration of recovery-oriented services within the criminal justice system.
Acknowledgments

Firstly, I would like to thank the many peer workers and recovery advocates that so kindly took the time to speak with me and support this project. This dissertation only exists because of their time, effort, honesty, insight, and generosity. This includes the many individuals in Massachusetts, Pennsylvania, and across the country who provided me the information and perspective necessary to develop this project, as well as the 117 peer workers and 14 FPS stakeholders across Pennsylvania who shared intimate details with me about their lives and work. Thank you all not only for generously giving of yourself and perspective, but for making the world a better place through the work that you do. I want to particularly acknowledge the amazing people at the Pennsylvania Mental Health Consumer Association, especially Liz Woodley, as well as those at Philadelphia’s Department of Behavioral Health and Intellectual disAbility Services. I appreciate Dr. Mark Salzer and others at the Collaborative on Community Inclusion of Individuals with Psychiatric Disabilities for providing me space in Philadelphia to conduct interviews, and for generously sharing survey instruments from previous peer worker studies that I adapted for use in this dissertation. I’d also like to thank Bob Rousseau at the Massachusetts Department of Mental Health for his efforts to bring FPS to this state.

The seeds of this project emerged from two very different settings: the peaks of the White Mountains in New Hampshire, and the public mental health clinics of downtown Boston. Over miles of weekend hiking, my friend Cassie Cramer shared with me her passion for recovery and the value of peer support. Secondly, over the course of facilitating interviews for Dr. Alisa Lincoln’s literacy study, dozens of Boston-based public mental health service users generously shared their life experiences with me, including how incarceration and police contact impacted their lives, opportunities, and health. Many thanks to Cassie and to the literacy study participants
who made me wonder what would happen if peer support could support not only recovery in mental health, but also recovery from criminal justice system involvement.

I am profoundly grateful to Dr. Alisa Lincoln, the chair of this dissertation and my mentor, for her guidance, time, and insight over the last seven years. Alisa kept me moving despite the many shiny ideas that threatened to leave me paralyzed with indecision. She provided me with countless opportunities to learn and develop. She taught me how to develop and conduct research, how to think critically, how to network, how to write (and rewrite), and how to be an interdisciplinary scholar. Perhaps most importantly, she taught me that I can be a scholar and a mother, a researcher and a friend, an academic and an advocate, and that all of these roles are important and interconnected.

I was fortunate to work with a brilliant and dedicated committee: Drs. Ineke Marshall, Phil Brown, and Jeff Draine. Since taking her course my first year in the program, Ineke has always advocated for me, brainstormed with me, and been wonderfully straightforward. Phil has pushed me to think more deeply about the literature and my own work, and provided a fresh perspective, all while providing his keen editorial eye. In addition to knowing all there is to know about peer work, Philadelphia, and the intersection of mental illness and criminal justice system exposure, Jeff is a true activist/scholar who lives his work on empowerment and inclusion. This dissertation is a collective effort, reflecting the hundreds of hours that Alisa, Ineke, Phil, and Jeff spent talking with me, reviewing drafts, and providing feedback.

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CHAPTER ONE: Introduction

Jason didn’t want to cancel or reschedule the interview, despite the excruciating tooth pain that had kept him from eating anything in the past 24 hours. He winced and held his cheek whenever laughing or smiling. We started the interview and Jason told me that he loves his job although it is really challenging – “It’s actually a very, very tense excellent job.” Jason works in Philadelphia as a Certified Peer Specialist (CPS), a peer worker with lived experience of recovery in mental health who is certified to provide Medicaid-reimbursable support services to those with similar challenges. Jason, unlike most of the peer workers with whom I spoke, earned his CPS certification while incarcerated in a State Correctional Institution (SCI) in 2012 and began working for a large behavioral health organization after his release back into the community in February 2016 (seven months prior to this interview). Jason, a 40-year-old black man, had been working in this capacity for three months when we met, but had previously spent over nine years incarcerated. Despite his experience providing peer support while incarcerated and his visible passion for the work, Jason was shocked that the organization wanted to hire a “convicted felon,” and he was very proud to be hired. He told me about his current work with peer clients, talking to them and giving them hope. He loves helping people even if it’s hard. “You really have to be on your A-game to get these people back into society, a functioning part of society.”

Forty-five minutes into the interview I asked Jason to tell me a little bit more about himself. He paused. “You’re sure you want to know about me? [“Yes.”] My life is not a rosy picture. [Sigh] I grew up here in North Philadelphia…” Jason told me about his difficult childhood, his path to incarceration, and the role that peer support has played in improving his life. He hopes to go back to school and get a college degree someday. Thinking back, he realizes that he suffered from depression since childhood but didn’t seek treatment because, “I couldn’t
afford doctors, nothing like that… I just had to do everything on my own.” Although he doesn’t say so explicitly, Jason is providing others with the support that he never had.

While everyone that Jason works with is in recovery in mental illness, some of his peer clients have also been involved in the criminal justice system. Jason had recently taken a continuing education training in Forensic Peer Support, a specialized field of peer support for individuals who were involved with the criminal justice system in addition to having mental health conditions. During the training Jason “kept smiling at certain things I was reading and [the director and training supervisor were] like, ‘Well, why are you laughing?’ I was like, ‘Because you guys have this on paper but I lived it and I’m telling you that may or may not work, that may or may not be true.’… What I was shocked about was that they were actually taking my advice.” The director and training supervisor listened to Jason’s contributions during the training because he had the lived experience to support his concerns and suggestions.

Jason said that there are many similarities between the challenges surrounding mental health recovery and those of reentry from incarceration that he and his peers face. However, he described in detail the ways that his peer clients’ families rejected them based on their mental health status, and later told me that a “door slams in your face when you’re coming home from prison…. [there’s] the feeling that society shuns you and it’s close to accurate.” Although obstacles regarding jobs and housing are substantial for returning citizens, Jason told me, “you just have to keep fighting.”

Jason knows all of this because of his work with his peers, but also because of his own personal experiences. He knows a lot about navigating parts of society, and which parts of society to avoid. I asked him whether he ever avoided situations or people due to stigma.

Jason: You actually do. Like, I was going to turn this down. I was going to say, ‘Well, if I go in there they’re going to look at me like I’m an ex-convict. I was giving myself a bunch of negative thoughts and then I
just told myself, ‘No, go ahead and say what you want to say so they can understand it from your point of view’.

Interviewer: I am so glad that you came.

Jason: This is a way for me to get our point of view across from the ex-offenders and the mentally ill. This is a way for us to get out, but yeah seminars and groups, things of that nature where I know that’s people who had never been to jail. I kind of hesitate to go because I’m like, ‘Well, do I want to sit in a room with a bunch of people who’s going to look at me like the different one?’ So it crosses your mind and to just not deal with the headache you just don’t go.

Jason’s insight and experience highlight the central themes interwoven through this dissertation: multiple stigmas and stigma management; community integration; occupational paths and inclusion; lived experience; recovery in mental illness; structural obstacles associated with criminal justice system involvement; and peer support work.

* * *

**Study Background**

This dissertation is about Forensic Peer Support (FPS), an innovative specialization within the broader occupational field of peer support. Peer support consists of individuals in recovery in mental health supporting others with similar histories. The field of peer support within the recovery paradigm of mental healthcare is undergoing substantial expansion and transformation throughout the world. The FPS field developed as a unique support for people experiencing mental illness and exposure to the criminal justice system and “involves trained peer specialists with histories of mental illness and criminal justice involvement helping those with similar histories. This type of support requires special attention to the needs of justice-involved people with mental illness” (Davidson and Rowe 2008). This project explores the ways that peer support workers experience and manage multiple social stigmas associated with mental illness and involvement with the criminal justice system. FPS provides a unique opportunity to
examine multiple stigmas and barriers to social integration due to FPS workers’ own lived experience of managing stigmas of past incarceration and mental illness, and their occupational interaction with similarly situated others. Furthermore, this scholarship provides an in-depth view of the transformation of the peer support field and explores how peer workers and advocates understand occupational integration of peer workers within this changing mental healthcare landscape.

Experiences of mental illness and exposure to the criminal justice system frequently co-occur in the United States, and individuals with these experiences are severely marginalized. Rates of mental illness among criminal justice involved persons are disproportionately high, as demonstrated by the more than 50% of American prison and jail inmates that meet criteria for mental health problems (James and Glaze 2006). While estimates differ, between 28 and 52 percent of people with SMI in the United States have experienced arrest (Sirotich 2009). Furthermore, rates of SMI among probationers and parolees are two to three times higher than those not on probation or parole (Feucht and Gfroerer 2011). Upon release, previously incarcerated individuals live with a long-lasting set of consequences related to housing, work, voting, and social incapacitation (Drucker 2011). Challenges of returning to the community include social isolation, material hardship, and stigma (Western et al. 2015), which are conditions that parallel those experienced by individuals with schizophrenia and other serious mental illness (Kelly 2005).

The experience of mental illness and exposure to the criminal justice and mental health care systems are statuses that remain deeply stigmatized and marginalized (Pescosolido 2013; Schnittker and John 2007). While the study of stigma and social integration is well established, including substantial research related to mental illness (Kelly 2005; Hartwell and Benson 2006; Link and Phelan 2014a; Pescosolido 2013) and separate research related to incarceration (Pager
2003; Schnittker and Bacak 2013; Schnittker and John 2007; Western et al. 2015), there is a substantial lack of understanding about how individuals experience, make meaning of, and manage the multiple, intersecting stigmas associated with mental illness and a history of incarceration and barriers to social and occupational integration.

The broader field of peer support has emerged as an important recovery-oriented mental healthcare service (Davidson et al. 2012). While peer support workers originally were employed primarily in consumer-run grassroots organizations, they are now working side by side with traditional mental healthcare workers and in organizations ranging from the Veterans Association, to city health departments, to behavioral health corporations across the globe. As the field continues to undergo rapid change, questions emerge about its role and future. As Watson writes, “Like a teenager, peer support occupies an uncomfortable ‘in-between’ identity, one that is crowded with contradiction, ambivalence, and a desire to be accepted” (2017: 129). FPS emerged as a specialization within the broader field of peer support during this time of occupational growth and transition in order to better serve the large proportion of individuals in recovery who have also had experience in the criminal justice system. This study of FPS also offers a look into these fundamental changes to the field, and how these changes are impacting occupational integration and occupational stigmas experienced by peer support workers.

**Guiding Research Questions**

This dissertation studies how FPS workers make meaning of, navigate, manage, and resist multiple stigmas and barriers to social integration. Furthermore, it assesses the occupational integration of multiply stigmatized peer workers as the broader field of peer support grows and transforms. The following questions guide this research:
1. How do peer support workers trained to work with individuals involved with the criminal justice system understand the nature and content of their work, and the factors that allow them to engage in this labor?

2. How do peer support workers understand, experience, manage, and resist stigmas associated with personal and professional experiences of mental illness and criminal justice system exposure?

3. What are the psychosocial and structural factors that support or hinder community and worksite social integration of peer support workers?

4. How do peer support workers experience, support, and understand the dual processes of social recovery in mental illness and reentry from incarceration?

5. How do peer support workers understand their clients’ experiences of stigma, integration, recovery and reentry?

To answer these questions, this dissertation draws on multiple data sources related to Forensic Peer Support in Pennsylvania, a state at the forefront of the development of the field. Data for this sequential mixed-methods study was collected in 2016. This includes a statewide online survey (n=117) of peer support workers in Pennsylvania, in-depth interviews with stakeholders (n=14), and follow up qualitative interviews with a subsample of the surveyed peer support workers (n=37).

**Study Significance and Contributions**

This study engages with stigma literature by speaking directly to questions of multiple stigmas, stigma resistance, stigma power, and structural stigma. It draws on and extends scholarship related to mental health recovery, community integration, citizenship, and professionalization, drawing connections between these literatures. It responds to calls to further sociological scholarship on peer support work and begins to address the virtual absence of
literature related to Forensic Peer Support. In addition to its contributions to stigma theory and professionalization, this research provides insight for policy and practice related to the development of the peer workforce and for the integration of recovery-oriented services into the criminal justice system. It presents an assessment of how Forensic Peer Support has been conceptualized and implemented, of the field’s current barriers, and of its considerable potential.

**Dissertation Overview**

This dissertation consists of eight chapters: the first three chapters frame the project, the following four chapters present empirical findings, and the last chapter includes discussion and conclusions. In the following chapter, chapter two, I present the theoretical framing that informs and situates my findings and analysis. This includes multiple bodies of social scientific literature related to stigma, social integration, recovery, and professionalization. In addition, the chapter provides the necessary background regarding the field of peer support and FPS as an emerging specialization, particularly as it exists in Pennsylvania. Chapter three describes the methodology of this study and its data sources. This CBPR-informed study utilizes a sequential mixed methods research design. Data include 51 in-person qualitative interviews and 117 survey responses.

Chapter four presents an overview of the field of Forensic Peer Support in the state of Pennsylvania, including how it emerged and its status as of data collection. I draw on survey and qualitative data to describe the FPS workforce, work tasks, and benefits of the field. Empirical findings continue in chapter five with an inquiry into how individuals experience, understand, and manage multiple stigmas. This chapter draws on qualitative interviews with multiply stigmatized peer support workers and looks at the role of sociopolitical, regional, and community contexts on stigma salience.
In chapter six, I argue that the state institutionalization of peer support has had both intended and unintended consequences for the work, worker identity, and occupational integration of peer support workers. Interview data from stakeholders and peer support workers inform this chapter. In the final empirical chapter, chapter seven, I draw on all data sources to describe the barriers and facilitators impacting the FPS field. This chapter speaks directly to policy and practice and concludes with a discussion of the future of FPS.

The last chapter, chapter eight, is a discussion and summary of main findings presented throughout the dissertation. It presents implications for both theory and practice, concluding with research limitations and suggestions. Findings from this project emphasize the centrality of community, context, and citizenship in both individual experiences of multiple stigmas and recovery-oriented mental healthcare services.
CHAPTER TWO: Review of the Literature and Background

This chapter presents the theoretical framework of this project as well as background information to contextualize and situate project findings. I begin with an overview of the stigma scholarship that speaks most directly to this project. This includes literature related to mental illness and criminal justice system involvement, as well as a discussion of stigma management. I emphasize recent trends in stigma scholarship that highlight resistance, power, structure, and intersectionality. Following this, I turn my attention to social integration and citizenship. I discuss both recovery in mental illness and prisoner reentry within the framework of social integration. Finally, I discuss the peer support field, including the recent push towards professionalization and specialization, including Forensic Peer Support (FPS).

Stigma Scholarship

Sociology has a long tradition of stigma scholarship, much of which draws on symbolic interactionist Erving Goffman’s seminal work *Stigma: Notes on the management of a spoiled identity* (1963). While Goffman identified stigma as “an attribute that is deeply discredited,” (1963: 3) he also emphasized stigma as both relational and as a process. Goffman differentiated between the discredited and the discreditable, depending on whether the stigmatized status was known or concealable. Goffman (1963) paid particular attention to the stigmatized, rather than stigmatizers, and the behaviors that individuals engage in to conceal, minimize, and manage their stigmatized identities. Research related to social stigma grew significantly in the latter half of the twentieth century and continues to develop.

Link and Phelan (2001; 2014a) contributed to contemporary social scientific understandings of stigma in substantial ways and inform this study’s conceptualization of stigma. In their pivotal 2001 *Annual Review of Sociology* article, Link and Phelan conceptualized stigma as the convergence of five interrelated components. These processual components include:
distinguishing and labeling differences, associating differences with negative attributes, separation of ‘us’ from ‘them,’ status loss and discrimination, and the role of power in stigma (Link and Phelan 2001). Furthermore, “stigmatization probably has a dramatic bearing on the distribution of life chances in such areas as earnings, housing, criminal involvement, health, and life itself” (Link and Phelan 2001: 363). Phelan, Link and Dovidio (2008) identified three main functions of stigma: Keeping people down, in, and away.

Recent stigma scholarship has expanded on these topics while simultaneously critiquing the field’s failure to adequately engage with issues of power and macrostructure. This section presents a review of stigma literature associated with the following subtopics: Stigma associated with specific attributes (mental illness and criminal justice system involvement); stigma management and resistance; power and structural stigma; and multiple, intersecting stigmas.

Stigma of Mental Illness and Mental Healthcare Use

Sociology of health and illness has devoted a great deal of attention to stigma. Due to its pervasiveness, disruption of multiple life domains, and negative impact on the health of populations, stigma can be considered a fundamental cause of population health inequalities (Hatzenbuehler, Phelan, and Link 2013). Research of stigma related to mental health is particularly well developed. Despite the long history of scholarship and multitudinous programmatic efforts to combat stigma, stigma related to mental illness remains common. In a recent longitudinal qualitative study, individuals with severe mental illness report that stigma and discrimination are “omnipresent potential problems to which participants remained eternally vigilant, taking various preventive measures” (Whitley and Campbell 2014: 1).

Rüsch, Angermeyer and Corrigan (2005) distinguish between public and self-stigma related to mental illness, where public stigma “comprises reactions of the general public” (p. 530) and self-stigma “refers to the reactions of individuals who belong to a stigmatized group
and turn the stigmatizing attitudes against themselves” (p. 531). While stigma related to mental illness is not a new concern and understandings of etiology have changed over time, Pescosolido reports that public mental illness stigma remains high (2013). There is widespread social distancing from individuals with mental illness and is a common perception among the general public that individuals with mental illness are dangerous to themselves and others. That belief appears to be increasing in the population (Pescosolido 2013). Corrigan and Rao (2012) posit that self-stigma related to mental illness occurs through a multi-staged process by which individuals internalize public stigma through awareness, agreement, application, and harm.

In addition to the stigma associated with mental illness, individuals can experience stigma associated with using mental healthcare services. Substantial evidence shows that fear of stigma related to mental illness serves as a common barrier for individuals to seek out and participate in mental healthcare (Rüsch, Angermeyer and Corrigan 2005; Corrigan 2004). Both public stigma and self-stigma impact service utilization through stereotypes, prejudice and discrimination (Corrigan 2004).

*Stigma of Criminal Behavior and Criminal Justice System Involvement*

Just as stigma can be associated with both mental illness and mental healthcare use, individuals can be stigmatized for both criminal behavior as well as involvement with the criminal justice system. However, this project focuses primarily on stigma associated with involvement in the criminal justice system rather than on the behaviors that resulted in that involvement. Criminologically informed research has primarily addressed stigma related to previous incarceration and criminal records, as illustrated by Pager’s work “The mark of a criminal record” (2003). Pager found that both race and having a criminal record significantly impacts one’s ability to obtain employment. Incarceration not only reflects existing stratification processes, but “the prison has emerged as a powerful and often invisible institution that drives
and shapes social inequality” (Wakefield and Uggen 2010: 401). Formal and informal stigma and status dishonor related to criminal justice involvement reduces educational, occupational, social, and other life chances (Wakefield and Uggen 2010).

Schnittker has been especially prolific in addressing the impact of incarceration on individuals and communities, beginning with his work on incarceration stigma and its long-term effects on health (Schnittker and John 2007). Stigma is at the heart of reentry challenges related to social inclusion: “Former inmates must establish social connections upon release, but they must do so while harboring the stigma of a criminal record. Furthermore, former inmates who have a psychiatric disorder may be particularly disadvantaged because they experience two stigmas simultaneously” (Schnittker, 2014: 122). In recent work on desistance (understood for this project as the process by which individuals cease offending) Maruna and LeBel (2015) acknowledge stigma as perhaps the “primary challenge facing the returning prisoner” (p. 67), noting that proving oneself worthy of forgiveness is almost necessary for finding a meaningful role in the world.

**Comparing and Differentiating Stigma Dimensions**

Jones et al. (1984) identified six different dimensions of stigma: concealability, course, disruptiveness, aesthetics, origin, and peril. In this section I present recent work by Pachankis and colleagues (2018) that draws on Jones et al. (1984) to develop a taxonomy of stigma, comparing 93 different stigmatized statuses. Here I compare stigma associated with mental illnesses and stigma associated with having a criminal record along these axes. According to Pachankis et al. (2018), having a criminal record is among the least visible of the 93 stigmatized statuses under study. Conversely, having a criminal record rates among the top five statuses for “peril.” It ranks 16th of the 93 statuses for the persistence of course, 25th for disruptiveness, 19th for unappealing aesthetics and 17th for controllable origin (Pachankis et al. 2018).
While the only measured stigma associated with the criminal justice system noted by Pachankis et al. (2018) was having a criminal record, they measured Jones et al.’s six dimensions (1984) for three types of mental illnesses (depression, schizophrenia, and bipolar), both during symptomatic conditions and under remission. Symptomatic schizophrenia scored almost as highly in the peril category as having a criminal record and was determined to be the single most disruptive stigmatized condition. While symptomatic conditions were determined to be more visible than those under remission, all mental illness related statuses were considered more visible than having a criminal record. Across the board, mental illnesses were considered having a less “controllable origin” than having a criminal record (Pachankis et al. 2018). This reflects Pescosolido’s work indicating Americans’ increased endorsement of neuroscientific understanding of mental illness (2013). Taken together, we see that stigma associated with a criminal record is considered perilous and controllable but not visible. While perilousness and visibility related to mental illness stigma differs greatly by illness designation, mental illnesses were not generally considered to be onset controllable (Pachankis et al. 2018).

**Stigma Management and Resistance**

Management of stigmatized identities is a central topic within stigma scholarship. Goffman’s 1963 pivotal book on the topic even includes the construct in its title (*Stigma: Notes on the management of spoiled identity*). Stigma coping techniques are varied, and can include secrecy (concealment), withdrawal, and education (Link et al. 1989). However, these techniques did not reduce distress for individuals with mental illness (Link, Mirotznik and Cullen 1991). Furthermore, the meaning of disclosure depends on individuals’ status and position (Tyler and Slater 2018). Stigmatized individuals can also engage in more active management techniques, including challenging and distancing (Link et al. 2002). Management techniques depend on whether stigmas are discredited, in which case individuals must manage the tension produced by
their spoiled identity, or discreditable, wherein individuals can choose to either conceal or disclose that identity (Goffman 1963). This differentiation is of particular importance for peer workers, whose occupational identity requires disclosure of a stigmatized status (mental illness) in work settings.

While there is a substantial work describing the experience and management of stigma, there is less work on stigma resistance, with Thoits (2011) a notable exception. Thoits distinguishes between deflecting and challenging resistance strategies, defining resistance as “opposition to the imposition of mental illness stereotypes by others” (2011: 6). The study of stigma resistance highlights the absent role of agency in classic labeling theories. One of the factors that Thoits identifies as increasing the likelihood of resistance is having a past experience of stigma. Thoits and Link (2016) expanded her earlier work to assess how these resistance strategies (challenging and deflecting) compared to concealment strategies in terms of stigma-related stressors and well-being. They found that individuals who frequently engage in resistance strategies have lower rates of internalized stigma, higher rates of self-esteem, and lower rates of depressive symptoms (Thoits and Link 2016). By becoming peer support workers, individuals are disclosing their status as a person in recovery, meaning that they cannot conceal their stigmatized status within their work environments. This has implications for stigma peer support worker management techniques and stigma resistance.

Stigma Power and Structural Stigma

While Goffman (1963) spoke of the relational aspect of stigma, much stigma research in the latter half of the twentieth century focused on microlevel processes and ignored broader issues of power and the production of stigma. Scholars have expressed concern regarding these limitations (Hatzenbuehler and Link 2014; Link and Phelan 2014b; Tyler and Slater 2018; Tyler 2018). In the introduction to a recently published monograph on the sociology of stigma, Tyler
and Slater argue, “The conceptual understanding of stigma inherited from Goffman, along with the use of micro-sociological and/or psychological research methods in stigma research, often side-lines questions about where stigma is produced, by whom and for what purposes” (2018:721). The compilation of articles explores stigma as power, existing in and serving the cultural and political economy. Macro-level structures and forces shape stigmatizing beliefs and attitudes and require further exploration (Tyler and Slater 2018).

Link and Phelan (2001), in their conceptualization of stigma as existing in the convergence of interrelated components, brought attention to the role of power: “Stigmatization is entirely contingent on access to social, economic, and political power that allows the identification of differentness, the construction of stereotypes, the separation of labeled persons into distinct categories, and the full execution of disapproval, rejection, exclusion, and discrimination” (p. 367). Link and Phelan later expanded on the concept of ‘stigma-power’ as a resource that allows people to keep others down, in, or away. The goals and interests of individual stigmatizers are frequently hidden, but are nonetheless achieved by the stigma coping efforts (attitudes, beliefs, and behaviors) of individuals with mental illnesses (Link and Phelan, 2014b). Nevertheless, Tyler and Slater (2018) argue that a failure of this conceptualization is that power remains the domain of individuals rather than institutions and states. This project adheres to their emphasis that stigma research must acknowledge, “the importance of the role of symbolic structures and social mediating agencies in the production of inequality and marginality” (Tyler and Slater 2018: 735).

Link and Phelan’s 2014 publication on stigma power was published as part of a special issue in Social Science and Medicine on ‘structural stigma and health’ that developed from the interdisciplinary Structural Stigma and Population Health Working Group at Columbia University. The concept of ‘structural stigma’ was also developed in part to respond to criticism
that stigma scholarship ignores macrosocial factors by focusing too narrowly on individual factors (Hatzenbuehler and Link 2014). Stigma, however, occurs on multiple levels, from intrapersonal, to interpersonal, to structural (Link and Phelan 2001). Structural stigma is defined as “societal-level conditions, cultural norms, and institutional policies that constrain the opportunities, resources, and wellbeing of the stigmatized” (Hatzenbuehler and Link 2014:2).

Although structural stigma associated with mental illness has been less studied than interpersonal stigma, there is substantial evidence that it exists and serves as a barrier to well-being – despite protections from ADA and the Fair Housing Act (Pugh, Hatzenbuehler and Link 2015). Much of the structural stigma that individuals with mental illness experience is a direct result of the mental healthcare system itself, although the media is also a prolific source of stigmatizing frames of mental illness and thus can also be considered a form of structural stigma (Pugh, Hatzenbuehler and Link 2015).

While the majority of structural stigma literature has focused on health, with a strong emphasis on health outcomes among LGBTQ individuals (Hatzenbuehler et al. 2014), the concept can also be easily applied to stigma related to criminal justice related involvement in the United States, given the large number of exclusionary policies towards those individuals. In fact, the above discussed recently published monograph on the sociology of stigma included an article exploring housing and stigma among formerly incarcerated people in which they contend that “incarceration represents a form of structural stigma that encompasses the societal conditions, cultural norms, and institutional policies that constrain opportunities, resources, and well-being of stigmatized groups” (Keene, Smoyer, and Blankenship 2018). This project utilizes and extends this promising subcategory of stigma scholarship focusing on structural stigma and stigma power.
Multiple, Intersecting Stigmas

Although the majority of stigma scholarship focuses on singular stigmatized statuses, researchers increasingly recognize that individuals frequently experience and manage multiple stigmatized statuses (Brinkley-Rubinstein 2015; Logie et al. 2011; Rice et al. 2018; Oexle and Corrigan 2018). There is substantial evidence that experiences of mental illness and involvement with the criminal justice system frequently co-occur among Americans, indicating that stigmas associated with those statuses co-occur. Although estimates vary, between 28% and 52% of people with serious mental illness (SMI) in the United States have experienced arrest (Sirotich 2009). Rates of SMI among probationers and parolees are two to three times higher than those not on probation or parole (Feucht and Gfroerer 2011). A 2006 Department of Justice report indicated that more than 50% of prison and jail inmates have mental health problems (James and Glaze 2006). Individuals with mental illness and criminal justice involvement frequently experience high levels of stigmatization (Pager 2003; Pescosolido 2013) indicating that formerly incarcerated individuals with mental illness are living with the strain of dual stigma. There is a great need for research addressing these multiple, simultaneously experienced forms of stigma. The one empirical study addressing stigmatizing beliefs related to both criminal history and mental illness together confirmed previous research that both mental illness and criminal justice involvement serve as barriers to employment hiring processes (Batastini, Bolanos, and Morgan 2014).

Much of the recent scholarship addressing multiple stigmas draws upon an intersectional framework. Intersectionality, as introduced by Crenshaw (1989), refers to overlapping systems of oppression and social statuses. Bowleg (2012) called for an increase in intersectionality-informed perspective within the field of public health. Logie utilized an intersectional stigma framework to understand HIV, gender, and sex work (2011), yet an intersectional framework of stigma remains
theoretically underdeveloped. One of the first academic works to explicitly use an intersectional framework to explore multiple stigma, Brinkley-Rubinstein’s 2015 article about formerly incarcerated HIV-positive African American men, highlighted the impact that intersecting forms of stigma have on health and reintegration. She notes that while much previous research presented the burden of multiple stigma as additive, “participants in this study, rather than highlighting the compounding nature of multiple forms of stigma often discussed HIV and incarceration stigma as separate phenomenon that needed to be navigated independently” (2015: 176). She contends that this separation might result in a compounded burden of navigation.

In the first few months of 2018 three major academic journals (Social Science & Medicine, Psychiatric Services, and Personality and Social Psychology Bulletin) published articles exploring different dimensions of multiple stigma. Pachankis et al. (2018) developed a quantitative taxonomy to explore similarities and differences amongst multiple stigma, and their implications for health and well-being. In contrast to this quantitative approach to the study of multiple stigma, Rice et al. (2018) utilized thematic analysis of 76 qualitative interviews to explore how women living with HIV perceive intersectional stigma. These researchers found that participants perceived interrelated forms of social marginalization in communities, interpersonal interactions, and within systems. According to Rice et al., utilizing intersectional approaches to stigma scholarship has “the potential to uncover the complexity of social processes of marginalization, barriers to accessing health and social services, and strategies employed to navigate stigma” (2018: 16). While Rice et al. (2018) reported on five salient forms of stigma across three socio-ecological levels, they emphasized how complex the social processes of marginalization are, and the impact on life experiences and opportunities.

The third publication, a commentary in Psychiatric Services, argues for an intersectional understanding of multiple stigma to inform mental health interventions. Oexle and Corrigan
(2018) discuss “two intersectional effects” – double disadvantage and prominence, where double disadvantage theory proposes an accumulation of disadvantage based on increasing stigmatized identities, and prominence theory posits that a single stigmatized identity might determine perception. “We believe that double disadvantage and prominence are not mutually exclusive but fluctuate depending on the number and type of intersecting social group memberships, their visibility and contextual factors” (2018: 588). It must be noted, however, that intersectionality scholars such as Rice et al. (2018) and Bowleg (2008) caution that the additive approach towards intersectionality (as reflected in the above-mentioned double disadvantage theory) is a simplification of intersectionality and may be a product of methodological challenges related to intersectional research.

The two ‘intersectional effects’ that Oexle and Corrigan (2018) identify regarding multiple stigma map neatly on two well-known sociological concepts. ‘Double disadvantage’ can be understood using the *cumulative disadvantage* framework (Sampson and Laub 1997), while the ‘prominence’ effect can be viewed as an updated understanding of Hughes’ *master status* concept. Sampson and Laub (1997) drew on a life course perspective and labeling theory to suggest that early disadvantage (or advantage) accumulates over time and shape how cohorts become differentiated. Hughes (1945; 1963) recognized that individuals have multiple statuses but theorized that one status or label is more significant or prominent than any of the other statuses. In the case of stigmatized statuses, one stigmatized status would be the “master” label and other stigmatized statuses would be subordinate.

**Social Integration**

Stigma is intimately related to the exclusion, inclusion, and integration of individuals within social groups and communities. This dissertation will utilize a definition of social
integration proposed by Ware et al. introduced an article entitled: “Connectedness and Citizenship: Redefining Social Integration” (2007). Social integration is “a process, unfolding over time, through which individuals… increasingly develop and exercise their capacities for connectedness and citizenship” (p. 471). Furthermore, Ware et al. (2007) propose this definition applies to all persons, including those with and without psychiatric disabilities. All individuals aspire to connectedness and citizenship, but marginalized individuals frequently find themselves farther removed from the ideal of social integration (Ware et al. 2007).

I chose to draw on this definition of social integration because it was developed within a recovery perspective of mental illness and as a response to the persistent exclusion of persons with psychiatric disabilities. While FPS workers and their peer clients face barriers to social integration associated with both mental illness and criminal justice system involvement, the peer support field itself emerged within the recovery paradigm of mental healthcare and thus can be best understood using its language. However, it is important to note that social integration has been defined multiple ways. Western et al. (2015), in their study on prison reentry discussed below, measured social integration by strength of family ties, stability of housing, and employment. Hartwell and Benson defined social integration as “the extent to which individuals are linked to one another” (2006: 329). Social integration also calls for a focus on structural factors and contexts, including resource availability and social conditions (Hartwell and Benson 2006).

*Mental Health Recovery*

One of the principal goals of recovery in mental illness is social integration. Peer support workers are tasked with supporting individuals in their recovery processes and are simultaneously engaged in their own recovery process. In this way, recovery is intimately tied with the social integration of individuals with mental illness and consumers of mental health
services. Despite the wide use of the term within research and clinical settings, there is little consensus on how to define ‘recovery’ as it relates to mental illness (Davidson and Roe, 2007; Pelletier et al. 2015). This project is based on a rehabilitative perspective of mental health recovery that developed in the 1980s and 1990s (see: Anthony 1993; Deegan 1996; Harding, et al. 1987).

There are important differences within the recovery perspectives. Harding and colleagues (1987) questioned the long-held assumption regarding the chronicity of schizophrenia, arguing that there is heterogeneity in clinical outcomes, including recovery. Alternatively, Anthony wrote that, “a person with mental illness can recover even though the illness is not ‘cured’” (1993: 525). Anthony (1993) emphasized that recovery was conceptually rooted in a consumer/survivor movement and is a personal process that includes developing purpose and meaning in life beyond mental illness. Recovery from mental illness also includes recovery from the stigma of mental illness (Anthony, 1993). Disability rights activist Deegan (1996) focused on the humanity of individuals who have been labeled with mental illness, and their role in their personal recovery. Davidson and Roe identify two distinct meanings of recovery, which they identify as ‘recovery from’ and ‘recovery in’:

- The first meaning of recovery from mental illness derives from over 30 years of longitudinal clinical research, which has shown that improvement is just as common, if not more so, than progressive deterioration. The second meaning of recovery in derives from the Mental Health Consumer/Survivor Movement and refers instead to a person’s rights to self-determination and inclusion in community life despite continuing to suffer from mental illness (Davidson and Roe 2007: 459).

For this dissertation, I conceptualize recovery as a social process rather than a clinical outcome, in which community inclusion, hope, and overcoming the negative social effects of mental illness are central components. Community inclusion is a prerequisite for the development of social integration.
Individuals with mental illness in the United States are a highly stigmatized and marginalized population, and therefore suffer from both direct (psychiatric) and indirect (social and material) challenges of mental illness. Recovery in focuses on these indirect challenges, including “overcoming the effects of being a mental patient – including poverty, substandard housing, unemployment, loss of valued social roles and identity, isolation, loss of sense of self and purpose in life, and the iatrogenic effects of involuntary treatment and hospitalization – in order to retain, or resume, some degree of control over their lives” (Davidson and Roe 2007: 462).

While the U.S. Department of Health and Human Services has identified recovery as “the single most important goal” for mental health service delivery systems in the U.S. (SAMHSA 2005: 5), there is a scarcity of sociological literature addressing recovery and the recovery process and a virtual absence of sociological perspective on recovery among previously incarcerated individuals. An exception to this is a chapter in a textbook on the sociology of mental health in which Yanos, Knight and Roe (2007) argue that the process of recovery offers a unique lens into greater understanding of structure and agency due to the marginalization and stigmatization of individuals with serious mental illness (SMI). Obdurate aspects of the social structure, such as involuntary hospitalizations, imprisonment, legal restrictions, housing, and institutionalized poverty, constrain agency among individuals with SMI. However, coping, goal setting, and collective action can improve one’s ability to negotiate these structural constraints, thereby increasing likelihood of recovery (Yanos, Knight, and Roe 2007).

Anthropologist Hopper has critiqued the ways in which recovery has been discussed and institutionalized: “Equally telling is what’s missing from such accounts – structure, first and foremost. Race, gender and class tend to fade away into unexamined background realities” (2007: 873). He argues for an alternative framework drawn from Sen’s capabilities approach: “A
capabilities-informed ‘social recovery’ will speak to citizenship as well as health” (p. 875). I concur with Hopper that citizenship and participation are central to the recovery process. Citizenship, as related to community integration, will be discussed later in this chapter.

Prisoner Reentry

Most individuals detained or incarcerated from jails and prisons will be released into the community, a process referred to here as ‘reentry.’ This transition from incarceration to the community presents challenges related to social integration. According to Western, Braga, Davis and Sirois, “Leaving prison presents the formerly incarcerated with the task of social integration, of establishing membership in free society, of forming and reestablishing relationships, and of learning new social roles” (2015: 1513). In their recent study of prisoner reentry in Boston, the authors found that many individuals experienced severe material hardship as well as lack of social integration in the months following incarceration (Western, Braga, Davis, and Sirois 2015). Additionally, individuals with a history of mental illness and/or history of addiction were among the least socially integrated returning citizens (Western, Braga, Davis and Sirois 2015). At year end 2013, the correctional population in the United States (those incarcerated as well as those offenders living in the community under probation and/or parole) was almost 6.9 million individuals, or roughly one in every 35 adults (Glaze and Kaeble 2014). Travis reminds us of “the iron law of imprisonment: they all come back” (2005: xvii). Nearly all do come back: 95% of all state prisoners are eventually released back into the community (Hughes and Wilson 2004). Ex-inmates with mental illness contend with multiple structural and psychosocial barriers to improved quality of life (Drucker 2011), exacerbated by the huge racial disparity in punishment under the current US criminal justice system (Alexander 2010). The racial distribution of the prisoner population is deeply skewed, as evidenced by the imprisonment rates for black males aged 25-39 years being six times greater than that of white males aged 25-39.
(Carson 2014). With so many young men of color serving time, African American communities are disproportionately impacted by the economic, social, mental health, and family consequences of past incarceration. “In health, as elsewhere, the prison has emerged as a powerful stratifying force that drives and shapes social inequalities” (Schnittker, Massoglia, and Uggen 2011: p. 139).

Scholars are increasingly studying prison as a stratifying force, with a focus on the challenges faced after individuals have served time: “Some of the strongest negative effects of incarceration emerge after release, suggesting that the struggle of reintegration into society are as important as the conditions of incarceration” (Schnittker, Massoglia, and Uggen 2011: 133). Incarceration dampens the future economic prospects of previously incarcerated individuals, impacts family life and family members, and is a force for increasing inequality in American society (Western 2006). Emerging literature discusses the consequences of mass incarceration, not only for those individuals previously incarcerated, but also for the communities they exit and those to which they return. These collateral consequences range from economic and social to physical and psychological.

The high rates of recidivism in the United States should therefore come as no surprise. Over three quarters of individuals released from State prisons in 2005 were arrested for a new crime within five years of release. Of those prisoners arrested within 5 years of release, 56% were arrested by the end of the first year (Durose, Cooper, and Snyder 2014). It is therefore important to understand factors related to desistance from offending. In his classic book Making Good, based on narrative analysis of interviews with repeat offenders, Maruna explored desistance from crime as a “process by which stigmatized, former offenders are able to ‘make good’ and create new lives for themselves” (2001: 6-7). He argues that desistance depends on sense-making through self-narrative that allows for the development of new identities.
Citizenship

Rowe’s work on citizenship and mental health (Rowe et al. 2001; Rowe and Baranoski 2011; Rowe and Pelletier 2012) provides a useful framework for incorporating recovery-oriented processes and language within the study of multiple experiences of marginalization. “We define citizenship as a measure of the strength of people’s connections to the rights, responsibilities, roles, and resources that society offers to people through public and social institutions and to relationships involving close ties, supportive social networks, and associational life in one’s community” (Rowe and Pelletier 2012: 369). Central to the framework is the understanding that individuals with mental illness need the chance to claim a life as contributing members of society, belonging not to the mental health system, but to themselves (Rowe and Baranoski 2011). While the current behavioral health system can manage symptoms, it does little to assist individuals in becoming socially integrated in a community (Rowe and Baranoski 2011).

Rowe’s framework of citizenship, with its emphasis on rights and responsibilities within community, is intertwined with the process of recovery:

The mental health recovery paradigm has challenged the traditional separation between various types of knowledge by arguing that the person with mental illness is best placed to know what is best for him or her in the pursuit of happiness and a life well lived. Recovery “brackets” the search for a “cure” for mental illness for the purpose of helping the person with a mental illness live her or his own life. A large part of what is to be “recovered” or achieved, we argue, is one’s citizenship. This recovery process may bring into question the very concept of citizenship in light of the lessons that can be learned from those who have been deprived of it due to stigma and discrimination. (Rowe and Pelletier 2012: 378)

Rowe’s construction of citizenship is an ideal to which one can aspire, focused not only on rights and resources, but roles and responsibilities. Furthermore, Rowe and colleagues recognize that individuals with mental illness are frequently multiply marginalized by criminal justice histories and homelessness. These marginalized individuals, whether by criminal justice status, mental health status, housing status, and/ or substance use status, are thus excluded from many aspects
of society, community, and social ties. One of the greatest barriers that individuals with criminal backgrounds and mental illness face in their recovery process and focus on citizenship is the experience of stigma.

The collective action and consumer involvement upon which the recovery movement is based can also be explained by the related concept of biological citizenship: “biological citizenship is not only individualizing but collectivizing. Based on a shared sense of illness identity, and thus biosocial membership, patients are not only active and expert but also become activist, advocating their care, negotiating the practice of expert systems and politicizing illness” (Rhodes, Harris, and Martin 2013). Recovery too has this dual focus on identity reconstruction and peer/consumer collectivity related to mental illness. However, FPS workers work not only within the scope of mental illness, but simultaneously focus on criminal justice system exposure. While criminal justice system exposure is not explicitly linked to illness identities, there are distinct racial and gender patterns and assumptions reflected in experiences of citizenship.

**Peer Support**

To further scholarship related to multiple stigmas and social integration, this dissertation will focus on a distinct group of peer support providers. Peer Providers are individuals who “use his or her lived experience of recovery from mental illness and/or addiction, plus skills learned in formal training, to deliver services in behavioral health settings to promote mind-body recovery and resiliency” (SAMHSA). Within mental health recovery-oriented services, people with lived experiences have increasingly been incorporated into treatment programs as effective providers and sources of support (Davidson, et al. 2012). Many of the recovery-oriented programs and organizations in the United States emphasize peer-centered services and support.

Peer support is an evidence-based practice that has led to the development of a growing workforce in behavioral healthcare. In 1999, Georgia was the first state to allow Medicaid
reimbursement for peer services. As of 2014, 32 states, including Pennsylvania, allow Medicaid reimbursement for peer services (NASMHPD 2014). There are a variety of peer provider job titles depending on region, including the commonly used Certified Peer Specialist (CPS).

According to a national survey, CPSs spend the majority of their time within their agency (59% of their time) while working with individuals (48% of their time is spent with individuals, in comparison to 25% with groups), providing peer support. The sample for this national survey was 66% female and 79% white (Salzer, Schwenk, and Brusilovskiy 2010). CPSs focus specifically on self-determination, health and wellness, hope, communication with providers, illness management, and stigma. However, it is clear that there is a great diversity of work experiences among CPSs (Salzer, Schwenk, and Brusilovskiy 2010).

Benefits and Barriers of Peer Support

Benefits of peer support for service recipients include reduction in hospitalizations and crisis services; improved quality of life, self-esteem and hope; reduced substance use; and the development of relationships of trust (NASMHPD 2014). A recent study showed that the use of peers within mental healthcare encourages clients towards a greater sense of empowered personhood, and also identified three ways in which peer support influences recovery: transforming experience into expertise, understanding the mechanics of peer support, and launching peers towards their own recovery (Austin, Ramakrishnan, and Hopper 2014). Peer provider models are also intended to reduce hospitalization and crisis services, improve quality of life and hope, reduce substance use, and increase one’s sense of empowered personhood (NASMHPD 2014).

There is also evidence that mental health peer providers themselves experience psychological and economic benefits. A statewide survey of employed, trained CPSs in Pennsylvania (n=154) in 2010 found that 60% were able to transition off, or reduce use, of public
assistance as a result of working as a CPS. These peer providers also experienced decreased use of certain mental health services, such as hospitalizations and emergency room visits, and reported increased levels of hope and confidence (Salzer et al. 2013). The peer provider benefits from their role in helping others and subsequent sense of life purpose, self-sufficiency, and self-efficacy. Additionally, peer provers can receive social support from coworkers and reciprocity with peer clients (NASMHPD 2014).

Despite these benefits, there are challenges related to the recruitment and retention of the peer provider workforce. A major barrier to peer provider retention is the lack of peer provider integration within some mental health agencies. According the National Association of State Mental Health Program Directors’ 2014 assessment of the peer provider workforce, challenges to peer provider integration include the following:

1. Non-peer staff attitudes towards peer workers and recovery
2. Role transformation and conflict
3. Lack of clarity about confidentiality
4. Peer jobs and salary range not well defined
5. Lack of support
6. Finding qualified individuals
7. Criminal background checks
8. Working at the agency where peer provider receives services
9. Ethics and boundaries

The seventh challenge, criminal background checks, are especially applicable in this study of peer providers with contact with the criminal justice system. However, other challenges related to peer support generally might impact the provision and development of Forensic Peer Support in Pennsylvania. NASMHPD has suggestions for the successful integration of new peer services into existing mental health programs, including a readiness assessment, policy review and development, training and evaluation of peer services, and commitment by leadership in hiring peer providers and shifting organizational culture towards recovery (2014). Furthermore, peer positions should have clearly defined job descriptions and competitive salaries (NASMHPD
These strategies, including good pay, role clarity, educational and promotional opportunities for peer providers, and a recovery-oriented organizational culture overall, are also effective strategies for the retention of peer providers (NASMHPD 2014).

The Growth and Professionalization of Peer Support

Peer support literature from across the globe shows that the field is changing, growing rapidly, and increasingly integrated within traditional healthcare systems – in Australia (Byrne, Happell, and Reid-Searl 2016), the United Kingdom (Watson 2017b; Gillard et al. 2017), the United States (Barrenger, Stanhope and Atterbury 2017), and New Zealand (Scott 2015). Byrne, Happell and Reid-Searl are frank about the inherent tension that exists with the Australian requirement of consumer participation within mental health services – it is the introduction of recovery-oriented services within the medical model. They write that this culture of the medical model “imposed a major limitation on the implementation, effectiveness and development of lived experience roles and themselves as individuals. It was also seen as a major limitation to the progress of recovery-oriented reform” (2016: 271). Gillard et al. (2017) discuss the challenges that peer support faces as it is introduced within mainstream mental health services in the UK and proposes several principles for the new peer worker role. Among these principles are that relationships should be based on shared lived experience, and that the validity of experiential knowledge should be emphasized (Gillard et al. 2017). Peer support has grown rapidly in the UK, and Watson (2017a) compares its development to that of a teenager – contradictory, ambivalent, and acceptance seeking. She also discusses the argument that peer support within mainstream mental health services has been co-opted (Watson 2017a). In New Zealand, Scott (2015) explores three conflicting discourses regarding training, formal qualifications, and professionalization of peer support. Based on these three highly differentiated discourses, “this article suggests that the occupational development debate within peer support is partially driven
by quite different understandings of what peer support is, and of where it should be going” (Scott 2015: 44). As peer work continues to expand, these questions of occupational identity and definition will increase in salience.

While there remains little American scholarship on the professionalization of peer support, scholars in the United Kingdom and New Zealand has recently begun to explore the relationship between peer support and professionalism, and the increasing professionalization of peer support in those countries. El Enany, Currie, and Lockett (2013) explored the professionalization of service users in the United Kingdom and the role of lay knowledge in processes that include service users. They find that the service user consultants acted like organizational insiders and considered themselves the “high fliers of the service user community” (2013:27). This contrasts with other scholarship on peer support that emphasizes its non-hierarchical nature (Scott 2015). Scott, focusing on the tension between authenticity and paid work that exists for peer support workers in New Zealand, proposes that peer support workers are “developing a new way of doing ‘professionalism’ which involved organizational structures encouraging more flexible boundaries, greater mutuality, and authenticity” (2011: 182). More recently, Tudor et al. (2018) presented the results of a panel discussion on the professionalization of peer support work in New Zealand. They conclude that peer support workers and clients would benefit from the regulation and professionalization of the field due, in part, to the increased status related to professionalization.

Despite the lack of American sociological scholarship on the professionalization of peer support specifically, there is a significant history of scholarship related to professions and professionalization (See: Carr Saunders and Wilson 1933; Parsons 1939; Hughes 1963; Friedson 1970; Abbott 1988). Of particular import for this dissertation is Abbott’s 1988 book *The System of Professions* in which he focuses on the work itself and interprofessional competition. Abbot
emphasized the importance of jurisdictional boundaries and how control over work tasks impact professionalization processes. Given that peer support workers are a relatively new and growing presence within traditional mental healthcare settings, issues of jurisdiction and control are of central importance. In this dissertation, I use Abbott’s general definition of professions: “exclusive occupational groups applying somewhat abstract knowledge to particular cases” (1988: 8). Peer support is exclusive in that only individuals with lived experience of mental illness recovery and who are willing to disclose that experience are considered, and the abstract knowledge is drawn from the same lived experience.

Forensic Peer Support

In addition to the above discussed growth and professionalization, specialized fields have emerged within the recovery-oriented mental health field of peer support. These specializations include Veteran Peer Support, Peer Support for Older People, and Forensic Peer Support. Forensic Peer Support (FPS) workers, a specialized type of Peer Providers, are a small but growing subset of the peer workforce who utilize their history of criminal justice involvement while delivering services related to mental health and justice system involvement. NASMHPD defines Forensic Peer Specialists as individuals “who have been diagnosed with mental illness and/or substance use and who have been incarcerated. They are trained and certified to work in jails and prisons, in jail diversion programs, and with referrals from mental health courts and drug courts to provide ongoing support to individuals to avoid incarceration in the future” (2014: 2). Little is known about the FPS workforce due to being a relatively recent development within the peer support field. FPS workers have the same goals as those detailed above for peer support in general, but have the additional aim of reducing recidivism and easing the challenges of community reentry (Baron 2011).
The field of Forensic Peer Support emerged a decade after the establishment of Certified Peer Specialists. FPS workers are defined in some literature as individuals with lived experience of incarceration and mental health recovery who have achieved “a reasonable degree of stability in their own lives” who work exclusively with individuals with psychiatric disabilities who have had contact with the criminal justice system (Baron 2011: p.1). However, there are several different overlapping yet distinct definitions of FPS. According to Chapman, Blash and Chan (2015), Forensic Peer Specialists are “mental health or substance use disorder peer providers with a history of criminal activity may be employed to help incarcerated individuals transition back into the community from jails, prisons, and probation programs. Forensic peer providers work with incarcerated individuals prior to release to engage in treatment and support and prepare for re-entry. They can help link newly discharged people with housing, vocational and educational opportunities, and community service, and assist consumers with maintaining adherence to conditions of supervision.” This type of support requires an understanding of how the culture of incarceration impacts behavior upon release, as well as the role and impact of trauma, which is prevalent among this population (Davidson and Rowe 2008).

While there is no known national data set tracking the use of FPS, two programs in the United States are recognized for their attention to building a knowledge base and skill set specifically related to Forensic Peer Support. The first, Howie the Harp Peer Advocacy and Training Center in New York City, has supported job readiness training for the past twenty years for this population. They do not, however, utilize the FPS or CPS training and certification models.

The second program was brought about by the 2010 initiative to establish a Statewide Forensic Peer Support Program in Pennsylvania (Baron 2011). FPS workers in Pennsylvania, who are required to have previously obtained training as a CPS, are employed by various
government and nonprofit agencies and work in a variety of settings, including community-based reentry programs, programs within jails and prisons, and mental health programs. Although FPS certification in Pennsylvania requires training, the specifics of the training itself vary by certification site (Baron 2011). Despite differences, all training is based on the Sequential Intercept Model:

The model envisions a series of points of interception at which an intervention can be made to prevent individuals [with mental illness] from entering or penetrating deeper into the criminal justice system… The interception points are law enforcement and emergency services; initial detention and initial hearings; jails, courts, forensic evaluations, and forensic commitments; reentry from jails, state prisons, and forensic hospitalization; and community corrections and community support. (Munetz and Griffin 2006: 544)

Forensic Peer Support workers perform a number of services and functions, including sharing experiences, supporting engagement in services, providing information, and addressing psychological, social and financial challenges of reentry. However, “given the history of stigma and discrimination accruing to both mental illness and incarceration, perhaps the most important function of Forensic Peer Specialists is to instill hope and serve as valuable and credible models of the possibility of recovery” (Davidson and Rowe 2008: 1-2). The need for Forensic Peer Support is directly related to the stigmatized status of past incarceration and mental illness, and thus FPS workers are important models for understanding multiple stigma management and successfully confronting barriers to social inclusion.

The last few years have witnessed an increasing number of FPS and related programs and workers across the United States (Temple Collaborative on Community Inclusion 2016). A peer support intervention is currently underway among recently incarcerated veterans in Pennsylvania and Massachusetts, which has the potential to expand our understanding of the benefits and challenges of peer support among justice-involved individuals (Simmons et al. 2017). The Temple University Center for Community Inclusion recently released a gray paper entitled
“Reentry and Renewal: A Review of Peer-run organizations that Service Individuals with Behavioral Health Conditions and Criminal Justice Involvement” based on a national survey of peer run organizations resulting in forty-one completed responses in fifteen different states. While the paper highlights just twelve of the programs, the responses indicated that programs range in budget from zero to three hundred thousand dollars, serving from six to nine-hundred individuals. The majority of the programs emphasized supporting individuals returning from the community from incarceration, and most have opened in the last two years (Temple Collaborative on Community Inclusion 2016). According to the report:

The main conclusion we have reached is that peer-run programs are beginning to recognize the need to serve individuals with mental health conditions and criminal justice involvement, but much more needs to be done, especially in funding such programs. One approach is for state mental health authorities and departments of corrections to collaborate…. Another approach is to incorporate more effective evaluation approaches in existing programs to prove effectiveness…. It is clear from the excellent work reported by the 12 programs highlighted in this document, as well as by many of the other programs, that peer-run services have an enormous amount to offer individuals with mental health conditions and criminal justice involvement. With more funding, more research, and many more such programs, these individuals have a much better chance to find hope and recovery, and build successful lives on their return to the community.

Results reveal a growing role for peer support workers and programs to serve the needs of individuals with mental health conditions and involvement with the criminal justice system. Suggestions for the development of these types of programs include effective training programs and increased research. Funding remains the most critical barrier (Temple Collaborative on Community Inclusion 2016). There is also evidence that similar FPS programming is emerging in the United Kingdom (Wolfendale and Musaabi 2017).

While I have found no evidence of literature focused on the experience of FPS workers that use the term “FPS,” Barrenger, Stanhope and Atterbury (2017) recently published a piece exploring how peer specialists with incarceration histories approach their work. Their study,
based on forty-five interviews with fifteen peer specialists, reveals how peer support workers construct new identities through training and peer work that values knowledge based on lived experience.

Peer specialists with incarceration histories have great potential to improve or change the interventions currently offered to those with mental illnesses involved in the criminal justice system. They have the ability to connect on a deeper level and gain the trust of those who may be particularly distrustful of the mental health and criminal justice systems. Through their own experiences and expertise, peers can not only serve as examples of what is possible but can also aid in practical support for community re-entry from jail or prison or for navigating the criminal justice and mental health systems. They can also aid in helping others to construct their own personal narratives that incorporate their past experiences. (Barrenger, Stanhope and Atterbury 2017: 18).

Peer workers in their study challenge dominant discourses directly despite power differentials and advocate for the individuals they serve.

**Conclusion**

This dissertation draws on data related to the Forensic Peer Support workforce to develop a greater theoretical understanding of multiple stigmas and social integration. There are both benefits and limitations associated with studying peer support to understand these topics. Conducting stigma research can be challenging due to a hesitance to disclose and discuss experiences of stigma and stigmatized statuses. This study circumvents that challenge by focusing on a population whose very occupation depends on those statuses. While many individuals in the United States have lived experience of past incarceration and mental illness, these histories and statuses are frequently concealed from employers, coworkers, and others. For FPSs, however, their chosen professional identity depends on those experiences; the FPS occupation requires disclosure due to its focus on lived experience. The disclosure of dual stigmatized statuses is particularly salient for this study. In doing so, however, this study is limited to exploring how multiply marginalized individuals who are ‘out’ navigate stigma and social exclusion. Nevertheless, this examination of the FPS field and workforce sheds light on
larger sociological issues of multiple stigmas, stigma power, social integration, and professionalization. In addition, it speaks to policy and practice related to mental healthcare, the criminal justice system, peer support work, and anti-stigma efforts.
CHAPTER THREE: Methodology

This dissertation utilizes a mixed-methods, CBPR-informed approach to study Forensic Peer Support (FPS) both as an occupation and as a lens through which to examine questions related to peer work, stigma, and community integration. A sequential explanatory model prioritizing qualitative data (Creswell 2009) was chosen based on several factors. These factors included the limited state of literature regarding Forensic Peer Support, community collaborator requests for descriptive data, and the strength of qualitative research in exploring processes and giving voice to marginalized persons (Krauss 2005; Hesse-Biber 2010). The sequential approach allowed each data source to inform the methodological choices of the next stage of data collection. This impacted some of the sub-foci of the project, allowing me to explore topics that emerged as critical to the field, including professionalization (see chapter six). This chapter will first discuss the research setting and community collaborations, before moving into a discussion of the mixed methods design. Each of the three data sources are discussed, followed by a description of analysis processes. I conclude this chapter with a discussion of positionality and context.

Research Setting

This research was conducted in Pennsylvania due to its history of leadership in the field of Forensic Peer Support and widespread embrace of broader peer support services. In recognition of the importance of peer support within recovery-oriented services, the Pennsylvania Office of Mental Health and Substance Abuse Services launched the Certified Peer Specialist Initiative in 2004. By 2007, Certified Peer Specialist (CPS) services were added to the state Medicaid plan, allowing all PA resident mental health consumers with Medicaid to access CPS services. According to the Pennsylvania Peer Support Coalition (PaPSC), as of October
over 4,200 individuals have been trained and certified as Certified Peer Specialists in the state of Pennsylvania (PaPSC 2018).

The Statewide Forensic Peer Support Specialist Program was an 18-month initiative, starting in July 2010, designed to establish a Statewide Forensic Peer Support Program in Pennsylvania. This collaboration between Drexel, the Pennsylvania Mental Health Consumers Association (PMHCA), and the Center of Excellence resulted in the training of 162 forensic peer specialists and 5 advanced-level facilitators throughout the state (Pennsylvania Center of Excellence 2016). Since the completion of that initiative, several organizations throughout Pennsylvania have conducted FPS training. However, there has been no central tracking mechanism, and it is thus impossible to ascertain how many FPSs have been trained and/or are employed in Forensic Peer Support work at this point.

**Community Collaborations**

This study was informed by Community-based Participatory Research (CBPR) principles, including focus on community, building on community strengths, collaborating with community partners, focus on relevant public health problems and multiple determinants of health, and dissemination of results to partners (Minkler 2014). CBPR has been widely used in efforts to increase health equity and redress power imbalances (Wallerstein and Duran 2010). While I did not form a broad community advisory board, this project did rely heavily on collaboration with two FPS workers at two different organizations - through project design, recruitment, and interpretation of results. The first collaborating organization, The Pennsylvania Mental Health Consumers Association (PMHCA) is a member organization headquartered in Harrisburg, Pennsylvania. Their organization has broad geographic reach, with much of their work focused on rural western Pennsylvania. I maintained primary communication with the Forensic Peer Specialist coordinator but also had support from the Executive Director of
PMHCA. My second collaborator was the FPS trainer for the Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) for the City of Philadelphia. DBHIDS hosts the Philadelphia Forensic Task Force, a collaborative team of multiple stakeholders working to improve services for incarcerated and previously incarcerated individuals with behavioral health issues. These collaborators assisted me with recruitment of Forensic Peer Support workers and stakeholders and provided perspective on survey design and initial findings. I have invited community partners to collaborate on some of the dissemination strategies.

**Mixed Methods Design**

This study utilized a sequential explanatory mixed method design with priority placed on qualitative data, analysis, and interpretation (Creswell 2009). The first stage in data collection was a state-wide online survey of peer support workers trained in Forensic Peer Support, followed by thirteen semi-structured interviews with stakeholders, and finally thirty-seven follow-up interviews with a subsample of the surveyed peer support workers in Pennsylvania. This represents a mixed methods qualitative methodology designed to provide, “a more robust understanding of results by triangulating results” (Hesse-Biber 2010: 466). I utilized methodological triangulation by collecting both survey data and in-depth qualitative interviews, and data triangulation through including both FPS and stakeholder perspectives. This allowed me to explore more fully the richness and complexity of FPS work and multiple stigmas, and to increase data credibility.

I utilized a sequential design for this data collection, and each step informed the design of the following steps. However, the end of each step of data collection overlapped with the timing of the next step of data collection. While I wrote initial drafts of the survey and the two interview guides for IRB approval, each was edited before implementation. The online survey (step one) was revised according to suggestions from my community partners. I used initial findings from
the survey to inform my stakeholder interview guide (step two). The survey revealed that there were many more individuals who had been trained in FPS work than were employed as “Forensic Peer Specialists,” so I asked stakeholders about the differences between training and occupational opportunities. Additionally, the survey showed that not all Forensic Peer Support workers had lived experience of incarceration, so the importance of criminal justice system lived experience was included in both stakeholder and peer worker interview (step three) guides.

Survey findings informed the peer support interview guide in unique ways, as well, including expanded discussion of barriers to peer support work. Data that emerged in the stakeholder interviews also informed my peer support interview guide. For example, many stakeholders talked about the Philly/rural divide, and the importance of counties, so I included a question about that topic. Their language choices also informed the language that I used in peer interviews. Professionalization of peer work and changes in the field emerged as critical topics in stakeholder interviews, so I included questions about occupational opportunities and identities in the peer worker interviews.

Qualitative methods and data were emphasized throughout this project. Qualitative research is uniquely capable of exploring meanings, processes, and mechanisms (Krauss 2005; Buston, et al. 1998), factors that drive my research questions. More importantly, qualitative research gives voice to marginalized persons (Hesse-Biber 2010), and a central motivating factor for this study is the social inclusion of individuals facing systemic silencing and multiple barriers to societal participation. This research depends on the narratives of participants with the understanding that individuals compose and reconstruct stories in order to understand and make meaning of their lives (Wertz et al. 2011; Riessman 2008). Narratives are central to the construction of identity and can speak to the “flow of power in the wider world” (Riessman
2008: p. 8), which are crucial elements in the dual processes of recovery and reentry. I describe the three main steps of this mixed methods project below.

I conformed to ethical guidelines regarding human subject research as per the approved Institutional Review Board protocol. Consent was obtained from all participants, including survey respondents who checked a box prior to beginning the online survey, and interview participants who signed consent forms approved by the Institutional Review Board. Consent forms can be found in Appendices E, G and I.

**Data and Sampling**

Data consist of 117 surveys from peer support workers trained in FPS, 14 semi-structured qualitative interviews with stakeholders, and 37 follow-up qualitative interviews with a subset of the peer support workers who had been involved with the criminal justice system. Detailed descriptive data for peer respondent participants are presented in chapter four.

*Online Survey of Peer Support Workers*

The purpose of the statewide survey of Peer Support workers was two-fold: to gather information regarding the composition and experiences of the FPS workforce throughout Pennsylvania and to facilitate recruitment for the qualitative interviews. To be eligible to participate in the survey, respondents had to be aged 18 years or older, reside in Pennsylvania, and have completed a FPS training (or similar training). Eligibility categories were determined by project aims and insight from community partners. This insight included the fact that many individuals trained in FPS are not employed in FPS, and some may also have no personal experience with the criminal justice system.

*Stakeholder Interviews*

The second step of data collection was semi-structured interviews with stakeholders in the field. I interviewed fourteen stakeholders in total. This included five individuals in
Philadelphia, and five men and nine women. Educational attainment varied from high school diploma to doctorate degree. Stakeholders worked for a wide variety of organizations, including: city and state mental health agencies, a regional correctional department, the Veterans Association, a multi-state behavioral healthcare corporation, two state advocacy non-profits, a university, and three regional recovery-oriented organizations. Five stakeholders have experience working in peer support prior to their current positions, three have facilitated FPS trainings, and two were involved in the development of FPS training curricula. Stakeholders were managers, supervisors, heads of organizations, and activists. See chapter four and Appendix A for additional demographic information.

Peer Support Worker Interviews

The final step in data collection process was an in-depth qualitative interview with a subset of survey participants. Based on the research aims related to multiple stigmas, only individuals who reported having personal involvement in the criminal justice system were sampled. I contacted individuals via email or phone, according to the preference they indicated during the survey. Thirty-seven in-depth qualitative interviews with peer support workers trained in FPS were conducted. See chapter four and Appendix B for characteristics and pseudonyms.

Instrument Design

Online Survey of Peer Support Workers

My two community partners were integral to the survey design. The Forensic Peer Support Coordinator at Pennsylvania Mental Health Consumers’ Association (PMHCA) provided substantive feedback on the initial draft of the survey. This feedback impacted some of the language that I used regarding peer work, ordering of questions, and the length of the survey. Dr. Mark Salzer of Temple University shared with me via email (4/3/2016) two surveys that he and his colleagues had developed and implemented for use with Certified Peer Specialists
Variables and measure design used in Salzer’s surveys influenced the development of this survey, specifically related to work tasks, work sites, and benefits of peer work. The survey instrument can be found in Appendix D.

The survey consisted of the following sections asked of all respondents: Demographics, mental health history, history of involvement with the criminal justice system, FPS training, employment, community inclusion, and stigma. Individuals who reported current or previous employment as an FPS worker were asked additional questions related to that specific occupation.

Demographic questions included age, gender, race, language use, relationship status, and zip code of residence. In addition, respondents reported annual income, receipt of public benefits, education attainment, and military service. Individuals who reported having ever used mental healthcare services were asked about age of symptom onset and age at which they first received mental healthcare, as well as several questions about specific mental health care service utilization (clinical, recovery oriented, and substance use related) in the past month, past year, or prior to the past year. Individuals were asked if they had ever been involved in the criminal justice system. Those who reported involvement were asked to report further information regarding arrest, incarceration, and community supervision. Dr. Jeff Draine, a committee member on this dissertation, provided insight into the formulation of questions related to criminal justice system involvement.

All participants were prompted to respond to questions related to the CPS and FPS training, as well as their current employment status. Individuals identifying as current Forensic Peer Specialists were asked an additional set of questions related to employment, work tasks and sites, subjective impact, occupational inclusion and satisfaction. Measures related to instrumental tasks and benefits to FPS were based on past surveys of Certified Peer Specialists (Salzer,
Schwenk, Brusilovskiy 2010; Salzer et al., 2013). I adapted the ten-item validated measure of community integration created by McColl et al. (2001) to investigate FPS integration within their worksite. Individuals who had worked as a Forensic Peer Specialist in the past were asked questions related to that employment and reasons for leaving the position.

The survey also included standardized measures related to stigma and social integration. Community integration was measured using McColl et al.’s ten-item Likert scale (McColl et al. 2001). This survey also included the ten-item version of the Stigma Experiences Scale (Stuart, Milev and Koller 2005) as well as five additional questions that I adapted from Stuart, Milev and Koller (2005) to measure stigma experiences related to criminal justice system involvement. Finally, I included a measure of stigma resistance adapted from Thoits and Link (2016).

Stakeholder Interviews

Interviews were conducted using a semi-structured interview guide. Topics included: job and organization; the role of FPS workers in their organization; FPS training; FPS work; benefits of FPS; future of the FPS and broader peer support workforce; stigma; and social exclusion. The online survey results informed the development of the interview guide. Topics influenced by the online survey include: whether FPS workers should have lived experience of the criminal justice system; discrepancies between individuals trained and individuals employed; peer support professional opportunities; the role of substance abuse in FPS work; and the future of the FPS field. The interview guide can be found in Appendix F.

Peer Support Worker Interviews

The peer support worker interview guide consisted of the following topics: current employment, FPS training and work, client challenges and experiences, personal history (including childhood, past criminal justice system involvement, and mental health recovery), stigma, and recovery. The interview guide was informed by the survey and stakeholder
interviews, resulting in the inclusion of questions related to the recovery or consumer movement as well as questions about professionalization and changes in the peer support field. Partway through data collection I amended the interview guide to include an additional question at the end of the interview regarding positive experiences of peer support. The interview guide can be found in Appendix H.

Data Collection

Online Survey of Peer Support Workers

I utilized SurveyMonkey to design and disseminate the survey based on its use in past statewide surveys of Certified Peer Specialists (Salzer et al. 2013). The survey was distributed via email in the summer of 2016 by individuals in at least six organizations related to peer support in Pennsylvania. The text of the recruitment email is presented in Appendix C. The distributors included both community partners, a representative from PaPSC, and four stakeholders whom I interviewed. However, it is also possible that individuals or organizations forwarded the email or survey link to other groups without informing me, and thus this count might be incomplete. No organization provided me with information regarding how many individuals they sent the survey link to, nor was there a way to track how many survey respondents received the survey weblink. For these reasons, I am unable to specifically identify the survey response rate.

The survey was completed 161 times. Of the 161 survey responses, 25 respondents were disqualified due to age, state of residence, or having not completed FPS training. After eliminating incomplete surveys and duplicate responses, 117 surveys remained for analysis. All individuals who completed the survey were given the opportunity to participate in a random drawing for a $50 gift card. The four randomly selected winners were informed via email and received their gift card in the mail.
Stakeholder Interviews

Stakeholder recruitment occurred in three ways: community research partners provided suggestions; I identified potential stakeholder interviewees through internet searches related to peer support in Pennsylvania and cold-contacted them; and I conducted snowball sampling via stakeholders. Thirteen of the fourteen stakeholders consented to audio recording of the interview. I took notes during the interviews and wrote memos following each interview. The briefest interview lasted nineteen minutes and the longest interview took one hour and forty-four minutes. Mean length of stakeholder interview was one hour and seven minutes. I conducted all stakeholder interviews at their place of employment at a time of their choosing.

Peer Support Worker Interviews

The online survey served as a recruitment method for peer support worker qualitative interviews. Respondents indicated their interest in participating in a follow up interview once they completed the online survey. The majority of peer support worker interviews based in Philadelphia took place in an office at Temple University provided by the Temple Collaborative on Community Inclusion. However, I met peer support workers in their preferred location. For example, one interview in Philadelphia took place in a public library, and another two interviews took place at the peer workers’ place of employment. The majority of interviews elsewhere in the state took place in coffee shops, cafes, and offices, according to respondent request. Interviewees did not seem to express reservations or discomfort talking about sensitive topics while in a public place nor in their offices.

All respondents consented to and had their interviews audio-recorded. I took notes during interviews and wrote memos after completion. Interviews lasted between 48 minutes and two hours and 29 minutes, with a mean interview time of one hour and 36 minutes. Interview participants were compensated for their time with gift cards worth $50. This rate was decided
upon after conferring with my research collaborators, reflecting the challenges that rural participants might face in terms of travel time and expense.

A Note on Qualitative Data Collection

The qualitative data collection process was brief but demanding. I began scheduling interviews with stakeholders in July 2016 and conducted the final peer support worker interview in November of that year. The data collection process took me back and forth across Pennsylvania multiple times. In Philadelphia I rented a room in South Philadelphia in a rapidly gentrifying neighborhood and took public transportation to interview sites. I also stayed with friends for five nights while in Pittsburgh. When it wasn’t viable to return to Philadelphia or Pittsburgh I stayed in motels and Airbnb rooms of varying cleanliness and comfort. I also returned home to Massachusetts for three brief visits to attend prenatal appointments with my midwife. I drove over 10,000 miles between arriving in Philadelphia in summer 2016 and returning home to Boston in November 2016.

I interviewed a total of 51 individuals in 26 different Pennsylvanian cities or towns, including 37 peer support workers and 14 stakeholders. I conducted 19 of the 51 interviews (including 4 stakeholder interviews and 15 peer support worker interviews) in Philadelphia. Therefore, I only conducted one interview in the majority of the towns that I visited. See map below (figure 1) for a visual depiction of travels. I tried to schedule interviews based on geography. This was initially successful, but toward the end of the interviewing process I had to drive farther distances between each interview due to rescheduled interviews, scheduling difficulties or “no shows.” There were only three “no shows” over the course of data collection, two of which occurred on the same rainy day 125 miles apart. Two of the three missed interviews were successfully rescheduled and conducted.
I conducted interviews in the following towns and cities across the state: Altoona, Greensburg, Mansfield, Pittsburgh, Towanda, Barnesville, Greensville, Middletown, Scranton, Warren, Butler, Harrisburg, New Kensington, Sharpsburg, West Norriton, Carlisle, Horsham, Norristown, South Strabane, West Rockhill, Danville, Johnstown, O’Hara, Erie, Kittanning, and Philadelphia. A map of Pennsylvania with interview locations identified follows:

Figure 1: Interview Location

Data Analysis

Both quantitative and qualitative analyses were conducted, although findings stem from a synthesis of the various data sources. I first discuss quantitative analyses, then qualitative analyses, and conclude this section with a discussion of data synthesis. Survey response data was cleaned and analyzed using SPSS software. I transformed response data into several additional variables, including two bivariate variables identifying geography (Philadelphia/ other areas in Pennsylvania) and experience providing FPS (current or past FPS workers/ never FPS worker).
Due to the small sample size, especially among current Forensic Peer Support workers, statistical procedures were limited to descriptive statistics, including frequencies, means, and crosstabs.

Upon completion of the qualitative interviews, all recorded interviews (n=50) were transcribed verbatim by professional transcription service. I reviewed all transcriptions while listening to the audio files. Minimal errors were corrected, most notably regarding jargon related to peer support and criminal justice system involvement. Interview data was analyzed using qualitative software NVivo by linking codes to specific segments of the text. Multiple codes were frequently attached to the same set of text. Separate codebooks were created for the stakeholder interviews and the peer support worker interviews due to the different subject matter, although some overlap in codebooks did occur. I created the codebook and coded the stakeholder interviews prior to the peer support worker interviews, in keeping with the sequential structure of this project.

I utilized thematic analysis for the qualitative data consisting of both inductive and deductive coding (Fereday and Muir-Cochrane 2006). I began with an a priori template of codes based on social theory and research aims and supplemented this with codes that emerged from the data. Both descriptive and analytic coding was conducted. Qualitative analyses were conducted in an iterative fashion, identifying both codes and sub codes. The final stakeholder codebook consisted of seven parent codes: Status of the FPS field, future of the FPS field, FPS training, regionality, criminal justice system involvement, recovery, professionalization, and stigma/ social integration. The final peer support worker codebook also consisted of seven parent codes: Peer support, mental health, criminal justice, personal history, professionalization, stigma/ social integration, and substance use. Most parent codes contained subthemes, and some subthemes also contained subthemes. Cases were defined by demographic and occupational variables in order to compare code reports between groups.
Stakeholders and peer support workers are distinguished throughout this dissertation by identification: peer support workers are identified with a pseudonym, while stakeholders are identified by a number. The peer support workers whom I interviewed are referred to by pseudonyms throughout this manuscript in order to maintain anonymity while retaining their sense of personhood. To assign the names, I utilized census records of the most commonly occurring US names by decade (U.S. Bureau of the Census 2016). For each participant I assigned the most popular first name during the decade in which the participant was born that started with the same letter as their given name. If I had previously assigned the name, or if the pseudonym and the actual name were the same, I chose the next most common name. To differentiate data source and perspective, I identify stakeholders by their interview number rather than a pseudonym.

Although the three main data sources were analyzed through different processes, findings result from a synthesis of all data. In order to answer the research questions driving the following four chapters, I drew on as many data sources as could speak to that topic. Therefore, most chapters draw on multiple data sources. The exception to this is the discussion of multiple stigmas, in which the qualitative interviews with peer support workers primarily informed analyses related to stigma processes. I continued to work with the two FPS trainers as research collaborators throughout the analysis process. They provided important insights on preliminary data based on lived experience of both past incarceration and recovery in mental illness.

Researcher Role, Positionality, and Context

Differences in power relations and my personal biography, including race, gender, mental health status, mental healthcare service use, criminal justice system involvement, sexual identity, educational and occupational status, place of residence, among others, were especially important for me to recognize, acknowledge, and reflect upon throughout all aspects of this research.
(England 1994). Specifically, as a middle-class, white, female graduate student residing in urban Massachusetts with no history of incarceration and no involvement in the peer mental health recovery movement, I was vigilant against the influence of master narratives and in recognizing my privileged identities (McCorkel and Myers 2003). I reflected on these positions and identities in memos written after interviews, throughout the data collection process, and throughout analysis. I believe that my statuses might have influenced some of the topics that respondents were interested in discussing. Specifically, I believe that participants might have unintentionally limited some of their discussions of race and masculinity in interviews with me. While I did not automatically identify myself as a peer to all respondents, I did so when asked directly or when respondents were projecting discomfort with me that I believed was related to assumed differences in recovery statuses.

My given name (Wallis) also impacted data collection. For convenience, much of my recruiting and coordinating communication with stakeholder and peer support workers occurred over email rather than by phone. I signed each email “Wallis.” Multiple respondents expressed surprise at my gender when we met in person, telling me that they were expecting to meet a male. Although no one explicitly mentioned my race, two individuals did tell me that the name Wallis makes them think of a Black basketball player with the last name “Wallace.” I think it is likely that having a name that does not explicitly read as white, female, and middle-class helped with recruitment.

It is important to note that the presidential election race was underway during my time in the field, and I believe this might have impacted my perspective on the study as well as the interviews themselves. I finished peer support interviews on 11/3/16 and the election was held 11/8/16, so it was extremely salient for many participants. Furthermore, because Pennsylvania was a swing state, the election also had a strong physical presence. Both candidates held rallies
throughout the state during this period. At one point, I ran into Trump rallies three days in a row, which I found quite challenging. Researcher bias played a role in this project, especially in terms of intellectual and visceral detest of Trump, despite my attempts to minimize it and maintain neutrality during interviews. I found myself slightly relaxing in interviews when respondents expressed support for democratic candidates or policies. Due to Trump’s history of violence against and disrespect for women, I believe my interaction with some older white male respondents was more reserved and self-protective than it might have been otherwise.

I believe the election also highlighted the differences between rural and urban Pennsylvania, both objectively and in my subjective experiences of the state. Signs for “Bernie” were common throughout both Philadelphia and Pittsburgh, despite his prior loss in the primaries to Hilary Clinton. There were some signs in support of Hillary Clinton in urban areas, although not as many as those supporting Bernie Sanders. However, immediately outside of cities every presidential sign or indication I observed was pro-Trump. One that stuck out to me was “Trump that Bitch,” which I saw on several large lawns. The stark regional political differences underscored a common narrative expressed by several participants – Philadelphia as its own country or state, completely distinct and separate from the rest of Pennsylvania. I found myself feeling much more comfortable in Philadelphia and Pittsburgh than I did in other areas of the state. I fear that this geographic division in comfort also impacted my interview technique, in that I found it easier to forge connections and quickly build rapport with respondents in urban areas than in rural areas.

This chapter described the sequential, mixed method, community engaged research approach that was utilized in this study of Forensic Peer Support. The following chapters present findings that speak to the research questions driving this study.
CHAPTER FOUR: Forensic Peer Support in Pennsylvania

In this chapter I draw upon each of my three sources of data (stakeholder interviews, online surveys, and interviews with peer support workers) to describe Forensic Peer Support work (FPS) in Pennsylvania. Stakeholders are identified by their interview number, while peer support workers are referred to throughout by pseudonyms. I begin with a discussion of how and when FPS emerged, present data related to FPS work tasks and characteristics of the workforce and conclude with a summary of its benefits.

A Note on Language

Much has changed in Pennsylvanian recovery services over the past two decades, including the expansion of peer support services, the codification of Certified Peer Specialists (CPSs), and the development of specialized peer support positions. While mental health care settings across Pennsylvania now recognize CPS as a specific occupational role, there is no broad recognition of specialized peer support positions, including those working with justice involved peers. In general, there is lack of consensus (both across the literature and reflected in my data) regarding both what “Forensic Peer Support” is, and what it looks like.

The term ‘Forensic Peer Specialist’ has an inconsistent meaning for study participants, even including those who do self-identify as a ‘Forensic Peer Specialist’. As one FPS trainer said, “First of all in the state of Pennsylvania, there is no certified forensic peer specialist… I mean, people do go by ‘Forensic Peer Specialists’. It’s not a real title” (#012). While some claim that it is not a ‘real’ title, other individuals do self-identify as Forensic Peer Specialists. This reflects a substantial disagreement regarding both language and role present amongst my participants. An individual who has been involved in FPS for the past decade, and who is a board member of a state-wide consumer run organization, could not remember the actual language used in the FPS training. Another stakeholder told me passionately, “I don’t even know why this is
called forensics. This is not forensics. Forensics is a whole different discipline and so I rail about that” (#015). Due to this debate and confusion around language, and in order to maintain clarity throughout the project, I begin this chapter with a definition of terms. This language will be used throughout the dissertation.

*Peer Support Worker:* “Peer support workers are people who have been successful in the recovery process who help others experiencing similar situations. Through shared understanding, respect, and mutual empowerment, peer support workers help people become and stay engaged in the recovery process and reduce the likelihood of relapse.” (SAMHSA 2017).

*Certified Peer Specialist (referred throughout as “CPS”):* A specific type of peer support worker. Certified in the state of Pennsylvania (among other states) to provide Medicaid-reimbursable peer support services to individuals with mental health diagnoses.

*Forensic Peer Support (referred throughout as “FPS”):* A specialization within the broader field of peer support that focuses on mental health recovery amongst individuals involved with the criminal justice system (interactions at all stages, from police contact to community supervision).

*Note:* While the terms “CPS” and “FPS” are visually similar, please keep in mind that CPS refers to peer workers while FPS refers to a specialization within the peer support field. Therefore, CPS refers to individuals and FPS refer to a type of work or training. The majority (94.5%) of peer support worker respondents in this dissertation are CPSs. All peer support worker respondents have completed training in FPS but fewer than half identify as engaging in FPS work.

**History of Forensic Peer Support in Pennsylvania**

To describe how and why Forensic Peer Support (FPS) emerged and developed across Pennsylvania during the last decade, I draw on fourteen stakeholder interviews as well as governmental and organizational documents. Stakeholder roles and characteristics are presented in Table 1 below (and in appendices).
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<thead>
<tr>
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<th>Location</th>
<th>Current Position</th>
<th>Organizational Affiliation</th>
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<td>Department of Prisons</td>
<td>Not voice recorded</td>
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<td>FPS Program Coordinator</td>
<td>Mental Health Department</td>
<td>FPS Trainer; Provides FPS</td>
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<td>Harrisburg</td>
<td>Executive Director</td>
<td>Mental Health Advocacy Organization</td>
<td></td>
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<td>#012</td>
<td>F</td>
<td>Harrisburg</td>
<td>FPS Project Specialist</td>
<td>Mental Health Advocacy Organization</td>
<td>FPS Trainer; Has worked as CPS; Involved in 2010 SAMHSA grant</td>
</tr>
<tr>
<td>#014</td>
<td>M</td>
<td>Central Western Pennsylvania</td>
<td>Program Manager</td>
<td>County Mental Health Consumer Organization</td>
<td>Manages 2-month-old FPS program for incarcerated peers</td>
</tr>
<tr>
<td>#015</td>
<td>F</td>
<td>Philadelphia</td>
<td>Director</td>
<td>Recovery Advocacy Organization</td>
<td>Wrote FPS Training Curriculum</td>
</tr>
<tr>
<td>#016</td>
<td>F</td>
<td>Central Pennsylvania</td>
<td>Program Coordinator</td>
<td>Statewide For-Profit Peer Support Provider</td>
<td>Oversees FPS work in multiple jails; FPS Trainer; Provides FPS</td>
</tr>
<tr>
<td>#017</td>
<td>F</td>
<td>Philadelphia</td>
<td>Faculty</td>
<td>University (Continuing Education)</td>
<td>Involved in 2010 SAMHSA FPS Grant and Training Curriculum</td>
</tr>
<tr>
<td>#019</td>
<td>F</td>
<td>Harrisburg</td>
<td>Program Specialist</td>
<td>Mental Health Department</td>
<td>Justice Liaison; Involved in 2010 SAMHSA FPS Grant and DOC CPS Program</td>
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<td>Harrisburg</td>
<td>Mental Health Worker</td>
<td>Mental Health Department</td>
<td></td>
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<tr>
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<td>F</td>
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<td>Director</td>
<td>County Mental Health Consumer Organization</td>
<td></td>
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<tr>
<td>#022</td>
<td>M</td>
<td>Northwestern Pennsylvania</td>
<td>Peer Support Team Leader and Trainer</td>
<td>County Mental Health Consumer Organization</td>
<td>FPS Trainer and advocate; Has worked as CPS</td>
</tr>
<tr>
<td>#023</td>
<td>M</td>
<td>Northwestern Pennsylvania</td>
<td>Program Supervisor</td>
<td>Veteran Transitional Housing</td>
<td>FPS and Incarcerated Veterans Trainer; Has worked as CPS</td>
</tr>
<tr>
<td>#024</td>
<td>F</td>
<td>Northeastern Pennsylvania</td>
<td>FPS Supervisor</td>
<td>County Mental Health Consumer Organization</td>
<td>Was MH Consumer at Employing Agency; Provides FPS</td>
</tr>
</tbody>
</table>
The Introduction and Growth of Certified Peer Specialists (CPSs) in Pennsylvania

Major shifts occurred within the framing and understanding of mental health and the approach to mental healthcare across the United States in the last two decades, as a movement of mental healthcare consumers, advocates, organizations, mental health providers and departments, and politicians embraced the concept of recovery (Braslow 2013). Pennsylvania, and its largest city, Philadelphia, played a central role in that transformation as state and city agencies and officials incorporated recovery into both policy goals and their overall approach to mental health (PA Recovery 2018). This was motivated partly by Pennsylvania’s Office of Mental Health and Substance Abuse Service’s 2005 publication “A Call for Change: Toward a Recovery Oriented Mental Health System for Adults.” The growth of peer support across Pennsylvania was a natural response to the state’s embrace of recovery as philosophy and aim (PaPSC 2018; OMHSAS 2005).

While individuals in Pennsylvania had been providing mental health peer support in voluntary and paid roles for years, in the mid 2000s peer support underwent formalization, resulting in an exploding number of Medicaid-reimbursable Certified Peer Specialists (CPSs). Much of this was motivated by the 2003 national report from the New Freedom Commission on Mental Health entitled “Achieving the Promise: Transforming Mental Health Care in America,” which critiqued the established mental health care system and called for a systemic transformation towards recovery (President’s New Freedom Commission on Mental Health 2003). The Deputy Secretary of OMHSAS during this time, Joan Erney, was a critical leader in Pennsylvania’s embrace of the recovery movement and formalization of Peer Support work. State legislation that facilitated the formalization of peer support included both the 2004 Certified Peer Specialist Initiative and the 2006 inclusion of Certified Peer Specialist as a Medicaid-reimbursable service (PaPSC 2018). OMHSAS launched the Certified Peer Specialist
Initiative in 2004 as part of their broader focus on mental health service system transformation from the medical model to recovery orientation. Upon successful completion of a two-week training course (provided by one of two sanctioned training providers in the state), peer providers gain the title of ‘Certified Peer Specialist’ (CPS) (PA Recovery 2018). As of October 2015, over 4200 individuals had been trained and certified as Certified Peer Specialists in Pennsylvania (PaPSC 2018). According to Mark Salzer, the Director of Temple University’s Collaborative on Community Inclusion of Individuals with Psychiatric Disabilities, as of 2016 over 1000 individuals have completed CPS training in Philadelphia alone.

CPS services are Medicaid-reimbursable in many states, including Pennsylvania. Every county in Pennsylvania is required by the state to offer peer support services under Medicaid reimbursement (PA Recovery 2018). The institutionalization of peer support roles through the adoption of Medicaid-reimbursable CPS services guarantees funding for the services, but also led to broad disagreements regarding professionalization and role identity, as will be discussed in chapter six.

The Birth and Development of Forensic Peer Support (FPS) in Pennsylvania

The history of Forensic Peer Support in Pennsylvania is a tale of specialization, obvious need, and an innovative program in a rural Northeastern county. Specialization within the peer support field developed rapidly following the success of the CPS program in Pennsylvania, which resulted in FPS and other specializations such as Veteran Peer Support, and Peer Support for Older Adults (PaPSC 2018). Providers and consumers recognized that some groups of individuals were more likely to require specialized services or would greatly benefit from working with peer providers with similar life histories. “Now it’s multiple, like rabbits. Now we’re into the realm of supporting veterans and people in the military. That whole community, we’ve taken the same format and translated [it]” (#013) to better serve populations with
particular histories or specific needs, including recovering individuals with a history of criminal justice involvement.

Stakeholders and peer workers across the state had long recognized a need for peer services for justice-involved individuals. In discussing the development of FPS, several stakeholders noted that a disproportionate number of individuals involved with corrections have mental health conditions (Steadman et al. 2009; James and Glaze 2006; Feucht and Gfroerer 2011). Individuals with mental illness face substantial challenges that lead to, and develop from, interaction with the criminal justice system. When one of the stakeholders had difficulty recalling the details of how FPS began, she told me, “I don’t remember how it came to us, but it just makes logical sense” (#013). Forensic Peer Support was frequently presented as an inevitable development: “a natural evolution,” “a natural outgrowth,” or a “natural progression.” Targeted programming for those with both experiences was “common sense” (#010), and individuals and agencies across the state recognized that peer support workers were in a unique position to effect change.

Stakeholders reported that in the early 2000s several regional consumer-run organizations and peer providers attempted to integrate peer support workers into prisons and other criminal justice environments, in both official or unofficial capacities. While most attempts were not successful, one small organization, a consumer-run support center in rural northeastern Pennsylvania, successfully launched and grew their FPS program in the early 2000s. An academic in Philadelphia praised this organization, “This little group of peer support services. They were out there doing it, kicking butt and figuring it out” (#017). According to a stakeholder, peer support workers from this small organization began entering county jails to speak with detainees with current mental health problems at the request of the county mental health director. They began by running groups and offering one-on-one peer sessions in the jails.
The program, still running, now includes three months of individual peer support with incarcerated peers prior to their anticipated release date. This work prepares and trains returning citizens for release and community reentry. Peer support workers continue to serve individuals once they have been released into the community, provided the peer clients remain in the county. A representative from the organization noted that their programs are responsible for a 14% drop in the county recidivism rate and the prevention of three inmate suicides.

Due to the success of the county program, statewide organizations collaborated with OMHSAS to develop a statewide FPS training curriculum for CPSs based on the organization’s original training. According to the same stakeholder, “The work and original curriculum content and materials were built on the work of members of the [organization], a consumer run provider of peer support that has been cultivating supportive and resourceful relationships with individuals incarcerated in correctional facilities” (#017). Subsequently this training has been utilized and adapted beyond Pennsylvania by organizations throughout the United States. Peers in the organization are deservedly proud. As one woman told me, “The people that we trained to do Forensic Peer Support, the classes that they’re training, they’ve been all over the country. It came from the little [organization] in rural [county]. It’s good. It’s really good” (#024). Much of the FPS work that is taking place across Pennsylvania is due to the hard work and determination of peer support workers scattered throughout the state.

*Forensic Peer Support Trainings*

In 2010 the Pennsylvania Mental Health Consumer Association (PMHCA) received an 18-month grant from the Pennsylvania Commission on Crime and Delinquency and additional funding from OMHSAS to implement Forensic Peer Support trainings across the state (PaPSC 2018). The curriculum for this training was based on the curriculum originally developed by the small organization in the rural northeastern county discussed above. The curriculum now
incorporates both peer knowledge and the specialized knowledge of university faculty, including project partners at Drexel University’s Behavioral Healthcare Education (BHE) and the Center for Excellence at Drexel University. Between 2011 and 2012, PMHCA and its collaborators conducted nine FPS trainings across the state, training 162 peer support workers. Under the grant, they also conducted two train-the-trainer sessions, resulting in 43 FPS trainers (PMHCA 2018). Between 2013 and 2015 the frequency of trainings slowed, and curriculum improvement halted due to lack of state funding. In 2015 PMHCA received a new three-year SAMHSA grant to update the FPS curriculum and provide additional train-the-trainers sessions. In the last several years, organizations and agencies across the country have contracted with PMHCA-associated FPS trainers to provide FPS training.

Since the original PMHCA training in 2011, multiple other organizations have developed their own FPS training programs. Some of these FPS trainings are based on the PMHCA model, while others are not. While some trainings, like those provided by PMHCA, are offered to peers working in a variety of settings and organizations across the state, others are offered only for individuals employed in specific organizations or working in specific communities. Despite differences between the trainings, most employ the Sequential Intercept Model (SIM) as the organizing theory (Munetz and Griffin 2006), illustrated in Figure 2.

Figure 2: Sequential Intercept Model
SIM is a conceptual framework designed for use by communities to address and minimize the criminalization of individuals with mental illness (Munetz and Griffin 2006). It is explicitly aimed at decreasing the burden of criminal justice system exposure resulting from behaviors associated with mental illness. Munetz and Griffin write that, “people with mental illness should not be arrested or incarcerated simply because of their mental disorder or lack of access to appropriate treatment – nor should such people be detained in jails or prison longer than others simply because of their illness” (2006: 544). The SIM is composed of the following five successive points of potential intervention, reflecting the flow of individuals through the criminal justice system:

1. Law enforcement and emergency services
2. Initial detention and initial hearings
3. Jail, courts, forensic evaluations, and forensic commitments
4. Reentry from jails, state prisons, and forensic hospitalization
5. Community corrections and community support services

The conceptual framework is designed to be utilized by communities to develop “target strategies” to increase diversion and access to community treatment within their particular setting and resource environment (Munetz and Griffin 2006: 548). Authors suggest that communities emphasize interventions occurring earlier in the sequence.

According to stakeholders, participants in the FPS trainings are encouraged to think about the specific needs and resources of the community in which they work and reside. The training facilitators lead participants through scenarios and role playing that address each of the five intercepts. Leaders of the training facilitate brainstorming and discussion by asking participants to consider SIM within their local communities: “We spend a big amount of time helping folks think through that [SIM] and identify for their area, for their geographic area, where they have the ability to influence” (#015). Multiple stakeholders emphasized the importance of local
decision making in Pennsylvania, recounting several times the state’s status as a commonwealth. FPS programming in Pennsylvania remains regionally specific.

While many of the FPS trainings are organized around SIM, additional training topics include: the culture of prisons and jails; vocabulary specific to the criminal justice system (such as turtle suits\(^1\) and CJAB – Criminal Justice Advisory Board), relapse, chemical dependency, stigma, reentry, Wellness Recovery Action Plans (WRAP), boundaries, and ethics. These discussions remain rooted in the specific contexts and settings in which the participants work, both related to the larger community and their employment setting. “A lot of it boils down to the company that you’re working for and what are the ethics that they carry. Boundaries, we say, are your personal, and ethics are that of the program that you’re working for” (#020). Trauma became a central topic in the 2016 update to the curriculum. Many interviewees emphasized the importance of developing trauma-informed programming, as well as the complicated relationship between criminal justice system exposure and trauma.

Participant engagement, participant expertise, and mutual learning is emphasized during trainings. One curriculum designer said of the interactive nature of the training, “Mutual learning… I call it dialogue, discover, and develop process” (#017). The peer support workers being trained are encouraged to use their own lived experiences to teach each other. Participants engage in frequent brainstorming exercises and switch off acting as participant facilitators. “It’s a very interactional curriculum. The people come together to learn but also to share experiences and learn from each other” (#013). The recognition and value of lived experience that is highlighted during these trainings is also a central component of peer support as a whole, as will be discussed in the context of expert knowledge in chapter six.

\(^1\) Formally known as an anti-suicide smock, a turtle suit is a garment used to prevent hospitalized or incarcerated individuals from attempting self-harm.
Peer Support in State Prisons in Pennsylvania

There is limited availability of formal peer support services for individuals across the state who are involved with the criminal justice system, as will be discussed later in the chapter. However, there is an important and significant exception to the lack of broad utilization of peer support services within the criminal justice system at the prison level. The Pennsylvania Department of Corrections supports a program in which qualified and interested prison inmates are trained and employed as CPSs (but do not complete formal FPS training). Over five hundred incarcerated peers have been certified since 2012 (Patrone 2018). According to an employee at The Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS), incarcerated individuals are employed as CPSs in every one of the twenty-six state correctional institutions (SCIs), including the two female SCIs. Incarcerated CPSs work in a variety of settings within the institutions, including in mental health units, libraries, reception areas, and in an on-call capacity in which Correctional Officers can refer inmates whom they suspect might benefit from the program.

The OMHSAS-associated stakeholder reported that the program emerged in 2010 through a pilot grant to bring the ten-day CPS training to six institutions, resulting in 89 trained inmates. The program is now directly funded through the DOC. In order to receive the training and work as a CPS in the SCI, inmates must meet the same qualifications as non-incarcerated peers, including having a high school degree or GED. The training that is provided to the incarcerated peers is very similar to that which is conducted in the community, and the CPS certification earned inside the prisons is equivalent to CPS certifications earned outside. All CPSs, including those incarcerated, are required to complete 18 hours of “Continuing Education” training. The Forensic Peer Specialist training qualifies for those hours, but has not yet been offered to incarcerated CPSs. The veteran peer support training is offered in nine facilities.
(through PMHCA) due to the high prevalence of incarcerated veterans in recovery. Many incarcerated CPSs have received additional training in mental health first aid and suicide prevention.

Both individuals eligible for release and those serving life sentences are trained to work as CPSs. Individuals serving life sentences were specifically chosen for training for “a couple different reasons. One of them was to sustain the program. Also, to give them more purpose within the department of corrections to help carry that program” (#020). Those peers that are released into the community are able to utilize their certification in order to find employment as a CPS in the community. “It was very important for us to make sure they were employable. We wanted them to leave the department of corrections with an employable skill if they wanted to get into the workforce” (#020). There is no tracking method to determine whether released peers do seek employment as a CPS in the community, or whether they are successful. However, over the course of this project I met two employed community-based peer support workers who had received their CPS certification while incarcerated in an SCI.

Stakeholders and state representatives believe this program to be valuable and a success. In describing the utilization of CPSs across the institutions, stakeholder #020 noted of DOC administrators, “They’re just using them so much, and they’ve recognized… what a strength it is to have them in the SCIs. They want more and more and more.” The recognition that the CPS program was having a positive impact has led to a prioritization of maintaining and growing the CPS program through the twenty-six SCIs. The president of a statewide advocacy organization also praised the efforts and reiterated that the DOC has noted its impact, “Pennsylvania has been lucky to have a department of corrections that has trained people to be Certified Peer Specialists. That’s not true in every state. As the peers are recognizing the importance of Forensic Peer
Support, so is the department of corrections and it was… The Office of Mental Health and Substance Abuse Services was in the middle of that” (#012).

It appears that this innovative program is creating positive change. “They've really been able to integrate it the way you would in the community to the best in their environment. They've been able to replicate that to some degree. They really have recognized the importance of it, and they've really embraced it” (#020). More research should explore their process of successfully integrating peer services within correctional settings and the program’s impact on incarcerated peer workers and peer clients, in order to attempt to replicate the program’s success in other states and settings. Although I hope to study this work in more depth in a later project, this dissertation will focus on Forensic Peer Support services delivered by non-incarcerated (community-based) peers.

While the SCI peer program is established and successful, there are few other large-scale peer support efforts taking place in correctional settings throughout Pennsylvania. The number of individuals residing in SCIs is dwarfed by the number of individuals involved with the corrections system in other ways, including individuals who have been arrested, are under community corrections such as probation or parole, or are residing in county and regional jails. The majority of criminal-justice-involved individuals with mental illness do not have the opportunity to benefit from peer support. However, there is some meaningful FPS work occurring throughout the state, which I discuss below.

Who are Forensic Peer Support Workers and What Do They Do?

In this section I present sociodemographic characteristics of FPS-trained peer support workers in Pennsylvania and then describe their work tasks. Data include survey responses from peer support workers trained in FPS (n=117) and thirty-seven follow up qualitative interviews with a subsample of survey respondents. I find that many more individuals are trained to provide
Forensic Peer Support than identify as ‘Forensic Peer Specialists’. While a few peer support workers in Pennsylvania are providing impactful Forensic Peer Support, data indicate that the breadth of the field remains fairly limited.

*Demographics of FPS-Trained Peer Support Workers*

In the Summer of 2016 I conducted an online survey of peer support workers trained in Forensic Peer Support in Pennsylvania. Links to the online survey were distributed via email by FPS stakeholders through at least eight different list-serves of peer support workers in Pennsylvania. (See chapter three for methodological detail.) One-hundred and seventeen (n=117) peer workers fully completed the survey. No specific data exists as to how many individuals in Pennsylvania have actually been trained in FPS, nor how many peer workers provide FPS. However, based on the source and breadth of survey distribution, respondent characteristics adequately reflect of the full population of FPS-trained peer support workers in Pennsylvania.

The mean age of respondents (n=117) was 50.4 years, ranging from 26 to 72, reflective of a career rooted in life experience. Half of the respondents identified as female and half identified as male. The majority of respondents identified as white (63.2%). This sample of peer workers has a greater proportion of males and people of color than previous samples of CPSs (Salzer et al. 2010; Salzer et al. 2013), likely due to the higher percentage of men and people of color involved with the criminal justice system compared to women and whites. A quarter of individuals (24.8%) resided in Philadelphia County. Almost all respondents had a high school degree or equivalent (98.3%), and 27.3% had a bachelor or graduate degree. The majority of these peer support workers report an annual income of below $30,000 per year. 65.8% of respondents are employed full-time, 27.4% are employed part-time, and 6.8% are unemployed, retired, disabled, or volunteering. Furthermore, 96.3% of employed survey respondents work
within the broad field of peer support, most frequently as CPSs. See Table 2 below for additional sociodemographic findings.

Table 2: Survey Participants (n=117) and Current FPS (n=25)

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<td>Female</td>
<td>58</td>
<td>50%</td>
</tr>
<tr>
<td>Male</td>
<td>58</td>
<td>50%</td>
</tr>
<tr>
<td>Racial Identity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black or African-American</td>
<td>36</td>
<td>31.6%</td>
</tr>
<tr>
<td>White</td>
<td>72</td>
<td>63.2%</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>3.6%</td>
</tr>
<tr>
<td>2+ Races</td>
<td>2</td>
<td>1.8%</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic or Latino/a</td>
<td>8</td>
<td>6.8%</td>
</tr>
<tr>
<td>Not Hispanic or Latino/a</td>
<td>109</td>
<td>93.2%</td>
</tr>
<tr>
<td>Age (years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td></td>
<td>50.4 years</td>
</tr>
<tr>
<td>Range</td>
<td></td>
<td>26-72 years</td>
</tr>
<tr>
<td>Military Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>24</td>
<td>20.5%</td>
</tr>
<tr>
<td>No</td>
<td>93</td>
<td>79.5%</td>
</tr>
<tr>
<td>County of Residence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Philadelphia</td>
<td>29</td>
<td>24.8%</td>
</tr>
<tr>
<td>County other than Philadelphia</td>
<td>88</td>
<td>75.2%</td>
</tr>
<tr>
<td>Educational Attainment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than High School degree</td>
<td>2</td>
<td>1.7%</td>
</tr>
<tr>
<td>High School degree or equivalent</td>
<td>15</td>
<td>12.8%</td>
</tr>
<tr>
<td>Some college, no degree</td>
<td>44</td>
<td>37.6%</td>
</tr>
<tr>
<td>Associate degree</td>
<td>24</td>
<td>20.5%</td>
</tr>
<tr>
<td>Bachelor degree</td>
<td>26</td>
<td>22.2%</td>
</tr>
<tr>
<td>Graduate degree</td>
<td>6</td>
<td>5.1%</td>
</tr>
<tr>
<td>Income (personal)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than $10,000/ year</td>
<td>14</td>
<td>12.6%</td>
</tr>
<tr>
<td>$10,000-19,999/ year</td>
<td>21</td>
<td>18.9%</td>
</tr>
<tr>
<td>$20,000-29,999/ year</td>
<td>29</td>
<td>26.1%</td>
</tr>
<tr>
<td>$30,000-39,999/ year</td>
<td>23</td>
<td>20.7%</td>
</tr>
<tr>
<td>$40,000-49,999/ year</td>
<td>9</td>
<td>8.1%</td>
</tr>
<tr>
<td>$50,000-59,999/ year</td>
<td>7</td>
<td>6.3%</td>
</tr>
<tr>
<td>$60,000/ year and above</td>
<td>3</td>
<td>2.7%</td>
</tr>
<tr>
<td>Unknown</td>
<td>5</td>
<td>4.5%</td>
</tr>
<tr>
<td>Current use of social services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare</td>
<td>23</td>
<td>19.7%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>32</td>
<td>27.4%</td>
</tr>
<tr>
<td>SSI</td>
<td>10</td>
<td>8.5%</td>
</tr>
<tr>
<td>SSDI</td>
<td>13</td>
<td>11.1%</td>
</tr>
</tbody>
</table>
As would be expected of peer support workers in the mental health field, survey participants reported extensive histories of mental health service utilization (See tables 3a and 3b below). The vast majority (95.7%) of respondents report having used mental health services at some point in their lives. Of these individuals, 61.9% report experiencing mental health symptoms before the age of 18, but only 20.2% report receiving any mental healthcare before 18 years of age. This reflects the broader mental health treatment gap in the United States. The most commonly utilized mental healthcare services were therapy, psychiatric medication, social work/case management, and inpatient psychiatric hospitalization. In addition, 52.7% of the survey respondents had been enrolled in an outpatient treatment program for alcohol and/or drug use, and 47.3% had been enrolled in an inpatient treatment program for the same. Half (50%) of all respondents have received peer run service, with 16.7% of respondents utilizing peer services in the past month.

Table 3a: History of Mental Health of All Survey Participants and Current FPS

<table>
<thead>
<tr>
<th></th>
<th>Survey Respondents (n=117)</th>
<th>Current FPS (n=25)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Sample %</td>
</tr>
<tr>
<td><strong>Age of onset of MH symptoms</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 18 years</td>
<td>69</td>
<td>61.6%</td>
</tr>
<tr>
<td>18-24</td>
<td>12</td>
<td>10.7%</td>
</tr>
<tr>
<td>25-44</td>
<td>26</td>
<td>23.2%</td>
</tr>
<tr>
<td>45 or older</td>
<td>5</td>
<td>4.5%</td>
</tr>
<tr>
<td><strong>Age of first MH service use</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 18 years</td>
<td>22</td>
<td>20.2%</td>
</tr>
<tr>
<td>25-44</td>
<td>27</td>
<td>24.8%</td>
</tr>
<tr>
<td>45 or older</td>
<td>46</td>
<td>42.3%</td>
</tr>
<tr>
<td>Have you ever used mental health care services? (any)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>112</td>
<td>95.7%</td>
</tr>
<tr>
<td>No</td>
<td>5</td>
<td>4.3%</td>
</tr>
</tbody>
</table>
Table 3b: Mental Health Service Use of Survey Participants and Current FPS

<table>
<thead>
<tr>
<th>Have you ever used any of the following services or treatments:</th>
<th>Survey Respondents (n=112)</th>
<th>Current FPS (n=24)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Past month (n)</td>
<td>Valid %</td>
</tr>
<tr>
<td>Psychiatric medication</td>
<td>57</td>
<td>51.8%</td>
</tr>
<tr>
<td>Therapy</td>
<td>38</td>
<td>34.9%</td>
</tr>
<tr>
<td>Case management/ Social worker</td>
<td>17</td>
<td>15.6%</td>
</tr>
<tr>
<td>Crisis hotline or warm line</td>
<td>1</td>
<td>0.9%</td>
</tr>
<tr>
<td>Peer run services</td>
<td>18</td>
<td>16.7%</td>
</tr>
<tr>
<td>Partial/ Day hospitalization</td>
<td>2</td>
<td>1.9%</td>
</tr>
<tr>
<td>Inpatient in psych. unit or hospital</td>
<td>2</td>
<td>1.8%</td>
</tr>
<tr>
<td>Outpatient Tx for alcohol and/or drug</td>
<td>2</td>
<td>1.8%</td>
</tr>
<tr>
<td>Inpatient Tx for alcohol and/or drug</td>
<td>1</td>
<td>.9%</td>
</tr>
</tbody>
</table>

While the literature defines Forensic Peer Support as involving “trained peer specialists with histories of mental illness and criminal justice involvement helping those with similar histories” (Davidson and Rowe 2008:1), in practice this is not always the case (see tables 4a and 4b). It was surprising that fewer than two-thirds (65%) of the participants report having ever been involved in the criminal justice system in any capacity, and only 54.7% report having ever been incarcerated. 9.4% of all survey respondents are currently under community supervision, such as probation or parole. Of the respondents who reported previous involvement in the criminal justice system, 38.2% were first arrested before the age of 18 and 23.6% spent five or more years incarcerated. Interesting geographical differences in criminal justice involvement were seen. While all current peer support workers in identifying as a “Forensic Peer Specialist” in Philadelphia have spent time incarcerated, only half of the “Forensic Peer Specialists”
elsewhere in the state have spent time incarcerated. See tables 4a and 4b below for information regarding criminal justice system exposure among surveyed peer support workers.

Table 4a: History of Criminal Justice System Exposure

<table>
<thead>
<tr>
<th></th>
<th>Survey respondents (n=117)</th>
<th>Current FPS (n=25)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Percent (Valid)</td>
</tr>
<tr>
<td>Have you ever been:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Involved in the criminal</td>
<td>76</td>
<td>65%</td>
</tr>
<tr>
<td>justice system</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arrested</td>
<td>74</td>
<td>64.1%</td>
</tr>
<tr>
<td>Incarcerated</td>
<td>64</td>
<td>54.7%</td>
</tr>
<tr>
<td>Community supervision</td>
<td>63</td>
<td>53.8%</td>
</tr>
</tbody>
</table>

Table 4b: CJ History of Survey Respondents and Current FPS With CJ Exposure

<table>
<thead>
<tr>
<th></th>
<th>Survey Respondents (n=76)</th>
<th>Current FPS (n=19)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Percent (Valid)</td>
</tr>
<tr>
<td>Total number of arrests</td>
<td></td>
<td></td>
</tr>
<tr>
<td>One arrest</td>
<td>15</td>
<td>19.7%</td>
</tr>
<tr>
<td>Two</td>
<td>19</td>
<td>25%</td>
</tr>
<tr>
<td>3-9</td>
<td>21</td>
<td>27.6%</td>
</tr>
<tr>
<td>10-19</td>
<td>11</td>
<td>14.5%</td>
</tr>
<tr>
<td>20 or more arrests</td>
<td>6</td>
<td>7.9%</td>
</tr>
<tr>
<td>Age of first arrest</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 18 years of age</td>
<td>29</td>
<td>38.2%</td>
</tr>
<tr>
<td>18-24 years</td>
<td>17</td>
<td>22.4%</td>
</tr>
<tr>
<td>25-44</td>
<td>21</td>
<td>27.6%</td>
</tr>
<tr>
<td>45 and older</td>
<td>7</td>
<td>9.2%</td>
</tr>
<tr>
<td>Total time spent incarcerated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 6 months</td>
<td>24</td>
<td>31.6%</td>
</tr>
<tr>
<td>7-12 months</td>
<td>10</td>
<td>13.2%</td>
</tr>
<tr>
<td>1-4 years</td>
<td>12</td>
<td>15.8%</td>
</tr>
<tr>
<td>5-10 years</td>
<td>15</td>
<td>19.7%</td>
</tr>
<tr>
<td>11 or more years</td>
<td>3</td>
<td>3.9%</td>
</tr>
<tr>
<td>Age of release from last</td>
<td></td>
<td></td>
</tr>
<tr>
<td>incarceration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 18 years of age</td>
<td>2</td>
<td>2.7%</td>
</tr>
<tr>
<td>18-24</td>
<td>13</td>
<td>17.3%</td>
</tr>
<tr>
<td>25-44</td>
<td>30</td>
<td>40%</td>
</tr>
<tr>
<td>45 and older</td>
<td>17</td>
<td>22.7%</td>
</tr>
<tr>
<td>Total time spent under</td>
<td></td>
<td></td>
</tr>
<tr>
<td>community supervision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 6 months</td>
<td>4</td>
<td>5.3%</td>
</tr>
<tr>
<td>7-12 months</td>
<td>6</td>
<td>8.0%</td>
</tr>
<tr>
<td>1-4 years</td>
<td>22</td>
<td>29.3%</td>
</tr>
<tr>
<td>5-10 years</td>
<td>27</td>
<td>36.0%</td>
</tr>
<tr>
<td>11 or more years</td>
<td>4</td>
<td>5.3%</td>
</tr>
<tr>
<td>Currently under Community</td>
<td>11</td>
<td>14.7%</td>
</tr>
<tr>
<td>Supervision</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Employment Among FPS-Trained Peer Support Workers

This section describes the personal and work characteristics of respondents who report working as a ‘Forensic Peer Specialist.’ An important finding is that few survey respondents identify as having ever worked as a ‘Forensic Peer Specialist’: Only 21.4% (n=25) of the sample were currently employed as a ‘Forensic Peer Specialist’, with an additional 16.2% (n=19) reporting that they previously worked as a ‘Forensic Peer Specialist’ but currently do not. There were few demographic differences between the broader sample of FPS-trained respondents and those respondents currently engaged in Forensic Peer Support work (see table 2). Two exceptions to this are race and gender: current ‘Forensic Peer Specialists’ are more likely to be male and African American than the broader sample, again reflecting the broader racial and gender trends in the American criminal justice system. A slightly higher percentage of current ‘Forensic Peer Specialists’ report past involvement with the criminal justice system compared to the entire sample.

Among those that responded that they are currently employed as ‘Forensic Peer Specialists’ (n=25), 14 reported working in this capacity for over 2 years, with 6 reporting five or more years. Almost half (11) of these respondents are the only FPS employed at their organization, despite evidence that organizations that hire more than one peer support worker have better peer employee retention (NASMHPD 2014). Current ‘Forensic Peer Specialists’ report earning at least $12.00 per hour, with 13 current ‘Forensic Peer Specialists’ reporting an hourly pay rate between $12.00 and $15.99 per hour. This is in keeping with national data reporting a mean hourly wage of $13.87 peer support provider pay (Cronise et al. 2016). See table 5 below for more detailed information regarding employment for current and past ‘Forensic Peer Specialists’.
Table 5: Current and Past Employment as a “Forensic Peer Specialist”

<table>
<thead>
<tr>
<th></th>
<th>CURRENT FPS (n=25)</th>
<th>PAST FPS (n=19)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>% of sample</td>
</tr>
<tr>
<td>Current Employment Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed, Full time</td>
<td>21</td>
<td>84%</td>
</tr>
<tr>
<td>Employed, Part time</td>
<td>4</td>
<td>16%</td>
</tr>
<tr>
<td>Not employed, looking for work</td>
<td>1</td>
<td>5.3%</td>
</tr>
<tr>
<td>Volunteer work</td>
<td>1</td>
<td>5.3%</td>
</tr>
<tr>
<td>Disabled, not able to work</td>
<td>2</td>
<td>10.5%</td>
</tr>
<tr>
<td>Length of FPS employment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 1 year</td>
<td>4</td>
<td>16%</td>
</tr>
<tr>
<td>1-2 years</td>
<td>7</td>
<td>28%</td>
</tr>
<tr>
<td>2-3 years</td>
<td>5</td>
<td>20%</td>
</tr>
<tr>
<td>3-4 years</td>
<td>3</td>
<td>12%</td>
</tr>
<tr>
<td>5+ years</td>
<td>6</td>
<td>24%</td>
</tr>
<tr>
<td>Pay rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than $10.00/hour</td>
<td>4</td>
<td>22.2%</td>
</tr>
<tr>
<td>$10.00-11.99/hour</td>
<td>4</td>
<td>22.2%</td>
</tr>
<tr>
<td>$12.00-13.99/hour</td>
<td>9</td>
<td>36%</td>
</tr>
<tr>
<td>$14.00-15.99/hour</td>
<td>4</td>
<td>16%</td>
</tr>
<tr>
<td>$16.00-17.99/hour</td>
<td>4</td>
<td>16%</td>
</tr>
<tr>
<td>$18.00-19.99/hour</td>
<td>4</td>
<td>16%</td>
</tr>
<tr>
<td>$20.00/ hour or more</td>
<td>2</td>
<td>8%</td>
</tr>
<tr>
<td>Length in current FPS position</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 1 year</td>
<td>4</td>
<td>16%</td>
</tr>
<tr>
<td>1-2 years</td>
<td>5</td>
<td>20%</td>
</tr>
<tr>
<td>2-3 years</td>
<td>3</td>
<td>12%</td>
</tr>
<tr>
<td>3-4 years</td>
<td>4</td>
<td>16%</td>
</tr>
<tr>
<td>5+ years</td>
<td>9</td>
<td>36%</td>
</tr>
<tr>
<td>Number of FPS employed at work site (including self)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>11</td>
<td>44%</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>8%</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>12%</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td>5-10</td>
<td>3</td>
<td>12%</td>
</tr>
<tr>
<td>11-20</td>
<td>2</td>
<td>8%</td>
</tr>
<tr>
<td>21-30</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td>Over 30 people</td>
<td>2</td>
<td>8%</td>
</tr>
</tbody>
</table>

Survey respondents identifying as current ‘Forensic Peer Specialists’ spend their time engaged in many activities, including supporting people in groups, supporting people individually, working with families, working with inmates or detainees, working with community members, working with employers, and administrative tasks (see Table 6 below). Respondents overwhelmingly report spending the most time supporting people individually, with
19 stating that they spend ‘all’ or ‘most’ of their work time doing so. ‘Forensic Peer Specialist’ workers report spending the least amount of time working with families and with inmates or detainees. This is in keeping with a past national survey of CPSs, where CPSs reported spending the most amount of time supporting people individually, a moderate amount of time supporting people in groups, and far less time working with families or other community members (Salzer et al. 2010).

Table 6: Time spent in FPS activities (N=25)

<table>
<thead>
<tr>
<th></th>
<th>Supporting people in groups</th>
<th>Supporting people individually</th>
<th>Working with families</th>
<th>Working with inmates/detainees</th>
<th>Working with community members</th>
<th>Working with employers</th>
<th>Administrative tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean (std. deviation)</td>
<td>2.64* (.1221)</td>
<td>4.12 (.881)</td>
<td>2.08 (1.077)</td>
<td>2.20 (1.080)</td>
<td>3.04 (.978)</td>
<td>2.24 (.663)</td>
<td>2.84 (.850)</td>
</tr>
<tr>
<td>N</td>
<td>4</td>
<td>1</td>
<td>7</td>
<td>8</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Valid %</td>
<td>16%</td>
<td>0%</td>
<td>28%</td>
<td>32%</td>
<td>4%</td>
<td>12%</td>
<td>12%</td>
</tr>
<tr>
<td>A little of the time</td>
<td>9</td>
<td>36%</td>
<td>4%</td>
<td>52%</td>
<td>28%</td>
<td>20%</td>
<td>52%</td>
</tr>
<tr>
<td>Valid %</td>
<td>1</td>
<td>4%</td>
<td>13</td>
<td>7</td>
<td>5</td>
<td>13</td>
<td>2</td>
</tr>
<tr>
<td>Some of the time</td>
<td>7</td>
<td>28%</td>
<td>20%</td>
<td>12%</td>
<td>32%</td>
<td>56%</td>
<td>36%</td>
</tr>
<tr>
<td>Valid %</td>
<td>5</td>
<td>20%</td>
<td>3</td>
<td>12%</td>
<td>8</td>
<td>14</td>
<td>16%</td>
</tr>
<tr>
<td>Most of the time</td>
<td>2</td>
<td>8%</td>
<td>36%</td>
<td>0%</td>
<td>4%</td>
<td>8%</td>
<td>0%</td>
</tr>
<tr>
<td>Valid %</td>
<td>9</td>
<td>36%</td>
<td>0</td>
<td>0%</td>
<td>2</td>
<td>8%</td>
<td>4</td>
</tr>
<tr>
<td>All of the time</td>
<td>3</td>
<td>12%</td>
<td>40%</td>
<td>8%</td>
<td>4%</td>
<td>12%</td>
<td>0%</td>
</tr>
</tbody>
</table>

*Where ‘none of the time’=1 and ‘all of the time’=5

‘Forensic Peer Specialist’ work also occurs in a number of settings including: at organization/program sites, in the community, at a client’s residence, in transit, and in jails/other criminal justice environments (see Table 7 below). These findings diverge somewhat from previous work. While Salzer et al. (2010) reported that CPSs spent almost twice as much time on site as they spent in the community, FPS workers in this survey reported spending more time in the community than at the organization or program site. 19 respondents identifying as a current ‘Forensic Peer Specialist’s spend some work time in jails, prisons, or other criminal justice environments.
Table 7: Time spent in FPS worksites (N=25)

<table>
<thead>
<tr>
<th></th>
<th>At the organization or program site</th>
<th>In the community</th>
<th>At a client’s residence</th>
<th>In transit</th>
<th>In jail, prison or other CJ environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean (std. deviation)*</td>
<td>2.60* (.957)</td>
<td>3.36 (.860)</td>
<td>2.60 (1.118)</td>
<td>2.56 (.651)</td>
<td>2.16 (.800)</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>Valid %</td>
<td>N</td>
<td>Valid %</td>
<td>N</td>
</tr>
<tr>
<td>None of the time</td>
<td></td>
<td></td>
<td>2</td>
<td>8%</td>
<td>1</td>
</tr>
<tr>
<td>A little of the time</td>
<td>11</td>
<td>44%</td>
<td>1</td>
<td>4%</td>
<td>6</td>
</tr>
<tr>
<td>Some of the time</td>
<td>8</td>
<td>32%</td>
<td>13</td>
<td>52%</td>
<td>9</td>
</tr>
<tr>
<td>Most of the time</td>
<td>3</td>
<td>12%</td>
<td>8</td>
<td>32%</td>
<td>4</td>
</tr>
<tr>
<td>All of the time</td>
<td>1</td>
<td>4%</td>
<td>2</td>
<td>8%</td>
<td>1</td>
</tr>
</tbody>
</table>

* Where ‘none of the time’=1 and ‘all of the time’=5

How Forensic Peer Support Workers Describe FPS Work

As described in the methods chapter, I completed qualitative interviews with thirty-seven of the peer support workers who had completed the online survey. I prioritized interviewing peer support workers who identified as a current or past ‘Forensic Peer Specialist.’ However, due to the low numbers of peer support works reporting employment as a ‘Forensic Peer Specialist’, I also interviewed peer support workers who report never having worked as a ‘Forensic Peer Specialist’. All interview respondents have been involved in the criminal justice system. Characteristics of interview participants are presented in Table 8 below.
Table 8: Peer Support Worker Characteristics (n=37)

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Worked as Forensic Peer Specialist</th>
<th>Has CPS Certification</th>
<th>Current Position</th>
<th>Gender</th>
<th>Age</th>
<th>Race</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charles</td>
<td>No</td>
<td>Yes</td>
<td>CPS/ PSS</td>
<td>Male</td>
<td>66</td>
<td>African American</td>
<td>Philadelphia</td>
</tr>
<tr>
<td>Pamela</td>
<td>No</td>
<td>Yes</td>
<td>Certified Peer Specialist</td>
<td>Female</td>
<td>54</td>
<td>African American</td>
<td>Philadelphia</td>
</tr>
<tr>
<td>Susan</td>
<td>No</td>
<td>Yes</td>
<td>Recovery Coach</td>
<td>Female</td>
<td>49</td>
<td>African American</td>
<td>Philadelphia</td>
</tr>
<tr>
<td>Larry</td>
<td>No</td>
<td>Yes</td>
<td>Employment Specialist</td>
<td>Male</td>
<td>58</td>
<td>African American</td>
<td>Philadelphia</td>
</tr>
<tr>
<td>Julie</td>
<td>No</td>
<td>No</td>
<td>Family and Community Inclusion Specialist</td>
<td>Female</td>
<td>55</td>
<td>African American</td>
<td>Philadelphia</td>
</tr>
<tr>
<td>Jason</td>
<td>Current</td>
<td>Yes</td>
<td>Certified Peer Specialist</td>
<td>Male</td>
<td>40</td>
<td>African American</td>
<td>Philadelphia</td>
</tr>
<tr>
<td>Mary</td>
<td>No</td>
<td>Yes</td>
<td>Family Specialist</td>
<td>Female</td>
<td>62</td>
<td>African American</td>
<td>Philadelphia</td>
</tr>
<tr>
<td>Amy</td>
<td>No</td>
<td>Yes</td>
<td>Corporate Peer Services Coordinator</td>
<td>Female</td>
<td>40</td>
<td>White/African American</td>
<td>Philadelphia</td>
</tr>
<tr>
<td>Mark</td>
<td>Previously</td>
<td>Yes</td>
<td>Mental Health Group Facilitator</td>
<td>Male</td>
<td>52</td>
<td>African American</td>
<td>Philadelphia</td>
</tr>
<tr>
<td>Richard</td>
<td>Current</td>
<td>Yes</td>
<td>Forensic Peer Support Specialist</td>
<td>Male</td>
<td>61</td>
<td>White</td>
<td>Southeast PA</td>
</tr>
<tr>
<td>Steven</td>
<td>Current</td>
<td>Yes</td>
<td>Veteran Forensic CPS/FSS</td>
<td>Male</td>
<td>59</td>
<td>White</td>
<td>Philadelphia</td>
</tr>
<tr>
<td>Brenda</td>
<td>No</td>
<td>Yes</td>
<td>CPS</td>
<td>Female</td>
<td>58</td>
<td>White</td>
<td>Southeast PA</td>
</tr>
<tr>
<td>Willie</td>
<td>No</td>
<td>Yes</td>
<td>Crisis Team CPS</td>
<td>Male</td>
<td>55</td>
<td>African American</td>
<td>Southeast PA</td>
</tr>
<tr>
<td>Kimberly</td>
<td>No</td>
<td>Yes</td>
<td>CPS</td>
<td>Female</td>
<td>30</td>
<td>White</td>
<td>Southeast PA</td>
</tr>
<tr>
<td>Wayne</td>
<td>Current</td>
<td>Yes</td>
<td>Certified Peer Specialist</td>
<td>Male</td>
<td>56</td>
<td>White</td>
<td>Southeast PA</td>
</tr>
<tr>
<td>Robert</td>
<td>Current</td>
<td>Yes</td>
<td>CPS Co-coordinator/ WRAP facilitator</td>
<td>Male</td>
<td>61</td>
<td>African American</td>
<td>Philadelphia</td>
</tr>
<tr>
<td>Sandra</td>
<td>Previously</td>
<td>Yes</td>
<td>Director of MH Recovery center</td>
<td>Female</td>
<td>54</td>
<td>African American</td>
<td>Southeast PA</td>
</tr>
<tr>
<td>Victor</td>
<td>Previously</td>
<td>Yes</td>
<td>CPS</td>
<td>Male</td>
<td>26</td>
<td>African American</td>
<td>Philadelphia</td>
</tr>
<tr>
<td>Pseudonym</td>
<td>Worked as Forensic Peer Specialist</td>
<td>Has CPS Certification</td>
<td>Current Position</td>
<td>Gender</td>
<td>Age</td>
<td>Race</td>
<td>Location</td>
</tr>
<tr>
<td>-----------</td>
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<td>-----------------------</td>
<td>------------------</td>
<td>--------</td>
<td>-----</td>
<td>--------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>James</td>
<td>No</td>
<td>Yes</td>
<td>Certified Peer Specialist</td>
<td>Male</td>
<td>39</td>
<td>Latino/White</td>
<td>Philadelphia</td>
</tr>
<tr>
<td>Jerry</td>
<td>No</td>
<td>No</td>
<td>Certified Recovery Specialist</td>
<td>Male</td>
<td>72</td>
<td>White</td>
<td>Philadelphia</td>
</tr>
<tr>
<td>Jessica</td>
<td>No</td>
<td>Yes</td>
<td>CPS</td>
<td>Female</td>
<td>40</td>
<td>White</td>
<td>Southeast PA</td>
</tr>
<tr>
<td>Ronald</td>
<td>No</td>
<td>Yes</td>
<td>Peer Specialist VA</td>
<td>Male</td>
<td>62</td>
<td>White</td>
<td>Southeast PA</td>
</tr>
<tr>
<td>David</td>
<td>No</td>
<td>Yes</td>
<td>CPSS</td>
<td>Male</td>
<td>46</td>
<td>White</td>
<td>Southeast PA</td>
</tr>
<tr>
<td>Gail</td>
<td>Previously</td>
<td>Yes</td>
<td>Certified Peer Specialist</td>
<td>Female</td>
<td>59</td>
<td>African American</td>
<td>Southeast PA</td>
</tr>
<tr>
<td>Melissa</td>
<td>Currently</td>
<td>Yes</td>
<td>CPS Supervisor</td>
<td>Female</td>
<td>36</td>
<td>White</td>
<td>Eastern PA</td>
</tr>
<tr>
<td>Patricia</td>
<td>Previously</td>
<td>Yes</td>
<td>Disabled</td>
<td>Female</td>
<td>58</td>
<td>White</td>
<td>Southeast PA</td>
</tr>
<tr>
<td>Stephen</td>
<td>No</td>
<td>Yes</td>
<td>Supervisor of Peer Support Services</td>
<td>Female</td>
<td>60</td>
<td>White</td>
<td>Southeast PA</td>
</tr>
<tr>
<td>Lawrence</td>
<td>Current</td>
<td>Yes</td>
<td>Director of Peer Support Services</td>
<td>Male</td>
<td>34</td>
<td>White</td>
<td>Central PA</td>
</tr>
<tr>
<td>Joseph</td>
<td>No</td>
<td>Yes</td>
<td>Certified Peer Specialist</td>
<td>Female</td>
<td>58</td>
<td>White</td>
<td>Eastern PA</td>
</tr>
<tr>
<td>John</td>
<td>No</td>
<td>Yes</td>
<td>CPS</td>
<td>Male</td>
<td>54</td>
<td>African American</td>
<td>Philadelphia</td>
</tr>
<tr>
<td>Michelle</td>
<td>Current</td>
<td>Yes</td>
<td>Certified Forensic Peer Specialist</td>
<td>Female</td>
<td>31</td>
<td>Latino/Native American</td>
<td>Northern PA</td>
</tr>
<tr>
<td>Amanda</td>
<td>No</td>
<td>Yes</td>
<td>Peer Recovery Navigator</td>
<td>Female</td>
<td>31</td>
<td>White</td>
<td>Southeast PA</td>
</tr>
<tr>
<td>Michael</td>
<td>No</td>
<td>Yes</td>
<td>4 Different part time jobs in mental health</td>
<td>Male</td>
<td>43</td>
<td>White</td>
<td>Central PA</td>
</tr>
<tr>
<td>Rebecca</td>
<td>No</td>
<td>Yes</td>
<td>Certified Peer Specialist/ Social work aide</td>
<td>Female</td>
<td>44</td>
<td>White</td>
<td>Central PA</td>
</tr>
<tr>
<td>Scott</td>
<td>Previous</td>
<td>Yes</td>
<td>Community Services Specialist/ Yes Mental Health Advocate/ CPS</td>
<td>Male</td>
<td>53</td>
<td>White</td>
<td>Northeast PA</td>
</tr>
<tr>
<td>Bruce</td>
<td>Previous</td>
<td>Yes</td>
<td>CPS Supervisor</td>
<td>Male</td>
<td>62</td>
<td>White</td>
<td>Northern PA</td>
</tr>
<tr>
<td>William</td>
<td>Current</td>
<td>Yes</td>
<td>CPS</td>
<td>Male</td>
<td>39</td>
<td>White</td>
<td>Central PA</td>
</tr>
</tbody>
</table>
In this section I draw on interview data with peer support workers identifying as current (n=9) or previous (n=7) ‘Forensic Peer Specialists’ to describe the nature and content of FPS work. Among interviewed ‘Forensic Peer Specialists’ (n=16), 5 reside in Philadelphia, 11 are male, 9 are white, all 16 have a CPS certification, and their mean age is 49 years. Interview respondents who identified as ‘Forensic Peer Specialists’ described a broad variety of work activities and environments, including incarceration, community supervision, specialty services, and Crisis Intervention Teams (CIT). I present a few of these respondents and how they describe their work tasks below.

Jason is a forty-year-old African American man living and working in Philadelphia. After nearly a decade of incarceration in a SCI, during which he was trained and employed as a CPS in a SCI, he was recently released and employed by a large behavioral-healthcare organization to provide individual peer support to clients in the community. While some of these peer clients have a history of criminal justice system involvement, some do not. Jason, like many of the peer workers I spoke with, spends much of his work time engaged in two activities: helping his peer clients locate and utilize community resources; and working with peer clients on setting short-term and long-term goals. While these may seem like simple tasks, Jason recognizes the broader purpose that they serve. When his peer clients find resources and achieve goals, it gives them a boost of self-confidence that encourages them to continue working on their recovery. Jason tells his peer clients, “do little things to accomplish small goals and society will accept you again”, explicitly linking these activities with community inclusion. Many of the techniques that he uses to work with justice-involved peer clients are identical to those used for non-justice-involved peers. However, Jason and other interviewees spoke at length about the societal exclusions that returning citizens face, including challenges related to housing, employment, and prejudice. While all peer clients need support locating and accessing resources, jobs and social support
networks, Jason contends that peer clients with criminal records face more structurally entrenched barriers to community inclusion.

*Richard*, a white man in his sixties, works for the same large organization as Jason. He provides individual peer support to detainees in a county prison in southeast Pennsylvania for one to three months prior to their release, and for up to a month afterwards. Despite working in the prison rather than the community, Richard describes many of the same work tasks and structural barriers to community inclusion. However, Richard also emphasized the challenges related to prison behavior and culture. He tells his peer inmate clients that the survival techniques and culturally specific behaviors common during incarceration, such as hypervigilance and violence, are problematic for individuals once they return to the community. Richard describes, “working with them [peer clients], and educating them, getting them to understand, you know, how society works.” It takes effort to change the attitudes and behaviors that served his peer clients while incarcerated but that later serve as barriers to community inclusion.

Despite differences in clientele and environment, many of the peer support workers talked about teaching their peer clients life skills, such as how to use the bus system. This seemingly simple task epitomizes the strength of peer support: rather than focusing narrowly on clinical factors related to behavioral health, peer providers give their clients the hope and skill set to more fully engage with the world around them. Riding the bus isn’t just about knowing the route numbers and learning how to use a reduced transit fare card; riding the bus allows recovering persons the opportunity and freedom to engage more fully with their community and truly become community members. Justice-involved peers experience even more barriers to social inclusion, and Forensic Peer Support workers told me about how they were able to help their peer clients with criminal records find employment, housing, meaning, reconnect with family members, and forge new friendships.
Melissa, like Richard, provides individual peer support to incarcerated individuals. In addition to working with detainees, she supervises the other six peer support workers in her western Pennsylvanian mental health organization. She is a white woman in her thirties and currently under community supervision. Melissa, like Jason and Richard, spoke at length about the importance of goal setting and informing peer clients about available resources. Melissa believes that one of the most important roles of peer workers for incarcerated peers is, “just linking them to the resources that are available has been huge for us. Just letting people know that there is help available.” She notes that many detainees were never been diagnosed or connected with services prior to incarceration. While Richard works with incarcerated peers for one to three months prior to release, Melissa works with peer clients for up to six months prior to release. Due to a recent funding increase, peer workers at Melissa’s agency are now also able to work with jailed peers who are awaiting transfer to state prisons (“sent upstate”) rather than release. However, there are differences in the support she provides peer detainees prior to release or transfer.

People that are being released in the community, it’s more goal centered, definitely. We’re working on getting out and working on housing and building a plan to be reintegrated back into the community. Where those people [who are sentenced to state prison], we’re just teaching them basic coping skills and how to prepare for being in long term, what to expect, and try to build some kind of support system within themselves, teach them about AA and other resources that will be available at the state level. If they have drug and alcohol, AA, NA, Bible studies, that kind of thing. Try to get some sort of hope for them. (Melissa)

Most peer workers discussed the importance of drug and alcohol use support and resources, especially for criminal justice involved peer clients.

Lawrence, a 34-year-old white male, is the director of peer support services for a nonprofit mental health facility in a poor county in central Pennsylvania. Many of the organization’s peer clients are on probation or in mental health court. He speaks highly of mental health and other “problem solving courts” that recognize ‘the importance of what we do. We make their job
Peer clients are frequently referred to his organization directly through the county mental health court. While Lawrence doesn’t provide individual peer support, he does facilitate 8-week WRAP groups for inmates in the transitional housing unit at the closest SCI. He noted multiple times throughout the interview that they are providing WRAP on a voluntary basis, without funding, and have done so for the past two years. The goal of providing free WRAP groups to inmates are twofold: 1. For the benefit of participating inmates, and 2. For the organization to make connections with decision makers in the justice system – they are “hoping obviously that that leads to some more stuff in the future.” Many of the peer workers that I interviewed, both stakeholders and peer support workers, spend many work hours engaged in activities aimed at forging connections, gaining buy-in, and obtaining funding.

Bruce is white, 62 years old, and lives in a small town in northern Pennsylvania. Bruce has multiple roles at the same company, including providing individual support to peer clients, supervising other peer workers, and managing the company’s fleet of 16 cars. Due to a recent health crisis, Bruce recently cut down from full-time to part-time employment, but the company has “yet to fill half of my shoes.” As a veteran with a personal history of criminal justice system involvement, and as someone who has taken both the FPS and Veteran Peer Support trainings, Bruce was assigned most of the veteran and justice-involved peer clients. He still provides support for two justice-involved peer clients, one of whom, Bruce told me proudly, had just gotten off of parole the week before. Bruce had been working with him on problem solving skills, coping skills, social and interpersonal skills, and trust. Some of the peer client’s doctor’s appointments were in a different county, due to the rural nature of the area. Bruce would help his peer client coordinate these out-of-county visits, which required consent from the parole officer. While he had positive work interactions with this parole officer, other interactions with criminal justice workers were not as easy. “On the forensic end of it, trying to get my foot in the door with
the county has been tough.” Bruce, like other peer workers I spoke with, has attempted to start peer programming within a jail but so far has been unsuccessful.

Michelle, a thirty-one-year-old Latina who spent almost a year incarcerated, serves on the County Criminal Justice Advisory Boards (CJABs) in her community. Michelle spoke frequently about her location in “small rural town America” and the specific challenges that that environment pose for peer support. Her previous probation officer, for example, is also a CJAB member. She is adamant about advocating for peer support services throughout the county and is hoping for the opportunity to one day provide individual support to incarcerated individuals. While this has not yet occurred, she does provide peer support to peer clients who are referred directly from probation and parole officers.

Michelle describes much of her work as stigma mitigation and advocacy:

We do a lot of advocating work for these individuals because of the stigma that comes with them. [Interviewer: Stigma related to what?] To them being in jail. It’s a small town, everybody knows what you did ... and if it’s something serious, you know, that it carries with you in this town. People know it, and they don’t want to employ you, they don’t even want to give these people an interview sometimes, so it’s a lot of advocating. Even going back to court sometimes to get custody of the kids back or sitting in a court room with them, you know, helping them out.

Chapter five will explore in more detail how peer support workers understand, experience, and resist multiple stigmas, and how they teach their peer clients to do the same.

Why Some Forensic Peer Support Workers Leave the Field

There are many reasons that peer support workers stop providing Forensic Peer Support. Some of these reasons are due to external factors, such as when funding for FPS programming runs out. Other individuals decide to leave the field even though the position remains available. This section will draw on survey and peer support interview data to explore some of the reasons why Forensic Peer Support workers leave the field.
Nineteen survey respondents reported that they had been employed as a ‘Forensic Peer Specialist’ in the past but are no longer employed in that position. Eleven of these ex- ‘Forensic Peer Specialists’ were employed in that role for less than one year. Among those individuals who previously worked as a ‘Forensic Peer Specialist’, four were unemployed at the time they completed the survey, either voluntarily or involuntarily. The remaining twelve individuals were still employed in the broader field of peer support but no longer providing FPS.

Data suggests that financial (both personal and programmatic) factors are the central reason why individuals previously employed as ‘Forensic Peer Specialists’ leave those positions. Survey respondents reported multiple reasons for leaving FPS positions, including programmatic changes, agency closures, promotions, low pay rates, and challenges with transportation. Many of these same factors were identified and expanded upon during the seven qualitative interviews I conducted with respondents who reported having previously worked (but not currently employed as) as a ‘Forensic Peer Specialist’, four of whom are discussed below.

Mark recently took a position at an agency outside of the city after spending over a decade providing individual Forensic Peer Support in Philadelphia. A 52-year-old African American, Mark now works as a mental health group facilitator, where he runs multi-week groups for returning citizens and facilitates trainings for probation and parole officers. He also facilitates both CPS and FPS trainings. He began facilitating trainings and groups because the pay is higher. While he enjoys his work facilitating groups and trainings, he misses providing one-on-one support. As he says regarding his previous one-on-one work:

[I was] good at it, but in order for me to make money I had to get promoted out of Certified Peer Specialist. I end up doing the training thing, because there was more money in that, right? But my power spot is Certified Peer Specialist. One-on-one, connecting with people, talking to people. I’m a trainer. Train people to be CPSes. I mean, there’s beauty in that, but it’s not really helping those who are challenged. But, I had to think about my livelihood. What was sad about that is why can’t somebody be good at what they do, be recognized for that, and get
paid. Instead of, oh well I can’t pay you for that. You’ve got to get promoted and do something else. And that’s sad. (Mark)

Many of the peer support workers I spoke of this tension - deciding to leave the work they find most meaningful (providing individual support) in order to earn a better wage (typically supervision or training).

Other peer workers who left ‘Forensic Peer Specialist’ positions still provide individual peer support. However, they take positions that are more stably funded, frequently as Medicaid-reimbursable CPSs working with individuals in the community. Victor, 26, was employed as a ‘Forensic Peer Specialist’ for only three months when the program he worked for ended. While it was likely that the program would be reinstated, Victor decided to accept a different, permanent, position as a CPS. As a ‘Forensic Peer Specialist’, he says, “I came, I left, because I went to another job, and he was offering me 20 hours a week, definite, so it wasn’t nothing [pause]. It was just money, pretty much.” Forensic Peer Support work as a whole is very unstably funded, as it is not covered by Medicaid or other insurance (unlike CPS). Wayne provided individual support for prison inmates for a short while, but the grant funding quickly ran out. He is also now employed as a CPS working with the general peer population in his community.

Gail, a 59-year old CPS in northwestern Pennsylvania, noted that her organization employs peer workers to work with detainees at the local county jail. However, those peer support workers are paid less than those working in the community. “That’s why I wouldn’t transfer [to work in the jail] because after I got the [FPS] certification, that’s where I wanted to go. They only pay $11 an hour. I was like, I can’t live off that!” Low pay is a significant barrier for the recruitment and retention of FPS workers.

Chapter seven will provide an in-depth analysis of the barriers that are limiting the current scope and impact of FPS, but it is also important to note here that many FPS work tasks are challenging. Some of the more difficult tasks that respondents described to me include
interacting with skeptical employees of the justice system, trying to support individuals who aren’t interested in being supported, providing services in resource scare environments, and watching peers stumble in their recovery processes.

**Benefits of Forensic Peer Support**

Despite its challenges, including low pay and difficult work, FPS provides major benefits. In this section I draw upon both survey and interview data to explore the positive impact that FPS has on the lives of peer clients, peer workers, and the community at large. ‘Forensic Peer Specialists’ (n=25) reported the extent of impact that FPS work has on themselves, their community, their peer clients, and their organization (see Table 9). Peer worker respondents overwhelmingly reported that their work was having a substantial impact; they believe this is especially true for their clients. The mean impact for clients was 4.48, where 1=no impact and 5=a great deal of impact. FPS workers also reported that the work that they were doing have a large impact on themselves (with a mean impact of 4.24). Salzer et al (2013) similarly reported that CPS workers reported experiencing a wide range of personal benefits resulting from engaging in peer support work. While still high, community impact had the lowest mean at 3.72.
Respondents echoed these opinions in the qualitative interviews, telling me many “success” stories. I heard stories of individuals reconnecting with family, finding and maintaining jobs, decreasing use of other mental health services and frequency of hospitalizations, leaving their house for the first time in years, and making friends. Both peer providers and stakeholders that I spoke with gushed about how incredible peer support is, or can be, and provided stories and examples of peer support at work, improving people’s lives. This is particularly true for justice-involved individuals, who are viewed as especially service-deprived.

According to stakeholders and peer workers, peer support is able to fill service gaps for individuals in recovery and involved with the criminal justice system in ways that other programs cannot. This is due to the unique qualities of peer support workers and the relationships that they develop with their peer clients. “I can remember several cases where up to a week before this individual is being released from prison, wouldn’t talk to anybody in the SCI, but that peer [FPS worker] has been able to connect with that individual, meet them on the day he’s released, and get him connected to whatever resources he needs to be connected to. It’s been

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<th>On yourself</th>
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<tr>
<td>Mean (std. deviation)*</td>
<td>4.24(1.128)</td>
<td>3.72(1.100)</td>
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<td>15</td>
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* Where ‘no impact’=1 and ‘a great deal of impact’=5
very successful. It really has” (#020). Those relationships, or connections, are integral to supporting recovery and decreasing the likelihood of recidivism amongst peer clients.

One stakeholder (who was also recently a FPS worker) said that peer workers are able to tell their peer clients:

‘You did a lot of stuff to those people to make them not love you. You stole your mom’s TV and sold it for crack.’ Sometimes I have to be just point blank, in their face, and that’s the beauty of the difference of the clinical side. I understand the clinical side, but I also understand just that personal side where I have a relationship with everybody I’m in contact with, and they don’t take offense. (#023)

Peer support workers can communicate more directly with peers than can clinical staff. The peer relationship becomes akin to “a surrogate family for some people” (#014), rather than a patient/provider relationship.

Forensic peer support workers also reported the personal benefits they experience through this work. Finding paid employment was a huge challenge for most of these peer support workers, and therefore a substantial benefit of peer work. However, providing peer support also plays a central role in many individual’s personal recovery plans and is something they are proud of doing. It provides an opportunity to contribute to society, which many of these peer workers had previously felt they lacked. Susan, a forty-nine-year-old African American woman in Philadelphia who spent more than 3 years incarcerated, remarked that she enjoyed peer work: “I love helping people. I want to help. I want to give back. Somebody helped me and it woke my eyes up, so maybe I can do the same.” Jessica, a forty-year old white woman in rural Pennsylvania, said she liked, “being able to give back to a system I took from for so, you know, or feel like I did and didn’t get what I thought I should have given.” In helping others heal, Jessica is helping to heal herself.

Stakeholders also described FPS and other peer work as a tool of recovery for the peer providers themselves. For peer support workers, their labor promotes their own recovery,
enhances career opportunities, improves familial relationships, and is a source of pride and contribution for peer support workers. These individual benefits for peer workers and peer clients, in turn, contribute to a stronger community as a whole. “I think that the larger benefit is that the more, for lack of a better way to put it, the more well-adjusted people we have in the community makes the community better.” (#023).

**Discussion**

Due to explicit state-wide mental health policies related to peer support programming and related recovery services, the number and status of peer support workers within Pennsylvania increased and improved substantially since the turn of the century. Forensic Peer Support was partially a result of the broader progression within peer support to create specialized services for populations with specific needs. Some specializations have grown and become institutionalized quickly. Veteran Peer Support, for example, has been embraced by the VA and is currently being utilized in a wide number of locations. Among other projects, the VA is currently funding a peer support intervention and evaluation for previously incarcerated veterans in Massachusetts and Pennsylvania (Simmons et al. 2017). The growth, implementation and institutionalization of non-veteran Forensic Peer Support, however, remains limited.

There is general consensus across peer support workers and stakeholders regarding the need for and benefits of Forensic Peer Support, but there are fewer individuals providing Forensic Peer Support in Pennsylvania than advocates of the field would prefer. While many people are trained in FPS and some do identify as Forensic Peer Specialists, the field remains limited in scope and impact. Part of its limited span is due to the inconsistent definition of the FPS field, workers, and scope of work. Both this data and other research indicate that there are many different understandings of Forensic Peer Support and its workers. For example, some scholars (Chapman, Blash and Chan 2015; Davidson and Rowe 2008) and many study
participants believe that FPS workers are required to have a history of criminal activity. Others, including Baron (2011) and other interviewees, recognize that many FPS workers do not have lived experience with the criminal justice system. Data from this project suggests the latter, with only 65% of all FPS-trained peer support workers reporting past criminal justice system exposure and 76% of self-described ‘Forensic Peer Specialists’ reporting the same.

There is also disagreement regarding where FPS workers should be working, and the tasks they should be focused on. Chapman, Bash and Chan (2015) emphasize the role that FPS should play in community reentry, stating that FPS workers “help incarcerated individuals transition back into the community from jails, prisons and probation programs,” “work with incarcerated individuals prior to release to engage in treatment and support and prepare for re-entry,” and “help newly discharged people with housing, vocational and education opportunities.” Baron (2011) also emphasizes the role of FPS in reentry. However, my data indicate that FPS programming also takes place at other areas of the criminal justice system, including with law enforcement and in crises, during community supervision, with jail detainees, and among prison inmates serving long-term sentences. Furthermore, while the work that is taking place under the name of ‘Forensic Peer Support’ varies substantially, it is also likely that there is much of this type of work being done that is not labeled as “Forensic Peer Support.”

While this data suggest that there is currently a limited role of Forensic Peer Support in Pennsylvania, a 2017 grey paper provides evidence that there are increasing numbers of similar programs across the country. The Temple Collaborative on Community Inclusion publication provides results from a national survey of 41 peer-run organizations in 15 states that serve individuals with behavioral health conditions and criminal justice involvement (Temple Collaborative on Community Inclusion 2016). The majority of the programs highlighted in the
publication are primarily grant-funded, including county, foundation, state, and federal grants. The majority of these programs were started only in the last few years.

A publication from the National Association of State Mental Health Program Directors (NASMHPD 2014) states that peer support provides the following benefits to peer clients: reduced hospitalization and crisis services, reduced substance use, improved quality of life and health, improved self-esteem, rediscovery of hope, and development of relationships of hope. Similarly, they list the following as benefits to peer providers: healing benefits from role as helper, social support from co-workers and reciprocity with peer clients, self-sufficiency and self-efficacy, and life purpose through meaningful work. While data from this project cannot speak directly to the benefits for peer clients, the peer support workers interviewed corroborated these personal benefits. Davidson and Rowe (2008) write, “the most important function of Forensic Peer Specialists is to instill hope and serve as valuable and credible models of the possibility of recovery.” Peer support workers in this study talked at length about their focus on hope and modeling recovery.

However, in addition to the benefits highlighted in the literature, these data show that a substantial benefit of peer support work is related to an increase in the peer client’s engagement with the community. Teaching peer clients how to use public transportation, as discussed above, is an example. Peer support workers and stakeholders concur that promoting community integration among individuals experiencing exclusion is at the core of Peer Support. Community integration is a central goal and a central benefit for both peer clients and peer workers, and for both individuals and populations.

While individuals with mental illness experience social exclusion, those also involved with the criminal justice system are additionally excluded from much meaningful community participation. This doubly marginalized population would therefore highly benefit from
providing and receiving services promoting social integration. However, this population simultaneously faces deeply entrenched macro level systems of exclusion associated with the criminal justice system that makes participation in peer services more challenging. Many participants discussed the substantial barriers returning citizens face trying to find employment, but multiple other structures of exclusions result from criminal justice system exposure, including barriers to housing and citizenship. Furthermore, exposure to the criminal justice system is likely to compound the direct consequences of mental illness due to justice system-related trauma.

It is very clear that returning citizens experience community exclusion. Chesney-Lind and Mauer (2003) write of the ‘invisible punishment’ that individuals returning to the community from incarceration face. Returning citizens with behavioral health conditions face additional challenges to community inclusion. Western et al. (2015), in a study of variation in social integration following prison release, found that individuals with a history of mental illness and/or history of addiction are among the least socially integrated returning citizens. This is a steep challenge to address, but one that FPS advocates and workers are keen to take on.

Conclusion

The strength of the recovery movement in Pennsylvania provided a fertile ground for the growth of specialized peer services in the past decade, including Forensic Peer Support. While some of the respondents are engaging in FPS, the field remains limited and ill-defined. Therefore, it is not FPS work, but peer support work in general (and past exposure to the justice system), that unifies this sample of respondents. For the remaining chapters in this dissertation I will draw on interview data from peer support workers who have had exposure to the criminal justice system, rather than focusing on FPS worker interview data exclusively.
Stakeholders in the peer support field remain passionate and hopeful about the potential benefits and impact of FPS. However, the field faces challenges. The following chapters will address some of these. In chapter five, I present findings related to multiple stigmas and the ways that peer workers manage and understand these barriers to community inclusion. Then in chapter six, I will explore the professionalization of peer support. Chapter seven will discuss barriers and facilitators to the FPS field and envisions the future of Forensic Peer Support.
CHAPTER FIVE: Multiple Stigmas in Multiple Contexts

One of the central aims of this project is to explore how individuals experience, navigate, and make meaning of multiple, intersecting stigmas. Forensic Peer Support workers provide a unique opportunity to examine this topic due to their lived experience of recovery in mental illness and involvement with the criminal justice system, both of which are stigmatized statuses, as well as their insight into how their peer clients experience similar marginalization. Furthermore, as discussed in chapter four, stigma management and advocacy are central components of FPS work. An inherent tension within peer support relates to disclosure of lived experience – which can also be conceptualized as stigmatized statuses. Peer support workers are able to successfully support their peer clients because of the very fact that they disclose their (shared) stigmatized statuses, but disclosure simultaneously leaves peer workers vulnerable to stigma related to statuses they might otherwise have been able to conceal. In this chapter, I draw on the 37 qualitative interviews with FPS workers (all of whom have a history of behavioral health conditions and involvement in the criminal justice system) to further our understanding of multiple, intersecting stigmas.

While there is a rich history of stigma literature related to single statuses, especially mental illness, stigma scholars have only recently focused on the role and impact of multiple stigma. Much of this new scholarship uses an intersectional framework (Crenshaw 1991). This makes sense, due to its focus on multiple social identities and marginalization. Data from this project support the use of an intersectional lens; it is clear that respondents experience multiple stigma and have multiple stigmatized identities, and that these stigmas are experienced in different ways. When peer respondents discussed the meaning and role of stigma in their lived experiences, a complicated vision of multiple stigmas emerged. Stigmas related to different statuses are neither unidimensional nor static. Rather, stigmas are contextual, dependent on the
specific locations of the individuals both experiencing and perpetrating stigma, and operate within a broad, ecological framework.

What the burgeoning literature on intersectional stigma fails to highlight, however, is the importance of context in determining how individuals experience and manage multiple stigma. In this chapter, I argue that the personal salience of multiple, intersecting stigma depends on the context in which the individual is situated. How individuals experience and make meaning of intersecting stigma depends on the sociopolitical, regional, and community context they occupy. Much of stigma management reflects the importance of context on stigma salience. Individuals understand and experience stigma within the broader context of communities, histories, and institutions. Exploring multiple, rather than individual, stigma highlights the importance of these larger circumstances. Below I describe how different context matter for individuals navigating both intersecting stigma and present findings to support my claim that the salience of multiple stigma depends on an individual’s context through a discussion of sociopolitical, regional and community context. Finally, I discuss the role of context management and peer support in minimizing and mitigating stigma.

**Findings Overview**

This chapter will present findings drawn from the interviews with peer support workers, all of whom have a history of behavioral health conditions and involvement in the criminal justice system. Through the insights that these peer support workers shared with me, I find that the context in which one lives has an impact on how individuals understand and experience multiple, intersecting stigmas. An intersectional framework, which is valuable in understanding multiple marginalized identities, is useful in understanding multiple stigmas, but how salient those stigmas are (and the relationship between them) depends on the context in which they take place. As Julie, a Family and Community Inclusion Specialist, told me, stigma depends on what
“circles” you’re in: “I think it depends on which environment, some of the environments I’m in, you’ll see a more respectful welcoming, I’m not only in this environment. I go to other environments, and I can see that there’s more fear.” Furthermore, I find the salience of stigma change, and can be managed, as individuals move into difference environments, or across context. I conceptualize context broadly, focusing on three strata: 1. Sociopolitical context (laws, policies, and histories); 2. The place-based, regional (urban, rural or suburban) context; and 3. Social communities (friends, families, and recovery communities).

This chapter presents the bulk of the findings according to the above three mentioned context (sociopolitical, regional and community). Two of these three sections are further organized according to stigmatized status: criminal justice system involvement, and mental illness. While it might seem counterintuitive to present findings separately related to mental illness stigma and criminal justice stigma, I find that participants speak about the two experiences separately, for the most part. There is precedent for discursive and organizational separation, as both Brinkley-Rubinstein (2015) and Rice et al. (2018) organize their findings related to multiple stigmas according to each individual stigma. Furthermore, Brinkley-Rubinstein (2015) also finds that her respondents speak about individual stigma separately, while Rice et al. (2018) note that, despite presenting findings separately, they interpret multiple stigmas as co-occurring. I focus specifically on the stigma of justice system involvement and mental illness because they were the aims of the study and I didn’t directly ask respondents about experiences of other stigmas. Despite this, it is important to note that participants brought up and discussed stigmas related to other statuses and identities, particularly stigma related to addiction and to homelessness.
Intersectional Stigma

Before the in-depth findings related to context, here I present a brief discussion of how respondents talk about the intersecting stigma they and their peer clients experience. When respondents spoke about multiple stigmas in the abstract, they used nuanced models. Specifically, they provided two main narratives of multiple stigmas in the abstract: an additive model, and a dominant model. In many ways, these narratives regarding multiple stigmas could fit neatly in previously identified theories used in deviance or inequality scholarship. Hughe’s ‘master status’ concept (1945) can be used to explain the ‘dominant’ stigma narrative, while the ‘additive’ stigma narrative falls within the ‘cumulative disadvantage’ framework (Sampson and Laub 1997). Furthermore, these two narratives map neatly onto the two theories that Oexle and Corrigan (2018) present in their work on intersectional stigma, namely prominence and double disadvantage.

In the ‘additive stigma narrative’ (double or cumulative disadvantage), each stigmatized status is felt independently, such that an individual with multiple stigmatized statuses experiences every stigma in addition to every other. Multiple stigmas are “combined” or added together. As Michelle says, “if there’s more than one factor, the stigma raises exceptionally high.” Respondents using this narrative focused on the double combination of mental illness and criminal justice system exposure. For example, Amanda talked to me about the additional challenges that returning citizens in recovery face compared to those without mental illness:

I think that if you’re working with people with mental illness there is some additional barriers or whatever. You’re kind of dealing with not only the prejudices that come from having a criminal background but then also prejudices that come from having a history of mental illness. So you’ve got the double edged sword there.

While several peer respondents talked about the additive “double” challenges of mental illness and criminal justice system involvement, others noted that other stigmas were frequently layered
onto those two, including homelessness, poverty, race, physical appearance, and sexual orientation.

The second common narrative of multiple stigmas that peer respondents used when describing multiple stigmas in the abstract was the ‘dominant stigma’ narrative (master status or prominence), which posits that a single social status takes precedence over all others in the stigmatizing process. Thus, the experience of multiple stigmas does not differ substantially from that of the single status that is most socially denigrated. However, there was disagreement regarding which status was most highly stigmatized. Melissa stated that “there’s definitely more stigma I think with the criminal justice system than with mental health.” Others disagreed, noting that mental illness is substantially more shameful. Several individuals discussed the strong stigma surrounding homelessness, indicating that any related stigmatized status (such as addiction, mental illness, and criminal justice system exposure) was subsumed by the homeless stigma.

While peer respondents talked about these models when discussing multiple stigmas theoretically (or in the abstract), when peer respondents spoke about how multiple stigmas actually operated in their lived experience they predominantly discussed singular stigmatized statuses. This is in keeping with previous work on intersectional stigma also utilizing qualitative interviews with multiply-stigmatized individuals (Brinkley-Rubinstein 2015). In order to more fully understand how intersecting stigma are actually experienced and understood, it is important to look more closely at how respondents spoke about their own lived experiences, and that of their peer clients. The next sections will focus on how stigma operates, and its salience, according to its context.
Sociopolitical Context

The unique sociohistorical and sociopolitical context of both mental healthcare and of the criminal justice system in Pennsylvania and the United States are vital to how their associated stigma are enacted and experienced. Peer respondents spoke about the impact of deinstitutionalization and the later incorporation of recovery philosophies in both national and state mental healthcare policy. Peer respondents also talked about mass incarceration, and the disproportional impact it has on men of color, although with far less frequency. This sociohistorical context greatly impact the individual current experiences of stigma that these peer workers and peer clients face.

This data show that the current sociopolitical moment also greatly impacts the salience of stigma. Broadly speaking, there are large contextual differences between laws and policies impacting individuals with mental illness, compared with the criminal justice system. This is despite the fact that there is substantial overlap between these populations. Legal protections for individuals with serious mental illness exist in national and state policies. Individuals involved in the criminal justice system, however, are systematically and enduringly marginalized. Due to these great differences in political context, the impact and salience of stigma related to these particular statuses differs vastly.

Criminal Justice

My peer respondents consider many of the policies related to the treatment and opportunities of individuals currently or previously involved in the criminal justice as discriminatory and stigmatizing. Much previous stigma scholarship focuses on the interpersonal level. In contrast to this, individuals in these interviews explicitly responded to questions related to stigma by discussing systemic barriers and institutionalized dehumanization enacted through the criminal justice system. While there were a few comments related to individual
discriminatory behavior by criminal justice system workers, the overarching opinions held by peer respondents was that criminal justice policies and institutions themselves were tantamount to legalized discrimination. Peer respondents referred to the far-reaching impact of criminal justice policies and structures by critiquing the ‘system’, labeling the entire ‘system’ as a source of stigma. When asked what challenges his peer clients face in terms of interacting with the criminal justice system, Richard responded, “the stigma is a big one… The system itself. Some of the issues are systemic, and it’s been in my face that that’s the case, okay? It’s just how it works.” Richard highlights that while specific employees within the criminal justice system may also be prejudiced against individuals involved in the system, the dominant challenge derives from the institution itself. This ‘system’ is huge, consisting of law enforcement, courts, jails and prisons, and community probation.

Peer respondents emphasized that the prison system is particularly damaging. Amy talked about feeling dehumanized when incarcerated for the first time at age 30, “Here it is, I’m 30, but no one takes that into consideration in the justice system and definitely not the prison system. They don’t care about your story. All they care is about number 210138206. That’s it.” She emphasized that individuals in the criminal justice system are treated as numbers rather than people. While Amy emphasized the dehumanizing aspects of the incarceration process, Mark highlighted how even the language embedded within corrections is stigmatizing. “Even urinalysis, like in the prison. Your urine is dirty. Yours is clean. I’m dirty. I’m clean. Even the language.” Systemic stigma that dehumanizes and degrades individuals involved in the criminal justice system is pervasive, and such language reproduces the institutionalized degradation.

While mental health organizations operating within the recovery paradigm (for example, most consumer-run agencies) generally do not perpetuate structural stigma against individuals in recovery, those institutions and systems that don't accept recovery principles can and do
perpetuate significant structural stigma. Structural stigma here is defined as “societal-level conditions, cultural norms, and institutional policies that constrain the opportunities, resources, and wellbeing of the stigmatized” (Hatzenbuehler and Link 2014:2). This is especially true of the criminal justice system and its policies, which was mostly presented as operating under a punitive (rather than rehabilitative, and certainly not recovery) framework. Amanda told me about her previous job at a Forensic Unit at a State Hospital.

As an advocate, it was my job, or I felt it was my job, to help protect people. It was really hard to do in a system that is very oppressive. It felt like a constant uphill battle. There was really no recovery principles there, everything was about 50 years behind the rest of the field. The environment itself, staff felt like they didn’t have a lot of power so then they would take it out on the patients.

Amanda reported that the patients in the forensic unit were treated poorly by the other staff, who took the attitude that they, “didn’t deserve the same as everybody else…. Just a lot of, I think, unfair prejudice.”

The pervasiveness of structural stigma within the criminal justice system is also reflected in the difficulties that individuals face upon begin released from incarceration. “When it comes to living arrangements, when it comes to jobs, we got to work twice as hard to get them as the next person. It’s not their fault. The community or society is going to be. Society has never been trained to accept a felon” (Ronald). Peer respondents tell their clients that life will just be more challenging for them with a criminal record, and they will have to work harder to overcome those additional barriers.

Organizations they always, you [a person with a felony record] need to have 90 different things to qualify as opposed to a regular person who may only 10 things to qualify. They feel the chips are stacked against them and in a certain way they are but that’s we get for committing the crime that we committed in the first place… Every avenue you try to go down it’s like a door slams in your face when you’re come home from prison and I just tell them [peer clients], ‘you just have to keep fighting’ but the feeling that like society shuns you and it’s close to accurate. (Jason)
Although frustrating and upsetting, this society-wide stigmatization is understood as the norm, so the focus remains on how individuals can adapt to it.

Probation and parole are also stigmatizing forces in the lives of many peer respondents and their peer clients. According to Jason, an FPS in Philadelphia, “most people coming home [from incarceration] are on some kind of probation or parole and that’s not an easy road to go down because they all hate you just because. Unfortunately. [Interviewer: Who hates you?] Parole officers, probation officers, the system itself. That’s why it’s basically just called the system but there’s a lot of things that incorporate the system. It just feels like no one is on your side.” While Jason names probation and parole officers in passing, it is “the system” itself which serves as the primary challenge for returning citizens. Wayne acknowledge that it's challenging to differentiate between the system and the individuals employed to carry out its tasks. Sometimes he’ll tell his peer clients that probation and parole is “not try to get over on you. But they, they sometimes laugh at you because they know logistically it’s the law and you know.” According to respondents, the very structure of probation and parole is challenging for returning citizens, and seemingly structured so that individuals fail.

Peer respondents highlighted the challenges related to stigma that both they and their peer clients face interacting with institutions and organizations after being released from incarceration. Stigma related to criminal justice system involvement operates through limiting employment opportunities for returning citizens. When Lawrence first came home, he successfully went through two rounds of interviews for a position, but “got to the third interview, found out that I was a felon. She threw my resume away in front of me. Literally turned her chair around, went like this [mimes crumpling up paper and throwing it] and said, ‘we’ll call you.’ There is that stigma out there.” When Jason came home he applied for a computer technician position. Despite having experience in the field, the position was given to an individual without
experience, but also without a criminal record. Jason believes, and other peer respondents concur, that “a wide majority actually of employers will not even consider” hiring someone with a felony on their record. Stephen, Patricia, Victor, and Wayne also shared with me their personal experiences trying to find employment with a criminal record, each emphasizing how many barriers there are for returning citizens to find jobs, especially well paid or respected jobs.

While some returning citizens can obtain employment, the type of employment is limited, with many highly respected and well-paid jobs out of reach. Stephen took a position as a van driver for several years because it was the only employment that he could obtain with his record. There are fewer justice-system related barriers to peer support employment compared to other types of positions. John oversees a program that helps recent CPS graduates find employment in Philadelphia. I asked him if having a criminal background makes it hard for those graduates to find job placements, and he told me that it normally did not. “I know as a Certified Peer Specialist, we have a leeway, like it’s kind of expected from a person with lived experience to have some kind of criminal background.” Wayne expressed gratitude for his current position as a CPS. “Thank god that I’m in a position where they hire me with my felony. Otherwise, I would probably have a problem.” He applied for positions at Walmart and Wawa but wasn’t hired due to his criminal record.

My peer respondents were overwhelmingly positive about being peer support workers, but it was also evident that their justice system involvement (and its resulting limitations on employment) played a role in why some individuals do this type of work. I asked Melissa if she felt like having a criminal record was going to impact her career. She responded, “Yeah. I feel stuck here, definitely. [Pause] I like it here, and it’s comfortable here. I definitely like my job, but at the same time, I wouldn’t look because I don’t think I can go anywhere else. Does that
make sense?” Having a criminal record also impacts how an individual is able to advance in their career, or to change career paths.

Peer respondents also noted that stigma related to some types of criminal records are harder for the peer clients to deal with. It is harder for some justice-involved peers to obtain employment than it is for others, “according to what your charges are” (Pamela). Sex crimes, especially those related to minors, seem to be the most highly stigmatized crimes. Thus, individuals with those types of crimes have a more difficult time finding employment, housing, and community integration. Several peer respondents talked about the challenges related to working with peer clients that “are Megan’s law,” which refers to both required registration of convicted sex offenders and community notification of registration (resulting in forced public disclosure). Ronald tells his peer clients in the VA that, while he was incarcerated for drug charges, “your fight is going to be a little more difficult than mine because there’s Megan’s law.”

Within the context of broader societal norms and values, certain types of criminal behavior elicit harsher stigmatizing responses than others.

While peer respondents most frequently discussed the challenges that returning citizens face in obtaining employment due to systemic stigma, they also discussed challenges related to housing and benefits. In many cases, lack of employment and lack of housing are interlinked. “Housing is always an issue and there are some places that will allow people that come out if they’re funded, and because we were able to be funded, they were able to get rent ‘cause they had no employment. And then the problem is employers are having a hard time accepting people with felonies” (Wayne). Finding quality housing is challenging for individuals with felony records even if they are employed. Ronald told me about the difficulty he had the previous summer when trying to find housing:

I wanted to upgrade from where I was at and find a place to live, get out of the area that I was in because my neighbor was a drunk and very abusive. So I wanted
to leave. I just want to move. I want to move into… And I went to about five different places to try and get a place to live, an upgrade. I was ready to buy new furniture. I’d had money saved up because I worked here and I was turned down. Why? Because I’m a convicted felon.

Keene, Smoyer and Blankenship argue that criminal background checks force applicants to “reveal concealable histories, turning aspects of their past into their present, and potentially activating stigma and discrimination” (2018:800). Ronald shows that to be true. Previously incarcerated individuals searching for housing face both interpersonal and structural stigma, and the damages of lack of housing or unstable housing are both material and symbolic (Keene, Smoyer and Blankenship 2018). Peer respondents report that individual whose criminal histories includes sex crimes or drug crimes experience more stigma that serves as a barrier to obtaining housing.

One of the challenges that individuals involved with the criminal justice system face regarding stigma is that the context in which it occurs is virtually impossible to avoid. While an individual can more easily stop interacting with a stigmatizing friend, stigma related to criminal justice system is embedded in the sociopolitical context of the whole country. Furthermore, criminal justice related stigma is not only pervasive, but is persistent. Peer respondents were aware of how long the mark of a criminal record lasts: “We don’t dilute [delude] ourself into thinking that this isn’t something that’s going to follow us all our life. I mean, once you get a record it’s a record. It does stop you” (Patricia). Mark told me about challenges related to employment twenty years after having last “been in trouble.” He linked this lingering dehumanization and marginalization directly with the labels associated with having been involved with the criminal record:

You a ex-offender. When do the label offender leaves? I served my time. I did what… I paid my debt to society. I’m trying to be a productive, responsible member. I’m working. I paid all my court costs and fines. I’m trying to make a living for me and my family, and you still call me a ex-offender. When does that handle go away? You know? Why can’t I just be a person? (Mark)
The stigma associated with justice system involvement is entrenched in both public and private systems, and lasts for many years. Therefore, despite having served time for their actions, individuals continue to suffer the consequences.

Structural stigma for individuals with felony records is so ingrained that some individuals assume it even where it doesn’t exist. For example, Kimberly told me that many of her peer clients believe that they do not have the right to vote because of their felony record. This is incorrect, and Kimberly works hard to inform her peer clients of their rights. While voting laws differ by state, felony disenfranchisement in Pennsylvania ends after the individual is released from incarceration.

The slight movement towards criminal justice system reform has resulted in a few attempts to change policies that stigmatize individuals involved in the criminal justice system. Peer respondents talked about the importance of initiatives and policies that remove some of the barriers that returning citizens face, such as ‘Ban the Box,’ a nationwide campaign encouraging employers and governments to prohibit prejudicial hiring practices that limit work opportunities for previously-incarcerated individuals. Much of the focus has been on eliminating questions regarding justice system involvement on employment applications. Pennsylvania is one of the many states that has adopted this policy for applicants for government positions.

‘Ban the Box’ is not the only attempt to increase access to opportunities for individuals with criminal records. Some of these efforts have been more successful than others. Amy told me proudly about the advocacy work that her employer, a large national social services agency, has done for minimizing barriers to employment for both individuals with behavioral health conditions and criminal records. However, several peer respondents told me about lists that they receive (from their agencies and other human services agencies) of companies or organizations that hire people with criminal backgrounds, including felonies. Several state and national for-
profit and non-profit organizations maintain such lists and while human service agencies and other organizations distribute these lists, they are also readily available online. However, these same peer respondents also told me that many of the companies that claim to hire individuals with a criminal record won’t actually do so. “We got like 400 companies that said they will work with people with background, but that’s a lie because once you send them to them they say, ‘Oh, you have a background.’ Yeah well you on the list. Well that don’t mean nothing” (Larry). These lists create a sense of false hope, and show how entrenched the systemic barriers to employment are for individuals with a criminal record.

Peer respondents made it clear that the stigma of criminal justice system involvement, and especially the stigma of a criminal record, is extremely salient to both them and their peer clients, in many aspects of their lives and across many times points in their lives. This is reflective of how far reaching and impactful the criminal justice system is across the entire sociopolitical context of this nation. Criminal justice related stigma is embedded in the normative American value system and within much national, state and local policy.

_Mental Health_

In sharp contrast to the criminal justice system, there are a number of antidiscrimination laws, policy and regulations that protect individuals with mental illness from systematic stigma. Furthermore, over one third of SSDI recipients in the country are qualified for a disability due to mental health conditions. While the current sociopolitical context in this country limits access to housing and public benefits for individuals involved with the criminal record, it does not operate in the same way regarding mental illness. In contrast to discussions of CJ stigma, peer respondents in this study rarely discussed discriminatory policies or institutions for individuals with mental illness. In fact, some of the peer respondents in this study highlighted the services
and benefits that individuals with mental illness are entitled to receive through governmental and nonprofit organizations, like housing vouchers and disability checks.

The drawback of receiving these benefits is that it might make it harder for individuals to conceal their stigmatized identity (having a mental illness). Richard told me about helping his peer clients find an apartment. “When you show your income, and you get benefits, it’s called a crazy check on the street. ‘You get a crazy check?’ There’s a line at the bottom that now it’s to the point where you can have it printed or not which indicates the source. I mean, you could be getting benefits from unemployment, okay, versus a mental health disability. Now you can request a copy so they can’t tell, the landlord can’t tell, that’s cool… You’re not going to have the slap in the face of ‘I’m not having anybody getting a crazy check live here.’”

Individuals are therefore more able to conceal mental illness than justice system involvement in the United States, and its related stigma is correspondingly more concealable. When I asked Wayne whether his peer clients believe that others think less of them because of their mental health, he responded “in some respects with the mental health yes. It depends on the severity of the mental health. The people that hear voices, they struggle with that.” Jason told me that he does not experience stigma related to mental illness because “I never showed that I was depressed.” His most stigmatized peer clients are those that “can’t control, they have to show that they have a mental illness because they can’t control.” Within the broader categories of stigmatized identities, visible presentation is subject to more stigma than those who can hide their stigmatized identity.

While not embedded within policies and regulations, peer respondents mostly believe that there is broad social stigma against individuals with mental illness in the United States. Some peer respondents considered stigma towards individuals with mental illness to be expected, almost a social norm. “Out in the world, it’s just straight stigma and biases. People don’t
understand mental health” (James). Stigma related to mental illness serves as a substantial barrier for individuals to obtain mental healthcare (Corrigan, Druss and Perlick 2014). David told me succinctly, “The stigma is so deeply entrenched in society. You know, it makes a lot of people not want to seek treatment.” Among survey respondents for this study, 61.9% report experiencing mental health symptoms before the age of 18, but only 20.2% report receiving any mental healthcare before 18 years of age. While a majority of peers were not able to access mental health services until years after their symptoms began (62% of survey respondents reported symptom onset before 18 years of age, compared to only 20% who obtained mental health care before 18), several also told me about choosing to delay service use because of the stigma associated with their diagnosis.

Peer respondents also discussed mental illness stigma perpetrated by the media. Several participants talked about how media depicts individuals with mental illness as violent or dangerous. “Well, out there in the world, there’s this idea that mental illness and dangerousness are one in the same, which we know isn’t true, but that’s not what the media necessarily tells you” (Amanda). Peer respondents believe that, by associating mental illness with violence, the US media is enacting and perpetuating social stigma.

While some peer respondents emphasized that stigma towards individuals with mental illness was pervasive throughout society, others told me that there is far less mental illness stigma than one might expect. These peer respondents talked about the importance of historical context when considering how they and their peer clients experience and understand stigma related to mental illness. They talked about deinstitutionalization, the anti-psychiatry movement, self-help and disability rights groups, and the recent increase in celebrity disclosure of mental illness. Peer respondents discussed how both mental illness and the mental health system has changed over time, with a corresponding decrease in stigma. Older adults, who grew up during a time period of
heightened stigma, are presented as more afraid of the stigma related to mental illness. However, according to these respondents, that isn’t a concern nowadays. Larry in Philadelphia told me that stigmatizing language and comments are “just not a conversation piece no more.” Larry says about mental illness, addiction and recovery, “[now] it’s an open conversation. I think it’s less judgement today, much less judgement today because people, like I said, mostly everybody’s family got somebody who’s dealing with mental health or addiction or disability. Really that kind of this is common. It’s common.” In this way, Larry believes that the sociohistorical context has changed the impact and extent of stigma for the better. As individuals become increasingly comfortable disclosing their mental health statuses it becomes apparent that a great number of individuals are in recovery. This can both lessen the sense of isolation and shame that individuals feel about their own mental illness, and can help decrease interpersonal stigma.

**Regional Context**

The region in which the stigmatized individual resides impacts how they understand and experience stigma. In this way, stigma depends on whether it takes place in urban, rural or suburban regions. Rural peer respondents outside of Philadelphia emphasized how important their town or county was in impacting the role (either mitigating or exacerbating) and salience of stigma for themselves and their peers. Some peer respondents argued that stigma plays a larger role in smaller towns than it does in cities. Kimberly, a CPS in Southeast Pennsylvania, also believes that stigma hits harder in small towns. “When I used to live up North in the Poconos, very small town, people are very judgmental about anything.” In small communities, the source of the stigma did not matter as much as having indication of difference.

Michelle, a ‘Certified Forensic Peer Specialist’ in Northern Pennsylvania, spoke at length about the impact of stigma in “small rural town America.” Her county is hard hit by the opioid epidemic and also has a high suicide rate, but individuals there are avoiding treatment for fear of
being “seen coming into the recovery center” and the stigma attached with seeking treatment. In addition to the stigma related to mental illness and addiction mentioned above, Michelle also told me that stigma related to criminal justice system involvement was high in her town.

However, not everyone in a small town emphasized the salience of stigma for themselves or their peer clients in their neighborhoods or communities. I met William at a convenience store coffee counter looking out over the main street of his small town in Central Pennsylvania. He differentiated between downtown, where we were, and some of the less impoverished surrounding areas. When asked whether his peer clients were treated poorly or disrespected because of mental illness or drug use, he responded, “I don’t think it happens down here where my peers spend all their time, but I imagine if you got to [less impoverished neighborhood] out to [other nearby town] probably a lot more stigma. This is pretty much - [pointing out the window to a park across the street] the soup kitchen looks out that park street.” A few minutes later I asked about stigma related to criminal histories and once again he pointed out of the window to the park and this time he laughed. “Do you see anybody out that window who probably doesn’t have criminal history?” Stigma has very little impact on individuals when most of their surrounding community has the same stigmatized status, which in this case is criminal justice system involvement. While individuals in recovery or those with a criminal record might experience stigma in the neighborhood down the road, William doesn’t think his peers experience much stigma because “everybody’s peers” in this community, indicating that most individuals have a history of mental illness, addiction, and/or justice system exposure. While research has begun to explore the spatial stigma associated with economically marginalized urban neighborhoods (Keene Smoyer and Blankenship 2018), economically marginalized rural areas experience similar spatial patterns.
Jason told me about his first job after he was released from incarceration in a suburban supermarket. He would go into the break room and “people automatically just get up and leave. I’m talking about in mid-lunch, food still right there and you’re wondering, ‘Well, why are you getting up leaving?’ because I worked in ShopRite in, I guess, suburban area to where they don’t get into trouble that much out there or whatever. You know you get hired at a place like that the boss has to tell the employees, ‘Well, this is an ex-convict’, and just from him doing that I saw the differences. Don’t even talk to me, I don’t care if you talk to me, but they made me feel weird. What are you all scared of me for, I’m a person.” Jason theorizes that part of the reason that he was shunned at his suburban job was because fewer people “get into trouble” there.

The proportion of individuals with a stigmatized status in a community (or those whose stigmatized status is known) can impact how people in those communities understand and experience stigma. Some respondents argue that substance or justice-system related stigma is less salient in communities with higher rates of addiction or incarceration. According to William, there is less stigma in his community context because a large proportion of the individuals comprising the community have the stigmatized status. However, this would depend on public recognition or disclosure of those stigmatized statuses. If there was a high degree of secrecy related to the high rates of mental illness, substance use, and criminal involvement in a community, individuals might still experience substantial stigma.

In contrast to the peer respondents in rural and suburban areas who reported stigma to be very salient and powerful in their communities, the respondents in Philadelphia rejected the very idea that stigma exists in their own lives. Peer respondents discussed the progressive stance that city policy and community members have developed, specifically regarding recovery in behavioral health. Robert, a CPS Coordinator for Philadelphia’s behavioral health department, described his work environment as “the Philadelphia Behavioral Health Recovery
Transformation System, where there’s zero tolerance for stigma.” According to peer respondents, this anti-stigma, pro-recovery stance has extended beyond the behavioral health department and is now present throughout much of Philadelphia itself. I asked Larry, a 58-year-old CPS Employment Specialist with the City of Philadelphia, whether his peer clients talk about being teased, bullied or harassed. He responded, “No. Those days are over. Those days are long gone. [Interviewer: What do you mean?] That’s not a stigma no more. That’s not a problem no more.” While peer respondents in Philadelphia talked about how stigma wasn’t salient in their lives, it is not advisable to extend these findings to other urban environments, given Philadelphia’s unique historical involvement in the recovery movement.

Even in Philadelphia, where Larry contends that mental illness is no longer stigmatized, there are neighborhoods or communities in which mental illness does seem to be stigmatized. Mary, a 62-year-old Family Specialist in Philadelphia, told me that the fear of stigma impedes her peer clients’ mental health service use. “A lot of the stigma was just being seen there. Neighbors coming in. I’ve had my peers who are coming for treatment, and all of a sudden they run into somebody they know from the neighborhood, and they’re like, ‘Oh my God. What is she doing?’ We had people that would not go in their neighborhood. They lived all the say in Germantown, they came to South Philly [12 miles] for treatment so they wouldn’t run into people in their communities because they weren’t comfortable with the fact that they were coming in for treatment.” The importance of social communities on how individuals understand, and experience multiple stigmas is presented below.

**Social Community Context**

This data show that the personal salience of multiple, intersecting stigmas also depends on the social community context in which an individual is situated. These social communities include family, friends, work groups, and communities centered around recovery. Peer
respondents talked about the importance of family context in the role that stigma played in their own, and their peer clients, lives. I asked Jessica about challenges that her peer clients faced in terms of relationships with family and friends. She told me, “the stigma attached with it, and not just being mentally ill or having addiction, but the stigma of you know being criminally involved.” The importance of the family context included stigma related to multiple statuses and identities. While some respondents presented the family context as the environment most fraught with stigma, other peer respondents discussed families that provide substantial support to individuals in recovery and a refuge from stigma. This section will discuss the role that social community context plays in how individuals understand, experience and manage stigma related to mental illness and criminal justice system involvement.

Mental Health

As discussed above, family members were the most commonly discussed source of interpersonal stigma for both peer respondents and peer clients regarding mental illness. According to Mary, many of her peer clients’ experiences of stigma “was what they grew up with. I know even in my family, it was unheard of that you talk about your depression. Everything stayed within the family.” Family’s impact on the meaning individuals place on stigma frequently derives from childhood experiences and cultural beliefs. Peer respondents talked about how mental illness was either not discussed or not believed in their families of origin. Amy told me about her family and its similarity with those of her peer clients: “my family don't believe in that stuff. They're like, ‘You got what? No,’ type of thing. You have to think about what people family situations are like. Some cultures and some families don't even want to hear it, address it, anything. ‘You don't hear voices, you just need to get some sleep,’ type of thing.”
While some peer respondents blamed family-based stigma on lack of knowledge and culture, others simply identified particular family members as prejudiced. I asked Patricia if she had dealt with stigma in her life and she laughed. “Sure. My dad is probably one of the most bigoted people I know. It's not just mental health issues or drug issues with him. It could be the gay card, it could be the black or white card. I mean my dad was just a bigot.” Others were more specific in describing parental stigma related to mental illness. When Scott’s mother visited him in the state hospital after two suicide attempts, she expressed her displeasure at having a ‘crazy’ son in a ‘loony bin.’ “That's where most of the stigma I got from, was from my mother.” Family members other than parents also discriminated against peer respondents. Stephen told me that, although she has since reestablished a relationship with her brother, “When I was hospitalized my brother rejected me for the longest time. He just couldn't understand why he did what he did. It was almost two years until he spoke to me.” Respondents told me about the experiences that their peer clients have regarding stigma originating in family communities. Willie’s client was teased about his psychiatric diagnosis by his sisters to the points of becoming suicidal, at which point he checked himself into an inpatient facility. This type of stigmatizing behavior can lead to a sense of exclusion within one’s own family: “My client that was told that she was just a mess by her family, their history and criticism and being stigmatized and being looked at a certain way and not feeling welcome” (Brenda). Other families are more direct in their exclusion, disowning them because their family “doesn’t want to deal with me because I’m this way” (Victor).

Some of my respondents also discussed feeling stigmatized by their coworkers at their places of employment. John, who has been working as a CPS for over five years, told me about the challenges that he faced with stigma after a recent divorce and related increase in mental illness symptomatology. “Especially since my own mental health relapse I had, I’ll say break down, whatever you wanna call it. ‘Cause I lost a lot of weight, and I was really down, you
know, stuff like that. Rumors were spreading out, all kinds of stuff was going on, ‘He gettin’ high.’ I kind of experienced that stigma, I kind of was hurt. I was really hurt.” While Wayne disclosed to me that he believed his current coworkers discriminated against him due to his mental illness, most others believe that stigma towards peer workers has declined over time. A more detailed discussion of peer support workers’ worksite inclusion can be found in chapter six.

In addition to communities and families, community organizations are also context that impact how individuals understand and experience stigma. Peer respondents talked about self-help groups such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). While AA and NA were presented as essential to some people’s recovery processes, they were also discussed in terms of stigma. Kimberly told me that “in like AA or NA people are going to look at [her peer clients] different because they have mental health issues… Don’t go in there and talk like straight mental health.” Despite their recovery orientation, AA and NA are not always welcoming to individuals with other stigmatized statuses. Wayne, who works with peers at a residential facility, told me that they recently had to stop going to a 12-step group in the community because his residential peer clients didn’t “like the stigma” they experienced in the community-based group. “Everybody from that program knew [the people in the 12-step group] were talking about them.” Another peer respondent told me about how unwelcoming individuals in his NA group were to a recovering heroin user who was on Suboxone because they didn’t believe you can truly be in recovery while on Suboxone.

Although Kimberly and Wayne discussed the stigma perpetrated within twelve step recovery communities, other peer respondents talked in depth about the informal recovery communities that they feel part of. Some peer workers socialize primarily with other individuals in recovery who identify with the broader recovery movement. As Larry told me about recovery:

Recovery, it's bigger than it's ever been. We say we are our own a society. That's how it is. We are our own society. We have our own language. Once you in
recovery, if you really in about recovery, hanging with our own people. You go to church, Baptists hang out with Baptists, lawyers hang with lawyers, cops hang out with cops. We hang out with people in recovery. You have to. You have to be in that circle. You have to continue. All my friends are in recovery. You have to just continue to live that way. I got so many friends now it's ridiculous, it's pathetic. It's pathetic but it's great because they all ... We talk about this, we don't always talk about drugs. We got life things going on. We got people with jobs, people with families, children, schooling. We talk about whatever is going on with us. It's a great thing.

These social communities, or friend groups, not only not foster support, they are actively anti-stigma, helping individuals view their previously stigmatized statuses as current strengths.

*Criminal Justice*

There was far less discussion of stigma related to criminal justice system involvement operating within social community context compared to stigma related to mental illness and substance use. While the sociopolitical context seems to be critical in determining the salience of stigma related to criminal justice system exposure, there is less evidence related to the role that social communities play. This is perhaps related to severe limitations on community integration that individuals involved with the criminal justice system sometimes experience. Barriers to housing can also serve as barriers to neighborhood communities. Without employment, coworker communities are irrelevant. There was little discussion of stigma or support related to criminal justice system exposure within recovery communities or community organizations.

In contrast to the lengthy discussions of how family supports or stigmatizes peer workers and peer clients, fewer peer respondents discussed the role of family related to criminal justice system stigma. Jessica was an exception, noting that stigma related to criminal justice system within families depends on the characteristics of each family. For some families, criminal involvement elicits negative responses, while that is not true in other families. Jessica described it: “Either one way or the other. ‘Oh my god, I can’t believe this in my family!’” But for families with a history of criminal involvement, it’s “‘that’s just what we do.’ You know what I mean,
like, ‘good job, next one to make it in.’” As families differ, so too do their responses to criminal justice system involvement.

Managing Context to Minimize Stigma, and the Role of Peers

Individuals engage in a variety of techniques in order to manage stigma.Thoits and Link (2016) have recently emphasized stigma resistance strategies such as challenging and deflecting. Peer respondents in this study shared their experiences resisting and challenging stigma in both individual and institutional situations. They stood up for stigmatized strangers in stores and on the bus; they challenged their family members and friends on their prejudicial statements; they pushed for community and work organizations to incorporate inclusive language and policies.

In addition to stigma resistance, peer respondents also talked about using stigma avoidance as a management technique. Specifically, peer respondents avoid situations, environments and context in which they are likely to experience stigma. These might include environments in which they are less able to conceal their stigmatized identity. Moreover, peer worker respondents reported encouraging their peer clients to avoid communities and context that they perceived as likely to be stigmatizing. This has meaningful implications for community integration, as will be discussed later in this chapter. However, first I present evidence of situational avoidance as a common stigma management technique.

Peer respondents presented avoiding situations in which stigma or discrimination seemed likely as a logical and obvious choice. I asked Jessica whether her peer clients avoided situations and people that might be stigmatizing. She responded, “Absolutely. Absolutely. But that’s not necessarily anything to do with mental illness, but if I know I’m not going to be accepted somewhere, I’m not going to want to go there. I think that’s more human [nature] than mental illness.” According to Jessica and other peer respondents, it is part of human nature to stay away from unwelcoming or disparaging environments and relationships.
Peer providers themselves avoid potentially stigmatizing situations. When I asked Jason if he ever avoided potential stigma, he told me, “You actually do…. Like, I was going to turn this [interview] down. I was going to say, ‘Well, if I go in there they’re going to look at me like I’m an ex-convict.’” He decided to do the interview, but there are other groups and events that he doesn’t participate in because, “Do I want to sit in a room with a bunch of people who’s going to look at me like the different one? So… to just not deal with the headache you just don’t go.” Jason self-limits the environments he goes into and the experiences he has in an attempt to minimize potential stigma and marginalization.

Peer respondents talked at length about the impact of disclosure. In many ways, choosing to disclose their stigmatized status, or not to disclose, was another way to manage stigma that is deeply linked to techniques of avoidance. Willie told me that he was careful about who he disclosed his diagnosis to because of “the stigma.” However, he also recognized that disclosure is a powerful tool in connecting with others, and central to why peer support is so effective. “I got a mental health diagnosis, and I’m careful with that, today, ‘cause I don’t disclose that to everybody, ‘cause it’s nobody’s business but my own. So, in helping other people, I have no problems with disclosing it, excuse it’s a means to build a relationship with that person, so self-disclosure is a powerful tool.” Disclosing their lived experience, while the most integral tool that peer support workers have in their work with peer clients, also opens the door to potential stigma. However, the meanings and consequences of disclosure depends on both the status of the discloser and the status of the disclosure recipient (Tyler and Slater, 2018). Disclosure to a peer client means something different for a peek worker than does disclosure to your boss, although peer workers have to do both.

Individuals decide what situations and individuals might engage in stigmatizing behavior based on what they have learned in their past. When asked whether his peers avoided stigma,
Michael responded, “To some degree, to what degree that’s possible. I think everyone sort of learns what situation we have to navigate with on our tippy toes about.” Peers learn which situations they should avoid (and which unavoidable situations they need to tippy toe through) because they have had bad experiences in the past. As Robert says, “Their experiences were negative being in society, and so they avoid it.” Many peers are fearful that they might experience similar challenges in the future. Robert continued, “It’s just fear of the same treatment being in society.” In these situations, peer clients are managing potential stigma with techniques they’ve learned over their life.

However, some peer support workers also teach their peer clients to manage stigma by avoiding specific context, environments, and individuals. When one of her peer clients told her about being treated poorly when applying for a job in a department store, Pamela, a CPS in Philadelphia, responded that she should have anticipated that: “You’re not going to go out to [wealthy suburb] and go into Neiman Marcus with a background in retail theft. Come on. That’s just ludicrous. I always tell them don’t put yourself in a position like that to get harassed or disrespected or anything. That’s basically what I tell them.” In this way Pamela is guiding her peer clients to avoid situations as a way to mitigate potential stigma. She is putting the onus on the stigmatized, rather than addressing the origin of the stigma. This makes sense, due to the individual-level tasks on which peer support workers focus.

Stigma management techniques are deeply related to community integration and inclusion. By avoiding certain circumstances or situations, stigmatized individuals are opting out of participating in that community. However, the peer providers I spoke with emphasized that there are many different ‘communities’. Therefore, it is possible for individuals to feel fully included and integrated in some context, while simultaneously avoiding others. Michael responded to my question about whether he felt excluded from parts of society by saying, “I’ll put it this way, not
the parts of society that I want to be involved with. That’s probably the best way of putting it.
I’m actively involved in multiple communities that I choose to be a part of.” Rather than thinking
of one broad community, Michael chooses to actively engage with certain individuals in some
context, while avoiding others.

Peer respondents told me about their experiences of community inclusion in communities of
their choosing, despite engaging in stigma avoidance in other environments. Several of the peer
respondents talked about having many friends and partners in recovery, or even also working in
peer support. Amanda’s husband and best friend are both support workers, for example. I asked
her whether she dealt with stigma in her life currently. “No, not really. I feel like for the most
part, the people who I surround myself with are people you understand and who aren’t
judgmental.” Amanda is creating her own support system.

However, not all of their peer clients are creating their own support system or finding
welcoming communities. In this way, using stigma avoidance might be a severe barrier to
community inclusion. When I asked Jason whether his peer clients felt excluded he took issue
with that phrasing:

I would say since they don’t even try to fit in I wouldn’t say excluded, I would
say… I guess not accepted at all, they don’t even try to feel accepted I guess
because because they don’t think they will be accepted. Excluded would be like if
you can be into something and then no one wants you in it. They don’t even try to
be in no social circles. The paranoia of, they think they already won’t be accepted.

Jason is framing his peer client’s avoidance behavior as a personal choice, resulting in isolation
and lack of community. But as Link and Phelan (2014b: 24) have shown, “the goals of the
stigmatizers are achieved but hidden in the stigma coping efforts of people with mental illness.”
Jason’s framing fails to recognize stigma power, and its frequent invisibility, in manipulating
individual behaviors.
Some peer respondents have recognized the potential downside of using stigma avoidance as one’s primary stigma coping technique. Joseph provided deep insight into the relationship between community inclusion and stigma avoidance when she said that some of her peers have “come to learn that the risk of going out into the community is worth the chance of being stereotyped and it’s okay because not to go out in the community is to say that they’re right that you’re supposed to just stay home or go to only places that people that live with mental illness goes to.” While stigma avoidance might be an effective stigma management technique, there are substantial side effects for individuals that include isolation and low self-efficacy. Furthermore, communities and stigmatizers themselves are thus able to maintain exclusionary beliefs and practices.

Peer work, however, can also play a role in the minimization of self-stigma. The recognition that society shuns them leads some individuals involved with the criminal justice system to lack hope, feel shame, and have low self-esteem – or self-stigma. Amy told me about working with a peer client who had been incarcerated for twenty-five years, and the challenges that he faced understanding that he was “worth more than what you’ve been told all those years in prison.” At the beginning, “he was ready to violate on purpose, just to go back.” Peer support is a valuable tool for remediating that self-stigma. Larry told me about the importance of working with individuals with criminal records on improving their perception of their self-worth.

It’s a huge issue because the person that has a background has this stigma that I’ve been in jail for so long I can’t get a job, their self-esteem’s very low. It’s a lot of issues dealing with that which we got to reverse and bring it back. No, you’ve done your time in jail. Now you’re at where you at today…. We bring them back up to a place so now they feel good about their self. (Larry)

Peer support workers also emphasized the importance of working with peer clients so that they recognize that, having spent time incarcerated, they don’t get trapped in self-identifying as a
criminal and work to move on with their lives, love and better themselves. “It’s really helping people to look beyond that, you know, and see some value in themselves” (Mark).

Discussion

While there is increasing interest in studying multiple stigmas (how people manage, understand and experience them) through an intersectional framework, there is a lack of emphasis on, and data regarding, the importance of the context and environment in which these multiple, intersecting stigmas are enacted and experienced. While Lincoln et al.’s (2017) article on double stigmas touched on this in their discussion of the importance of setting, especially for stigma related to limited literacy, data in this study more directly highlights the importance of socioecological context. The analysis in this chapter focuses on the role that contextual factors play in multiple stigmas’ salience. In doing so, it answers Oexle and Corrigan’s (2018) call to investigate contextual factors regarding multiple stigmas, and Bowleg’s (2008) emphasis on the importance of taking sociohistorical context into account in intersectionality.

Peer respondents report that they and their peer clients understand and experience intersecting stigmas within the broader context of communities, histories, institutions, and policies. The role of context should not be undervalued when furthering scholarly understanding of intersectional stigmas, because marginalized identities exist within broader social landscapes. Not only does the salience of different stigmatized statuses vary within and across context, but the importance of each socioecological level of context varies amongst different stigmatized statuses. The most striking example in this data is the importance of the sociopolitical context in framing and highlighting stigma related to criminal justice system exposure. This makes the stigma related to criminal justice system involvement particularly entrenched for individuals in this country. Therefore, one of the main challenges for FPS work is forced disclosure of stigmatized identities and institutionalized stigma related to criminal justice system involvement.
The sociopolitical context is particularly challenging for individuals facing any stigma because it has such a broad impact. While individuals can change their social communities, it is more difficult to escape the broader sociopolitical environment. This is particularly alarming in the current Trump era of increasingly exclusionary policies and explicitly hateful rhetoric. Tyler (2018) argues that stigma has long been considered apolitically and ahistorically and explores these failures through a recent critical analysis of Goffman’s work on stigma using Black epistemologies of stigma and highlighting historical context. Just as it is useful to situate Goffman’s *Stigma* (1963) within the Jim Crow and Black freedom struggles of the early 1960s, it is important to situate these findings within the context of the end of the Obama administration, the Trump presidential election, and the Black Lives Matter movement.

Data collection for this project occurred during the Summer and Fall of 2016, immediately prior to the November eighth presidential election. Several of the peer respondents brought up the election during the interviews. Some of this discussion centered around the importance of active citizenship, and the actions that peer workers were taking to increase voter turnout. This was framed within the broader discussions of community inclusion and stigma resistance. However, a few of the respondents referred to Trump’s discrimination and violence towards marginalized groups, including individuals with disabilities and women. Trump ended up winning Pennsylvania by one of the narrowest margins in US history. The state’s stark political and ideological divisions were clear throughout my data collection. Bernie posters and murals were ubiquitous across Philadelphia (despite his Spring 2016 primary loss to Hilary Clinton), while thousands of Trump signs and bumper stickers lined the roads and highways of rural Pennsylvania (one declaring, “Trump that Bitch”).

While the potential impact that policies under the Trump administration has on stigma should not be understated, the diversity of political presentation across Pennsylvania also reflects
the importance of regional context. As discussed above, several peer respondents in rural areas highlighted the challenges that their peers faced related to stigma and believe these challenges to be specific to their rural regions. Conversely, peer respondents in Philadelphia proudly highlighted the city’s recovery movement and its impact on decreasing stigma in their urban space. Findings from this data suggests that broader anti-stigma programming needs to adapt to specific environments, settings, histories, and context.

While there were stark differences in the ways that urban and rural respondents discussed stigma, there were surprisingly few differences in the way that male and female respondents discussed stigma. There were racial differences in discussions of stigma, with white respondents more likely to highlight stigma and black respondents more likely to highlight recovery. However, race and place were highly associated in this study, with thirteen of the fifteen peer respondents who identify as black or African American residing in Philadelphia. Because respondents narratively framed their discussions of stigma and recovery through discussions of place – either through discussions of the city of Philadelphia or their rural county – rather than race, the data in this chapter highlights place rather than race. This is not to imply, however, that race does not play an important role in the understanding and meaning of multiple stigmas.

It is also important to note that many peer respondents were hesitant to discuss stigma at all, especially stigma that related to mental illness. A large proportion of peer respondents were unfailingly positive, reframing the narrative to one of recovery rather than of stigma. This echoes findings from Rice et al.’s article on intersectional stigma: “In the face of perceptions of intersectional stigma and discrimination within our sample, most participants shared an optimistic outlook for the future” (2018:15). Not only were the peer respondents predominantly positive and focused on recovery rather than stigma, they described multiple sources of resilience and resistance – which is also evidence of the importance of context on the salience of stigma.
When your environment is primarily one of peer work and the recovery community, stigma fails to feel as significant as it could, or as it once did, feel.

While intersectional stigma is experienced on an individual level, it is clear that the context in which the individual resides plays an important role on the salience and impact of those stigma. In this way, how individuals understand, and experience multiple stigmas is deeply tied to the communities they inhabit, and the inclusions or exclusions they experience within those communities. Stigma management work, including that done by FPS workers, involves community management work - the adoption of new inclusive communities, the avoidance of known exclusive communities, and even the creation of new communities. Furthermore, managing stigma can reproduce power and justice inequality (Keene, Smoyer and Blankenship 2018). For individuals managing multiple stigma, this community management work becomes even more complicated.
CHAPTER SIX: The Professionalization of Peer Support Work

Occupational status, professionalization, and the changing nature of peer support repeatedly emerged as topics that participants (both peer support workers and stakeholders) urgently wanted to talk about. As a central topic of discussion and debate, it became clear very early in my data collection that I needed to start paying more attention to these factors, despite the fact that my identified research questions focused on multiple stigmas and social inclusion. As I continued the data analysis process, however, it became apparent that these seemingly disparate topics are indeed intertwined with my research questions. This chapter will explore the inherent tension between institutionalization of peer support and the field’s consumer-based origin, and the resulting debates regarding professional definitions and jurisdiction. Furthermore, this tension has implications for the experiences and management (including resistance) of stigma within occupational contexts. While the last chapter explored the meaning and experience of multiple stigmas in society, this chapter looks at the changing nature of peer support and its implications for occupational inclusions and exclusions, occupational stigma, and professional identity.

Rather than focusing on the specialization of peer support known as FPS, in this chapter I look at the broader peer support field in Pennsylvania. There are two reasons for this: While the majority of my peer respondents are peer support workers, many are not specifically FPS workers. Furthermore, respondents spent much of each interview talking about peer support broadly, rather than FPS specifically. For this chapter I draw primarily on 35 interviews with Certified Peer Specialists (CPSs\textsuperscript{2}). Of the 37 interviews conducted with individuals trained in

\footnote{\textit{In this project I define CPSs as “a specific type of peer support worker. Certified in the state of Pennsylvania (among other states) to provide Medicaid-reimbursable peer support services to individuals with mental health diagnoses.”} (see chapter four). CPSs in Pennsylvania have completed a two-week long (75 hours) certification training with one of two approved vendors in the state. CPSs working in Medicaid-billable programs are required to complete 18 hours of continuing education per year, 12 of which must focus on recovery or peer support. These continuing education trainings do not have to have CEUs attached nor do trainers need specific qualifications.}
FPS, 35 were CPSs. I also draw upon the fourteen stakeholder interviews (see chapter three) to contextualize and supplement these findings. Peer support workers are identified by pseudonym, while stakeholders are identified by number or occupation. This chapter is grounded in literature related to professionalism, stigma management, and stigma resistance (see chapter three for a detailed discussion of these topics). Abbott’s central 1988 work on jurisdictional control in professions and Thoit’s and Link’s 2015 article on stigma resistance serve as key pieces in the theoretical framework.

In the preface to his book *Systems of Professions*, Abbott wrote that his interest in the topic of professionalism, expertise, and competition began with “the general issue of how modern societies institutionalize expertise. I knew that the common form of that institutionalization was professionalism” (1988: xii). I begin with the similar assumption that the processes of institutionalization and professionalization are intertwined concepts. Here I will refer to the “institutionalization of peer support” as the process by which the field gained legitimacy and became embedded within the official administrative structures of the mental healthcare system. The inclusion of CPS services within the Medicaid payment program played a key role in the institutionalization of peer support in Pennsylvania, although it should be noted that similar processes are taking place in different healthcare systems across the world, including New Zealand, France, and the United Kingdom. The “professionalization of peer support” refers to an occupational process, including the introduction of training, certification, and emphasis on expertise.

In this chapter I argue that the state institutionalization of peer support in Pennsylvania, as reflected in its status as a Medicaid-reimbursable service, has had diverse and unintended consequences on the field of peer support and the experiences of peer support workers themselves. These changes can be seen at three distinct levels: 1. The nature and content of peer
support work itself; 2. The occupational inclusion and stigmatization of peer support workers within the broader mental health service field; and 3. The occupational self-identity that peer support workers create and maintain. There was substantial variation among how respondents thought about the changes across all three of the categories. While some respondents were passionate advocates of the professionalization of peer support, other respondents mourned the loss of pre-institutionalized peer support and rejected these changes. I present findings related to each of these three categories in the following section.

Institutionalization of Peer Support in Pennsylvania

Before examining the professionalization of peer support work, occupational competition, and occupational self-identity, I begin with a brief discussion of how Pennsylvania has institutionalized peer support. As presented in chapter four, the institutionalization of peer support in Pennsylvania began in the early 2000s. Pennsylvania’s Office of Mental Health and Substance Abuse Services (OMHSAS) and mental health advocates and organizations across the state of Pennsylvania made a commitment towards transforming the mental health system towards a recovery orientation. This had important consequences for the peer support field, as “Peer support had been recognized as one method of helping to transform mental health services from a medical model to a recovery-oriented system” (PaPSC 2018). In 2004, OMHSAS received a grant from the federal Center for Medicare and Medicaid Services to develop a training and certification process for peer support workers, greatly increasing the number of CPSs across the state.

Peer support services were added to the state’s Medical Assistance Program in 2006, thus making CPS services a Medicaid-reimbursable service across Pennsylvania and subsequently expanding rapidly (Department of Public Welfare 2007). This inclusion was explicitly linked to the statewide system transformation initiative on recovery-oriented mental health services. Peer
support services are now a required Medicaid service in Pennsylvania, meaning that every county is mandated to offer those services. Furthermore, “counties must insure that the service is available in sufficient quantity to meet the need and must insure that there is a choice of at least two providers” (PA Recovery 2015: 2) and each provider agency must be approved by OMHSAS. In order to provide Medicaid-reimbursable services, peer support workers need to meet staff qualification and have the CPS certification. Due to these changes, CPSs are increasingly working in traditional mental healthcare organizations and interacting more with non-peer staff. This has effectively institutionalized peer support services. The institutionalization of peer support services has important implications for the work, occupational inclusions and exclusions, the professional identity of peer support workers. Each will be discussed below.

The Changing Nature of Peer Support Work in Pennsylvania

The integration of peer support services within broader mental health care services in Pennsylvania has often resulted in a clash between the recovery and the medical models of care. While some respondents in this study were enthusiastic about the professionalization of the field, many were concerned that the institutionalization of the peer support field threatens that centrality of lived experience. There is an inherent tension between institutionalization and the consumer-driven origin of the field as the occupation that began in the hands of the peers themselves becomes the domain of state agencies and policy makers. This tension is seen both in the changing nature of peer support, and in the wide-ranging opinions respondents expressed regarding the changes.

The Growth of Peer Support

One of the intended consequences of the institutionalization of peer support services in Pennsylvania has been the growth of the field. The implementation of peer support services as a
Medicaid reimbursable service has resulted in a larger service field with more individuals employed and more consumers receiving peer services. Thousands of individuals in Pennsylvania have been trained and certified as CPSs since the 2006 inclusion of Certified Peer Specialists as a Medicaid-reimbursable service and the field is “just growing and growing and growing” (Steven). While the institutionalization of peer support had many unintentional outcomes, the inclusion of peer support as a Medicaid-reimbursable service (and mandating counties insure the availability of peer support services for county residents) was successful in expanding peer services to individuals in most communities across the state. Several respondents linked the CPS certification process with increased job opportunities for peer support workers. For instance, the director of a state mental health advocacy organization told me that Medicaid reimbursement “made [peer support] a more viable way to earn a living” (#013). This same stakeholder is advocating for a national, in addition to state, certification for peer support workers. She believes it would be a positive change, comparing it to the development of the social work profession, despite the fact that social work certification is through a professional organization.

Some peer respondents also believed that the institutionalization of peer support work has led to an increased acceptance of peer support. Richard, who has been involved with the peer support field for over a decade, described some of the changes that he has witnessed:

You can see the progression. I have. A CPS is a certificate program. You get a certificate. It’s ink on paper that says you have completed this two-week course. It’s becoming more accepted. The county of Philadelphia actually mandated, a couple of years ago that any agency in the mental health field needs to have a certain percentage of their staff be CPSs, which greatly opened up job opportunities. (Richard)

Richard links the increasing presence of certified peer support workers with increasing acceptance of the field. Both Richard and the advocacy organization director would like to see the professionalization of peer support work continue and compare their vision with that of
archetypal professions. Richard talked about the push towards institutionalization as a movement: “The movement is to get licensed, certified, accredited. There’s accredited organizations, ethics, all that. Like an attorney or a doctor, anything like that.” However, there are a great number of differences between these fields in terms or qualifications and training. While physicians and lawyers are required to attend many years of post-graduate education, the CPS training requires a high school (or equivalent) degree and lasts for two weeks. Peer support is unique in that its main qualification is that workers have ‘lived experience’ of stigmatized statuses (including recovery in mental illness) and draw upon that stigmatized expertise when supporting their peer clients.

The Scope and Practice of Peer Support Work

The institutionalization of peer support has fundamentally changed the scope and practice of peer support work itself. Abbott emphasized the importance of looking at work itself (the labor and tasks), and the relationship between that work and the occupation, in order to understand professionalism (1988), and there is substantial evidence that the work of peer support changed substantially following its state institutionalization. A supervisor at a consumer-driven mental health organization in northeastern Pennsylvania discussed the changes in peer support services reflected in this institutionalization: “The peer support that we offer now through certification is Medicaid reimbursable. They want peer support in a specific way. We have to abide by that… The traditional way of doing peer support, just sitting down and having a cup of coffee, is not there anymore” (#024). There is a distinct difference between how she conceptualizes pre-Medicaid reimbursable peer support and post-Medicaid reimbursable peer support. This respondent views ‘traditional’ peer support work as informal and based on
relationship building, while Medicaid-driven peer support is more formal and less flexible.

Lawrence, a director of peer support services in central Pennsylvania, also differentiated between Medicaid and non-Medicaid funded peer support. He frequently used the term ‘true peer support’. When I asked him what he meant by ‘true,’ he responded:

Well, truly recovery-based individual first. It’s very easy in a billable [Medicaid] system to fall into, ‘I got to get my billables,’ even if that means, ‘Oh, crap I have five no-shows this week. Let me call this guy I already saw three times and just go hang out with him.’ What I mean is really, really helping people and helping them make connections that are going to empower them rather than enable them. I think we are so often falling to that mentality of billable services, billables, billables. billables.

While Lawrence believes that ‘true’ recovery-based peer support is possible within the Medicaid billable structure, it is much more challenging. Rather than being able to focus exclusively on the needs of peer clients, peer workers must juggle multiple demands and consider pay structures. Some of the peer support workers I interviewed were extremely critical of this professionalization of peer support, positing that the underlying recovery tenets of peer support cannot survive within mental healthcare bureaucracies and requirements.

Scott has also been involved with the peer support field for many years, and he spoke about the unintended consequences of the institutionalization of peer support work in the state, including the focus on paperwork:

I didn’t know about the paperwork that was going to be involved. I just knew that, oh, I get to work with peers and share my personal [experiences] - I thought that was a good idea. I was part of the committee was developing the peer specialists and what that meant. We didn’t really know what it meant… [It meant] that if you can’t help a person put together a recovery plan or write a personal note on how the progress of a person without putting your opinion in that note, then you’re not ready [to be a CPS]. (Scott)

While the original motivation for the certification of peer support was to expand accessibility to individual peer support based on experiential knowledge and lay expertise, the certification
simultaneously ushered in a number of new requirements for the workforce, including work tasks most commonly associated with professional clinicians (“paperwork”). Respondents posited that these changing requirements and certifications are actually alienating some individuals who would be able to provide powerful individual support from the field, and there is some evidence that they may be right. For instance, William, a CPS in Central Pennsylvania, expressed frustration at the emphasis on paperwork: “It’s just – let us do this [peer support] and give us a little slack on the documentation. You know what I mean? We’re not doctors and seven years ago I was shooting dope.”

Stakeholder #023, a program supervisor and FPS trainer who previously worked as a CPS, strongly critiqued the changes that he had witnessed in the peer support field as it underwent professionalization and incorporation into the broader mental health service field, arguing that it has changed the scope of peer practice:

They changed the scope of what peer support really is. At the end of the day, again, I believe peer support is one peer sharing his or her story with another. Now there’s that movement that kind of makes people, what I like to refer to as mini clinicians. Minus the white coat, they’ve got their clipboard and they’re taking notes, ‘How does that make you feel?’ I think it gets away…. There’s even some agencies that have confidentiality standards in terms of what can share. If you tell me I can’t share my story, then you’re taking the number one thing I’ve got to reach somebody.

Stakeholder #023 believes that peer support is now in the domain of non-peers, and echoes the concerns that Lawrence spoke of regarding the decline of ‘true’ peer support. As peer support becomes more integrated into mainstream mental health services, and non-peer providers become involved, there is a declining emphasis on lay expertise and stigmatized knowledge, as seen through the introduction in peer worker confidentiality restrictions.

Another concern regarding how the state institutionalization of the field has impacted peer support work itself is related to the relationships between peer support workers and their peer clients. Janet, a 58-year-old CPS in Eastern Pennsylvania, explains, “I think doctors and
maybe even lawyers, some professions, in the class they’ll teach you, in school they’ll teach you how to practice professional distance, but at CPS training we teach professional closeness.” As she points out, the clear ‘professional’ boundaries that exist within other occupational fields do not always apply in peer support. Lawrence, a 34-year-old Director of Peer Support Services in central PA who was recently promoted from peer support worker, expresses a similar sentiment about professional boundaries: “I don’t ever want to lose that connection because I see that in other professions in the mental health field. ‘I’m the professional, you’re the client.’ There’s this defined line” (Lawrence). He is concerned that this closeness will be lost as peer support becomes increasingly professionalized and integrated within the broader mental health field - and as he himself advances professionally. Thus, as the field is increasingly professionalized, and as peer support workers such as Lawrence advance professionally, there is increasing pressure for peer worker/peer client relationships to replicate non-peer provider/client relationships.

Some respondents maintain that with increased professionalism should come increased pay. When I asked about pay and benefits for the CPS employees, the program manager for a county mental health organization told me, “Our benefits aren’t very good and our salaries aren’t either. That’s part of my goal here, my strategic plan, that we expect people to be professional. With that comes a professional package and it’s a work in progress” (#014). This program manager explicitly links the growing professionalization of peer support with its increasing monetary value. However, while the institutionalization of peer support services has had diverse effects on the field of peer support, substantially increased pay does not appear to be one of them. Peer support workers were very upfront about their disappointment in their pay and benefits both on an individual level and for workers in the field generally. Jessica, a CPS in southeast Pennsylvania, told me bluntly, “My pay sucks,” and then later in the conversation, “You don’t get in it [the mental healthcare field] to make money, but I would like living wages.
That would be great.” While providing peer support offers nonmaterial benefits to CPSs, such as supporting their own recovery process and providing meaning and fulfillment, the monetary benefits for CPSs remain poor. Melissa, a CPS Supervisor in eastern Pennsylvania, described how demoralizing it is when she helps her peer clients find low skill, low stress jobs (such as working as a checker at a grocery store), and then finds out that her peer client gets paid more than she does. She echoes Jessica’s assessment of CPS salary: “That stinks.” It is particularly galling to be underpaid in a field that is increasingly identifying as professional.

**Occupational Inclusions and Exclusions of Peer Support Workers**

The state institutionalization of peer support has had an impact on the integration and exclusion of peer support workers within the broader mental health service field. Prior to its inclusion as a Medicaid-reimbursable service, and the related county-level service requirements, peer support workers primarily worked for consumer-run and grass roots organizations across the state. Now, however, many peer support workers are employed by governmental health agencies and large healthcare corporations where most of their coworkers do not identify as peers. These shifts from primarily peer to primarily non-peer coworkers, and from working within a recovery-oriented organization to ones historically based on the medical model, have had an impact on how integrated and included peer support workers feel within their work environments. This is despite the increased prestige associated with the professionalization of these roles.

**Institutionalization of Peer Support as Barrier to Peer Employment**

On a very basic level, the professionalization of peer support has created an additional barrier to employment for some potential peer workers. As Scott noted (see quotation on page 7), you can’t be a CPS if you can’t write a progress note. Those who cannot meet the paperwork requirements that are required under institutionalized peer support are excluded from the field. This was not the case prior to the incorporation of peer support services as a Medicaid-
reimbursable service, when peer support could include activities such as sharing coffee together without the need for documentation. Stakeholder #023 expressed concern about some of the changes taking place in the field, and about how those changes are excluding individuals from working in the field:

In terms of licensing and certification I think the more complex we make that process, it alienates some people… They may not be able to do a whole lot of things, but if they can sit with somebody for a couple hours a day and just share their own experience, that validates them. I think we've alienated some folks by saying, “You've got to do this and you can't do that. You can't be this.” (#023)

Just as the work itself has changed due to the institutionalization of peer support, so has the workforce.

While Medicaid reimbursement does increase access to peer support, it also limits who can provide peer support to those individuals who are qualified to take, and capable of completing, the training. There are many individuals who are not able to meet the current criteria to become CPS workers because they do not have a high school diploma or equivalent. Yet some of these same individuals might be able to support and serve peer clients well. Stakeholder #024, a supervisor at a county mental health organization in Northeast Pennsylvania, told me about the challenges and transformations related to this changing orientation within peer support. One of the peer support workers that reports to her is not certified because he could not achieve the educational requirements to take the CPS training: “He has tried to go back to get his GED so we could send him for a certification. He’s just not capable. The level of his work that he offers and delivers is exceptional. I’d rather have the lived experience. I really would. The certification is a formality.” Luckily, the agency that employs this stakeholder and peer worker has obtained additional grant funding that allows this non-certified individual to continue providing peer support outside of the Medicaid-reimbursable system. However, this is not always an option, and in other circumstances this individual would be excluded from the peer support workforce.
Recovery Orientation and Organizational Inclusions/ Exclusions

The institutionalization of peer support has had an impact on the occupational integration of peer support workers within broader mental health organizations. Organizational orientation towards the recovery perspective of mental health was associated with peer support workers’ feelings of inclusion and integration in their worksites. When their workplaces maintained a fundamental commitment to recovery principles, peer employees felt heard, seen, and valued. In interviews, peer employees at Philadelphia’s Behavioral Health department were uniquely vocal about their occupational inclusion and respected status. According to one employee, “Being a CPS, not only being a CPS, but having the CPS title, people give you respect because respect is due. People see you have a wealth of knowledge, especially in this field… They call me asking questions, especially the professionals because they know our vast experience. You get a lot of respect because they know what you been through.” This can be seen as a result of the department’s commitment to recovery. As the website expresses, “The DBHIDS management team and our employees embrace a vision of recovery, resilience, and self-determination. We continue to shift to a model of care directed by the person in recovery” (DBHIDS 2018). Peer support workers are themselves recognized as persons in recovery. This recovery orientation not only impacts individuals receiving services, but it also impacts individuals providing services.

While peer support is easily integrated within recovery-oriented organizations, it can take more time and effort to become accepted in workplaces that are not recovery oriented. Richard, a Forensic Peer Specialist in southeastern Pennsylvania, told me about the challenges that peer support has faced within the dominant medical model paradigm, including “resistance from the medical community.” Resistance from medical providers has on-the-ground implications because peer support services requires a referral from a medical provider to be covered by Medicaid. According to Richard, doctors become more supportive once they witness the positive clinical
outcomes (including decreased psychiatric hospitalization rates) that peer support facilitated. In order to be accepted within organizations emphasizing a medical model, peer support has to support the medical model’s goals and ideals.

Due to the state’s emphasis on ‘system transformation’ towards recovery practices, the institutionalization of peer support in Pennsylvania corresponded with an increase in organizations and practitioners embracing recovery language. However, respondents identified differences between organizations that claim to be recovery oriented, and those that are truly recovery oriented in practice. Jessica, a 40-year-old CPS in southeast Pennsylvania, told me that she felt stigmatized and treated like “the token consumer for [her] county” in treatment team meetings and community meetings. “When I would walk into the room eyes would roll, like ‘Here we go. We’re going to have to watch what we say because [Jessica] will say something.’” Recovery practices dictated that peers (or consumers) participate in these settings, but Jessica did not feel welcome or heard in those spaces. At the first treatment team meeting she attended, Jessica’s non-peer colleagues began asking her about her own experiences and medication history, rather than focusing on their shared female client. “Finally, I just said, ‘Excuse me, Doctor, do you believe in recovery?’ And the whole room was like [gasp]. All the air like left the room. Of course, the good doctor does. But his response was a lot more honest than that. He said, ‘I believe people like you can recover, not necessarily her.’” The true integration of peer support workers within broader mental healthcare setting depends on how colleagues, supervisors and organizations conceptualize and define recovery. The doctor in Jessica’s story utilized a more limited clinical definition (similar to how Davidson and Roe (2007) define “recovery from”) while the peer movement arose from a more inclusive definition of recovery (a “recovery in” definition).
**Professional Jurisdiction and Status**

As mentioned above, peer support workers are increasingly working with non-peer providers on treatment teams. There was substantial variation among respondents on whether peer support workers felt respected or marginalized in these groups. In some scenarios, respondents reported increasing inclusion and integration of peer workers by non-peer staff. Richard, a 62-year-old CPS in southeast Pennsylvania, told me about changing acceptance of peer support within his organization: “Originally we weren’t considered part of a treatment team. It was doctors, it was nurses, there was psychiatrists. Now we get to sit at the table too. We were always at the kids’ table in the past, but now we get to sit at the big table and help make the decision.” Richard and some other peer respondents spoke of the benefits regarding scope of impact and occupational status that have occurred along with the professionalization of peer support.

However, whether or not peers felt included and welcome by non-peer coworkers varied by the status differentials between themselves and their non-peer coworkers. Some peer workers told me that they felt that their voice was heard just as much, or even more, than that of doctors and other more formally-educated clinicians. When asked about her relationship with clinicians on the treatment team that she works on, Jessica responded:

> They actually really respect my opinions and my views and like listen to what I have to say… I’ve really thought it was probably going to be more of a fight when I got onto this team. Almost all of them have Master’s degrees or more and I don’t know… They very much value like what I have to say.

Jessica was surprised at the equitable voice that she carries in her worksite with her highly educated non-peer coworkers.

Coworkers with higher education attainment and professional prestige were frequently willing to value peer work and integrate peer workers into the worksites. However, these advanced professionals, such as psychiatrists, are not under threat of jurisdictional loss (Abbott
1988) from peer support workers. The types of work tasks that peer support workers engage in and the types of work tasks that these advanced professionals engage in occupy completely different spheres of labor. Therefore, high status professionals are perhaps more willing to include and integrate peer support workers into their organizations and work because their own status is not threatened.

However, the relationship between peer and non-peer staff becomes more complicated as status differential decreases. Mark, a mental health group facilitator in Philadelphia, told me about some of his interactions with non-peer workers when facilitating team meetings:

[The social worker]’s like, ‘I’ve got a bachelor’s degree. I’ve been to school. I studied. Got all As. Owe school all this money, right? I am skilled in this field and I’ve got my degree to prove it. [The CPS] walks in with a high school diploma. Are you trying to tell me that his voice is just as important as mine?’ And I said, ‘Yes, it is. Yes, it is, because he got this lived experience.’ Right. ‘I’m not saying that his voice means more than yours, but it is just as important.’ That’s hard to swallow. That’s hard to swallow, right?

Mark recognizes that it is challenging for many non-peer workers to accept peer worker’s lay expertise and their shared authority in work decisions, partly because of the culturally normative value placed on educationally-based qualifications. Bruce, a CPS supervisor, told me about the challenges that he faces as a peer representative on his local Criminal Justice Advisory Board (CJAB). “It’s not that we’re not heard, it’s more like [pause] like you’re the new kid, and your expertise isn’t appreciated I guess, like you don’t know anything.” While Bruce feels that he does have expertise, he believes that it is not recognized in non-peer settings. And in these settings, such as on CJABs and treatment teams, peer support workers are very much “the new kid.”

By increasing the number of peer support workers in non-peer work environments, the institutionalization of peer support has led to debates regarding professional boundaries and jurisdiction. Non-peer workers in occupations with high work-task overlap with peer work are at
a higher threat of jurisdictional loss and are therefore less likely to welcome peer support workers into their worksites. Melissa, the CPS supervisor in eastern Pennsylvania, said that the case managers at her worksite treat her and other peer colleagues poorly, and devalues their work, despite the fact that “we do just as much as them.” She then told me, “They think we’re trying to take their jobs,” laughed, and reassured me that she didn’t want their jobs. She went on, “There is one [case manager] in particular that I have to work with, she has fourteen of the same clients that I do. And she just don’t like me. [Interviewer: Why?] I don’t know, She says, she commonly tells me that I’m ‘just a Peer Specialist. You need to take him grocery shopping if he needs groceries. That’s what you do.’” Case managers, feeling under jurisdictional threat in their occupations, can devalue and undermine peer support workers and their work. In this case, Melissa’s coworker tells her that she views her role as that of a “taxi driver,” despite the fact that taking peer clients grocery shopping is explicitly not one of Melissa’s work tasks.

Other participants shared with me the many tensions and challenges that arise from working with Case Managers or Case Workers in team settings. Ronald, a CPS for the VA, told me about how powerless and unheard he felt in environments that are meant to be collaborative. “I’ll clam up in treatment teams sometimes when I offer something, and it’s always tabled. It always goes nowhere and then six months later it’ll get talked about again, waiting for one of the case managers to bring it up so it’ll work. As long as the peer specialist brings it up it’ll never work.” Ronald recognizes that his ideas are devalued and ignored and believes that it is because of his role as a peer specialist. Even more frustrating is that he sees his ideas enacted when non-peer specialist workers suggest them.

Peer workers frequently engage in similar work tasks as do more formally educated workers, such as caseworkers, and yet earn far less money. This can lead to feeling devalued. “I would like to see our CPS across the board get a better rate, you know, for anything ‘cause like, I
think our role is as important as just as anyone else’s role. We just don’t have the education piece by accredited colleges, or something” (Willie, a crisis team CPS in southeast Pennsylvania). The disparity in pay, and corresponding lack of material indication of value, can be particularly galling in team settings when peer workers are working alongside other providers in supposed collaboration. Furthermore, some respondents believe that their peer status will negatively impact any potential career advancement. “Do I believe that in this system I have an equal opportunity to move up in leadership? Nope. Absolutely not” (Ronald, CPS). While peer workers may be accepted as valuable when employed in explicitly peer positions, this does not imply that peer workers will be accepted in non-peer higher status and higher pay positions.

**Stigma and Occupational Exclusions**

While some organizations and non-peer workers have enthusiastically embraced peer support, many others have not. Several peer respondents told me about the tensions they felt at their places of work regarding their role and expertise among more formally educated coworkers. John, a CPS, told me that he feels CPSs are “at the bottom of the barrel.” I asked him to explain what he meant, and John continued, “I mean, at a facility you come in, I guess the CPS, you come in at the bottom. You got your case managers, your therapists, your directors, and all that kind of stuff, and then you got your CPS.” Others peer respondents told me directly that they felt discriminated against and unheard. Gail was forthright in her discussions of having non-peer coworkers that are “blatantly are mean to you” because of being a peer worker.

While the structure of the current peer support field makes it difficult for some peer support workers to earn a livable wage or to advance professionally, peer support workers face an additional barrier to occupational integration and advancement: stigma. Stigmatized knowledge allows peer workers to provide peer support, but it commonly also serves as barrier to career advancement and acceptance. And while peer support workers pursue formal education to
facilitate their career advancement, that education is frequently not enough to combat or mitigate stigma. Sandra, the director of a mental health recovery center who earned a bachelors and graduate degree after working as a CPS, told me, “I’ve heard people, my own colleagues, talk about CPSs like they weren’t up to par. Okay, they have a label too. Even after you’re educated or whatever, they still look at a CPS… I have a guy that’s an excellent candidate to be a CPS. He won’t do it because of the stigma that’s attached to it.” Not only does stigma limit career paths for CPSs, but stigma also limits who is willing to enter the peer support field at all. As peer support work has become increasingly common within non-peer and non-recovery-oriented spaces, the opportunities for experiencing structural and interpersonal stigma also increases.

**Peer Support Workers’ Occupational Self-Identity and Stigma Management**

As peer support has undergone professionalization, peer support workers have responded by redefining professionalism and their own occupational role. Ronald, a Peer Specialist in southeast Pennsylvania, recalled being reprimanded by non-peer colleagues and told that his work “doesn’t sound very professional.” Ronald responded, “I’m a peer. What is professional to you? I’m a professional peer. I’m a professional drug addict and drunk. You tell me what professional means to you and I’ll explain why I’m doing what I’m doing as a professional.” By framing his status as a “drug addict and drunk,” rather than someone in recovery or a former addict, Ronald is highlighting the tension between a stigmatized identity and the shifting orientation towards professionalization within the broader peer support field. Ronald turned the very concept of professionalism on its head with his contradictory identity of ‘professional drug addict,’ thus reflecting the intrinsic tension that some peer workers and advocates see between professionalization and the peer movement.
Peer Workers as Professionals/ Peer Workers as Un-Professionals

The professionalization of peer support work has prompted many peer support workers to reconsider their own occupational identity. The transition from service-user to service-provider requires individuals to do identity work, and the institutionalization of their field and inclusion within mainstream mental health services makes that identity transition even more apparent. Lawrence, the Director of Peer Support Services in Central Pennsylvania who discussed “true” peer support, told me about his internal confusion regarding his transition from felon to professional: “It’s weird for me, you know what I mean? To think here I am in a professional position now presenting to professionals in the field in two weeks and they used to lock me up 10 years ago. This is a weird world me for me.” Regardless of whether individual peer support workers embrace or reject a professional self-identity, most must engage in identity work to incorporate their occupational role, especially as that occupation undergoes professionalization.

There was substantial disagreement among my respondents about whether peer support workers are currently, and whether peer support workers should be, considered ‘professionals.’ Some peer respondents wanted to be viewed as a professional. Mark, a mental health group facilitator in Philadelphia who has been in the field for over a decade, explained the changes in how peer support workers have been seen: “It wasn’t no cake walk being viewed as professionals… [But] it’s been a tremendous amount of progress. People started saying that these peer support specialists is helpful, like this stuff is helpful. They bring a lot to the table, and it started being viewed as a professional position, you know.” For Mark, acceptance and recognition of peer support work as an effective and useful field hinged on being accepted and recognized as a professional field. Mark encourages his peer coworkers to ‘conduct yourself as a professional’ so that they can be ‘viewed as a professional.’ This embrace of a traditional
professional identity is in sharp contrast to Ronald’s explicit linking of professionalism with stigmatized identities.

While some peer respondents explicitly called themselves professional, other peer respondents identified themselves in opposition to professionals. Larry, a 58-year-old in Philadelphia defined a CPS as, “A person, a peer, that helps you doing what you need to do or making your goals. We’re not therapists. We’re not telling you what to do. We’re not the doctor. We’re just like you. I think that helps because we’re same as you. That helps. It helps. We’re not a guidance counselor. We’re none of that.” Many peer respondents stated that peer support is more effective in reaching and supporting individuals in recovery than other types of mental health services provided by more traditional professionals like doctors or therapists. According to these peers, it is precisely this practical and personal knowledge, gained from lived experience, that is what makes peer support so effective for many individuals. Not only are peer support workers more knowledgeable, trustworthy, and presumed nonjudgmental than clinicians like therapists, respondents like Michelle believe peer workers are more trustworthy for consumers because they can’t be manipulated in the same way that professionals can. “That's the best part about this job. I can sit in a room with somebody and let them talk to me, lie to me all they want, and at the end of a session and go, ‘You just wasted your whole hour because you lied.’ They're like, ‘She really knows what she's talking about. She's just not a therapist.’” These peer support workers present themselves as more effective than clinicians such as therapists, precisely because they have an expertise – lay expertise – that cannot be taught in trainings and that most clinicians do not possess.

Some peer respondents, like Janet, explicitly did not want to be viewed as a professional: “I’ve had people that would work with me but wouldn’t go to a PR or see a therapist because they feel like they’re professionals and where they see us [CPS] as just somebody that’s
struggled and made a headway, and they appreciate that.” Janet believes that she is able to do the work that she does precisely because she is not viewed as a professional. Professionalizing peer support work could put in jeopardy the unique relationship that peer workers have with peer clients, thus partially undermining the very benefits that the field offers.

**Occupational Identity and Stigma**

I argue here that the way that respondents understand and experience stigma is associated with how they conceptualize their own occupational identity. Indeed, the diversity in occupational identity among peer support workers frequently reflects their diversity of stigma management techniques. Thoits and Link (2016) proposed that individuals use multiple coping mechanisms to respond to and manage stigma. These include both stigma concealment responses and stigma resistance responses, with stigma resistance strategies further differentiated into challenging and deflecting responses (Thoits and Link 2016). Peer support workers employ these three stigma strategies (concealment, challenging-resistance, and deflecting-resistance) when defining their occupational status.

Thus far, this section has focused on whether or not peer support workers identify as professionals. However, a subset of respondents told me that they concealed their occupational identity as a peer support worker. Instead, these peer support workers told their friends and families that they were Social Workers, Case Managers, or other types of behavioral health workers. They avoided telling individuals that they were peer workers in order to conceal their own stigmatized identities. Being a CPS signified having a mental illness – mandatory disclosure in occupational environment - and an FPS worker label also implied criminal justice system involvement. Initially, Amy, a Corporate Peer Services Coordinator, didn’t want to be a CPS because “it’s beneath me.” Once she took the training and began working as a CPS, however, she found that she enjoyed the work. However, “I still had some stigma about it. I didn’t dare tell
nobody I was a CPS. I told my dad I did outreach... I was still like, sneaking around, I’m not telling nobody I’m a Certified Peer Specialist.” Amy recognizes that she concealed her identity as a peer worker both due to her internal self-stigma, and as a way to manage the threat of external stigma from her dad and others.

Embracing a professional identity can be a way for peer support workers to resist the stigma associated with being a peer. Rebecca, a CPS in central Pennsylvania, used to tell individuals that she was a Social Worker, and avoided being on a peer panel because of “the stigma of it and I wanted to fit it, in a professional standpoint.” Although she now tells people that she is a Certified Peer Specialist, she makes sure to have a very “professional appearance.” Rebecca has moved from utilizing concealment as her primary stigma coping mechanism to resisting stigma through deflection. According to Thoits and Link (2016: 1) “deflecting consists of blocking or rebuffing others’ stereotyping and unfair treatment as inapplicable and irrelevant to oneself.” Through her ‘professional’ appearance, Rebecca is signaling that stereotypes about mentally ill people do not apply to her. When I asked what allowed her to stop calling herself a Social Worker and start being “proud to say” she’s a CPS, Rebecca responded, “Having that recovery acknowledgement and recognition within my own agency… and others in the community.” Rebecca’s response supports the previous discussion related to recovery orientation and professional identity. She continued her explanation: “And definitely having more people being recognized as we are able to carry many hats in professionalism, as well.” For Rebecca, the broader professionalization of peer support has served to combat stigma associated with peer status, and helped her stop concealing her occupational identity.

The second form of stigma resistance that Thoits and Link (2016:1) identify is “challenging [which] refers to confronting or opposing other people’s negative attitudes and
unfair actions.” Michelle, an FPS worker with a history of mental illness, incarceration, and addiction, told me that:

I don’t try to hide or change who I am. This is what you get on the surface and what I’ve done is what I’ve done. There’s physical evidence on my body of what I’ve done and where I’ve been in my life. I’m not going to cover that up or hide it just because I have a professional job now because it benefits what I do. For me to be that person that everyday wears long sleeved shirts and tries to hide the tattoos and stuff like that, I’m not fitting in with the population. Even when I go to agency meetings and stuff like that, CJAB meetings, I don’t. If it’s hot, guess what, my sleeves are getting rolled up and if you don’t like it, you don’t like it. It’s the way it is. It’s who I am.

In sharp contrast to those who try to conceal evidence of stigmatized identities, Michelle challenges potential stigmatizers by showing her actual physical marks, including tattoos, self-harm scars, and fading track marks. While Rebecca takes care to maintain a professional appearance in order to deflect stigma, Michelle resists potential stigma by confronting individuals with her ‘unprofessional’ appearance. In this quote she distinguishes between having a professional job and having a professional identity. By differentiating between her professional job and her identity, Rebecca indicates that peers can maintain professional roles without rejecting their other identities and histories. Peers who vehemently resist the professionalization of the field and identify themselves occupationally in opposition to professions go even farther in terms of stigma resistance. Highlighting their stigmatized status and the knowledge that emerges from that status as of highest value can be seen as incompatible with a professional identity, and therefore peer challenge others’ stigmatizing attitudes by embracing their stigmatized identities rather than more culturally sanctioned professional identities.

Discussion

The aim of the inclusion of peer support as a Medicaid-reimbursable service in Pennsylvania was to promote recovery through increasing access to peer services and
occupational opportunities for peers. While this goal has been achieved, there are a number of additional, unanticipated consequences. This chapter has shown that the state institutionalization of peer support in Pennsylvania has impacted peer support workers in three ways: their work, their inclusion within non-peer mental health services, and their professional identity. As stakeholder #24, who has been involved with peer support in Pennsylvania since 1995, told me, “peer support back then is not what it is today. There’s pros and cons with everything.” While over 4,600 individuals have been trained as CPSs in the state since 2004 (PAPSC 2018), the scope of peer practice has changed, and peer workers are facing new barriers to occupational integration. Given this range of outcomes, it is not surprising that respondents expressed a wide range of opinions regarding the professionalization and institutionalization of peer support.

While this chapter highlights the institutionalization of peer support work in Pennsylvania, it is important to note that similar changes are taking place throughout the world. Scholars have written about the professionalization of peer support in New Zealand (Scott 2011; Tudor et al. 2018) and its integration within traditional healthcare systems in Australia (Byrne, Happell, and Reid-Searl 2016) and the United Kingdom (Watson 2017a; Gillard et al. 2017). These authors discuss many of the same challenges associated with introducing recovery-oriented services within mainstream mental health services that are identified in this chapter. The United States, however, has a unique, and uniquely challenging, healthcare system and thus it is important to look at these processes in different regions.

The lessons we learn about the professionalization of peer support workers has implications for many fields, including Community Health Workers and Doulas, due to the broader trends towards professionalizing lay health workers. In many ways, Abbott’s 1988 work on professional jurisdiction and competition for that jurisdiction applies to lay occupations. In introducing peer support or other lay workers into new environments, we must consider the occupations that can
consider themselves under threat. Within the Pennsylvanian mental healthcare system, this appears to be Case Workers rather than high status professionals like Psychiatrists.

However, peer support differs from other lay health occupations because peer support workers’ primary qualification for pursuing the work, recovery in mental illness, is stigmatized, and workers are mandated to disclose that stigmatized status. As we see here with peer support, professionalizing stigmatized occupations can result in complex and disparate outcomes for the field and for workers.

These data reveal a tension between peer worker’s desire to achieve a professional status and their dedication to their lay status. This tension is heightened as their work increasingly occurs in environments that value traditional professionalism. In order to stay true to their status as peers, peer workers need to highlight their lived experience. Simultaneously, in order to gain prestige and acceptance in non-peer spaces, peer workers need to adopt professional behaviors and values. However, lived experience and lay status is frequently in opposition to professional behaviors and values. In these data we see some peers embracing their “peerness,” some peers embracing professionalism, and some peers expressing discomfort with the tension that exists between those statuses and therefore in their own self-concept. Not only do jobs provide material benefits, they also greatly impact worker’s self-concept, identity, and beliefs about self-worth. The disclosure and utilization of stigmatized statuses required of peer worker has a substantial impact on those factors.

While this chapter focused on peer support broadly, it is likely that the institutionalization of specialized peer support services, including FPS, would result in similarly complicated outcomes. FPS workers who have been involved with the criminal justice system would have to face and manage additional stigma. Furthermore, as presented in chapter five, the stigma associated with criminal justice system involvement is more structurally rooted than stigma
associated with mental illness in the contemporary United States. This entrenched stigma would likely make it more challenging to institutionalize the FPS field but could also have negative implications for inclusion of FPS workers. This chapter shows that there is greater integration of peer support workers within mental health organizations that embrace the recovery philosophy. The US criminal justice system, as fundamentally not recovery oriented, would likely be an environment in which professionalized FPS workers frequently experience exclusion. In the following chapter (seven) I explore the facilitators and barriers that have contributed to the current state of Forensic Peer Support in Pennsylvania (as described in chapter four) and describe how respondents envision the field’s future.
CHAPTER SEVEN: Barriers, Facilitators and Envisioning the Future of FPS

Two of the major findings identified in chapter four are: 1. There are fewer individuals working as Forensic Peer Support providers in Pennsylvania than are trained to do so, and 2. Despite this limited workforce, both workers and stakeholders believe and report that the FPS support work that is being done is having a positive impact on workers, organizations, communities and peer clients. Multiple stigmas (chapter five) and the institutionalization of general peer support services (chapter six) have played a role in how the peer support workers have experienced and understood their work, as well as how the service field has developed.

Several additional factors have influenced the development and implementation of FPS work in Pennsylvania. This chapter will examine these factors, discussing both the barriers that have limited the overall growth and impact of the field, as well as the facilitators that have allowed FPS to grow and thrive in the settings in which it has been able to do so. These barriers and facilitators, operating at individual and system levels, have contributed to both the spread and stagnation of Forensic Peer Support in Pennsylvania. Barriers include: challenges related to the criminal justice system; lack of funding; and high stress, low pay, and low status work. Due to the extent of the challenges related to the criminal justice system, multiple areas are discussed, including the lack of recovery orientation, inaccessibility, and stigma. Factors facilitating Forensic Peer Support work include: recovery orientation within organizations and communities; relationship building with criminal justice system workers; and demonstrated effectiveness. In this chapter I draw on all of my data sources, with peer support workers identified by pseudonym and stakeholders identified by interview number.

Given the complexity of these facilitators and barriers, it is hard to predict how the FPS field might develop and shift in the future. I conclude this chapter with a description of how peer support workers and stakeholders envision the future of FPS – their hopes, concerns, and
excitement. While substantial barriers do exist, Forensic Peer Support and its workforce has the potential to flourish and grow. This study of Forensic Peer Support in Pennsylvania can provide insight into program design and revision, as well as how organizations can develop, support and maintain their Forensic Peer Support workforce. Lessons learned at this site have implications for the dissemination and practice of Forensic Peer Support programming in Pennsylvania, the nation, and across the world.

**Barriers Related to the Criminal Justice System**

The US criminal justice system consists of three main branches: law enforcement, courts, and corrections. At this point, none of the three branches of the criminal justice system have demonstrated wide-spread support of FPS programming and workers. However, peer support has made greater inroads in the correctional system than it has in the other two branches. Therefore, many of the examples related to the criminal justice system discussed below, and throughout this dissertation, speaks specifically to corrections. I will continue to use the term “criminal justice system” to reflect the language used by my participants, despite the disproportionate focus on corrections. This lack of FPS programming in law enforcement and the courts was acknowledged and criticized by both peer and stakeholder respondents, and much of the discussions related to the future development of FPS relates to those two branches.

The criminal justice system serves as a substantial barrier to the development and implementation of FPS services in Pennsylvania, despite the innovative CPS programming that exists in State Correctional Institutions (SCIs) (see chapter four). While CPSs in the state work within the mental healthcare system, FPS is unique in that it attempts to serve individuals involved with both the mental healthcare and the criminal justice systems. I identify three interrelated factors, reported by peers and stakeholders, related to the criminal justice system that
serve as a barrier to the implementation and growth of FPS in Pennsylvania: lack of recovery orientation, inaccessibility, and stigma.

*Recovery Orientation*

The Pennsylvanian mental health care system, and Philadelphia’s in particular, experienced a substantial transformation in the past two decades towards recovery, which has had a large impact on the growth and implementation of peer support services (see chapters four and six). However, the criminal justice system has not experienced such a shift towards recovery and this has limited the ability of the FPS field to easily access the criminal justice system to serve many potential justice-involved peers. Mary, who works for her city’s behavioral health department, highlights that mental healthcare system transformation towards recovery took over a decade. As she said regarding the challenges of integrating FPS into the criminal justice system: “We’re looking at a whole transformation of the [criminal justice] system in some respects. It took ten years for us to get to the point where we are with our [mental health] system transformation here. That’s a whole other system. I think some has happened, but it’s trickling. Very little, that I know of.” What Mary doesn’t mention is that this ‘system transformation’ took place after the state’s mental healthcare department made an explicit and wide-spread institutional decision to make their system recovery-oriented. Much of the incorporation of recovery principles into policy goals and mental healthcare was motivated by a 2005 publication by the state’s Office of Mental Health and Substance Abuse Service that advocated for a recovery-oriented mental healthcare system (PaPSC 2018). None of the three branches of the criminal justice system in the state have developed any such approaches. This leads to a philosophical disconnect between recovery-oriented mental health services and the aims and orientation of the criminal justice system.
Inaccessibility

The second criminal-justice-related factor limiting FPS in PA relates to access. The CJ system is notoriously challenging to penetrate. Stakeholder #014, a program manager for a consumer run mental health organization in central Pennsylvania, told me about the challenges that he has faced in trying to launch FPS programming in their county:

The goal for the last three and half years or so has been to get the forensic piece going. Like I said, we tried and tried and tried. I got two different grants to go in, but like I say, they kind of got eaten up just trying to get through the system. It was so hard. Initially they didn't like us at all... The COs [correction officers] and everybody. The previous warden, we met with him and he was very unreceptive to the idea. He said, 'this is jail.' He said he wasn't a social worker and blah, blah, blah. It was really hard to get past that. (#014)

As shown in the above quote, the challenge of “get[ting] through the system” is intimately tied to the stark differences between a recovery driven service and a punishment (or even rehabilitative) driven system.

Furthermore, each correctional facility’s response to proposed FPS services depends on the whim of its decision maker. An FPS supervisor who oversees a program that engages with several different jails described her work, "I kind of have to know which jail, what I'm doing to make sure that I don't tick off any warden or any staff member" (#016). While some wardens and other prison representatives in the state have welcomed peer support workers into the facilities, others have not. Kimberly, a CPS in southeast Pennsylvania, said bluntly about the stagnation of FPS, “It’s not growing because the prison doesn’t want us in there.” While the state Even those jails that are more welcoming to FPS workers have challenges for service delivery. Wayne, who provided peer support to jail inmates until program funding ended earlier in the year, complained about not being able to bring in pens and pencils into the jail because they are considered contraband. In addition, he sees the approval process to enter the jail (that must be repeated every six months) as unnecessarily time-consuming and tedious.
Developing, implementing and promoting peer support within the criminal justice system is complicated because decision makers and stakeholders from multiple systems need to work together. A project specialist in Harrisburg told me that in order for the FPS field to thrive, “We need everybody at the table. That's what [cross-systems work] looks like to me. Judges, lawyers, probation, parole, corrections, bring the church, the ministries, mental health advocates, therapists, counselors, anybody. Whoever you are, if you have a vested interest in your community, you belong at that table.” However, when you have all of these representatives, perspectives and voices “at the table” there can many challenges in terms of coming to agreements or finding commonalities. As an FPS trainer stated:

What ends up happening is we get all of these people at the table, and for lack of a better way to put it, everybody's ego gets involved. 'We're the Pennsylvania Department of Corrections and we want your program to do this!' Then Probation and Parole says, "Well, we want to do this!" Then you have the mental health advocates, 'We want it to do this!'” Nobody comes to the table and remembers that at the end of the day we're trying to help somebody… Nobody is really ready to let go of that ego or break out of their silo and say, 'Okay, this is what we're bringing to the table.' (#023)

Forensic Peer Support, while birthed from the recovery branch of mental health services, is also reliant on cooperation from different branches of the criminal justice system. Not only are the institutional aims different, this stakeholder indicates that attempts at cross-system collaboration results in competition over jurisdictional control.

**Structural Stigma**

The third way that the criminal justice system is serving as a barrier to the development of FPS relates to stigma. As discussed in previous chapters, stigma can serve as a barrier both to individuals pursuing peer occupations and to the development of peer fields in general. Stigma is serving as an especially challenging barrier to the implementation and development of FPS programming because of the particular nature of criminal justice related stigma. I showed in chapter five that stigma related to the criminal justice system is experienced and enacted
differently than stigma related to mental illness, partly due to the political and cultural context of the contemporary United States. While fear of stigma related to both mental illness and criminal justice system involvement serves as a barrier for individuals to enter the peer workforce, stigma related to criminal justice involvement is associated with more structural barriers that makes providing peer support challenging. Having a criminal record, while valuable experience and a sought-after qualification for providing FPS, limits peer workers’ ability to work with justice involved peers.

There are substantial structural limitations related to criminal records that impede FPS-trained peer support workers to engage in FPS work. While FPS trainers and employers might prefer that their applicants have lived experience with the criminal justice system, these applicants face employment challenges related to that experience. Seventy-six percent (76%) of survey respondents who are currently working in FPS report having had criminal justice system involvement. The supervisor of a CPS who had been trained while incarcerated in an SCI lamented that the CPS could not enter the jail to provide support, support that he is uniquely qualified to provide, because he was still on parole. A different stakeholder noted, “we have not hired people because they couldn’t go in the jail. It defeats the purpose in a way” (#021). While this is legal policy, it also reflects how respondents discussed stigma and the criminal justice system – as structural. As Keene, Smoyer and Blankenship (2018) observe, stigma is enacted both interpersonally and through state-sponsored policies. Individuals with criminal records face additional barriers to FPS work, such as restricted access to jails and prisons, and stigmatizing justice staff.

These restrictions are limiting the very growth and effectiveness of the field itself. One stakeholder told me that he had applied for a position in Forensic Peer Support. Despite being an advanced level facilitator for the training and providing FPS for years, he didn’t get the job. The
reason they gave him: they don’t hire people with a criminal justice background. He mused, “Do you understand the concept of forensic peer support? If you’re going to exclude people with a criminal background, then you’re not looking for forensic peer support” (#023). Kimberly, a CPS in southeast Pennsylvania, told me that while she would like to be able to provide FPS, she doesn’t think she can do so because of her criminal history:

There is a full-time position that opened up or is opening up there in [County] that I really want and they want me to have, but they won’t let me back in the prison because, and back in jail because of my past history with them. I wasn’t a model inmate at all so they really don’t want me back there, but that’s been the barrier for a lot of people that should and would be better going in, they want people that have never been in jail. (Kimberly)

As the strength of peer support depends on shared lived experiences, this calls into question the definition, specificity, and potential of forensic peer support. This is a substantial barrier to the development of the FPS field.

**Additional Barriers**

**Funding and Medicaid**

The second main barrier to the growth of FPS in Pennsylvania is lack of funding. Lack of funding is directly linked with the challenges related to the criminal justice system, as discussed above. The project specialist in Harrisburg advocating for “everybody at the table” above recognized that one of the main challenges with cross-systems work is that funding streams for each system is different. As she says, “Damn, funding!... Our systems have built too many walls, and I know it’s funding.” As discussed in chapter four, the primary reason that individuals leave FPS positions is financial, including challenges related to temporary and unstable program funding.

Stakeholders and peer support workers agreed that lack of funding for FPS programs is extremely problematic. When asked what challenges the FPS field faces, #012 responded, “the
funding. It’s always worry about the money, worry about the money. We do need money. You can’t do it without money. We all know this.” The criminal justice system in particular was cited as failing to fund peer support, opting instead for “more jails or more guards… more officers on the street” (#023). Even when individuals at correctional facilities support the idea of FPS, funding remains an issue. Jessica told me about her experience attempting to increase FPS services in her community, “When we talked to the warden, he was very open about the idea of peer support within… Going inside or being at booking or you know like different phases, but then the barrier came of “Who’s going to pay for it?” ... That’s as far as we can get, so it’s a little bit frustrating.” Even when individuals in the criminal justice system do support the inclusion of FPS services, funding remains a substantial barrier.

The question of ‘who is going to pay for it’ is not unique to FPS. Money is limited in much of the state for many different kinds of services. A stakeholder in rural northern Pennsylvania explained that his community was experiencing a severe doctor shortage primarily due to low wages in the area. The impact of the doctor shortage was reverberating across other services, including standard peer support work. Without doctors, individuals could not receive psychiatric diagnoses. Without diagnoses, CPSs cannot submit claims to Medicaid for reimbursement.

As discussed in chapter six, the growth of broader peer support services in Pennsylvania is directly tied to the professionalization of CPSs and inclusion of CPS services in the state Medicaid plan. However, there are many contexts in which peer support is not reimbursable by Medicaid. This includes peer support provided in residential facilities such as jails, prisons, and other correctional facilities. Furthermore, returning citizens also frequently face a gap between time of release and reactivation of Medicaid, during which FPS services are also not Medicaid reimbursable. This significantly limits the type and amount of support that FPS workers can
provide, and it is proving to be a substantial barrier to the growth of FPS. As Medicaid does not support FPS work, the funding frequently comes in the form of grants. David, a CPS supervisor in Southeast Pennsylvania, says that FPS workers “have a role, [but] the role is so limited that they’re not making what I would mark as a significant impact because the only way you get into that role is through grant funding.” According to David, grant funding is not a substantial or reliable enough source of funding for the field to thrive and grow.

**Low Pay, High Stress, and Lack of Career Ladder**

Peer support work in general is a low pay, high stress occupation, and there is currently a very limited peer career ladder (or career potential). These qualities are serving as barriers to the development of a peer support workforce. The pay for peer support work is frequently low. Says one stakeholder, “Peers aren’t generally paid a really good wage. Some start at ten dollars an hour so it’s not always a living wage” (#012). Another states, “Our benefits aren’t very good and our salaries aren’t either” (#014). Gail, who worked in FPS previously but does not currently due to low pay, notes, “They probably need somebody to advocate, ‘Hey, you need to be paying these people a lot more money going directly into jail with the people!’” While all peer support roles are paid modestly, it seems that some FPS workers receive even less. As shown in chapter four, approximately 90% of peer workers who were currently employed in FPS (but no longer FPS workers) were earning less than $14 per hour in FPS positions. Conversely, 56% of those individuals currently providing FPS earn $14 or more per hour. Individuals are more likely to continue working in these positions when paid a reasonable wage. This is supported by qualitative data indicating peer workers interested in providing FPS have chosen to remain in standard CPS positions due to pay disparities.

It is especially important that peer support workers are paid adequately because the work that they do is high stress and high demand. The job that FPS workers get paid so little for is a
challenging one. Peer specialists in general frequently suffer from burnout and overwork. However, the opportunities for dual stigmatized individuals are so limited that many times the peer support workers feel that they are supposed to be blindly grateful for the work despite its challenges, and to say, “I’m so glad to have a job,” and in the meantime you’re [peer specialists are] getting sicker and sicker and sicker” (#017). This is especially ironic and cruel considering peer specialists are employed to model recovery and promote hope.

In addition to low pay and high stress, peer support workers in general have little opportunity for occupational advancements. Stakeholders were upfront about this challenge. Stakeholder #012, a project specialist at a state advocacy organization, talked about the lack of career ladders within the field of peer support, and how much she would like to see that change. “What we’re talking about at a state level is how do we provide those step-ups in a person’s career to allow them advancement in what they’re doing. You know what I mean? You become a Certified Peer Specialist and you never have that gain of employment.” While there are CPS supervisor positions, that is the extent of the formal career ladder for CPSs, and there is no formal career ladder for FPS workers at all.

A more basic problem than lack of opportunity for professional advancement is the shortage of Forensic Peer Support jobs altogether. “What do you do with that education? You can perform a service but there’s no jobs” (#024). As indicated with the survey data, many more individuals are trained to provide FPS than have obtained paid positions that enable them to do so. “Even if [peers] got forensic training, well who’s going to hire them because there is no Forensic Peer Specialist position anywhere” (#021). While there are some Forensic Peer Specialist positions across Pennsylvania, stakeholders, and peer workers are clamoring for more.
Facilitators

Recovery-oriented Communities and Organizations

Many of the facilitators that have encouraged Forensic Peer Support services in communities across Pennsylvania reflect the opposites of the above listed barriers. For example, while the lack of recovery orientation within the criminal justice system restricts the field, FPS programming flourishes in communities and organizations that prioritize and value recovery. As discussed above, the criminal justice system does not broadly support recovery principles and has not broadly accepted FPS programming. The first FPS program in the state was developed and implemented by a consumer-run, recovery-oriented mental health organization in a rural county and much of the contemporary statewide FPS training and programming in the state is based off of that original recovery-driven program. Grassroots organizing and consumer advocacy continues to be a primary driver of the FPS field.

However, state-wide departments and cities that embrace recovery have also played a part in the development of FPS services. Funding for the statewide FPS training initiative came from the state’s mental health department, OHMSAS, which has recovery as a central, guiding principle. Forensic Peer Support appears to be more accepted and growing in Philadelphia, a city that has deeply embraced the recovery paradigm (for example, hosting the nation’s largest Recovery Walk every September), compared to other cities and towns across the state. In communities and organizations that have not embraced recovery principles, Forensic Peer Support has a harder time with implementation and growth. The implementation of FPS programming has been spotty and patchwork across the state, reflecting the vastly different perspectives towards recovery that communities and organizations maintain.
Localized Relationship Building with the Criminal Justice Workforce

Many of the successful FPS programs throughout the state began by developing relationships with local stakeholders and workers in the criminal justice system. While the criminal justice system frequently serves as a barrier to FPS programming growth and implementation, there are localized exceptions to this. Respondents talked about the importance of developing relationships with high power officials in their local criminal justice settings, such as wardens and judges, in order to advocate for funding and access. Stakeholder #014 helped develop and now manages a new FPS program in central Pennsylvania. He spent over three years attempting to start FPS in his county, only to be rebuffed. However, recently the jail hired a new warden who was more receptive to the proposal. “The warden, the new warden, is a very therapy-minded person and really leans real far that way. She kind of really supports us and so we're getting many, many referrals.” After a long three years of trying, stakeholder #014 finally got buy in from a principal gatekeeper, the new warden – an individual who values mental healthcare. This cross-systems work facilitated the development and implementation of FPS programming in their local jail. In order to develop FPS programming, it is important to develop relationships and get buy-in from high status CJ representatives, like wardens and judges.

However, in order for that FPS programming to be accepted and effective, it is also important to develop relationships with individuals doing the on-the-ground work within the criminal justice system, such as correctional or parole officers. Mark, who previously worked as an FPS in Philadelphia, told me that he had a hard time supporting his peer clients in the prison because of resistance from employees within the prison. “I've learnt that it's not so much the people at the top that you've got to build a rapport with. It's the people that do the day-to-day work. Just being thrust into something without letting them know what's happening. Because one prison social worker was like, ‘I'm going to have to call the union, because I don't even know
Mark told me that he was threatened and harassed by a couple of non-peer workers in the prison. Just as non-peer mental healthcare workers can experience jurisdictional threat from peer support workers (see chapter five), so can non-peer criminal justice system workers. This can have negative ramifications for both the effectiveness of FPS programming and the experiences of FPS workers.

**Showing Effectiveness**

The final factor that facilitates the development of FPS programming is the capacity of programs to show their effectiveness. Programs that are able to claim that FPS leads to positive outcomes were able to grow and support the development of related FPS programming. There is a lack of formal evaluation regarding FPS programming due in part, according to respondents, to lack of funding. Therefore, the majority of current outcome data is anecdotal or unofficial. For example, one consumer-run organization with a flourishing FPS program reports that their work has led to a 14% decrease in recidivism rates at the local jail based on their own count, and this has encouraged local criminal justice officials to continue supporting the programming. Several stakeholders and peer workers believe that further research should be done to show how well FPS “works” for peer clients and peer workers.

It is not clear, however, what counts as a “positive outcome” for Forensic Peer Support. The organization mentioned above measures success by decreasing recidivism rates. Melissa, an FPS in Eastern Pennsylvania, points out the challenges with focusing exclusively on recidivism:

> It’s very hard when we’re doing our outcomes and stuff that we are giving all these percentages that we’re going to say, ‘90% of the people we see are not going to go back to jail.’ That’s, like, impossible. There are so many different factors that go into if somebody goes back to jail or not. It’s very difficult. For how long do you say that? We can work with them for two years and then after we’re done they screw up once and they’re back in jail. Does that mean we failed? [Laughter] I don’t know. It’s very difficult. (Melissa)
Melissa points out that there are many factors that go into whether and when individuals recidivate, and peer support is not able to address all of those various factors. Therefore, recidivism rates are not a particularly accurate way to measure the success of FPS programming (even when there is a corresponding decrease in recidivism). Furthermore, recidivism should not be considered a binary outcome – length of time and types of actions also need to be considered. Focusing on recidivism also ignores the impact that FPS can have on justice-involved peers at different intercepts with the criminal justice system, such as interactions with law enforcement, in court, or during detention. Recidivism is not the only potential outcome measure that respondents consider valuable. However, it is challenging to measure more qualitative outcomes, such as increased recovery-orientation and hope, which are important goals of peer support work. Nevertheless, for FPS to continue to grow, programs must start, or continue, to show that they have positive outcomes – despite lack of clarity over which outcomes are important and how to measure them.

**Envisioning the Future of Forensic Peer Support**

Peer support workers and stakeholders spoke with me about how they envisioned the future of Forensic Peer Support in their communities, their state, and across the country. Their reflections echoed the tension that exists between enthusiasm for the field and concern about its development. When asked what he thinks “might happen in terms of the Forensic Peer Support workforce and field,” Scott, who previously worked in Forensic Peer Support, responded with a question of his own: “Where it’s going? Or where I hope it’s going?” Several other interviewees emphasized this distinction between their dreams for FPS and their understanding of its challenges. In this section I discuss the beliefs, hopes, and fears that peer workers and FPS stakeholders have regarding the future of FPS, focusing on whether and how the field will grow.
**Expansion of Forensic Peer Support**

Across the board, peer support workers and stakeholders hope that Forensic Peer Support expands, with more peer support workers reaching greater numbers of peers across Pennsylvania, the United States, and the globe. Stakeholder #012, an FPS trainer, “would like to see it be everywhere… cross the world,” While Michael told me, “I’m hoping it constantly grows.” While there were no reservations as to whether field *should* grow, there were differing opinions regarding whether the field *would* grow. Many of the stakeholders and peer support workers expressed concerns regarding its potential for expansion, emphasizing the challenges and barriers discussed in the previous section. Others expressed a moderated optimism, while several expressed the belief that the growth of FPS is, happily, inevitable. As stakeholder #024 stated, “As far as Forensic Peer Support, it’s coming. It’s coming.” According to Charles, “It’s going to grow.” Victor, who worked previously as a Forensic Peer Specialist, and Melissa, a current Forensic Peer Specialist, spoke virtually identically of their vision of expansion: Victor thinks “it’s just going to keep growing,” while Melissa thinks “it’s going to just continue to grow. I think it’s a good thing. I don’t know. I think it’s going to be the new way to do things.”

Interviewees believed that FPS would grow for two main reasons: because peer support services in general have grown substantially in recent years, and because the need for forensic support in particular is extremely high. Regarding the need for Forensic Peer Support in general, participants are aware that individuals with mental illness or substance use disorder are highly likely to be involved in the criminal justice system. A couple of respondents also discussed growing political and cultural “outcry” regarding mass incarceration, police brutality, and the treatment of justice-involved individuals in the United States. Some participants expressed a desire not only for the growth of FPS, but for FPS to play a role in broader system level change. “We want to be a part of the, the change of the system. [Name] said it best, ‘We don’t want to
change a system. We want to be a part of the change.’ You know what I mean? Because it’s broke. Across the systems, they’re broke. They need change” (#012). Select stakeholders and peer workers critiqued the criminal justice system in particular, with one stakeholder calling for its dismantling.

The growth of Forensic Peer Support was most commonly seen as an extension of the growth of peer support services as a whole. When I asked FPS worker Steven about the future of FPS in general, he responded by telling me about the growth of Certified Peer Specialists:

It’s going to get bigger and bigger. I see it every day, how it’s changing how peer support is becoming more important each day. And it’s growing beyond your imagination. When I first started, there was only a few CPSs. Now, you have hundreds, if not a couple thousand CPSs. It’s built already like nationwide. You know. You have CPSs in other countries. So it’s amazing.

The large, rapid expansion of CPS work was presented as evidence that the field of FPS will experience parallel growth. Mark told me about being discouraged from taking the CPS training when it first began. “They said, ‘Mark, man that’s a passing phase.’” However, now Mark not only provides individual peer support, but is a facilitator for CPS trainings across the country. “So, so, it wasn’t a passing phase, right?” Stakeholders and peer support workers who have been involved with the development and expansion of CPS work in Pennsylvania for the past decade saw how quickly and successfully peer support programming can expand, and many therefore believe that FPS will follow in that path. However, not everyone saw FPS developing at the same pace as other peer support services have. Wayne voiced these concerns:

I think it hasn't moved fast enough and it hasn't gone far enough, soon enough. I just think it's in slower pace and I don't know what causes that. Is that the laws? Is that the logistics that stop things from moving? But I don't see them moving along like regular peer support has moved on. I mean, I've been in regular peer support for eight years. The forensic population, I was trained and all, but I don't see them moving as fast and I think that's because of the logistical law and that process that slows it down. Or the courts slow that down. And I don’t, you know. How do you change the legislation of law making that's gonna justify letting people go in to support people in jail?
There was some recognition that FPS faces barriers related to the criminal justice system that other types of peer support services did not face (as discussed above), and thus might not develop along the same meteoric path as CPS work did.

Future Programmatic Aims

Peer support workers and stakeholders are actively reimagining Forensic Peer Support and coming up with ways to support more individuals in more settings. Amanda, a Peer Recovery Navigator in southeast Pennsylvania, has been working with a collaborator to try to implement FPS in their community. She described the many forms and settings in which she imagines FPS, and how she believes it might come to fruition: “Me and another person had gotten together and looked at, in an ideal world, if funding and whatever wasn't an issue, where would we like to see peer support in the system? So we came up with ideas,” including introducing FPS programming in community corrections, in mental health court, in the new diversionary programs, and in each base service units of her current organization. These plans did not include details or funding strategies at this point.

Peer support workers who are currently, or had previously, worked with criminal justice-involved peers discussed more specific programmatic aims and goals. Melissa, who had concerns regarding the FPS training she attended, believes it is important to implement a formal FPS training that includes a prison retreat. Wayne suggested that peer support workers should run employment workshops specifically for returning citizen peer clients. He is also interested in standardizing Forensic Peer Support across the state so that peer clients in every county can receive support. Scott, who previously worked as a Forensic Peer Specialist, had several suggestions for where and how to implement FPS workers along each sequential intercept, with an emphasis on diversion. He envisions increasing numbers of peer support workers on Crisis Intervention Teams, in mental health court, and at state psychiatric hospitals. Mark proposes a
separate FPS unit inside prisons (rather than singular FPS workers in mental health agencies) and housing programs for returning citizens run by FPS workers.

Many peer support workers and stakeholders discussed the importance of expanding FPS to specifically assist with community reentry. There is a general recognition that returning citizens face a number of challenges upon their release that could be eased with peer support. However, it is critical that peer workers and peer clients begin working together while the peer client is still incarcerated, in order to build rapport and develop trust, and to work on a comprehensive plan for release into the community. Janet, Mary, and Ryan, none of whom have worked as Forensic Peer Specialists, all emphasized the importance of having a peer worker work with individuals in prison prior to their release. As stakeholder #014 says, “I would like to see the forensic program be the thing that helps people stay out of jail and not go back. So many people, when they get out and they don’t have anything, they’re right back in jail… I would like to see us make a difference there.” As discussed in chapter four, there are a few programs across the state that have been able to implement FPS services to inmates prior to and after release into the community. It seems likely that this type of programming will continue to grow in various locations. One stakeholder (#015) recently submitted a grant “that would provide reentry CPS support for women, specifically, who are leaving the Philadelphia prison system.”

While many interviewees emphasized community reentry, others discussed the importance of utilizing FPS services in diversionary programs. “If we can divert them from even entering that system, that’s the goal. Let’s get them not even to have to enter, not even have to penetrate further into these systems” (#012). It is important to recall that the majority of current FPS programming in Pennsylvania relates to reentry, and that diversionary FPS programming would be relatively new and innovative. Several stakeholders also highlighted the potential
utility in integrating peer services in crisis intervention, whether that is through adult mobile crisis units or other types of crisis teams.

How Forensic Peer Support Will Grow

Participants predict that the growth of FPS will depend on several factors, including increased funding, legislation, increased awareness, and research. Others talked about the importance of increasing awareness of FPS services, not just among funders but also among legislators, service providers, and the general population.

While some individuals can identify specific paths by which FPS will grow (most notably increased funding), many individuals are just not sure how the expansion will take place. Just as there is some mystery as to what the future of Forensic Peer Support will look like, there is mystery as to how it will get there. As David says, “I’m not sure what’s going to happen. I know there’s a demand, I know there’s a role. Whether the supply will meet the demand, I don’t know. The country is so large, the industry so diverse, so we need significant change and I wouldn’t want to be the one who decided what that was.” The current situation is so complicated that it seems impossible to predict the future status, even if there is consensus that some change needs to happen. As Melissa says regarding the future of FPS, “I don’t know. It makes my brain hurt.”

Stakeholders and peer support workers alike acknowledge the importance of research in bringing more light to the field. Interviewees took the time out of their busy lives to speak with me because of their passion for FPS and their desire for the field to develop and flourish. David saw the interview as an opportunity to advocate for FPS: “I’m just happy to do a small part and hope I can help. And you know, I think we can all make a difference and collaboratively we can make a significant impact.” He teased me about how this research will solve the barriers, including lack of funding, currently limiting the field’s growth. David said to me, “You’ll take care of all the legislative funding changes that we need, so I look forward to [laugh] I mean, I
hope… We’ll be able to double our staff next month and we won’t have nothing to worry about. No, everything will be good now that this [research] has happened.” Mark, who took a promotion out of individual Forensic Peer Support work for the pay increase, was more sincere in his hope that FPS research, including this dissertation, could enhance the field. At the end of the interview he told me, “I think that [the FPS field] can pick up more traction if the right people get behind it. People like you. People like you that does research, right, and develop papers and wow, something can really happen with this, you know, and word gets out and the right people hear it, and people get behind it. I think that that’s going to make it move forward.” While I am not able to double David’s staff next month, I do hope that insights from this research can help promote and improve FPS programming and services.

**Discussion**

There was broad consensus among my respondents that FPS services and programs should expand and grow across Pennsylvania and the nation, despite some disagreement regarding whether and how it would do so. This desired growth of FPS services can be seen as a continuation of the growth of general peer support services across the state that has occurred in the past decade. This expansion, as discussed in chapter six, resulted in part from the institutionalization of peer support services and professionalization of peer workers. We see, however, that the institutionalization of general peer support services also impacted the field and service provision in unanticipated ways (beyond growth), including limiting the scope of practice and increasing some types of occupational exclusions. It will be important to keep both these strengths and weaknesses in mind when promoting the expansion of Forensic Peer Support. For example, a centralized funding source could increase the number of FPS workers and FPS clients, but it could have ramifications similar to those associated with the inclusion of peer
support as a Medicaid-reimbursable service – such as increasing arguments over jurisdictional control and occupational stigma, and decreasing autonomy over work practices.

While FPS remain somewhat limited, Veteran Peer Support, another specialization within the broader peer support field, has experienced a rapid expansion since its initial inclusion in the Department of Veterans Affairs (VA). However, this growth was a result of the institutionalization similar to that which has occurred to general peer support in Pennsylvania. In a 2008 handbook the VA mandated that all veterans with serious mental illness have access to peer support services (Department of Veterans Affairs 2008). This kind of broad institutionalization (as seen across the VA) is not possible for FPS as it is currently conceptualized. This is because the “criminal justice system” consists of multiple branches acting at different intercepts along the criminal justice continuum – all of which have vastly different leadership and sometimes competing interests. The majority of these departments and leaders in Pennsylvania have expressed resistance to FPS programming.

The exception to this resistance, of course, is the widespread use of CPSs within state correctional facilities (SCIs). While this program is notable, it is important to remember that it only impacts state prisoners, and that there are no requirements for county or city correctional departments to provide peer support for their detainees, nor any requirements for judicial or law enforcement agencies. As the Sequential Intercept Model (SIM) shows, there are a lot of places that the CJ system engages with the broader population (Munetz and Griffin 2006) and incarceration in an SCI is only one of the many intersections. So, while there is peer support for one part of the incarcerated population, there is no state-wide and very little county- or community-level acceptance or support for peer support. Forensic Peer Support is only cropping up in specific areas where charismatic advocates are able to influence leaders in various parts of the CJ system who themselves are frequently already invested in the recovery mode.
Some of the barriers and challenges that stakeholders and peer support workers identified in this chapter correspond closely to those identified in literature regarding peer support in general. Participants in this study, consistent with previous literature, report challenges related to boundaries, power imbalances with peer staff and clinical staff, and inconsistent understandings of job tasks or roles (Wolfendale and Musaabi 2017; NASMHPD 2014). Worker retention depends on creating an inclusive workplace culture emphasizing recovery, providing opportunities for peer workers promotion, role clarity, and hiring more than one peer support worker to prevent isolation and burn-out (NASMHPD 2014), which would be beneficial for many of the peer providers interviewed for this study.

Some of the criminal-justice-specific challenges identified in this chapter have also been discussed in previous literature. Baron (2011) identified the difficulties some agencies face in hiring individuals with histories of criminal justice system exposure, as well as the sense that some have of FPS work as a “dead end job.” Authors of the report Reentry and Renewal (Temple Collaborative on Community Inclusion 2016) note some of the specific challenges that peer programs serving individual with criminal justice involvement face. These include lack of funding, challenges building trust with staff in correctional facilities, and stigma; these findings are echoed here. A representative from the organization Hands Across Long Island identified another stumbling block in the different philosophical paradigms driving correctional facilities and peer support: “You have to respect that this environment [correctional facilities] is one of punitive thinking and we are coming in with the idea of recovery” (Temple Collaborative on Community Inclusion 2016). This distinction cannot be overstated. There are echoes of this philosophical clash throughout these data, including stakeholder #014’s memory of an unreceptive warden rejecting peer support with the statement, “‘This is jail.’ He said he wasn’t a social worker and blah, blah, blah.” Jail is for punishment, not for recovery.
Peer support workers themselves were clear that there are structural barriers at play in limiting the scope of Forensic Peer Support. There was frequent criticism of ‘the system’ (sometimes referring to branches of the criminal justice system, and sometimes as an ambiguous structural entity that they have little to no power to impact). When I ask peer support workers why they don’t think FPS has grown and prospered, several mentioned “the system.” While individuals with mental illness have long faced stigma and related barriers to community participation, individuals involved with the criminal justice system also face substantial legal barriers to community participation. Those experiencing both simultaneously confront interpersonal discrimination and structural exclusion.

Conclusion

This chapter presented the factors that have allowed FPS to develop and work within specific communities within Pennsylvania, and the factors that have limited its broader expansion. The growth of FPS services remains the ultimate programming goal for FPS stakeholders and FPS-trained peer support workers, although I would caution advocates to consider the unintended consequences associated with formalizing peer support programming. In the next, and final chapter, I will discuss these findings alongside those presented in chapters four, five and six to discuss multiple stigmas, occupational exclusions, and Forensic Peer Support.
CHAPTER EIGHT: Discussion and Conclusion

This dissertation began by introducing Jason, the 40-year-old Philadelphian who recently started working as a community-based Certified Peer Specialist (CPS) after spending nearly a decade incarcerated in a state penitentiary. My interview with Jason foreshadowed many of the theoretical and applied contributions that this project offers, including insight on multiple stigmas and stigma management, community integration, occupational inclusion, lived experience, recovery in mental illness, structural obstacles associated with the criminal justice system, and contemporary peer support work. I begin this chapter by revisiting that interview and highlighting these themes.

Jason talked about the challenges that individuals face in the dual processes of recovery and reentry, the majority of which have to do with barriers to community integration and stigma. However, Jason articulated qualitative differences in the meaning and impact of stigma related to mental illness compared to stigma related to criminal justice system involvement. He spoke at length regarding the pain of exclusion and stigma associated with mental illness specifically within the family context: “For your family not to understand you have a mental illness… my clients, it’s imperative that they get their families in their lives. They really want that appreciation, they want to be accepted by them and it hurts.” Every one of his peer clients face challenges related to family-perpetrated mental illness stigma. Conversely, he dismissed questions related to reentry stigma within families by simply noting that families differ. He did, however, repeatedly emphasize the challenges that peers with criminal records face in terms of securing housing and employment. According to Jason, once you’ve been incarcerated, “[in organizations] you need to have 90 different things to qualify as opposed to a regular person who may only need 10 things to qualify. They feel the chips are stacked against them, and in a certain way they are.” Jason is highlighting the salience of interpersonal stigma associated with mental
illness within the family context, and the salience of structural stigma associated with criminal justice system involvement within broader society and institutions. While Jason and his peer clients are multiply stigmatized, the dominance of individual stigmas depends on the social environment highlighted at the moment. This speaks directly to one of the main findings of this study: the salience of multiple stigmas depends on the social contexts in which individuals experiences them - and individuals move within and between multiple contexts.

Peer work is intertwined with stigma management in many ways. Part of Jason’s job is to help his peer clients navigate stigma in these differing contexts, as well as increasing hope and decreasing self-stigma. However, peer workers themselves are also burdened with the emotional labor associated with disclosing and managing their own stigmatized statuses. While disclosing these stigmatized statuses to peer clients is fundamental to the strength of peer support (through shared lived experience), peer workers simultaneously are forced to disclose these stigmatized statuses in their occupational environments. While Jason was happily surprised at how his employing organization, supervisors and coworkers accept and respect him, not all peer workers with whom I spoke felt this way. I also spoke with peer workers like John, who told me that peer workers in his organizations are “at the bottom of the barrel.” As peer work continues to expand beyond exclusively peer-run organization into spaces dominated by non-peer workers, this mandatory disclosure will continue to impact both organizations and the peer workers themselves. On one hand, the inclusion of peer workers in non-peer organizations can actively resist community-level stigma by promoting contact. On the other hand, the peer workers themselves face heightened threats of occupational stigma.

Jason himself identified this challenging balance between public perceptions and personal experiences of stigma when he told me, “I was going to turn this down. I was going to say, ‘Well, if I go in there, they’re going to look at me like I’m an ex-convict.” Jason overcame his
fear of being stigmatized during the interview so that “they can understand if from your point of view… This is a way for me to get our point of view across from the ex-offenders and the mentally ill.” Jason recognizes how powerful the work of disclosure can be in resisting and opposing stigma, despite the fact that it can simultaneously invite stigma that would be easily avoided by not participating.

Jason’s interview highlights much of what is wonderful about peer support. It can be challenging for individuals with psychiatric disabilities and criminal records to gain employment, but Jason has gainful employment that he finds deeply meaningful. He reports that his peer clients are improving. His lived experience is valued and heeded not only by his peer clients but by his employing organization, as evidenced by the integration of his advice during their Forensic Peer Support (FPS) training. However, critical analyses reveal that peer support simultaneously faces challenges, many of which will be discussed throughout this chapter. In this final chapter I summarize the main findings, discuss sociological contributions and implications for policy and practice, and present limitations and suggestions for future research.

Research Questions

This research speaks to the following five interrelated research questions:

- How do peer support workers trained to work with individuals involved with the criminal justice system understand the nature and content of their work, and the factors that allow them to engage in this labor?
- How do peer support workers understand, experience, manage, and resist stigmas associated with personal and professional experiences of mental illness and criminal justice system exposure?
- What are the psychosocial and structural factors that support or hinder community and worksite social integration of peer support workers?
• How do peer support workers experience, support, and understand the dual processes of social recovery in mental illness and reentry from incarceration?
• How do peer support workers understand their clients’ experiences of stigma, integration, recovery, and reentry?

Each empirical chapter speaks to one or more of the above research questions. Chapter four presented information regarding the nature and content of FPS work. Chapter five spoke to understandings and experiences of multiple stigma on the personal level, while chapter six discussed how peer support workers experience and manage multiple stigma in their work places. Chapter seven discussed factors that allowed (and restrained) workers from engaging in FPS work. Chapters four, five and seven directly address experiences of reentry and recovery, the many similarities between those processes and the role of peer support.

Throughout this dissertation, but especially in chapter five, discussions of peer client experiences are interwoven with discussions of peer worker experiences. This intermingling is intentional and reflects a fundamental belief regarding peer clients that peer workers expressed time and again: peer workers are no different than peer clients. Peers are peers. When telling me about experiences or anecdotes, respondents themselves would frequently jump between personal experiences and those of clients. In this way, peer workers understand their clients’ experiences as parallel to their own. Similarity of lived experience is the central aspect of this parallel. I asked Bruce, a CPS Supervisor in Northern Pennsylvania, whether there were any ways in which he felt different than the peers he has supported. He told me, “Not really, no. I think I feel equal because I think we wear the same shoes, or we have worn the same shoes.” How peer workers fundamentally understand their own experiences of stigma, integration, recovery, and reentry is how they understand their peer clients’ experiences.
Pennsylvania’s statewide dedication towards recovery transformation (PA Recovery 2018), especially in its largest city of Philadelphia, provided a rich environment in which peer support services flourished and grew, leading to increasing specialization. This specialization included Forensic Peer Support, which was seen by interviewed stakeholders (n=14) as a ‘natural’ development of the broader peer support field due to the high rates of recovering individuals involved with the criminal justice system. In addition to semi-structured interviews with FPS stakeholders, this project drew on online survey responses from peer support workers in Pennsylvania trained in FPS. Survey data (n=117) revealed that only a small fraction of those individuals trained to provide FPS are employed in FPS. Furthermore, there is substantial disagreement regarding the work and status of Forensic Peer Support, including the position of “Forensic Peer Specialist”, and there is also no official state recognition of specialized peer positions.

Additionally, the extent of criminal justice system involvement reported by FPS trained peer support workers (65%) was substantially more limited that could be anticipated based on peer support literature related to lived experience (Watson 2017b; Moran et al. 2012; Baron 2011). That proportion increases only slightly among current FPS workers, to 76%. Further analyses (see chapter seven) demonstrate how structural barriers associated with criminal justice system involvement keep many potential FPS workers from serving in that capacity precisely because they have the lived experience – a frustrating paradox.

Survey data also showed that current FPS workers spend most of their work hours providing individualized peer support. Nineteen of the 25 current FPS workers spend some of their work hours in criminal justice settings. Follow-up qualitative interviews with a subset of the surveyed peer support workers with criminal justice system exposure (n=37) reveals that FPS
work supports processes of recovery and community inclusion, teaches life skills, identifies resources, and helps with stigma management. Some FPS workers support their clients through the reentry process, but others work at other stages along the criminal justice system continuum, including in crisis teams and in specialty courts. While FPS work has been primarily defined as individual level work (Baron 2011), the individuals I spoke with also reported engaging in advocacy, activism, and community service, frequently in attempts to gain access to justice involved peers or create institutional level change in the criminal justice system. Interviewed FPS workers (n=16) report that their justice-involved peer clients face many of the same challenges, and need similar types of support, as non-justice-involved peer clients do – including increasing community inclusion and managing stigma. However, peer clients with criminal justice system involvement frequently confront additional structurally entrenched barriers to housing and employment.

Almost as many surveyed individuals report having previously been employed in FPS (n=19) as are currently employed in that role (n=25). Ex-FPS workers report that financial factors, both personal and programmatic, caused them to leave these FPS positions. FPS programs are frequently grant-funded resulting in temporary positions. While the pay of current FPS workers described in chapter four is similar to national reports of Certified Peer Specialist pay (Cronise et al. 2016), past FPS workers reported earning less.

Finally, survey data showed that FPS workers believe the work has a large impact on peer clients, peer workers, communities, and organizations. This was supported in interviews with both peer workers and stakeholders. Respondents believe that FPS is having a positive impact, filling service gaps, and supporting individuals who would resist other types of services. In sum, chapter four presents how the field of FPS emerged in Pennsylvania, the current status of FPS training and work, current FPS work practices, and the ways in which FPS workers believe their
work to be valuable. I find that there is a discrepancy between how the FPS was envisioned and how it is being implemented. These differences between theory and practice include characteristics of peer workers (specifically history of criminal justice system involvement), points of FPS intervention within the criminal justice system, and lack of occupational opportunity.

Multiple Stigmas in Multiple Contexts

Drawing on qualitative interviews with FPS-trained peer support workers across Pennsylvania (n=37), I find that individuals conceptualize multiple stigmas differently when discussed in the abstract, as compared to how they describe them playing out in lived experience. Respondents conceptualized intersecting stigmas in the abstract in nuanced ways, drawing on two main narratives – one dominant, and one additive – that map neatly on Oexle and Corrigan’s two theories of intersectional stigma that they call prominence and double disadvantage (2018). The prominence model conforms with Hughes ‘master status’ concept (1945) while the double disadvantage model can be understood within a ‘cumulative disadvantage’ framework (Sampson and Laub 1997).

While respondents’ narratives reflect these two nuanced frameworks when discussing multiple stigmas in the abstract, their descriptions and discussion of stigma within the context of their lived experience did not follow these models. Respondents discussed experiences of each stigma stigmatized status separately, in keeping with research on intersectional stigma published by Brinkley-Rubinstein (2015) and Rice et al. (2018). Furthermore, I find that the experiential salience of each stigma depends on the context in which the stigmas are experienced. I conceptualize context using an ecological framework of 1. Sociopolitical, 2. Social community; and 3. Geographic.
I find that individuals with lived experience of mental illness and criminal justice system involvement highlight stigma associated with mental illness when discussing experiences within social communities (especially within families) and highlight criminal justice involvement stigma when discussing experiences within the broader sociopolitical environment (highlighting barriers to resource obtainment, “society,” and the political economy). In other words, the sociopolitical context seemed to highlight the salience of criminal justice associated stigma, while the social community context highlights the salience of mental health stigma. It is important to note that although I focus here primarily on the dual stigmatized statuses of mental illness and criminal justice system involvement; participants spoke of their experiences of stigma associated with a wide array of statuses and identities. These included class, race, gender identity, sexual orientation, and, most frequently, homelessness and substance use.

It is crucial to consider the sociopolitical context in which stigma associated with mental illness and with criminal justice system involvement is felt and perpetrated because of the stark and fundamental differences in the laws and policies related to those statuses. There are legal protections for people with mental illness in the United States, despite the fact that they simultaneously face substantial interpersonal stigma and barriers to employment and education. Individuals with criminal records are excluded from many of the legal protections that exist for individuals with mental illness. This is despite the fact that there is a large overlap in these populations (Steadman et al. 2009; James and Glaze 2006; Feucht and Gfroerer 2011).

Respondents framed sociopolitical barriers to accessing public resources, such as Medicaid and housing vouchers, exclusively within narratives of criminal justice involvement. Conversely, discussions of mental illness stigma within the context of housing and public benefits highlighted experiences of interpersonal stigma occurring when accessing those resources. Respondents
identified criminal justice system associated policies themselves to be perpetrating structural or systemic stigma.

Stigma associated with the criminal justice system is enacted, in this country, through structural pathways and is particularly obdurate due to the sociopolitical and historical context of the criminal justice system. Respondents spoke at length regarding barriers to resources, including employment, housing, income, and others, that they associated with involvement in the criminal justice system. While it has been widely demonstrated that a criminal record serves as a barrier to jobs, especially for men of color (Pager 2003; Solomon 2012), I find that this even includes Forensic Peer Support jobs that theoretically should privilege criminal justice involvement. It is nearly impossible to avoid stigma associated with the criminal justice system because it is embedded in the sociopolitical context of the nation. Not only is this structural stigma pervasive, but it is persistent across the life course.

This is not to claim, however, that respondents believe stigma associated with mental illness and recovery to be insignificant in their lives. Rather, the stigma associated with mental illness is highlighted within a different context: social communities, including families, friends, and other affinity groups. Participants shared many experiences of interpersonal stigma-associated mental illness that they and their peer clients have experienced within these contexts. These experiences serve as significant barriers to recovery and social integration. Family was highlighted as a particularly frequent source of this stigma, with numerous discussions of how hard peers work to gain their families’ acceptance and the detrimental impact that stigma has on their sense of self-worth. While some respondents spoke about the important support they received in 12 step groups, other respondents reported experiencing or witnessing exclusionary stigma in those settings. Strikingly, there were no such common narratives regarding the salience of stigma associated with criminal justice involvement within social communities.
The personal salience of multiple, intersecting stigmas depends on an additional identified context: The geographic or regional context. Respondents hypothesized that the salience of stigma associated with either status decreased in communities with high rates of stigmatized identities. Data highlighted a distinct urban/rural divide in many topics, including stigma. Some respondents in rural counties believe that stigma hits harder in rural and suburban areas, which could be explained by barriers to stigma concealment. Indeed, respondents in Philadelphia were less likely to discuss stigma as a current or pressing concern. However, many of those same respondents explicitly linked the decreased salience of stigma to Philadelphia’s embrace of the recovery transformation. Recovery orientation supports social integration on the interpersonal, programmatic, and structural levels. Social communities and interpersonal relationships can be built upon individual belief in recovery, while recovery can also be embedded in organizational philosophy.

Respondents discussed stigma management techniques that they used in their personal and work lives, that they taught their peer clients, and others that their peer clients used. In fact, stigma management and resistance were named as important work tasks in which peer workers consistently engage. I find that participants’ occupational definition of themselves, including their acceptance or rejection of professional status, served as a stigma resistance strategy. While peer respondents discussed acts of stigma resistance that they engaged in in their personal and work environments, several also acknowledged that they used concealment as a stigma management technique among friends and family, despite having to disclose their stigmatized status in work environments. Situational avoidance (or changing one’s social environment) was a commonly reported stigma management technique of both peer workers and clients, again highlighting the importance of context. While this can be a successful technique, avoiding contexts in which stigma is likely to occur puts the onus on the stigmatized rather than the
stigmatizer, revealing the pervasiveness of stigma power (Link and Phelan 2014b), and closes off access to these contexts and their associated resources.

The Complexities of Professionalizing Peer Support

One of the more surprising findings was the extent to which participants placed importance on professionalization and the institutionalization of the broader peer support field in Pennsylvania, which I discussed in chapter six. I use the term ‘professionalization’ to discuss an occupational process, including training, certification, and emphasis on expertise. The ‘institutionalization of peer support’ refers to the process by which the field itself gained legitimacy and became embedded within the official administrative structures of the mental healthcare system. While the majority of Certified Peer Specialist (CPS) (n=35) and stakeholder respondents (n=14) spoke of these changes, respondents expressed wide variation in opinions and understandings regarding professionalization and institutionalization of their field. This discussion of professionalization and institutionalization is intertwined with issues of stigma, as I will discuss later in this section.

The inclusion of CPS services in the state Medicaid plan in 2006 (Department of Public Welfare 2007) played a key role in the institutionalization process of the peer support field in Pennsylvania. As an intended consequence, the field grew substantially and there are, as of 2015, over 4200 trained CPSes in the state (Pennsylvania Mental Health Consumer Association 2018). Many of these peer workers are working in traditional mental healthcare settings, rather than primarily in consumer-driven organizations. The processes of institutionalization and professionalization have fundamentally challenged the consumer-driven origin of the field, and bring to light issues of occupational exclusions, occupational stigma and jurisdiction threat (Abbott 1988). In chapter 6, I argue that this state institutionalization of peer support in Pennsylvania has also had unintended and complicated consequences for the field and for the
peer workers themselves. These changes can be seen on three levels: peer work itself; the occupational inclusion of peer workers; and peer worker occupational identity. I present these consequences in order below.

Interview respondents report that the scope and practice of peer support work has undergone changes since the implementation of CPS support as a Medicaid-reimbursable service. Workers have less flexibility in their work practices as they conform to Medicaid mandated structures and procedures. This limits their ability to provide individual-centered care and is altering some relationships between peer workers and clients. Furthermore, the bureaucratic requirements associated with these changes, including GED requirements and paperwork-oriented work tasks, serve as barriers for some individuals to enter or remain in the workforce.

The second consequence of the institutionalization of peer support discussed by participants is associated with occupational inclusions and stigma, which is directly related to my previously discussed findings related to stigma. Alongside institutionalization, peer support has undergone professionalization that increases occupational prestige. The designation of CPS services as reimbursable by Medicaid, and the associated pressure on counties to increase access to peer services, led to a large increase in the number of peer workers employed in traditional mental healthcare environments. This shift from peer to nonpeer occupational spaces has impacted the integration and inclusion of peer workers within their work environments. While multiple factors are associated with peer integration, organizational orientation and commitment to recovery were highlighted as especially supportive. For example, employees of Philadelphia’s city behavioral health department (which holds recovery as its central principle (DBHIDS 2018)) report not only inclusion, but citizenship and ownership of their work environment. Conversely,
peer workers in healthcare organizations operating within the medical model paradigm reported substantial occupational exclusion.

Peer workers reported a wide variety in how respected and accepted they felt interpersonally when serving on teams with non-peer workers. I find that acceptance varied according to the status differential between the peer worker and the non-peer workers. While peer support workers reported acceptance by high status professionals, such as psychiatrists and center directors, they reported rejection and discrimination by low status professionals like case managers. I posit that these differences in occupational inclusion by status relates to threat over occupational jurisdiction (Abbott 1988). This threat and associated stigmatizing can be seen as the result of both the increased occupational prestige associated with the professionalization of peer support, as well as the high work-task overlap that low status non-peer workers have with peer workers. This stigma serves as barrier to occupational integration and advancement, even when peer workers obtain similar educational and other qualifications.

Data reveal substantial disagreement among peer support worker regarding whether they identify as, or even want to be considered, professionals. Much of this disagreement relates to previously discussed occupational inclusion and prestige, with some peers suggesting that increasing acceptance of peer support depends on the continuing professionalization of the peer workforce. Alternatively, other peer workers and stakeholder view both the essence and strength of peer support as residing in its status as not professional due to the centrality of the peer identity. I contend that the way that peer support workers conceptualize their occupational identity (along the professional-peer continuum) is associated with how they understand and manage stigma.
Barriers, Facilitators, and the Future of Forensic Peer Support

Drawing on all data sources, I identified three main barriers that have significantly limited the breadth and impact of the FPS field: the criminal justice system, funding, and characteristics of the work. Challenges associated with the criminal justice system were diverse, serving as the most significant barrier operating through multiple blockaded pathways. In this context, the ‘criminal justice system’ refers to the three commonly-identified main branches – law enforcement, courts, and corrections. While previous literature has suggested that there might be challenges related to working with the criminal justice system (Temple Collaborative on Community Inclusion 2016), this study identifies and details how those barriers are operationalized. The criminal justice system has limited the scope of FPS by the following mechanisms: the system’s lack of recovery orientation, difficulties with system access, lack of cross systems work, and stigma. Before addressing these factors, it is important to note a difference between the aims of FPS and the current implementation of FPS as it relates to the criminal justice system. While FPS was developed and is being promoted as working within the three main branches of the criminal justice system (law enforcement, courts, and corrections), in practice, FPS in Pennsylvania is primarily occurring within corrections rather than with law enforcement or in court. Therefore, these limitations focus specifically on corrections.

The punishment orientation of the criminal justice system serves as a significant barrier to the introduction and implementation of recovery-oriented programming such as peer support work. While both the criminal justice system and mental health system have indicated a greater focus on community integration, as evidenced by the increased focus on mental health recovery-oriented services and the growing number of inmate reentry programs (Ritter, 2014; SAMHSA, 2012), data from this project indicate that individuals experience the criminal justice system as punitive and exclusionary. This punishment orientation stands in stark contrast to the mental
health system; peer respondents describe how they have seen the mental health system move towards recovery and integration in both practice and philosophy. Respondents report using much of their time and resources attempting to gain access to criminal justice involved peers and note that those attempts are frequently unsuccessful. Additionally, FPS workers report difficulty with worksite integration when that worksite is the prison or another criminal justice system environment, as coworkers resist their presence and integration.

It is also difficult to serve individuals involved with multiple systems. While mental health decisionmakers prioritize an individual’s recovery, decisionmakers from the criminal justice system are perceived as prioritizing the efficient processing of individuals through the system rather than individual rehabilitation. Furthermore, the threat of loss of jurisdictional control among decisionmakers impedes individuals from multiple system from collaborating effectively. This parallels the threat of loss of jurisdictional control that impedes the integration of peer workers into non-peer spaces. Substance use, associated with both mental illness and criminal justice system involvement, complicates this cross-system work. Finally, the structural stigma of criminal justice system involvement discussed in chapter five serves as a barrier to the expansion of FPS programming through the restriction of justice involved peers with criminal records from providing FPS.

Funding and characteristics of the work serve as additional barriers. Many individuals involved with the criminal justice system are not eligible for Medicaid, and therefore FPS frequently relies on unreliable, short term grant funding. While there are many opportunities in the state to work as a CPS, there is a shortage of FPS jobs, for many of the reasons outlined above. Furthermore, there are few occupational advancement opportunities for CPSs and there is no official FPS career ladder. Peer work itself is a high stress occupation (Grant, Reinhart, Wituk and Meissen 2012) and the pay remains low.
Despite these barriers, FPS work is indeed taking place in communities across the state. Three main facilitators supporting and driving this work are: recovery-oriented communities and organizations, localized relationship building with the criminal justice workforce, and demonstrating effectiveness. Successful FPS programs require buy-in from both the local decision makers as well as the day-to-day workers within the Criminal Justice system, with decision makers allowing access to the system and daily workers serving as either barriers or facilitators for the effective implementation of service (Temple Collaborative on Community Inclusion 2016). FPS programs are more easily accepted, and funded, when they show effectiveness, especially when using tradition outcome measures promoted by mental healthcare and reentry services.

Peer workers and stakeholders alike desire that the FPS field grow, following the meteoric rise of CPS services across the state. However, while all desire the field to grow, there was disagreement as to whether or not it will. Those who believe it will grow highlight the general growth of peer services and the good that the field could do for the large number of justice-involved individuals in recovery in the state. Others, however, were more skeptical, highlighting many of the barriers discussed above.

**Race and Forensic Peer Support**

An important finding of this dissertation that has not yet been discussed is the striking lack of discussion regarding race. I found this shocking, given the astounding overrepresentation of people of color under the jurisdiction of the criminal justice system (US Department of Justice 2018) as well as the Black Lives Matter movement that was in full swing during data collection.

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3 The Black Lives Matter movement protests police brutality against people of color and racism in the criminal justice system. The death of Michael Brown by police officer Darren Wilson in Ferguson, MO on August 9, 2014 is seen as a key moment in the birth of the movement. In July, 2016 alone (during data collection) protests occurred in 88 different American cities, including three protests in Philadelphia (NYTimes 2016).
Part of this silence is likely a result of my research aims and instruments, which did not highlight race, as well as my status as a white female researcher. However, I also believe that two other factors also play a role in this absence: respondents’ emphasis on region and structural racism within the criminal justice system itself.

Prior to discussing these two potential factors, I provide brief evidence of the absence of respondent discussion regarding race and the criminal justice system and remind readers of the racial and geographic demographic diversity of my sample. In the interviews, participants very rarely discussed the role of race in their personal experiences or in their work, which was in stark contrast to their discussions of mental illness, criminal justice system involvement, poverty, drug use, and housing instability. A search of all interview transcripts yielded zero occurrences of the following phrases related to the criminal justice system, race, and the Black Lives Matter movement: *Black Lives Matter*, *police brutality*, *Ferguson*, or *war on drugs*. One white peer respondent used the term *mass incarceration* when discussing the curriculum of the FPS training, one white peer respondent used the term *racism* when discussing stigma, and one respondent – a black stakeholder with a doctorate – used the term *slavery* when explicitly linking the current criminal justice system to American slavery (see: Wacquant 2002; Alexander 2010).

Racial distribution of both peer and stakeholder interview respondents reflected regional segregation, with most black respondents residing in Philadelphia and most white respondents residing in more rural areas of the state. Of the 37 peer support workers with whom I spoke, 15 individuals identified as black or African American, two identified as Latinx, and 20 identified as white. Among the 15 peer support workers who identify as black, 13 reside in Philadelphia. In contrast, only two of the 20 interviewed white peer support workers reside in Philadelphia. Stakeholder demographic distribution was similar in both racial and geographic factors.

In most cases, respondents presented their lives and work as reflections and products of
place while ignoring the role of race. Individuals in Philadelphia spoke about changes in the city, while respondents in other areas emphasized the importance of rurality. This can be reflected in some of the findings, for example regarding recovery orientation in Philadelphia and challenges with transportation in rural counties. However, in this situation, as in much of this country, there are racial implications that place-based narratives too easily overlook.

While race and geography are related in these data, I believe that the failure to discuss race is a failure of the peer support field in general, and FPS in particular. A recently published international charter on peer support identifies four key principles in the operationalization of peer support. The first principle reads: “Peer support is based on human/civil rights perspective” (Stratford et al. 2017: 4). This absence of discussion regarding racial disparities in both the criminal justice system and in mental healthcare fails the development of the FPS field because it ignores critical issues of human and civil rights in this country.

These racial disparities in the criminal justice and mental healthcare systems are undeniable. People of color are disproportionately likely to be involved with the criminal justice system at all stages, and these disparities have persisted despite slight declines in both the state and federal prison populations (U.S. Dept of Justice 2018). However, racial disparities in criminal justice system involvement begin at an early age. While the overall rate of youth commitment in the US fell by 47% in the decade between 2003 and 2013, the racial gap in that commitment (between black juveniles and white juveniles) increased by 15%. As of 2013, black youth in Pennsylvania are more than eight times more likely to face commitment than white youth (The Sentencing Project 2016). This is of particular importance in the context of mental illness and recovery, as half of mental disorders start by the mid-teen years (Kessler et al. 2007). Not only do black Americans experience high rates of criminal justice system involvement, recent scholarship in *Social Science and Medicine* reveal that the negative impacts on well-being
and life opportunities associated with that involvement are greater for Blacks than for whites (Blankenship et al. 2018).

These astounding racial disparities in criminal justice system involvement and impact are compounded by racial disparities that exist within the mental healthcare system. While rates of mental illness are similar among racial groups, people of color have decreased access to mental healthcare (McGuire and Miranda 2008). Furthermore, racial disparities in mental healthcare access are increasing for both Black and Latinx Americans compared to whites (Cook et al. 2017). There is little research currently available regarding the lack or presence of racial disparities in recovery-oriented mental healthcare. However, Morrow and Weiser (2012) critiques the literature on mental health system transformation towards recovery for ignoring issues of structural racism and ethnocentrism. Furthermore, in their systematic literature review of peer interventions for individuals with serious mental illness Cabassa et al. report “a stark underrepresentation of racial, ethnic, and language minority groups” (2017:88).

Given this context, it is remarkable that race does not play a central role in the discussion of FPS work and the development of the FPS field. I believe this to be related to a central issue with the recovery orientation that Hopper identified a decade ago: the disregard of structure (Hopper 2007). Much of the stigma entrenched within the criminal justice system is based in structural racism, while peer work emphasizes individual-level experiences of recovery. FPS’s neglect of race reflects the broader field’s neglect of structural factors.

**Key Sociological Contributions**

Having reflected upon the research questions, key findings, and the silent importance of race, these results suggest important implications for sociological inquiry. I extend the discussions initiated in this and previous chapters to further explore topics of multiple stigmas, citizenship, and the professionalization of peer support.
Theorizing Multiple Stigmas and Stigma Management

In attempting to broaden scholarly understanding of how individuals experience and understand multiple stigmas, this project brings to light the central importance of context in shaping and informing those experiences and understandings. Furthermore, context is multilayered and best viewed within a social ecological framework recalling human development and community health promotion literatures (Bronfenbrenner 1979; Stokols 1996). In a critical review of transgender stigma and health, Hughto, Reisner and Pachankis (2015) applied a social ecological model to show the multiple levels at which stigma operates, from structural to interpersonal to individual. Data in this dissertation shows that stigma operates on these multiple levels, and that operationalization depends on the individual’s specific social location within these multiple contexts. I identify three contextual levels in this work: social communities, regions, and the sociopolitical. Stigma based on differing statuses hold different importance among the levels. When discussing their family, respondents highlighted the salience of stigma related to mental illness. However, when discussing policy, these respondents emphasized stigma related to having a criminal record.

Oexle and Corrigan (2018) theorize two distinct models of intersectional stigma: what they call prominence and double disadvantage, and I label the dominant and additive narratives. Prominence, or the dominant narrative, can be explained through Hughes’ “master status” concept (1945). Double disadvantage, or additive narratives, have similarities with cumulative disadvantage theory (Sampson and Laub 1997). I note in chapter five that, while respondents’ abstract discussions of multiple stigmas fall neatly into those categories, respondents highlight singular stigmatized statuses when discussing experiences of stigma, and they do not explicitly use either model to make meaning of their experiences.
Drawing on *both* master status (Hughes 1945) and cumulative disadvantage (Sampson and Laub 1997) I propose a third model of intersectional stigma that can be used to understood how multiple stigmas are experienced. Data reveal that individuals focus on specific individual stigmatized status when describing lived experience, which might be evidence in support of the master status hypothesis. However, I argue that *which* of the multiple stigmatized statuses is ‘master’ depends on the context in which they are experiencing or resisting the stigma. Drawing on data from this project we see that stigma-associated mental illness is most salient, or the master status, within familial contexts. Simultaneously, I find that the stigma of a criminal record is most salient (the master status) within the context of housing and work policies.

When we consider that individuals experience their lives within and across multiple contexts, we can see that both mental illness and having a criminal record can be the master status for the same individual – although at different times in different contexts. In this way, cumulative disadvantage (Sampson and Laub 1997) can help explain the experience of multiple stigmas. While Sampson and Laub (1997) focus on the accumulation of disadvantage across the life course, this theory of multiple stigmas focuses on the accumulation of stigma across environments and contexts. The same individual who deals with mental illness stigma at home also has to deal with CJ stigma when applying for jobs – accumulating the burden. Therefore, multiple stigmas can be understood using a combination of master status and cumulative disadvantage theories. Furthermore, this understanding of multiple stigmas highlights the importance of understanding individual experiences within broader social, historical, and cultural contexts that is fundamental to the intersectional research paradigm: “The intersectionality analyst must be able to analyze research findings within a macro sociohistorical context that transcends the observed data” (Bowleg 2008: 320).
While stigma scholarship is shifting towards a greater recognition of power and structure (Link and Phelan 2014; Tyler and Slater 2018; Hatzenbuehler and Link 2014), I also argue that it is important for stigma scholarship to highlight the current political and social climate and context. Since Trump’s election, America has witnessed an increase in hate crimes and a growing sense of political division. Furthermore, policies limiting the rights and status of many marginalized groups, including immigrants, refugees, women, transgender individuals, LGBT youth, and others, have been drafted and enacted, resulting in further state sanctioned stigmatization. The consideration of sociopolitical context when addressing stigma is of particular importance in this moment in history.

Additionally, these data highlight the overwhelming impact of the US criminal justice policy on the lives and experiences of involved individuals. Not only is the structural stigma of justice system involvement overwhelming, participants describe it as virtually impossible to escape. While it is challenging to avoid family members who stigmatize and create new friendships based on recovery principles, respondents have less power to shift policies limiting employment and housing opportunities for returning citizens from correctional facilities. This has implications for Forensic Peer Support. Peer support has been shown to help individuals manage and avoid stigma within social communities and to overcome interpersonal level barriers to social integration, making it effective in supporting individuals with mental illness. However, I have shown that stigma associated with the criminal justice system is more salient in the sociopolitical context and is more structurally entrenched. This alters the type of support required to manage and overcome associated stigma and barriers to social integration. Peer support typically operates on the individual level, while Forensic Peer Support requires additional work at the structural level.
This dissertation also contributes to literature on stigma management and community integration. Since the context in which stigma is experienced impacts the experience of that stigma, one way to manage that stigma is to manage the context in which this occurs. I call this community management work. While much has been written about stigma avoidance (Link et al. 1989; Link et al. 2002), individuals involved in community management work not only avoid stigmatizing communities but frequently seek out or even create supportive communities to act in their stead. Peer support workers, for example, frequently befriend other individuals working in recovery-oriented services and create new social communities.

This stigma management technique can support individuals in their own experiences of community integration. I use here Ware et al.’s definition of community integration as a process in which individuals “increasingly develop and exercise their capacities for connectedness and citizenship” (2007: 471). Peer respondents highlighted an increase in their social connections, as well as the roles and responsibilities they maintain in these communities and within broader society. However, community management work does little to impact the stigmatizing power of the individuals and communities that peers avoid. In this way, community management work is just that – managing stigma, not resisting or combatting it. By curating their social experiences, individuals in these communities are rarely confronted with situations where they would deflect or challenge stigma, the two common resistance strategies identified by Thoits (2011).

While individuals can achieve community integration in the communities of their choosing, community management work does little to address the strength of ‘stigma power’ (Link and Phelan 2014b). Stigma power continues to keep individuals down, in or away from many settings and communities, even if peers frame that avoidance as their own choice. Furthermore, peer workers frequently encourage their peer clients to engage in community management work as primary stigma management technique, meaning that the stigmatizing
public might have decreased contact with individuals with stigmatized statuses. However, we know that contact or exposure helps reduce stigmatizing attitudes and behaviors in others (Corrigan and Fong 2014). Therefore, this avoidance may have implication for stigma levels in the broader community by decreasing opportunities for exposure.

Peer work itself, however, can be viewed as a type of stigma resistance, due to peer worker’s public disclosure of their recovery status. This can be beneficial for peer workers themselves, as those who resist stigma report higher self-esteem than those that conceal stigma (Thoits and Link 2016). Thoits defines stigma resistance as, “opposition to the imposition of mental illness stereotypes by others” (2011: 6), indicating that resistance occurs in response to the second stage of the stigma process – stereotyping (Link and Phelan 2001). In their work on citizenship and mental health, Rowe and Pelletier (2012) highlight the importance of having the opportunity to be a contributing member of society. A long-held stereotype regarding individuals with mental illness relates to their ability to work or to otherwise be a contributing member of society. Peer work resists this stereotype by showing that individuals in recovery can and do contribute, as well as display other attributes of citizenship, including maintaining multiple roles and responsibilities and even serving as a resource.

Peer work resists stigma through both challenging and deflecting techniques, depending on the worker, organization and environment. Thoits notes that while both strategies protect the individuals engaged in the resistance, only challenging “opens possibilities for victory in changing others’ negative views or actions” (2011: 11). In other words, only challenging resistance strategies address stigmatizers and stigma power itself.

I suggest that a major adverse impact of the institutionalization of peer work is that professionalized peer workers are more likely to resist stigma through deflection rather than challenging. While a professional peer worker is disclosing their mental health status, its salience
decreases due to their status as a professional. Prior to professionalization, the central attribute of a peer worker remained one’s ‘peer-ness’, or mental health status. In this way, peer workers are directly resisting the stereotype that individuals with mental illness are unable to contribute to society. Peer work even emerged from the collective resistance of the consumer rights movements. As it becomes increasingly integrated within mainstream mental healthcare settings, I fear that peer work will become less able challenge stigma through individual or collective resistance. Despite this decreasing impact of disclosure, peer support workers themselves will stay face the negative consequences of disclosure, especially in the non-peer work spaces that peer workers are increasingly employed.

Much of the broader shift towards recovery orientation was due to the efforts of mental health service users and activists who reimagined what it could mean to be a person in recovery and protested past inhumane mental health practices and beliefs. I stated above that peer work emerged from the collective resistance of the consumer rights movement, which can be seen in the growth of peer-run recovery organizations that proliferated across the United States at the end of the twentieth century. However, as peer support becomes more mainstream, it may lose its connection to that consumer rights social movement and activism. On the one hand, this can be seen as reflective of the movement’s success. On the other hand, the broader utilization of peer support means that the peer support that is developed and promoted now and in the future are less reflective of the fundamental values of the peer support social movement.

*Citizenship, Structural Inequalities and Forensic Peer Support*

This research also speaks to challenges related to citizenship and participation experienced by individuals involved in both the mental health and the criminal justice systems. I use here Rowe and Pelletier definition of citizenships as “a measure of the strength of people’s connections to the rights, responsibilities, roles, and resources that society offers to people
through public and social institutions and to relationships involving close ties, supporting social networks, and associational life in one’s community” (Rowe and Pelletier 2012: 369). The transformation towards a recovery orientation within the mental healthcare system was in part due to challenges regarding citizenship. As Rowe and Pelletier argue regarding the recovery paradigm in mental health, “A large part of what is to be ‘recovered’ or achieved, we argue, is one’s citizenship” (2012: 378). For the most part, the mental healthcare system has made great strides in promoting the citizenship and participation of its consumers, and that is reflected in the passion for the recovery orientation that respondents repeatedly expressed.

However, there are limitations with the recovery paradigm. Anthropologist Hopper has critiqued the ways that the recovery paradigm itself has ignored structural inequalities: “Equally telling is what’s missing from such accounts – structure, first and foremost. Race, gender and class tend to fade away into unexamined background realities” (2007: 873). While recovery can acknowledge the impact of the indirect consequences of mental illness, including poverty, isolation, substandard housing, and unemployment (Davidson and Roe 2007), the notable lack of discussion regarding race, class and gender that peer respondents and stakeholders produced in this data indicate that they persist as “unexamined realities”.

Peer work remains embedded within structural inequalities, including substantial material disadvantage, many of which are ignored. This can be seen in the narrative of peer workers regarding their peer clients as well as in their own lives. Peer workers recognize that individuals employed in the human services are underpaid and are frustrated that their hard work isn’t fairly compensated and that they continue to struggle economically. As Jessica told me about peer work, “You don't get in it to make money, but I would like living wages. That would be great.” For peer support workers to adequately assist their peer clients in increasing their “connections to the rights, responsibilities, roles, and resources that society offers to people through public and
social institutions” (Rowe and Pelletier 2012: 873) they need to recognize that these rights, responsibilities, roles and resources are gendered, classed, and raced. While the importance of structural inequalities and barriers to citizenship appears more clearly when focusing on the criminal justice system, as I do below, it is important to address the limitations and exclusions embedded in mental healthcare, even within recovery-oriented services.

The criminal justice system limits social inclusion and citizenship for involved individuals in direct and indirect pathways. While there are many occupational fields that legally restrict employment from individuals with a criminal record, respondents told me about lists of organizations that claim to hire those individuals. When individuals attempt to gain employment in those organizations, however, they find that those claims are unfounded. While the restraints on citizenship perpetrated by the criminal justice system are pervasive and impactful, assumptions and beliefs regarding those restraints can be limiting in and of themselves. For example, three peer workers told me about encouraging their peer clients and other acquaintances to register to vote and to vote. One of the barriers they face, however, is the widespread belief that individuals with a past felony conviction can’t vote – which is untrue in the state of Pennsylvania. Peers sometimes do not apply for resources or opportunities, such as jobs or housing, after witnessing or experiencing previous failure. In this way, false beliefs about the criminal justice system’s total power to limit opportunity also serve as a barrier to citizenship.

This project also shows that the limitations on citizenship placed by the criminal justice system is structurally rooted and culturally entrenched. Rather than merely serving as a tool of social exclusion, the criminal justice system reflects the structural violence perpetrated against historically marginalized members of this nation, especially men of color. The current carceral state is serving the same function of social control and dispossession as did historic slavery and Jim Crow (Wacquant 2002; Alexander 2010), and thus it should come as no surprise that
recovery of its members is not prioritized. It remains to be seen whether it is even possible to foster recovery within a system that perpetrates such violence against its subjects.

Peer workers face a steep challenge in attempting to address the structural violence faced by those involved in the criminal justice system, even when peer workers gain access to support those individuals. However, data from this project indicate that peer programs face substantial challenges with implementation in the criminal justice system and that peer workers with lived experience with the criminal justice system are frequently barred from working within the criminal justice system. While the NASMHPD (2014) publication claims that FPS workers have been incarcerated, only 60% of these surveyed FPS workers report past incarceration. The inclusion of individuals with no personal involvement in the criminal justice system directly reflects the systematic exclusion, and lack of citizenship, of individuals involved with the criminal justice system.

Barrenger, Stanhope, and Atterbury’s recent paper based on a series of interviews with fifteen peer support workers with incarceration histories states:

There is a long history of social and human service systems’ focusing on individual maladies, engaging in blame, and exercising control over the poor instead of recognizing and addressing the larger structural forces contributing to poverty and its associated ills, such as homelessness and child maltreatment (Lash, 2017; Lyon-Callo, 2008). The trick is for peer specialists to help refocus these practices on the larger systemic forces instead of engaging in the practices of blame and social control (2017:17).

This historic focus on the individual fault while ignoring structural forces is arguably even deeper within the criminal justice system with its punitive philosophy than it is in the human service system. I support a shift towards recognizing larger systemic forces within both the human service system, the criminal justice system, and the mental health system. Respondents indicated that they are observing changes within the mental health and human services systems in which focus has turned from maladies to strengths. However, the role of peer support workers
in creating such a shift within the criminal justice system at this point is significantly constrained by the system’s structural violence and limitations on peer workers’ citizenship. In order to do so, FPS advocates must draw on the strength of current advocacy groups and social movements related to criminal justice reform. Just as it was surprising to me that participants rarely discussed either race or the Black Lives Matter protests, I found it notable that respondents didn’t discuss social movements related to decarceration, prisoner rights, or restorative justice. Should peer support workers wish to be involved in structural change, they need to align themselves with other activist groups attempting the same.

*Professionalization of Peer Support*

This dissertation speaks to the institutionalization and professionalization in multiple ways. In this section I discuss the following related topics: 1. The tension between occupational growth and responsiveness to local needs; 2. Global trends in the transformation of peer support; 3. Loss of jurisdictional control; and 4. The threat of professionalization on peer relationships.

One of the central tensions in this project relates the dilemma of institutionalizing peer support: While the institutionalization of peer support allows the field to expand and increased access to peer services, institutionalized peer support cannot adequately respond to the unique needs of either individual peer clients or the specific communities and contexts in which those individuals are recovering. While it is positive that peer support is expanding into new communities and serving new peer clients, these growing programs have to adhere to broader standards and practices that don’t adapt to local needs and systems. However, Stratford et al. (2017) argue that peer support should be “created anew” at each site, reflecting the unique efforts of each community, rather than resulting from top-down development approaches. This is challenging to do as governmental and non-consumer-run mental health organizations continue to implement new peer programming requirements. One of the main functions of peer support is
its role in the management and resistance of stigma. As stigma is enacted and experienced in different locations and contexts, peer support works best when it can remain responsive to the local environments in which those stigmas play out (Stratford et al. 2017). With outside drivers, as in the case of institutionalization, those local environments are forgotten. This tension was seen in the wide range of responses that respondents expressed regarding the changing field. This ranged from enthusiasm for the growth and prestige associated with institutionalization and professionalization to frustration over shift from “true” peer support to peer support driven by external factors like Medicaid.

While American sociologists have been notably absent in the discussion, scholars in other countries have begun to speak to these issues. Jones and Pietila (2018) highlight tensions similar to those noted above that they observed among Finnish peer workers attempting to “retain critical distance from professionals” while simultaneously “align[ing] themselves with professionals” (2018:1). There was wide disagreement between scholars regarding the benefits and downsides of this formalization and professionalization of peer support. Tudor, et al. (2018) of New Zealand argue in favor of the “professionalization, standardization, and recognition” of the peer support field, stating that it would benefit peer support workers, clients, and the broader field. However, other scholars fear that peer support is losing its identity and value due to these changes. Scott (2011), also in New Zealand, believes that the inclusion of peer support within standard healthcare systems has led to peer support becoming “watered down.” As UK-based Watson states in a guest editorial for the journal Mental Health and Social Inclusion, “There is growing need to understand the identity of peer support as it is colonized, embraced and co-opted in different mental health contexts” (2017a: 131). Byrne et al. highlighted the inherent tension of consumer participation in the medical model in Australia. They argue that the culture associated with the medical model of mental health services “imposed a major limitation on the
implementation, effectiveness and development of lived experience roles and themselves as individuals” (2016: 271). Even those organizations that claim a recovery perspective can have cultural residue of the medical model, and recovery itself can have different meanings for consumers and clinicians.

While the institutionalizing forces might differ according to regional factors, it seems as if peer support across the globe is undergoing significant transformation. As indicated by the varying analyses presented by international scholars above, there are both benefits and challenges associated with this transformation. One of the fears is that institutionalization will take peer support out of the hands of peers, therefore changing the work and minimizing its effectiveness. In order to avoid this, peer workers need to remain at the helm of the field throughout this transformation. During his FPS training, Jason identified areas of the curriculum where his lived experience differed from information provided by the training and was “shocked… that they were actually taking my advice.” The insight that Jason and other peer workers provide needs to be heard and central to the transformation of peer support in order or the field to remain impactful.

A related theme running through this dissertation is threat of loss of jurisdictional control. I have discussed this at length on the individual level. For example, peer workers report conflict with and disrespect with both case workers and correctional officers. However, the threat of loss of jurisdictional control is also applicable at the systems level. It is important to understand the central aims of the controlling system. If the ultimate goal of an organization considering peer support is not one of recovery, it is unlikely to implement peer support to its full potential, if at all. We can observe this mismatch in the challenge of introducing peer services into the criminal justice system. While the formal goals of the criminal justice system include rehabilitation, an aim that is aligned with recovery, criminal justice policy is principally punitive in practice
(Andrews and Bonta 2010). There is an inherent conflict between recovery and punishment orientations, serving as a threat to the jurisdictional control of the criminal justice system.

Institutionalization and professionalization of peer support go hand in hand. The professionalization of peer occupations has implications for the peer provider/ peer client relationship as well for stigma management. The fundamental basis for a peer relationship is shared lived experience and an emphasis on mutuality (Scott 2011). However, professionalization threatens this mutuality by inserting a status differential. While professionalizing peer support workers can increase prestige and job opportunities, the centrality of “peerness” in peer support can get lost under the veneer of professionalism. Earlier, I noted that Stratford et al. (2017) identified four principles in the operationalization of peer support. The last principle the team identified in the international charter is: “reciprocal/ non-hierarchical relationships.” Professionalizing peer support positions, however, changes the peer-to-peer relationship by adding prestige and hierarchy between professional and clients. Thus, it seems virtually impossible to professionalize peer support while still adhering to the fundamental principles of the field.

This section discussed the dilemmas associated with the institutionalization and professionalization of peer support, including the tension between growth and locality, global trends, jurisdictional control, and the threat of professionalization on peer relationships. In the following section I draw on this and previous sections to present implications for policy and practice related to peer support services broadly, Forensic Peer Support specifically, and anti-sigma efforts.
Implications for Policy and Practice

Peer Support Services

Many of the applied recommendations for the field of peer support revolve around the increasing inclusion of peer support programs in traditional mental healthcare work environments. Organizations need to adhere to best practices when introducing peer workers into non-peer occupational environments in order to support occupational integration, and thus improve the experience of both peer providers and peer service recipients. Many of these practices have been identified in prior work, but these data indicate that they are not always being employed. The National Association of State Mental Health Program Directors identified nine distinct challenges to peer provider integration (NASMHPD 2014). Peer workers described many of these challenges during this study, including role transformation and conflict, undefined peer jobs and salary range, criminal background checks, and non-peer staff attitudes towards peer workers and recovery.

This project in particular highlights the importance of two specific practices: 1. Having clearly defined job descriptions and 2. Shifting the organizational culture towards recovery (NASMHPD 2014). According to Gillard et al. (2013:188), the “lack of consensus around what constitutes peer practice can result in feelings for peer workers of inequality, disempowerment, uncertainty about identity and being unsupported.” When there is a lack of consensus or definition regarding the scope and practice of peer work, peer workers bear the brunt of the negative ramifications. Clearly defined job descriptions also guard against peer work morphing into “employment ‘ghettos’ where new workers find their role to be a repository of unwanted tasks” (Gillard et al. 2013: 10).

Data indicate that much of this stems from perceived threat of jurisdiction loss by non-peer staff in low to moderate status positions. Clarification of job roles could help decrease this
sense of jurisdictional threat, supporting the occupational integration of peer support workers. While NASMHPD (2014) highlights the importance of organizational leadership in shifting organizational culture in order to support the introduction of peer workers, I find that it is equally or more important to support the training of non-peer coworkers. While high status workers, such as department heads and psychiatrists, can serve as the gatekeepers to increase the use of peer support work in mental healthcare, it is essential that non-peer workers (especially those with low status and high work-task overlap) are supported through the introduction of peer workers. Otherwise, not only do peer workers experience occupational exclusion, but worker retention and quality of care fails.

Findings from this project also inform NASMHPD’s suggested cultural shift towards recovery within receiving organizations. There are multiple definitions of recovery, and occupational acceptance and integration depends on which definitions are used. If an organization supports the clinical definition of recovery, this will come into conflict with the understanding of social recovery that defines peer work. Furthermore, cultural shifts towards recovery will require more than the adoption of recovery-oriented language.

How peer support work and workers are introduced during this time of growth and adaption has long term implications for the scope and capacity of the whole field. As Gillard et al. argue, without appropriate support and consideration, “There is a risk that the potential impact of any emerging [peer worker] role will be constrained and diluted” (2013: 188). Not supporting the occupational integration of peer support workers within non-peer spaces will undermine the very definition and benefit of peer work itself.

One of the most efficient ways to amplify the voices of peers and service consumers would be to mandate their inclusion in research and program development. At a national level, NIMH could require grant applicants to work directly with service users or peers and to indicate
the extent of their involvement on all application materials. At a state level, the Pennsylvania Office of Mental Health and Substance Use Services (OHMSAS) could mandate the inclusion of peer workers within all departments across the agency. While OMHSAS currently supports a statewide coalition of consumers, family members and professionals that they call the “Pennsylvania Community Support Program”, similar advisory groups should inform all departmental decision making. Finally, peer insight is necessary for the development and implementation of services for individuals with mental illness who are involved in the criminal justice system. Specifically, Substance Abuse and Mental Health Services Administration’s (SAMHSA) GAINS Center for Behavioral Health and Justice Transformation is dedicated to expanding services for this population through technical assistance for communities and professionals, as well as through the distribution of grants. Grant applicants for GAINS center funding could be mandated to include peers in the development and implementation of proposed programming, and peers should also be employed to provide technical assistance.

Forensic Peer Support

This research highlights several factors that advocates need to consider when promoting the development, implementation, growth, and institutionalization of FPS. While some of the barriers and challenges that the FPS field faces are similar to those identified in broader peer support literature (see suggestions above), differences remain. Challenges related specifically to FPS include: lived experience of criminal justice system involvement and characteristics of the system, funding gaps, and conceptualizing outcomes. I briefly address each of these concerns and offer recommendations below, and I close this section by suggesting that FPS advocates draw on the insight and challenges of the broader recovery paradigm.

A central disconnect between how FPS has been conceptualized (Baron 2011) and how it has been implemented relates to peer workers’ lived experience of criminal justice system
involvement. I find that many individuals trained and working in the field of FPS have not been personally involved in the criminal justice system and argue that this is due to the structural barriers to employment that individuals with criminal records face. FPS advocates have expanded the definition of ‘lived experience’ to include those who have supported friends and family members with criminal justice system involvement. While this has expanded the number of individuals able to provide FPS, I believe that this redefinition undermines the strength and impact of FPS. In order to stay true to the broader values of peer support, FPS should be provided by those with only personal lived experience of criminal justice system involvement. Effort needs to be placed on expanding access to FPS training and work by individuals with personal lived experience rather than expanding the overall number of individuals trained.

Other characteristics of the criminal justice system that impact the development and implementation of FPS include its wide scope and structures of exclusion. While it is important to focus on community reentry, FPS programming should also aim to intervene at earlier stages in the criminal justice system, including the first three intercepts - law enforcement, initial detentions and court hearings, and jails/ courts (Munetz and Griffin 2006). The CPS model within Pennsylvanian State Correctional Institutions is addressing only one small portion of the involved population. As I argued in this dissertation, individuals involved with the criminal justice system have substantial challenges with community integration due to the system’s unique structure of entrenched exclusion. While this institutionalized stigma is a main barrier to the growth of FPS, it is also something that must be addressed directly by FPS advocates and workers.

Funding gaps also need to be addressed for the stability of FPS programming. A recent report demonstrating the rapid growth of programs aimed at serving this population showed that the vast majority of these programs depend on grant funding (Temple Collaborative for
Community Inclusion 2016). The majority of current and past FPS workers I spoke with in this study also reported that their programs were funded through grants. Grants are typically time constrained and have set end dates. Workers therefore have precarious employment, and many of the programs do not exist long enough to show effectiveness. Much of the strength of CPS services in Pennsylvania depends on the stability of its funding source – Medicaid. While FPS cannot be covered by Medicaid, it is important to identify and seek out funding sources that are stable so that programs can last long enough to implement change.

In order for programs to maintain funding and for new programs to be implemented, FPS needs to provide evidence of positive outcomes. It is difficult for any peer support program to show evidence of positive outcomes because recovery-oriented aims are individualized and therefore frequently differ from traditional mental healthcare outcomes (Watson 2017b). This challenge is exacerbated in FPS because criminal justice related outcomes need to be considered, in addition to both recovery and traditional mental healthcare outcomes. Nevertheless, for FPS to grow and flourish, its programming needs to include formal evaluation. Stakeholders representing the mental healthcare system, the criminal justice system, and consumers need to work together to identify and agree upon clear outcomes. These outcomes would ideally include both quantitative and qualitative changes. For example, rather than understanding recidivism as a dichotomous variable, factors such as length of time in the community and type of offense need to be considered. In terms of mental health, both external and subjective measures of recovery should be included.

Finally, I recommend that those advocating for the growth of FPS services seriously consider the costs and benefits associated with the growth of CPS services in Pennsylvania, especially if they believe their paths to be similar. FPS advocates need to consider whether the growth of the field is worth the changes that institutionalized and professionalized peer support
incurs. There are both pros and cons of growing a field when the growth results from institutionalization, and I caution advocates to consider potential unintended consequences. Additionally, I encourage program advocates and developers to consider the role of a recovery-oriented practice within a punishment-oriented system. Gaining access is only the first step; staying true to underlying philosophies will continue to be a challenge.

Anti-Stigma Efforts

As the salience and experience of stigma depends on the context in which it occurs, anti-stigma programming needs to be adapted to specific environments, settings, contexts and histories. Furthermore, programming should consider context within an ecological framework, considering not only social communities, but regional differences and social policies. Communities, and social locations within those communities, impact how stigma can be resisted and diminished. When implementing anti-stigma programming, individuals need to work with peer stakeholders to learn about the specific resources, histories, and philosophies of the communities in which those programs are being implemented. This is supported by previous work indicating that grassroots stigma change efforts are more impactful than population level efforts (Corrigan and Fong 2014). In addition, data from this dissertation suggests that many 12-step groups could benefit from inclusivity and anti-stigma training. While these groups may be effective in promoting community integration for individuals with one stigmatized status, they should not exclude those with differing stigmatized statuses.

Limitations

Several limitations related to data, sampling, and researcher status should be noted. A main limitation to this study relates to potential sampling bias in both the online survey and qualitative interviews. It is likely that the stakeholders and peer workers who participated were biased towards the peer support field in general, and towards Forensic Peer Support, in
particular. This is particularly true in the case of the interviews, when respondents had to go out of their way to meet a stranger during their limited free time. Based on this presumed positive stance towards peer support work, any limitations or concerns with the field are likely underreported. Furthermore, due to sampling techniques I was also unable to calculate response rates.

A second sampling bias relates to stigma. I asked respondents to share intimate details with me, not only about their work but also about their own histories and experiences. At the end of an interview, one peer worker shared with me that he had considered canceling the interview in order to avoid potential stigma. It is likely that individuals concerned about experiencing stigma, or individuals with higher self-stigma, did not choose to participate in the study. Therefore, this sample is biased towards individuals with lower self-stigma and more comfort engaging in stigma-resistance.

There were two limitations specific to the follow-up qualitative interviews with peer support workers. While the initial research design proposed interviews with a random sample of FPS workers, this was not possible due to the low number of these types of workers. When sampling for follow-up interviews, I therefore prioritized current and past FPS workers, but also included other peer support workers trained in FPS. Secondly, it was difficult to find locations in which to conduct these interviews. Many were completed in public spaces, such as coffee shops, which might have restricted what respondents’ felt comfortable discussing.

A limitation related to how we can interpret and understand findings in this study is its cross-sectional nature. This study relies on respondent recall of their histories and past experiences, and it is frequently difficult for individuals to recall the past accurately. Due to the limited sample size of this study and its English-only implementation, I am not able to speak to racial or ethnic differences beyond the gross black-white binary. It is also important to note that
this research reflects the state of FPS in Pennsylvania and cannot be generalized to reflect the state of the field in other settings.

Finally, researcher orientation and personal biases influenced this study, despite attempts to maintain objectivity. I am a relative outsider to this community in many ways: I do not reside in Pennsylvania, I am not a peer worker or active in the recovery movement, and I have never been involved in the criminal justice system. Furthermore, my social identities include being a white, female, middle class researcher pursuing a graduate degree. Despite building rapport, it is likely that some respondents were reserved with me based on these statuses. Furthermore, I entered this research with personal biases, including belief in the recovery paradigm and critiques of the criminal justice system. While I did my best to rely on the data to inform my analyses rather than external beliefs, this research, as is true with all research, is influenced by researcher bias.

Future Research

I plan on conducting further analyses of data from this project, especially as related to the construction of stigmatized knowledge as expertise, the geography of recovery, and the role of substance use in FPS. However, future research studies are needed to expand upon both the theoretical and applied findings demonstrated in this study.

This project highlights the continued importance of stigma scholarship. While this research can speak to the understanding and experience of stigma related to mental illness and criminal justice involvement, it fails to fully explore other intersectional stigmatized statuses. Further research would broaden our understanding of the role of multi-level context on the salience of multiple stigma, and how various statuses and settings interact. Of particular interest would be an in-depth exploration of race and multiple stigma. This research has also drawn on the burgeoning literature related to structural stigma and stigma power. However, additional
research is needed to further understand how processes supporting structural stigma and interpersonal stigma interact and sustain each other. Similarly, this research draws explicitly on literature related to stigma resistance. There is a unique opportunity to further understanding of stigma resistance, particularly as it operates and interacts at the interpersonal and structural levels.

The professionalization of peer support workers noted in this dissertation is occurring within broader trends of professionalization of lay health workers. This includes community health workers and promotores. For all of these workers, lived experience both serves as occupational qualification and is increasingly conceptualized as expertise. However, this experiential expertise is frequently highly stigmatized for peer support workers. Therefore, a comparative study of the professionalization of peer support workers and community health workers could shed light on the role of stigma in the understanding and acceptance of experiential expertise. Community health workers frequently work with individuals with stigmatized conditions other than mental illness or criminal justice system involvement. This includes stigmatized medical conditions, including HIV/AIDS, T.B., or obesity, as well as stigmatized social statuses and conditions, including immigration status and housing instability. The comparative research would assess differences and similarities between professionalization and stigma among both peer workers and community health workers supporting individuals with differing stigmatized statuses. Furthermore, new research would extend this project’s work on threat of jurisdiction control to speak to the broader lay health workforce.

The rapidly changing peer support field deserves additional exploration, specifically related to the trend towards formalization and institutionalization of peer services. This research situates Pennsylvania’s peer support transformation in its inclusion in the state Medicaid policy. However, these trends are occurring in nations across the world with vastly different healthcare
policy and practice environments. The importance of context and community in this project indicate that these factors need to be central factors in future peer support research. A comparative global study of the institutionalization of peer support would elucidate the common processes and differing challenges that peer support faces across sites, its impact on peer practice, and implications for the occupational integration and stigma of peer workers themselves. Related research should address which types of specializations emerge and which are successfully implemented, and structural and cultural factors associated with those developments. It is unclear whether peer support for individuals involved with criminal justice systems is emerging in other international contexts, and how FPS might develop given differing sociopolitical environments.

While this current project explores how peer workers and advocates for the field understand the work and profession of FPS, it is of critical importance to develop our understanding of how peer clients understand and experience these services. Evaluation procedures for FPS programming needs to be implemented, despite the challenges involved in identifying valuable outcomes. In addition, an external evaluation of the CPS program in SCIs could offer insight into the implementation and utility of a currently operating peer program in a criminal justice setting, providing insight as to whether recovery-oriented programming in these settings can be truly transformative, or just new tools of social control. Finally, a significant gap in the mental healthcare literature (as noted in the Race and FPS section earlier in this chapter) is the lack of research assessing racial disparities in recovery-oriented services, including peer support.

Conclusion

This study of Forensic Peer Support reveals that the salience, impact, and management of multiple stigmas depends on the contexts and communities in which those exclusions are
enacted. For the peer workforce to mitigate stigma and increase social integration, peer workers need to be cognizant of and responsive to the contexts in which their peer clients live. A central challenge with Forensic Peer Support is the state-sanctioned structural stigma associated with the criminal justice system. Although increasing formalization and professionalization of the broader field of peer support has resulted in a phase of unprecedented growth, these processes are also resulting in additional complex and unanticipated consequences.


*Psychiatric Services* 68(1):9-16.


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Appendix A: Stakeholder Characteristics

Table 1: Stakeholder Characteristics (n=14)

<table>
<thead>
<tr>
<th>Interview ID</th>
<th>Gender</th>
<th>Location</th>
<th>Current Position</th>
<th>Organizational Affiliation</th>
<th>Notes</th>
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<tr>
<td>#010</td>
<td>M</td>
<td>Philadelphia</td>
<td>Senior Administrator</td>
<td>Department of Prisons</td>
<td>Not voice recorded</td>
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<tr>
<td>#011</td>
<td>M</td>
<td>Philadelphia</td>
<td>FPS Program Coordinator</td>
<td>Mental Health Department</td>
<td>FPS Trainer; Provides FPS</td>
</tr>
<tr>
<td>#013</td>
<td>F</td>
<td>Harrisburg</td>
<td>Executive Director</td>
<td>Mental Health Advocacy Organization</td>
<td></td>
</tr>
<tr>
<td>#012</td>
<td>F</td>
<td>Harrisburg</td>
<td>FPS Project Specialist</td>
<td>Mental Health Advocacy Organization</td>
<td>FPS Trainer; Has worked as CPS; Involved in 2010 SAMHSA grant</td>
</tr>
<tr>
<td>#014</td>
<td>M</td>
<td>Central Western Pennsylvania</td>
<td>Program Manager</td>
<td>County Mental Health Consumer Organization</td>
<td>Manages 2-month-old FPS program for incarcerated peers</td>
</tr>
<tr>
<td>#015</td>
<td>F</td>
<td>Philadelphia</td>
<td>Director</td>
<td>Recovery Advocacy Organization</td>
<td>Wrote FPS Training Curriculum</td>
</tr>
<tr>
<td>#016</td>
<td>F</td>
<td>Central Pennsylvania</td>
<td>Program Coordinator</td>
<td>Statewide For-Profit Peer Support Provider</td>
<td>Oversees FPS work in multiple jails; FPS Trainer; Provides FPS</td>
</tr>
<tr>
<td>#017</td>
<td>F</td>
<td>Philadelphia</td>
<td>Faculty</td>
<td>University (Continuing Education)</td>
<td>Involved in 2010 SAMHSA FPS Grant and Training Curriculum</td>
</tr>
<tr>
<td>#019</td>
<td>F</td>
<td>Harrisburg</td>
<td>Program Specialist</td>
<td>Mental Health Department</td>
<td></td>
</tr>
<tr>
<td>#020</td>
<td>F</td>
<td>Harrisburg</td>
<td>Mental Health Worker</td>
<td>Mental Health Department</td>
<td>Justice Liaison; Involved in 2010 SAMHSA FPS Grant and DOC CPS Program</td>
</tr>
<tr>
<td>#021</td>
<td>F</td>
<td>Greater Philadelphia</td>
<td>Director</td>
<td>County Mental Health Consumer Organization</td>
<td></td>
</tr>
<tr>
<td>#022</td>
<td>M</td>
<td>Northwestern Pennsylvania</td>
<td>Peer Support Team Leader and Trainer</td>
<td>County Mental Health Consumer Organization</td>
<td>FPS Trainer and advocate; Has worked as CPS</td>
</tr>
<tr>
<td>#023</td>
<td>M</td>
<td>Northwestern Pennsylvania</td>
<td>Program Supervisor</td>
<td>Veteran Transitional Housing</td>
<td>FPS and Incarcerated Veterans Trainer; Has worked as CPS</td>
</tr>
<tr>
<td>#024</td>
<td>F</td>
<td>Northeastern Pennsylvania</td>
<td>FPS Supervisor</td>
<td>County Mental Health Consumer Organization</td>
<td>Was MH Consumer at Employing Agency; Provides FPS</td>
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249
### Appendix B: Peer Worker Characteristics and Pseudonyms

Table 8: Peer Support Worker characteristics (n=37)

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Worked as Forensic Peer Specialist</th>
<th>Has CPS Certification</th>
<th>Current Position</th>
<th>Gender</th>
<th>Age</th>
<th>Race</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charles</td>
<td>No</td>
<td>Yes</td>
<td>CPS/ PSS</td>
<td>Male</td>
<td>66</td>
<td>African American</td>
<td>Philadelphia</td>
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<tr>
<td>Pamela</td>
<td>No</td>
<td>Yes</td>
<td>Certified Peer Specialist</td>
<td>Female</td>
<td>54</td>
<td>African American</td>
<td>Philadelphia</td>
</tr>
<tr>
<td>Susan</td>
<td>No</td>
<td>Yes</td>
<td>Recovery Coach</td>
<td>Female</td>
<td>49</td>
<td>African American</td>
<td>Philadelphia</td>
</tr>
<tr>
<td>Larry</td>
<td>No</td>
<td>Yes</td>
<td>Employment Specialist</td>
<td>Male</td>
<td>58</td>
<td>African American</td>
<td>Philadelphia</td>
</tr>
<tr>
<td>Julie</td>
<td>No</td>
<td>No</td>
<td>Family/Community Inclusion Specialist</td>
<td>Female</td>
<td>55</td>
<td>African American</td>
<td>Philadelphia</td>
</tr>
<tr>
<td>Jason</td>
<td>Current</td>
<td>Yes</td>
<td>Certified Peer Specialist</td>
<td>Male</td>
<td>40</td>
<td>African American</td>
<td>Philadelphia</td>
</tr>
<tr>
<td>Mary</td>
<td>No</td>
<td>Yes</td>
<td>Family Specialist</td>
<td>Female</td>
<td>62</td>
<td>African American</td>
<td>Philadelphia</td>
</tr>
<tr>
<td>Amy</td>
<td>No</td>
<td>Yes</td>
<td>Corporate Peer Services Coordinator</td>
<td>Female</td>
<td>40</td>
<td>White/ African American</td>
<td>Philadelphia</td>
</tr>
<tr>
<td>Mark</td>
<td>Previously</td>
<td>Yes</td>
<td>Mental Health Group Facilitator</td>
<td>Male</td>
<td>52</td>
<td>African American</td>
<td>Philadelphia</td>
</tr>
<tr>
<td>Richard</td>
<td>Current</td>
<td>Yes</td>
<td>Forensic Peer Support Specialist</td>
<td>Male</td>
<td>61</td>
<td>White</td>
<td>Southeast PA</td>
</tr>
<tr>
<td>Steven</td>
<td>Current</td>
<td>Yes</td>
<td>Veteran Forensic CPS/FSS</td>
<td>Male</td>
<td>59</td>
<td>White</td>
<td>Philadelphia</td>
</tr>
<tr>
<td>Brenda</td>
<td>No</td>
<td>Yes</td>
<td>CPS</td>
<td>Female</td>
<td>58</td>
<td>White</td>
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</tr>
<tr>
<td>Willie</td>
<td>No</td>
<td>Yes</td>
<td>Crisis Team CPS</td>
<td>Male</td>
<td>55</td>
<td>African American</td>
<td>Southeast PA</td>
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<tr>
<td>Kimberly</td>
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<td>30</td>
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<tr>
<td>Wayne</td>
<td>Current</td>
<td>Yes</td>
<td>Certified Peer Specialist</td>
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<td>56</td>
<td>White</td>
<td>Southeast PA</td>
</tr>
<tr>
<td>Robert</td>
<td>Current</td>
<td>Yes</td>
<td>CPS Co-coordinator/ WRAP facilitator</td>
<td>Male</td>
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<td>Philadelphia</td>
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<tr>
<td>Sandra</td>
<td>Previously</td>
<td>Yes</td>
<td>Director of MH Recovery center</td>
<td>Female</td>
<td>54</td>
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<td>Southeast PA</td>
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<tr>
<td>Victor</td>
<td>Previously</td>
<td>Yes</td>
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<td>Philadelphia</td>
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<tr>
<td>James</td>
<td>No</td>
<td>Yes</td>
<td>Certified Peer Specialist</td>
<td>Male</td>
<td>39</td>
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<td>Philadelphia</td>
</tr>
<tr>
<td>Pseudonym</td>
<td>Worked as Forensic Peer Specialist</td>
<td>Has CPS Certification</td>
<td>Current Position</td>
<td>Gender</td>
<td>Age</td>
<td>Race</td>
<td>Location</td>
</tr>
<tr>
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</tr>
<tr>
<td>Jerry</td>
<td>No</td>
<td>No</td>
<td>Certified Recovery Specialist</td>
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<td>Jessica</td>
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<td>Yes</td>
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<tr>
<td>Ronald</td>
<td>No</td>
<td>Yes</td>
<td>Peer Specialist VA</td>
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<tr>
<td>David</td>
<td>No</td>
<td>Yes</td>
<td>CPSS</td>
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</tr>
<tr>
<td>Gail</td>
<td>Previously</td>
<td>Yes</td>
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<td>Female</td>
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<td>Southeast PA</td>
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<tr>
<td>Melissa</td>
<td>Currently</td>
<td>Yes</td>
<td>CPS Supervisor</td>
<td>Female</td>
<td>36</td>
<td>White</td>
<td>Eastern PA</td>
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<tr>
<td>Patricia</td>
<td>Previously</td>
<td>Yes</td>
<td>Disabled</td>
<td>Female</td>
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<td>Southeast PA</td>
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<tr>
<td>Stephen</td>
<td>No</td>
<td>Yes</td>
<td>Supervisor of Peer Support Services</td>
<td>Female</td>
<td>60</td>
<td>White</td>
<td>Southeast PA</td>
</tr>
<tr>
<td>Lawrence</td>
<td>Current</td>
<td>Yes</td>
<td>Director of Peer Support Services</td>
<td>Male</td>
<td>34</td>
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<td>Central PA</td>
</tr>
<tr>
<td>Joseph</td>
<td>No</td>
<td>Yes</td>
<td>Certified Peer Specialist</td>
<td>Female</td>
<td>58</td>
<td>White</td>
<td>Eastern PA</td>
</tr>
<tr>
<td>John</td>
<td>No</td>
<td>Yes</td>
<td>CPS</td>
<td>Male</td>
<td>54</td>
<td>African American</td>
<td>Philadelphia</td>
</tr>
<tr>
<td>Michelle</td>
<td>Current</td>
<td>Yes</td>
<td>Certified Forensic Peer Specialist</td>
<td>Female</td>
<td>31</td>
<td>Latino/ Native American</td>
<td>Northern PA</td>
</tr>
<tr>
<td>Amanda</td>
<td>No</td>
<td>Yes</td>
<td>Peer Recovery Navigator</td>
<td>Female</td>
<td>31</td>
<td>White</td>
<td>Southeast PA</td>
</tr>
<tr>
<td>Michael</td>
<td>No</td>
<td>Yes</td>
<td>4 Different part time jobs in mental health</td>
<td>Male</td>
<td>43</td>
<td>White</td>
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</tr>
<tr>
<td>Rebecca</td>
<td>No</td>
<td>Yes</td>
<td>Certified Peer Specialist/ Social work aide</td>
<td>Female</td>
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<td>White</td>
<td>Central PA</td>
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<tr>
<td>Scott</td>
<td>Previous</td>
<td>Yes</td>
<td>Community Services Specialist/ Yes Mental Health Advocate/ CPS</td>
<td>Male</td>
<td>53</td>
<td>White</td>
<td>Northeast PA</td>
</tr>
<tr>
<td>Bruce</td>
<td>Previous</td>
<td>Yes</td>
<td>CPS Supervisor</td>
<td>Male</td>
<td>62</td>
<td>White</td>
<td>Northern PA</td>
</tr>
<tr>
<td>William</td>
<td>Current</td>
<td>Yes</td>
<td>CPS</td>
<td>Male</td>
<td>39</td>
<td>White</td>
<td>Central PA</td>
</tr>
</tbody>
</table>
Appendix C: Survey Recruitment Email

Subject: Online Survey for Forensic Peer Specialists

Email Message Body:

I am writing to request your participation in a brief survey. We are interested in learning more about the status of Forensic Peer Support in Pennsylvania. If you have participated in Forensic Peer Specialist training in the past, we would very much appreciate your participation.

The survey is brief and will only take about 5 minutes to complete. Please click the link below to go the survey website (or copy and paste the link into your Internet browser).

Survey link: http://www.surveymonkey.com/s/XXXXX

Your participation in the survey is completely voluntary and all of your responses will be kept confidential. The Northeastern University Institutional Review Board has approved this survey. Should you have any comments or questions, please feel free to contact me at ForensicPeerSpecialistStudy@gmail.com.

Thank you very much for your time and cooperation. Your responses are very important!

Sincerely,

Wallis Adams
Northeastern University
Boston, MA
Appendix D: Survey Instrument

[Survey begins on the next page]
Forensic Peer Specialists

Forensic Peer Specialist Survey

Consent to Participate in 15 Minute Survey

Northeastern University, Department of Sociology and Anthropology
Name of Investigator(s): Alisa Lincoln & Wallis Adams
Title of Project: Recovery and Reentry: Multiple Stigmas and Inclusion Among Forensic Peer Specialists

Request to Participate in Research

We would like to invite you to participate in a web-based online survey. The survey is part of a research study whose purpose is to learn about the field of Forensic Peer Support. This survey should take about 5 minutes to complete.

We are asking you to participate in this study because you have completed Forensic Peer Specialist (FPS) training in the state of Pennsylvania. You must be at least 18 years old to take this survey.

The decision to participate in this research project is voluntary. You do not have to participate and you can refuse to answer any question. You DO NOT have to answer every question. Even if you begin the web-based online survey, you can stop at any time.

The possible risks or discomforts of the study are minimal. You may feel a little uncomfortable answering personal survey questions.

There are no direct benefits to you from participating in this study. However, your responses may help us learn more about Forensic Peer Support.

You will not be paid for your participation in this study.

Your part in this study will be handled in a confidential manner. Any reports or publications based on this research will use only group data and will not identify you or any individual as being affiliated with this project.

If you have any questions regarding electronic privacy, please feel free to contact Mark Nardone, NU’s Director of Information Security via phone at 617-373-7901, or via email at privacy@neu.edu.

If you have any questions about this study, please feel free to contact Wallis Adams (ForensicPeerSpecialistsStudy@gmail.com), the person mainly responsible for the research. You can also contact [Alisa Lincoln, al.lincoln@neu.edu], the Principal Investigator.

If you have any questions regarding your rights as a research participant, please contact Nan C. Regina, Director, Human Subject Research Protection, 490 Renaissance Park, Northeastern University, Boston, MA 02115. Tel: 617.373.4588, Email: n.regina@neu.edu. You may call anonymously if you wish.

This study has been reviewed and approved by the Northeastern University Institutional Review Board (# 16-05-12).

By clicking on the survey link below you are indicating that you consent to participate in this study.
Please print out a copy of this consent form for your records.

Thank you for your time.
Wells Adams

* 1. By checking the box below you are indicating that you consent to participate in this study.

Do you understand the information provided above and agree to take part in the research?

☐ I understand the information provided and agree to take part in this research

### Forensic Peer Specialists

#### Preliminary Questions

* 1. Are you 18 years of age or OLDER?

  ☐ Yes
  ☐ No

* 2. Do you reside in Pennsylvania?

  ☐ Yes
  ☐ No

* 3. Have you completed Forensic Peer Specialist (FPS) training/education (or similar training)?

  ☐ Yes
  ☐ No

### Forensic Peer Specialists

#### Demographics
1. In what year were you born? (enter 4-digit birth year; for example, 1976)

2. What is your gender?
   - Male
   - Female
   - Other (please specify)

3. Are you Hispanic or Latino/a?
   - Yes
   - No

4. Which of the following choices describes your race? (Please select all that apply)
   - White
   - Black or African-American
   - American Indian or Alaskan Native
   - Asian
   - Native Hawaiian or other Pacific Islander
   - Other (please specify)

5. In what language do you speak most often at home?
   - English
   - Spanish
   - Chinese
   - Vietnamese
   - Russian
   - Other (please specify)
6. Which of the following best describes your current relationship status?

- Single and never married
- Married or partnered
- Divorced or separated
- Widowed
- Other (please specify)

7. In what ZIP code is your home located? (enter 5-digit ZIP code; for example, 00544 or 94305)

Forensic Peer Specialists
Income, Employment, and Education

1. How much total money did YOU personally earn last year? (Approximately)

2. Do you currently receive any of the following benefits? (Please select all that apply)

- Medicare
- Medicaid
- Supplemental Security Income (SSI)
- Social Security Disability Insurance (SSDI)
- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
- Other (please specify)
3. What is the highest level of school you have completed or the highest degree you have received?

- Less than high school degree
- High school degree or equivalent (e.g., GED)
- Some college but no degree
- Associate degree
- Bachelor degree
- Graduate degree

4. Have you ever served in any branch of the United States military?

- Yes, I have
- No, I have not

**Forensic Peer Specialists**

**Mental Health Care Y/N**

* 1. Have you ever used mental health care services? (examples: Peer services, Individual or group therapy, inpatient or outpatient services, psychiatric medication prescription, dual diagnosis treatment, etc.)

- Yes
- No

**Forensic Peer Specialists**

**Mental Health Care**

1. How old were you the very first time you experienced any challenges related to your mental health? (approximate age in years)

2. How old were you when you first received mental health care? (approximate age in years)
3. When was the MOST RECENT time that you used the following health care services?
(Options: In the past month; In the past year; I have used this service, but not in the past year; Never)

<table>
<thead>
<tr>
<th>Service</th>
<th>In the past month</th>
<th>In the past year</th>
<th>Prior to the past year</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taken psychiatric medication prescribed by a psychiatrist or doctor</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Participated in therapy</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Received services from a case manager or social worker</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Used a crisis hotline or a warm line</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Used any peer run services</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Used a partial or day hospitalization service</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Been an inpatient in a psychiatric unit or psychiatric hospital</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Enrolled in an outpatient treatment program for alcohol and/ or drug use</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Enrolled in an inpatient treatment program for alcohol and/ or drug use</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Forensic Peer Specialists</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of CJ involvement (y/n)</td>
</tr>
</tbody>
</table>

* 1. Have you ever been involved in the criminal justice system?
   ○ Yes
   ○ No

<table>
<thead>
<tr>
<th>Forensic Peer Specialists</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of Criminal Justice System Involvement</td>
</tr>
</tbody>
</table>
1. How old were you when you were first arrested?

2. Approximately how many times have you been arrested in your life?

3. Approximately what is the total amount of time you’ve spent incarcerated in your life?

4. How old were you when you were most recently released from incarceration?

5. Approximately what is the total amount of time you’ve spent under community supervision (probation or parole) in your life?

6. Are you currently under community supervision (probation or parole)?
   - Yes
   - No

**Forensic Peer Specialists**

**Forensic Peer Specialist Training**

1. When did you complete Forensic Peer Specialist training?

2. With which organization or trainer did you complete Forensic Peer Specialist training?

3. Have you completed Certified Peer Specialist (CPS) training?
   - Yes
   - No
4. What is your current employment status?
- Employed, working full-time
- Employed, working part-time
- Student
- Not employed, looking for work
- Not employed, NOT looking for work
- Retired
- Volunteer work
- Disabled, not able to work

Forensic Peer Specialists
Current employment (all)

1. What is your current job?

2. How long have you been employed in this role?

Forensic Peer Specialists
Forensic Peer Specialist employment ever (y/n)

1. Have you ever worked as a Forensic Peer Specialist (FPS), or in a similar role?
- Yes, I am currently employed as a FPS
- I previously worked as a FPS, but am not currently employed as a FPS
- No

Forensic Peer Specialists
Forensic Peer Specialist Employment (current)
1. About how long have you been employed as a Forensic Peer Specialist?

2. About how long have you been employed in your current position?

3. What type of organization or program do you work for?

4. How many Forensic Peer Specialists are employed at your organization (including yourself)?

5. What is your pay rate?
   - Less than $10.00/hour
   - $10.00 - $11.99/hour
   - $12.00 - $13.99/hour
   - $14.00 - $15.99/hour
   - $16.00 - $17.99/hour
   - $18.00 - $19.99/hour
   - $20.00/hour or more

6. How much of your work time do you spend in the following locations?
   - All of the time
   - Most of the time
   - Some of the time
   - A little of the time
   - None of the time

   At the organization or program site
   In the community
   At a client’s residence
   In transit
   In jail, prison or other criminal justice environment
   Other (please specify)
7. How much of your work time do you spend on the following activities?

<table>
<thead>
<tr>
<th>Activity</th>
<th>All of the time</th>
<th>Most of the time</th>
<th>Some of the time</th>
<th>A little of the time</th>
<th>None of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supporting people in groups</td>
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<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<tr>
<td>Supporting people individually</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<tr>
<td>Working with families</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Working with inmates</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Working with community members</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Working with employers</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<td>Administrative tasks</td>
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<tr>
<td>Other (please specify)</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

8. How much of an impact do you feel your work has?

<table>
<thead>
<tr>
<th>Impact</th>
<th>A great deal of impact</th>
<th>A lot of impact</th>
<th>A moderate impact</th>
<th>A little impact</th>
<th>No impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>On yourself</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>On your community</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>On your clients</td>
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<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>On your organization</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>
9. For each of the following statements, please indicate whether you agree or disagree.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neutral/Neither agree nor disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>My supervisor and I have a good working relationship.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My coworkers and I have a good working relationship.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am satisfied with my overall compensation.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am satisfied with my overall job security.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am satisfied that I have the opportunities to apply my talents and expertise.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am satisfied with my opportunities for professional growth.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
10. For each of the following statements, think about the organization or program that you work for. Please indicate whether you agree or disagree.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Always agree</th>
<th>Sometimes Agree</th>
<th>Neutral</th>
<th>Sometimes Disagree</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel like part of this organization, like I belong here.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I know my way around this organization.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I know the rules in this organization and I can fit in with them.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel that I am accepted in this organization.</td>
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<td>I can be independent in this organization.</td>
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<td>I like where I'm working now.</td>
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<tr>
<td>There are people I feel close to in this organization</td>
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<tr>
<td>I know a number of people in this organization well enough to say hello and have them say hello back.</td>
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<tr>
<td>There are things that I can do in this organization that are fun.</td>
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</table>

**Forensic Peer Specialists**

**Past FPS employment**

1. How long were you previously employed as a Forensic Peer Specialist (FPS)?

2. What type of organization or program did you work for as a FPS?
3. What was your pay rate (as a FPS)?

- Less than $10.00/hour
- $10.00 - $11.99/hour
- $12.00 - $13.99/hour
- $14.00 - $15.99/hour
- $16.00 - $17.99/hour
- $18.00 - $19.99/hour
- $20.00/hour or more

4. What were your reasons for leaving the FPS position?

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<thead>
<tr>
<th>Forensic Peer Specialists</th>
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<tr>
<td>Community Inclusion</td>
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</table>
1. For each of the following statements, think about your everyday life and your community. Please indicate whether you agree or disagree.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Always agree</th>
<th>Sometimes agree</th>
<th>Neutral</th>
<th>Sometimes disagree</th>
<th>Always disagree</th>
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<tbody>
<tr>
<td>I feel like part of this community, like I belong here.</td>
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<td>I know my way around this community.</td>
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<td>I know the rules in this community and I can fit in with them.</td>
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<tr>
<td>I feel that I am accepted in this community.</td>
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<td>I can be independent in this community.</td>
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<tr>
<td>I like where I’m living now.</td>
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<td>There are people I feel close to in this community.</td>
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<tr>
<td>I know a number of people in this community well enough to say hello and have them say hello back.</td>
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<tr>
<td>There are things that I can do in this community for fun in my free time.</td>
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<tr>
<td>I have something to do in this community that is useful and productive.</td>
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</table>

**Forensic Peer Specialists**

**Stigma**
1. How often do you think the following:

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<thead>
<tr>
<th></th>
<th>Always</th>
<th>Often</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
<th>Not applicable (N/A)</th>
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<tbody>
<tr>
<td>Do you think people will think less of you if they know you have a mental illness?</td>
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<tr>
<td>Do you think people will think less of you if they know you were previously involved in the criminal justice system?</td>
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<td>Do you think that the average person is afraid of someone with a serious mental illness?</td>
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<td>Do you think that the average person is afraid of someone who was previously involved with the criminal justice system?</td>
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</table>
2. Please respond to the following questions:

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<tr>
<th>Question</th>
<th>Yes</th>
<th>Unsure</th>
<th>No</th>
<th>Not applicable (N/A)</th>
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<tbody>
<tr>
<td>Have you ever been teased, bullied, or harassed because you have a mental illness?</td>
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<tr>
<td>Have you ever been teased, bullied, or harassed because of involvement with the criminal justice system?</td>
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<tr>
<td>Have you felt that you have been treated unfairly or that your rights have been denied because you have a mental illness?</td>
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<tr>
<td>Have you felt that you have been treated unfairly or that your rights have been denied because of involvement with the criminal justice system?</td>
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<tr>
<td>Have your experiences with stigma affected your recovery?</td>
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<tr>
<td>Have your experiences with stigma affected your community reentry?</td>
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<td>Have your experiences with stigma caused you to think less about yourself or your abilities?</td>
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<td>Have your experiences with stigma affected your ability to make or keep friends?</td>
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<tr>
<td>Have your experiences with stigma affected your satisfaction with or quality of life?</td>
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<tr>
<td>Do you try to avoid situations that may be stigmatizing to you?</td>
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</table>
3. How often in the past three (3) months did you:

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<tr>
<th></th>
<th>Very often</th>
<th>Fairly often</th>
<th>Sometimes</th>
<th>Almost never</th>
<th>Never</th>
<th>Not applicable (N/A)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tell someone you disagreed with them when they said something stigmatizing about people with mental illness?</td>
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<tr>
<td>Tell someone you disagreed with them when they said something stigmatizing about people involved in the criminal justice system?</td>
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<tr>
<td>Let someone know that their behavior was stigmatizing?</td>
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<tr>
<td>Tell someone that they were treating you or someone else in a stigmatizing way due to mental illness?</td>
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<tr>
<td>Tell someone that they were treating you or someone else in a stigmatizing way due to involvement in the criminal justice system?</td>
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<tr>
<td>Correct someone who referred to people with mental illness in an uncomplimentary way?</td>
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<tr>
<td>Correct someone who referred to people involved in the criminal justice system in an uncomplimentary way?</td>
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</table>

**Forensic Peer Specialists**

Follow up interview
1. Are you willing to participate in a follow-up in-person interview? I am interested in speaking with you about your work and training as a Forensic Peer Specialist, as well as any lived experience of mental illness and criminal justice system involvement. If selected, you will be compensated with a $30 Target gift card to compensate you for your time and travel expenses. Interviews will take place in a mutually agreed upon location and time, and will take place within the next few months. If selected, Wallis Adams will contact you using the contact information you provide on the next page. If you have any questions or concerns, please email: forensicpeerspecialiststudy@gmail.com. Please indicate your interest below:

☐ Yes, I am interested in participating in a follow-up in person interview

☐ No, I am not interested in participating in a follow-up interview

---

**Forensic Peer Specialists**

**Follow up interview contact information**

1. Please provide the contact information below so that Wallis Adams might contact you to schedule a follow-up interview.

Please note: Personal information provided below will not be shared or used for any other purpose other than scheduling follow-up interviews or to contact winners of the drawing (see below).

**Contact Information for Follow-up Interview**

- Your name:
- Your home phone number:
- Cell phone/ other phone number:
- Your email address:
- Your home address:
- Your work address:
- Friend or Relative's Phone number:
- Friend or Relative's name:
- Other contact information:
- How would you prefer to be contacted?
- What days and times are best to reach you?
2. Four people who complete this survey will be randomly selected to win a $50 Target gift card. If you wish to be included in the drawing, please check below. (If selected, you will be contacted through the information you provided above)

- Yes, I would like the chance to win a $50 Target gift card
- No, I would not like the chance to win a $50 Target gift card

3. Do you have any other comments, questions, or concerns?

This is the end of the survey! Thank you for your participation!

Forensic Peer Specialists

Random drawing contact information
1. Four people who complete this survey will be randomly selected to win a $50 Target gift card. If you wish to be included in the drawing, please provide your contact information below. Please note: Personal information provided below will not be shared or used for any other purpose other than to contact the winners. You are NOT REQUIRED to provide the following information.

<table>
<thead>
<tr>
<th>Contact Information for Gift Card Random Drawing</th>
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</thead>
<tbody>
<tr>
<td>Your name:</td>
</tr>
<tr>
<td>Your home phone number:</td>
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<tr>
<td>Cell phone/other phone number:</td>
</tr>
<tr>
<td>Your email address:</td>
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<tr>
<td>Your home address:</td>
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<tr>
<td>Your work address:</td>
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<tr>
<td>Friend or Relative's Phone number:</td>
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<tr>
<td>Friend or Relative's name:</td>
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<tr>
<td>Other contact information:</td>
</tr>
<tr>
<td>How would you prefer to be contacted?</td>
</tr>
<tr>
<td>What days and times are best to reach you?</td>
</tr>
</tbody>
</table>

2. Do you have any other comments, questions, or concerns?

This is the end of the survey! Thank you for your participation!

---

**Forensic Peer Specialists**

Survey complete!

Thank you very much! If you have any questions, please email: ForensicPeerSpecialistStudy@gmail.com
Appendix E: Consent Form (Survey)

Northeastern University, Department of Sociology and Anthropology
Name of Investigator(s): Alisa Lincoln & Wallis Adams
Title of Project: Recovery and Reentry: Multiple Stigmas and Inclusion Among Forensic Peer Specialists

Request to Participate in Research
We would like to invite you to participate in a web-based online survey. The survey is part of a research study whose purpose is to learn about the field of Forensic Peer Support. This survey should take about 5 minutes to complete.
We/I are asking you to participate in this study because you have completed Forensic Peer Specialist (FPS) training in the state of Pennsylvania. You must be at least 18 years old to take this survey.

The decision to participate in this research project is voluntary. You do not have to participate and you can refuse to answer any question. Even if you begin the web-based online survey, you can stop at any time.

The possible risks or discomforts of the study are minimal. You may feel a little uncomfortable answering personal survey questions.

There are no direct benefits to you from participating in this study. However, your responses may help us learn more about Forensic Peer Support.

You will not be paid for your participation in this study.

Your part in this study will be handled in a confidential manner. Any reports or publications based on this research will use only group data and will not identify you or any individual as being affiliated with this project.
If you have any questions regarding electronic privacy, please feel free to contact Mark Nardone, NU’s Director of Information Security via phone at 617-373-7901, or via email at privacy@neu.edu.

If you have any questions about this study, please feel free to contact Wallis Adams (ForensicPeerSpecialistStudy@gmail.com), the person mainly responsible for the research. You can also contact [Alisa Lincoln, al.lincoln@neu.edu], the Principal Investigator.

If you have any questions regarding your rights as a research participant, please contact Nan C. Regina, Director, Human Subject Research Protection, 490 Renaissance Park, Northeastern University, Boston, MA 02115. Tel: 617.373.4588, Email: n.regina@neu.edu. You may call anonymously if you wish.

This study has been reviewed and approved by the Northeastern University Institutional Review Board (# xx-xx-xx).

By clicking on the survey link below you are indicating that you consent to participate in this study. Please print out a copy of this consent form for your records.

Thank you for your time.
Wallis Adams
Appendix F: Stakeholder Interview Guide

***Not all questions are relevant for all participants; adapt to role and setting***

1. I’d like to begin by asking you some questions about your **current job and organization**. Can you tell me a bit about your organization?
   a. What is the mission? Geographic area? How long has it been around?
   b. What is your **position** here?
   c. What responsibilities do you have?
   d. How long have you worked at ___?
   e. How did you come to be involved in this field?

2. A key part of this study is to understand the role of Forensic Peer Support. Can you tell me about the **role that FPSs play in your organization**?
   a. How did it come to be part of the organization?
   b. **How many** Forensic Peer Specialists are employed in your organization?
   c. Demographics? Are there men and women, people who speak languages other than English, different ages?
   d. Do all FPSs in your organization have **training** in this work? Have they completed Forensic Peer Specialist training? Have they worked as CPSs before?
   e. Do all FPSs in your organization have a history of **involvement in the criminal justice system**? Are there any challenges with hiring these individuals, or other legal challenges in their ability to work as forensic peer specialists?
   f. What are some of the ways that your **organization supports** Forensic Peer Specialists in their work?

3. Can you describe the **nature and content of forensic peer specialist TRAINING**?
   a. What is covered? **Topics**?
   b. How long, where, when?
   c. What about recovery from **substance use**? Does FPS training cover these issues?
   d. **When did your organization start training** FPSs? **Why** did training begin?
   e. **How many individuals** have been trained?
   f. What are the **requirements to participate** in FPS training? Do individuals have to have **personal experience** with the CJ system? Are there any individuals who are not able to take the training?
   g. How do they find out about the training?
   h. How do individuals **pay** for the training?

4. My online survey showed that **fewer than half of individuals who have been trained in FPS have worked as an FPS in a paid, formal position. Why do you think this might be?**
a. Do you know if the **individuals you’ve trained** have been placed in professional positions?
b. How might people use FPS training in **other occupations**? (CPS?)
c. How might people use FPS in **other aspects of their life**? In their **recovery**?

5. What are some of the **benefits and weakness of Forensic Peer Support**?
   a. For **mental health recovery**?
   b. For **reentry** into the community?
   c. What do you think some of the benefits are of FPS for **clients**?
   d. What do you think some of the benefits are of FPS for **organizations**?
   e. What do you think some of the benefits are of FPS for themselves, **personally**?
   f. Benefits for the **community**?
   g. Do you have any **concerns** regarding the role that FPS play?
   h. Are there **ways to strengthen** the Forensic Peer Support workforce?

6. How did you originally come to learn about **Forensic Peer Specialists** and Forensic Peer Support?
   a. What can you tell me about **how the field has developed** and changed in your organization?
   b. In the community? Pennsylvania? In the United States?

7. I’m interested in how you think the **broader FPS workforce will develop**. What do you expect to happen to the FPS workforce in the coming years?
   a. What do you think some of the **challenges** are for the FPS workforce?
   b. For FPS themselves?
   c. What are some of the things happening that will allow the workforce to develop further?

8. Sometimes people with mental illness or criminal justice system involvements are stigmatized. Is **stigma** something that FPSs are talking to you about?
   a. How does **FPS training address issues of stigma**?
   b. How do **stigmas differ**? Between incarcerations, mental health, substance use?
   c. Do FPSs deal with stigma on a **personal level**? On behalf of their **clients**?
   d. What is the role/impact of MH stigma within ? CJ stigma? Substance abuse stigma? Any differences?
   e. Does stigma play a role in your understanding of the importance and utility of **Forensic Peer Support**? Or about the mental healthcare and criminal justice systems in general?
   f. Or within mental healthcare and criminal justice systems in general?
   g. How does **your organization** talk about and respond to issues of stigma?

9. People with mental illnesses or those who have been incarcerated are frequently **excluded from a lot of parts of society**.
   a. How does FPS **training address issues of exclusion**?
b. What do you think the role of FPS workers is in dealing with this exclusion/increasing inclusion?

c. For themselves personally and for their clients?

d. How does your organization understand and increase community inclusion for your clients and staff?

10. Is there anything else about your personal experiences or forensic peer support that you would like me to know? Anything it’s important that I know that we haven’t covered? Thank you so much for your time.
Appendix G: Consent Form (Stakeholder Interview)

Northeastern University, Department of Sociology and Anthropology
Name of Investigator(s): Alisa Lincoln, Wallis Adams
Title of Project: Recovery and Reentry: Multiple Stigmas and Inclusion Among Forensic Peer Specialists

Informed Consent to Participate in a Research Study

We are inviting you to take part in a research study. This form will tell you about the study, but the researcher will explain it to you first. You may ask this person any questions that you have. When you are ready to make a decision, you may tell the researcher if you want to participate or not. You do not have to participate if you do not want to. If you decide to participate, the researcher will ask you to sign this statement and will give you a copy to keep.

Why am I being asked to take part in this research study?
We are asking you to be in this study because you have knowledge of the Forensic Peer Specialist workforce in Pennsylvania.

Why is this research study being done?
The purpose of this study is to learn about the role of Forensic Peer Specialists in the mental health care system and the criminal justice system in Pennsylvania.

What will I be asked to do?
If you decide to take part in this study, we will ask you to complete a 1 hour audio- recorded interview with Wallis Adams.

Where will this take place and how much of my time will it take?
You will be interviewed in a time and place that is convenient for you. The interview will take about 1 hours.

Will there be any risk or discomfort to me?
There are no foreseeable risks to this study. However, it is possible that some of the question that we will ask you may make you feel uncomfortable. You may refuse to answer any questions and you may take a break at any time during the study. You may stop participation in the study at any time.

Will I benefit by being in this research?
There will be no direct benefit to you for taking part in the study. However, the information learned from this study may help inform practices and policies regarding Forensic Peer Support that might improve the lives of people with mental illness and experiences of past incarceration.

Who will see the information about me?
Your part in this study will be confidential. Only the researchers on this study will see the information about you. No reports or publications will use information that can identify you in any way or any individual as being of this project. Data will be kept in a locked file cabinet.
Can I stop my participation in this study?
Your participation in this research is completely voluntary. You do not have to participate if you do not want to and you can refuse to answer any question. Even if you begin the study, you may quit at any time.

Who can I contact if I have questions or problems?
If you have any questions about the study, please feel free to contact Wallis Adams (ForensicPeerSpecialistStudy@gmail.com), the person mainly responsible for the research. You can also contact Alisa Lincoln (Al.lincoln@neu.edu), the Principal Investigator

Who can I contact about my rights as a participant?
If you have any questions about your rights in this research, you may contact Nan C. Regina, Director, Human Subject Research Protection, 490 Renaissance Park, Northeastern University, Boston, MA 02115. Tel: 617.373.4588, Email: n.regina@neu.edu. You may call anonymously if you wish.

Will I be paid for my participation?
You will be given $40 upon completing the interview.

Will it cost me anything to participate?
You are responsible for costs related to transportation to the interview locations.

I agree to take part in this research.

________________________________________  _________________
Signature of person agreeing to take part  Date

____________________________________________
Printed name of person above

_____________________________________________________
Signature of person who explained the study to the participant above and obtained consent  Date

____________________________________________
Printed name of person above
Appendix H: Peer Interview Guide

Section A: FPS Employment

1. I’d like to begin by asking you some questions about your current job. Can you tell me about your experience of providing peer support?
   a. Can you tell me about your experience of providing peer support for individuals involved with the criminal justice system?

2. How did you come to be involved in this field?
   a. What led you to want to do this type of work?
   b. How did you originally come to learn about this type of work?

3. I’d like to find out a bit about your organization and the role you play there. [If worked as FPS in past, phrase questions in past tense] Can you tell me about the organization that you work for?
   a. How large is your organization? How many “peers” do you serve?
   b. What is your position at the organization?
   c. What responsibilities do you have?
   d. How long have you worked at ___?
   e. How long have you lived in this area? How does that impact your ability to do your work?

4. [For those few who were currently employed providing forensic peer support but no longer are]: What were some of the reasons that you are no longer employed to provide peer support to individuals with criminal justice system experience?
   a. What did you enjoy and dislike about the job?
   b. Do you provide peer support in your everyday life, even if you aren’t doing it professionally?

5. What do you enjoy about the work?
   a. What do you not like?
   b. What do you think the most important aspects of your job are?
   c. What are the hardest aspects of your job?

6. How do you feel about your pay and benefits? Pay and benefits for peer support workers in general?

7. Do you feel included among your work colleagues in things like conversations or social outings with your colleagues?
   a. Can you tell me about a time when you were or were not included?

8. Are you satisfied with the extent to which your current job could lead to higher level jobs with more status or responsibility?

9. What are some of the challenges that you have faced as an FPS?

10. Can you tell me about your experience with Forensic Peer Support training?
11. What do you expect to happen to the FPS workforce in the coming years?
   a. Do you think it will become more respected and rewarded as a profession?
   b. What factors or institutions will help or hinder these changes?
   c. What do you expect will happen regarding training and certification?
   d. Can you tell me any concerns you have about the field and how it is changing?

12. Can you tell me about the recovery movement?
   a. Or any other movements that have been important in the development of peer support?

Section B: Client Insight

13. What are some of the most common challenges that your “peers” face in regards to mental health recovery?
   a. What are some of the things that help your “peers” overcome those challenges
   b. Can you give me an example?
   c. Do they consider themselves in recovery?

14. What are some of the most common challenges that your “peers” face in regards to their interaction with the criminal justice system?
   a. What are some of the things that are helping your “peers” overcome those challenges?
   b. Can you give me an example?

15. What are some of the challenges that your “peers” face besides recovery and reentry?
   a. With family or friends?
   b. Housing?
   c. Substance use?

16. Do your “peers” think that others think less of them because they have a mental illness?
   a. Or because they were involved in the criminal justice system?
   b. Or for any other reason?
   c. Have your “peers” been treated unfairly?
   d. Do they think that people are afraid of them because they have a mental illness?
   e. Or because they were involved in the criminal justice system?
   f. Or for any other reason?
   g. Can you tell me about any time that your “peers” were teased, bullied or harassed because of having a mental illness or criminal justice system involvement?
   h. Do you think these experiences make it harder for your “peers” to recover, or to have a fulfilling life?
   i. Do your “peers” tell you that they avoid situations or people that may be stigmatizing?
j. How willing are your “peers” to let people know that their behaviors are stigmatizing?

17. Do your “peers” talk about feeling excluded from the community or from different social groups?
   a. What are some of the reasons that they feel excluded?
   b. Can you give me an example?
   c. What do people do in those situations?

Section C: Personal Experiences

18. I’d like to learn about your own history a little bit. Can you tell me about your childhood?
   a. Where did you grow up?
   b. Who did you grow up with?
   c. What was school like for you?
   d. What were your relationships with families and friends like when you were a child?

19. I’m interested in your experiences with the criminal justice system. Can you tell me about your first interaction with the criminal justice system?
   a. What were your subsequent interactions like?

20. What was your experience returning from prison/jail to the community?
   a. What was hard? What was helpful?
   b. What was hard? What was helpful?
   c. If you were under community supervision, what was that experience like?

21. Can you talk to me about some of your experiences with mental health and mental healthcare?
   a. When did you first experience any signs that you might have challenges with mental health?
   b. When and why did you first start using mental health services?
   c. What kinds of services have been helpful?
   d. What kinds of services have not worked for you?
   e. Are there services that you are not receiving that you would like to?
   f. What was your experience with peers before you became a peer specialist?

22. Are there ways that you feel similar to your “peers”?
   a. Are there ways that you see yourself as different than your “peers”?

23. Do you consider yourself in recovery?
   a. Can you tell me your recovery story?

24. Earlier you described ways that you feel that your “peers” are treated with less respect than other people. Have you had experience with that as well?
   a. What has that been like for you?
   b. Do other people think less of you because you have a mental illness?
   c. Or because you were involved in the criminal justice system?
   d. Or for any other reason? [Example for above]
e. Have you been treated unfairly?
f. Do they think that people are afraid of you because they have a mental illness?
g. Or because you were involved in the criminal justice system?
h. Or for any other reason? [Example?]
i. Can you tell me about any time that you were teased, bullied or harassed because of having a mental illness or were involved in the criminal justice system?
j. Do you think these experiences made it harder for you to recover, or to have a fulfilling life?
k. Do you avoid situations or people that may be stigmatizing? Did you do so in the past? What makes you more or less likely to avoid these situations now?
l. How willing are you to let people know that their behaviors are stigmatizing? Can you give me an example?
m. Have you ever told someone you disagreed with them, or corrected someone, when they said something uncomplimentary about people with mental illness? Or about people who were involved in the criminal justice system?

25. Sometimes people with mental illnesses or those who have been incarcerated are excluded from a lot of parts of society.
   a. What are the challenges that you face as someone in recovery in mental health?
   b. As someone who has interacted with the criminal justice system?
   c. What do you think the role of FPS are in dealing with this exclusion?

Section D: Ending the Interview

26. Is there anything else about your personal experiences or forensic peer support that you would like me to know? Thank you so much for your time.
Appendix I: Consent Form (Peer Interview)

Northeastern University, Department of Sociology and Anthropology
Name of Investigator(s): Alisa Lincoln, Wallis Adams
Title of Project: Recovery and Reentry: Multiple Stigmas and Inclusion Among Forensic Peer Specialists

Informed Consent to Participate in a Research Study

We are inviting you to take part in a research study. This form will tell you about the study, but the researcher will explain it to you first. You may ask this person any questions that you have. When you are ready to make a decision, you may tell the researcher if you want to participate or not. You do not have to participate if you do not want to. If you decide to participate, the researcher will ask you to sign this statement and will give you a copy to keep.

Why am I being asked to take part in this research study?
We are asking you to be in this study because you have training as a Forensic Peer Specialist, reside in Pennsylvania, and have been exposed to the criminal justice and the mental health systems.

Why is this research study being done?
The purpose of this study is to learn about life experiences of Forensic Peer Specialists, including their experiences of the mental health care system, the criminal justice system, training and work as a FPS, and other life events.

What will I be asked to do?
If you decide to take part in this study, we will ask you to complete a 1-3 hour audio-recorded interview with Wallis Adams.

Where will this take place and how much of my time will it take?
You will be interviewed in a time and place that is convenient for you. The interview will take about 1-3 hours.

Will there be any risk or discomfort to me?
There are no foreseeable risks to this study. However, it is possible that some of the question that we will ask you may make you feel uncomfortable. You may refuse to answer any questions and you may take a break at any time during the study. You may stop participation in the study at any time.

Will I benefit by being in this research?
There will be no direct benefit to you for taking part in the study. However, the information learned from this study may help inform practices and policies regarding Forensic Peer Support that might improve the lives of people with mental illness and experiences of past incarceration.

Who will see the information about me?
Your part in this study will be confidential. Only the researchers on this study will see the information about you. No reports or publications will use information that can identify
you in any way or any individual as being of this project. Data will be kept in a locked file cabinet.

Can I stop my participation in this study?
Your participation in this research is completely voluntary. You do not have to participate if you do not want to and you can refuse to answer any question. Even if you begin the study, you may quit at any time.

Who can I contact if I have questions or problems?
If you have any questions about the study, please feel free to contact Wallis Adams (ForensicPeerSpecialistStudy@gmail.com), the person mainly responsible for the research. You can also contact Alisa Lincoln (Al.lincoln@neu.edu), the Principal Investigator

Who can I contact about my rights as a participant?
If you have any questions about your rights in this research, you may contact Nan C. Regina, Director, Human Subject Research Protection, 490 Renaissance Park, Northeastern University, Boston, MA 02115. Tel: 617.373.4588, Email: n.regina@neu.edu. You may call anonymously if you wish.

Will I be paid for my participation?
You will be given $40 upon completing the interview.

Will it cost me anything to participate?
You are responsible for costs related to transportation to the interview locations.

I agree to take part in this research.

_____________________________________________  __________________________
Signature of person agreeing to take part                  Date

_____________________________________________  __________________________
Printed name of person above

_____________________________________________  __________________________
Signature of person who explained the study to the participant above and obtained consent                  Date

_____________________________________________  __________________________
Printed name of person above