

Peer Support Among Individuals With Severe Mental Illness: A Review of the Evidence

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This article reviews the history and potential effectiveness of peer support among persons with severe mental illness. Following a historical overview, we describe the three primary forms of peer support that have been developed to date by and for this population, and examine the existing empirical evidence of the feasibility, effectiveness, and utilization of each of these approaches in contributing to the recovery of individuals with psychiatric disabilities. These three forms are (1) naturally occurring mutual support groups, (2) consumer-run services, and (3) the employment of consumers as providers within clinical and rehabilitative settings. Existing studies of mutual support groups suggest that they may improve symptoms, promote larger social networks, and enhance quality of life. This research is largely from uncontrolled studies, however, and will need to be evaluated further using prospective, controlled designs. Consumer-run services and the use of consumers as providers promise to broaden the access of individuals with psychiatric disabilities to peer support, but research on these more recent developments is only preliminary and largely limited to demonstrations of their feasibility. We discuss issues entailed in participating in peer support for this population, and then close with a discussion of the implications for future policy, research, and practice.

Key words: peer support, mutual support, consumer-run services, consumers as providers, effectiveness. [*Clin Psychol Sci Prac* 6:165–187, 1999]

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To me, mental illness meant Dr. Jekyll and Mr. Hyde, psychopathic serial killers, loony bins, morons, schizos, fruitcakes, nuts, straight jackets, and raving lunatics. They were all I knew about mental illness, and what terrified me was that professionals were saying I was one of them. It would have greatly helped to have had someone come and talk to me about surviving mental illness—as well as the possibility of recovering, of healing, and of building a new life for myself. It would have been good to have role models—people I could look up to who had experienced what I was going through—people who had found a good job, or who were in love, or who had an apartment or a house on their own, or who were making a valuable contribution to society.

Deegan (1993)

This eloquent plea for peer role models was made by a woman who has spent the last 24 years of her life living with schizophrenia and who, most recently, has herself become such a role model for others with this disorder. During that time, she completed her doctoral training in clinical psychology and directed a community mental health center prior to becoming a national leader of the Mental Health Consumer Movement (MHCM) in the United States. Her argument—that people coping with severe mental illness could benefit from having peer role models who have been successful in managing their own disabilities—is both persuasive and challenging.

On the one hand, it certainly seems reasonable to suggest that people with schizophrenia and related disorders might benefit from being exposed to others who have recovered to some degree from the same disorder. Such experiences could act to counter stigma and prevailing cultural stereotypes about mental illness, and might offer the person hope and motivation to work for a better future. Beliefs such as these are integral to MHCM's conceptualization of "recovery," which—in contrast to the

definition of an asymptomatic endstate offered in the American Psychiatric Association's *DSM-IV* (American Psychiatric Association, 1994) and practice guidelines for the treatment of schizophrenia (American Psychiatric Association, 1997)—refers to an ongoing process of learning to live with one's disability and gradually rebuilding a sense of purpose, agency, and meaning in life despite the limitations of the disorder (Davidson & Strauss, 1992; Deegan, 1992, 1993; Weingarten, 1994, 1997). From the perspective of MHCM, having visible examples of individuals with psychiatric disabilities who have resumed valued roles and reintegrated successfully into their communities could provide a useful impetus and concrete guidance for a shift in the focus of current treatment efforts beyond symptom reduction and stabilization precisely to such a notion of recovery (Carling, 1995; Frese & Davis, 1997; Reidy, 1994).

This core argument of the MHCM for the availability of peer role models seems all the more persuasive when one considers the important role of this resource in recovery from substance use disorders and other life circumstances. The substance abuse treatment community has long operated on the belief that there is value in mutual support groups and in hiring as counselors people who are in their own recovery from addictions due to their firsthand knowledge of the terrain and their credibility as role models. In addition, access to peers who have survived and/or recovered from similar circumstances is available through mutual support groups for individuals with a variety of other conditions. In Connecticut alone—a state with a census of approximately 3 million—in 1996 there were nearly 900 publicized mutual support groups in 108 different categories, covering every serious medical condition and life circumstance from anemia to bereavement to coping with handicapped children, divorce, and retirement (Connecticut Self-Help Network, 1996). The role of such groups in offering hope, facilitating coping, and enhancing quality of life for people facing adversities has become widely accepted in numerous arenas both inside and outside of the general medical community (Borkman, 1990; Jacobs & Goldman, 1989; Katz, 1981; Katz & Levine, 1980; Kurtz, 1990; Levine, Katz, & Hoist, 1976; Salem, Seidman, & Rappaport, 1988).

On the other hand, however, despite this well-established practice in the field of addictions treatment and the growing scholarly literature documenting the

ubiquity and effectiveness of mutual support for a range of conditions and life circumstances (e.g., Borkman, 1991; Gartner & Riessman, 1984; Humphreys & Rappaport, 1994; Kyroutz & Humphreys, 1996), similar practices have attracted little attention to date in the treatment and rehabilitation of persons with mental illness. In the quote above, Deegan (1993) noted the lack of available role models in her own treatment and rehabilitation. In her oft-cited 1982 editorial calling for the promotion, and study, of mutual support among persons with serious mental illness, Estroff (1982) noted the lack of recognition of the legitimacy and utility of this resource within mental health. In the over 15 years since Estroff issued her challenge to the field, research has shown consistently that very few professionals refer their clients to mutual support groups, and that few individuals with serious mental illness make use of these options on their own (Chesler, 1990; Salzer, McFadden & Rappaport, 1994). Despite the persuasiveness of the argument for peer role models and mutual support for persons with serious mental illness, and their demonstrated benefit for individuals in other circumstances, most people with psychiatric disabilities continue either not to have access to, or to choose not to take advantage of, these potential resources.

This article reviews the history and evidence for the effectiveness of peer support among individuals with serious mental illness. Following a brief history, we describe the three forms of peer support that have been developed by and for this population to date, and examine existing empirical evidence of the feasibility, effectiveness, and utilization of each in contributing to the recovery of individuals with psychiatric disabilities. Due to its having been traditionally the primary vehicle for the provision of peer support—and to its having been, as a result, the object of considerable discussion—we begin with a conceptual definition and examination of (1) naturally occurring mutual support. Next, we examine two additional routes that have been developed more recently to expand the access of individuals with severe mental illness to peer support beyond mutual support groups: (2) consumer-run services and (3) mental health consumers as providers within clinical and rehabilitative settings. In the remainder of the article, we consider some of the issues entailed in participating in peer support for individuals with psychiatric disabilities, and conclude with a discussion of the im-

plications for future mental health policy, research, and practice.

HISTORICAL BACKGROUND

The first person to place an explicit value on the role of peer support in the treatment of mental disorders was Harry Stack Sullivan. While running an inpatient service for young men with schizophrenia at Sheppard and Enoch Pratt Hospital outside of Baltimore in the 1920s, Sullivan actively recruited young men who had recovered from their own psychiatric disorders to be aides on his unit. He felt that their own life experiences of psychosis and recovery would lend a particular sensitivity to their work, making them uniquely qualified to assist their peers in working through similar struggles in a humane and compassionate manner. Having had his own experience of psychosis, this also may have been true of Sullivan himself (Perry, 1982).

One can argue that the role Sullivan envisioned for his psychiatric aides was played in other clinical settings as well by people who had achieved some level of success in coping with their own psychiatric disabilities. In particular, the therapeutic communities developed in inpatient settings by Jones (1953), Edelson (1964, 1970a, 1970b), and others encouraged the use of peer support and mentoring, as well as confrontation, conflict, and collaborative problem-solving, as essential elements of the treatment milieu. Under the rubric of developing adaptive ego functions, it was considered mutually beneficial when one patient would offer his or her strengths to another in the roles of leader, role model, or friend. Sullivan's innovation was to extend the reach of the therapeutic milieu by offering a salary to bring back onto the unit successful patients who no longer needed the milieu for their own treatment.

It has been within the last 20 years that we have begun to revisit this strategy. Two unintended consequences of deinstitutionalization help to account for this. One has been the Mental Health Consumer Movement, mentioned above, which began as ex-patients banding together to protest the treatment they received while hospitalized (Chamberlain, 1978, 1984, 1990; Deegan, 1992; Frese & Davis, 1997; Zinman, 1986; Zinman, Harp, & Budd, 1987). Two of the core elements of this movement early in its evolution were mutual support groups and independent consumer-run services, both of

which were designed initially to serve as alternatives to the formal mental health system. Having established its political identity as independent from the mental health system, this movement is now coming of age and seeking more of a collaborative relationship with providers (Emerick, 1989; Kaufmann, Freund, & Wilson, 1989). One important focus of this collaboration has been the training and hiring of consumers as staff in clinical and rehabilitative settings (Davidson, Weingarten, Steiner, Stayner, & Hoge, 1997; Mowbray, Moxley, Jasper, & Howell, 1997; Moxley & Mowbray, 1997; Stephens & Belisle, 1993). With the 1990 passage of the Americans with Disabilities Act, it became illegal in the United States to discriminate in the workplace on the basis of a history of psychiatric disability. This landmark legislation fueled the fires of consumer advocates, who now have legal backing to become a part of the system they wish to reform (Deegan, 1993; Moxley & Mowbray, 1997).

The other unintended consequence of deinstitutionalization has been a recognition that hospitals met a range of human as well as clinical needs, and that to be effective, community-based services need to move beyond reduction of psychopathology to focus on the restoration of community life (Carling, 1995). Along with this recognition has been an increasing awareness that clients being discharged into the community need more of a bridge into supportive social networks than that provided by formal mental health treatment alone (Gartner & Riessman, 1984; Godley, Sabin, McClure, Smerken, & Manion, 1988; Skirboll & Pavelsky, 1984). With the advent of the Community Support Movement (Parrish, 1989) in the 1970s, there has been a growing realization of the need to recreate a therapeutic milieu "without walls" in the community (Stein & Test, 1978). As Sullivan had explored *within* the hospital walls, mental health consumers, ex- or current patients who have achieved a level of mastery over their own disabilities, have been suggested as being able to play a useful role in establishing such a milieu in the community (Edmunson, Bedell, & Gordon, 1984; Moxley & Mowbray, 1997).

Although the mutual support group traditionally has been the primary vehicle for the creation of such a peer support milieu, we would suggest that some of the principles of mutual support may find additional expression both through consumer-run services and through the employment of consumer providers within mental health

settings. As there has been more research on conventional mutual support groups, we summarize this literature by highlighting its major findings. Research on consumer-run services and consumer providers, which are more recent developments, is summarized by reviewing the studies conducted in each area to date.

A CONCEPTUAL DEFINITION OF MUTUAL SUPPORT

In its most basic form, we define mutual support as a process by which persons voluntarily come together to help each other address common problems or shared concerns. Participation in such a process reflects an intentional effort to find a social niche in which there are resources and structures available to enhance an individual's ability to address such concerns. The resources and structures made available through mutual support derive from several of its characteristics.

First, sharing similar life experiences with others can increase a person's understanding of his or her situation and reduce social isolation. Involvement in mutual support may increase participants' social networks and may offer participants acceptance, support, understanding, empathy, and a sense of community, leading to an increase in hope and autonomy and an assumption of personal responsibility (Carpinello, Knight, & Janis, 1991; Levy, in press; Salem, Seidman & Rappaport, 1988).

Second, a structured process of social interaction may allow people to adopt socially valued roles, in which they no longer are restricted to a passive role of "patient" relying on expert advice but now also may serve as role models for newer members, provide feedback and assistance to others, and receive feedback for their own efforts to address their problems (Levy, in press; Maton, 1987; Roberts et al., 1991). Riessman (1965, 1990) identified this shift in role as the "helper therapy principle" and since has been joined by many researchers in documenting the impact this switch in perspective and activities can have in people's lives (Maton, 1987; Roberts & Thorsheim, 1991; Roberts et al., 1991).

Third, mutual support can be distinguished from naturally occurring social support in that it is an intentional process which includes standard procedures, routines, and prescriptions for addressing problems and issues of everyday life (Levine & Perkins, 1987; Levy, in press). That is, mutual support creates a specific behavioral setting (cf. Barker, 1968; Levine & Perkins, 1987; Rappaport, 1977) that may offer new information, perspectives, training,

and skills, and in which a supportive social climate may be fostered (cf. Moos, 1973). Mutual support in these settings often includes tasks of learning new information for how to address one's problem, such as coping strategies or alternative perspectives, and being exposed to successful role models, allowing for vicarious learning, modeling, and an enhancement of problem-solving skills (Gartner & Reissman, 1984; Kaufmann et al., 1989; Kurtz, 1990; Kurtz & Powell, 1987; Levy, 1976; Rootes & Aanes, 1992; Stewart, 1990).

Fourth, mutual support may offer worldviews and ideologies to assist persons in making sense of their experiences (Antze, 1976; Cain, 1991; Denzin, 1987; Humphreys, 1992; Kennedy & Humphreys, 1994). The exact forms in which mutual support is instantiated are greatly influenced by the particular ideology of those promoting it. The specific roles participants adopt, the skills they learn, and the nature of their social networks will be a function of the setting's ideology. Several writers have focused on the role of ideology in mutual support as a *cognitive antidote* to participants' problems (Antze, 1976; Kennedy & Humphreys, 1994; Levine & Perkins, 1987), assisting people in making cognitive changes in how they cope with difficulties, offering new worldviews and new ways to view themselves. With our definition, we finally see the development of mutual support, particularly in settings for persons with psychiatric disabilities, as possibly providing an *environmental antidote* as well (Kloos, 1998) to the realities of isolation and despair that many such persons encounter (Davidson, Hoge, Godleski, Rakfeldt, & Griffith, 1996). Through this combination of means, we contend that mutual support is an approach to structuring human relationships, ideology, and activity in ways that offer emotional and instrumental support for persons who are struggling with particular life difficulties.

MUTUAL SUPPORT AMONG INDIVIDUALS WITH PSYCHIATRIC DISABILITIES

Despite the broad network of 12-step and abstinence-based groups for people with a variety of addictions noted above (e.g., Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, Gamblers Anonymous), as well as groups for the spouses and children of people with addictions (Alanon, Alateen, Adult Children of Alcoholics), there are to date only a few groups that have been developed especially for people with serious mental illness. Organizations like GROW (Maton & Salem, 1995;

Omark, 1979; Rappaport et al., 1985; Shannon & Morrison, 1990; Snowden, 1980; Young & Williams, 1987, 1988), Recovery, Inc. (Kurtz & Chambon, 1987; Lee, 1971; Medvene, 1985; Raiff, 1982; Wechsler, 1960), Emotions Anonymous (Kurtz & Chambon, 1987), and Schizophrenics Anonymous (Joseph R. & Donald F., 1973; Ryback, 1971; Snowden, 1980) have attempted to provide a supportive social network and concrete cognitive and behavioral guidelines for people being discharged from psychiatric hospitals. In the case of GROW, the support groups were formed and organized by former mental hospital patients, and in the case of Recovery, Inc., by psychiatrist Abraham Low. Both hoped to offer persons with histories of significant psychiatric difficulties guidance in negotiating their everyday lives, effective role models, and a belief that they can recover. Several authors have questioned whether these groups continue to be utilized by persons with psychotic disorders or if they have become more of a support for people with less severe disabilities (Emerick, 1989; Kurtz & Chambon, 1987; Shannon & Morrison, 1990; Young & Williams, 1988). As of the mid-1980s, however, 74% of GROW member study participants had been hospitalized before going to their first group (Kennedy, 1989). Currently, GROW continues to receive referrals and funding from state departments of mental health contingent upon their inclusion of people with serious mental illness, including diagnoses of schizophrenia (GROW in America, 1994; D. Maxwell and P. Voltarel, personal communication, February 29, 1996).

Although new groups continue to form as part of the Mental Health Consumer Movement (MHCM), most of the published, systematic research has focused on Recovery, Inc. and GROW (Borkman, 1991; Emerick, 1989, 1991; GROW, 1979; Kyrouz & Humphreys, 1996). We review *empirical findings of who utilizes these mutual support groups and what benefits can be gained from them by persons with serious mental illness*. The review focuses on studies that compare mutual support group participants to nonparticipants, include longitudinal data, or both. We have excluded from this review those studies that characterize themselves as "mutual support" but are actually psychotherapy or support groups led by professionals who do not share the condition addressed by the group. Although the body of work that we review is not large, it is helpful in documenting the limited use but potential value of mutual support for persons with histo-

ries of psychiatric disorders and in identifying directions for future research in this area.

Who Uses Mutual Support?

Several studies report that approximately 60% of members of mutual support groups for persons with serious mental illness are women, most are currently single, and most (i.e., 55–74%) have been hospitalized for psychiatric difficulties (Kaufmann, Schulberg, & Schooler, 1994; Kennedy, 1989; Luke, Rappaport, & Seidman, 1991). Utilization of mutual support groups appears to be a matter of person–environment fit rather than a matter of universal appeal (Levine & Perkins, 1987; Luke, Roberts, & Rappaport, 1993). For example, Kaufmann et al. (1994) found in a controlled study of 90 participants that only 17% of persons who were invited to attend a mutual support group did so. Luke et al. (1993) conducted a 30-month study of 799 GROW members in 13 groups and found that approximately one third of persons who came to a GROW meeting did not continue after one or two meetings, another third came for 3–4 months, and the last third participated for periods exceeding 4 months. These findings of low rates of utilization underscore the fact that mutual support appears currently to be appealing to only a minority, perhaps up to one third, of individuals with severe mental illness.

Mutual support group members who do continue to participate appear to do so because they valued the mutual support meetings and the broader mutual support experience (Roberts, 1987), reported an *instillation of hope*, and developed greater self-understanding (Kennedy, 1995; Llewelyn & Haslett, 1986). In lieu of published data from controlled outcome research about those persons who do not continue, Markowitz et al. (1996) found that experiences of negativity from group members, as well as the illness itself, were major reasons why members of these groups dropped out. Clearly, more systematic studies are needed to learn why some persons with serious and persistent mental illness participate in mutual support groups while most others do not.

Potential Benefits of Mutual Support

While conventional outcome research has focused primarily on symptom reduction, changing conceptions of what constitutes recovery dictate that other indices of functioning be included to understand the impact that mutual support can have on the lives of persons with psy-

chiatric disorders. For example, a sole focus on symptoms misses the social consequences of mental illness, on which mutual support may have a stronger influence (Humphreys, 1997; Kaufmann, 1996). Furthermore, mutual support groups, as phenomena of interest, are understood as more than simply a treatment modality; they have also been described as normative communities, social support networks, and political action organizations (Humphreys & Rappaport, 1994; Maton & Salem, 1995; Salem et al., 1988). Here we review literature on the influence of mutual support on indicators of "treatment" efficacy, that is, (a) symptom reduction and (b) rates of hospitalization, as well as on (c) the promotion of social integration.

Conclusions about the influence of mutual support on symptom reduction are limited by the nature of existing data (Humphreys & Rappaport, 1994; Levy, in press). Kaufmann et al. (1994) found in their controlled study that members of mutual support groups did not differ in symptom expression from control group members in other treatment. Similarly, Raiff (1984) found that members of Recovery, Inc. did not have a change in symptoms while participating. However, Galanter's (1988) study of Recovery, Inc. found improved psychiatric symptomatology, increased coping skills, and increased life satisfaction for members. Both Galanter and Raiff found that Recovery, Inc. members who had participated in the groups for more than 2 years had the lowest level of symptomatology. Likewise, more committed GROW members changed in more positive directions than less committed members over 10 months of observation (Luke, 1989). Furthermore, a high level of group attendance was positively related to reports of lower rates of isolation and brooding when away from group, as well as increased support seeking (Reischl & Rappaport, 1988). Taken together, these findings appear to indicate that, in general, participants who select to continue in groups do not do worse, and those who are more committed to the group may be found to have significant gains.

This pattern of findings is perhaps more clear in several studies investigating how participation in mutual support groups is associated with rates of hospitalization. Studies of the Manic Depressive and Depression Association (MDDA; Kurtz, 1988) and Recovery, Inc. (Galanter, 1988) report significantly lower rates of hospitalization after their members joined the respective groups compared to before they joined (MDDA: 82% before, 33% after; Recovery, Inc.: 52% before, 7% after). Galanter also

reports that Recovery, Inc. members had increased utilization of outpatient services during this period. While these results are promising, interpretation of them is limited given their reliance on self-reports of hospitalizations, retrospective data, and lack of a comparison group. Additionally, the period of time prior to participation is longer than the period of participation, making comparisons extremely tenuous. However, this trend appears to continue in the only study that used hospital records to investigate similar questions in a prospective fashion (Kennedy, 1989; Rappaport, 1993). Using 12 demographic indices to best match GROW participants with people who had used services of the Illinois Department of Mental Health, researchers found that the two groups had no differences in rates of hospitalization and length of stay for the 32 months prior to GROW members joining a group. All participants had at least five recent hospitalizations during the baseline period. Similarly, the researchers found no differences in the rate of hospitalizations 32 months after members joined GROW; however, the length of stay in hospital was dramatically different. GROW members were hospitalized on average 179 days during the first 32-month period (i.e., pre-GROW) and 49 days for the second 32-month period (i.e., after joining GROW), while Department of Mental Health patients in the control group had 175- and 123-day stays for the same time periods. The data do not reveal why the length of stay is different, but from her observation, Kennedy (1989) suggests that the difference may be due to many GROW members using the mutual support group materials while in the hospital, supportive visits from other GROW members, and a tendency for hospital staff to release GROW members earlier because the staff knew that they were going back to situations in which members would have significant social support.

A second broad area of potential benefit of mutual support for persons with serious mental illness is in the area of social integration. Reidy (1992) defines social integration as "affording people with disabilities the opportunity to participate in all aspects of community life" (p. 3), which can be understood as having three essential elements—voluntary relationships, valued social roles, and life-enriching activities. We use this social integration conceptual framework to organize the remaining research findings about mutual support groups.

Many researchers have found that persons with serious psychiatric disabilities who come to mutual support

groups have markedly reduced social networks when compared to persons who do not have mental illness (Kennedy, 1989; Ribisl & Luke, 1993). Many members tend to be unemployed (Kaufmann et al., 1994; Kennedy, 1989; Segal, Silverman, & Temkin, 1995) and have never been married (Kennedy, 1989; Kaufmann et al., 1994). Several different researchers have found in cross-sectional studies that longer participation in mutual support groups (e.g., 9 months) is positively correlated with having larger social networks when compared to persons who have shorter periods of participation (e.g., 3 months; Carpinello et al., 1991; Rappaport et al., 1985; van Uchelen, 1989). While cross-sectional data do not indicate direction of influence (whether people with larger networks participate longer or people who participate longer develop larger networks), it is interesting to note that in the study by Rappaport et al. (1985), longer term participants had larger social networks but did not differ in their history of psychiatric hospitalization, age, education, or marital status. Prospective studies of network supports are needed to understand better the benefits and mechanisms of increased relationships associated with mutual support experiences.

As argued by Reidy (1992), valued roles are essential for persons to view themselves as instrumental and valuable, and for positive self-esteem. A primary emphasis of mutual support is that one should not be restricted to the role of a "helped" but also become a "helper" (Riessman, 1965). Through behavioral observation of 799 individuals in 13 GROW groups over 2.5 years, Roberts (1989) found that the frequency of helping others within group was positively related to increased social adjustment, although such helping was not associated with reductions in psychiatric symptomatology. Zimmerman et al. (1991) found that GROW intentionally creates roles for newer members as a means of expanding their groups. Similarly, over the course of 6 months of observation, Kloos (1998) found that a residential treatment facility operated by GROW had many more formal social roles (e.g., work team leader, activity organizer, representative to state boards, etc.) and more instrumental activities for members than a similar facility operated by a mental health center that emphasized staff roles (see also Carpinello et al., 1991).

Mutual support also appears to have promise in enhancing the quality of life for persons with persistent psychiatric disabilities. Several studies suggested that con-

tinued group membership is associated with increased perceptions of self-esteem, better decision-making skills, and improved social functioning (Carpinello et al., 1991; Galanter, 1988; Kaufmann et al., 1994; Markowitz et al., 1996). In fact, Markowitz et al. (1996) found modest positive effects for self-concept and interpersonal satisfaction, while "traditional services" had a small negative effect on study participants. Carpinello et al. (1991) found continued participation also was positively correlated with more members pursuing educational goals and finding employment. Chamberlin (1978, 1996) and Deegan (1992) note that mutual support also can lead to collective action in the form of political advocacy, which might be considered an example of empowerment (Cornell University Empowerment Group, 1989).

The basis for these indications may be the many reports of positive experiences and personal growth from participating in mutual support. For example, data from the series of studies about GROW by Rappaport and colleagues suggest that GROW's practice of mutual support encourages helpful assistance among members and discourages negative interactions (Toro, Rappaport, & Seidman, 1987). Additionally, Roberts et al. (1991) conducted a rigorous, psychometrically sound behavioral analysis of the types of statements made in GROW groups and found that they were supportive seven times as often as they were negative. Furthermore, they found that highly personal and emotional self-disclosure was relatively infrequent (7% of comments) when compared to helping comments (25%). These results, while promising, are largely based on retrospective, self-report data, however, and do not provide a rigorous test of these hypotheses. Systematic and more rigorous research is needed to substantiate such claims and to identify the mechanisms of action taking place in mutual support groups in the areas of life satisfaction, security, education, work, social relationships, and spirituality (Galanter, 1988; Humphreys, 1997; Kennedy, 1995).

Mutual Support Summary

These data suggest promising trends and are useful in beginning to suggest a theory about how mutual support might assist persons with severe mental illness. Conclusions about the effectiveness of mutual support will remain tentative, however, until there are more systematic, prospective studies completed with comparison groups. Our review includes only one controlled out-

come study involving this population. Clearly, more rigorous research is needed to test these suggestions about the possible value of mutual support in promoting recovery. As we understand the existing evidence, we suggest that research focus on the potential for peer involvement both in efforts to address mental health concerns and in supporting mental health treatment. Given the evidence, mutual support should not be viewed as a panacea for addressing the range of needs of individuals with psychiatric disabilities, but as one potential resource that might contribute to social integration. In addition, the low rates of utilization and high attrition make it clear that mutual support groups alone, and in their current form, do not constitute a sufficient strategy to ensure opportunities for peer support and access to effective role models for persons with serious mental illness. Using the framework of "person-environment fit" (Kelly, 1966, 1971; Riger, 1984), other types of peer support may need to be offered to engage larger number of individuals in such activities, particularly in nongroup settings. Consumer-run services and the use of consumers as providers are two more recent developments that may offer broader access for individuals with psychiatric disabilities to the potential benefits of peer support.

CONSUMER-RUN SERVICES

As noted above, a second important development within the MHCM has been the creation of independent consumer-run drop-in centers and residential, outreach, and vocational programs (Chamberlin, 1990). While such programs were originally developed as alternatives to the formal mental health system, they too are entering into a phase of partnership and collaboration (Kaufmann, Ward-Colasante, & Farmer, 1993). As with mutual support groups, use of consumer-run services involves a voluntary and intentional effort on the part of an individual to take advantage of the emotional and instrumental support available from his or her peers. In addition, the behavioral settings created by these services have the potential to incorporate the same kinds of expectations, routines, roles, information, and ideology found in mutual support groups.

Consumer-run services also may differ from mutual support groups, however, in two important ways. First, in contrast to mutual support groups, the peer support provided in consumer-run programs may not be entirely *mutual*. Although peers may be encouraged to support each other, the providers of service are paid employees of

the program and may neither expect nor be allowed to receive support or other assistance from clients of the program. As such programs typically do not operate within conventional definitions of therapeutic or professional boundaries, however, it is an empirical question of the degree to which such peer relationships may in fact be mutual as opposed to the degree to which they may approximate conventional, one-directional, professional-client relationships (Armstrong, Korba, & Emard, 1995). Second, the presence of a more formalized infrastructure in a consumer-run program, and the necessity for more structured activities and interactions that it brings, may provide a particularly supportive setting for the cultivation of a consistency and regularity in peer support interactions that often is missing from more informally occurring mutual support groups.

Descriptive and Effectiveness Studies

In Table 1, we review studies of consumer-run services that were identified by key word searches on Medline and PsycInfo databases. Most studies (Kaufmann et al., 1993; Mowbray, Chamberlain, Jennings & Reed, 1988; Mowbray & Tan, 1993; Segal et al., 1995) have tended to be descriptive, characterizing who uses these services, who pays for them, who refers to them, and who runs them, and show that consumer-run services are feasible and may be valuable. Some studies have also assessed client outcomes of these services (Kaufmann, 1995; Nikkel, Smith, & Edwards, 1992).

The studies reviewed in Table 1 suggest that consumer-run services can be viable organizations and can provide useful services. Several themes emerge from this review. First, despite the distrust that ethnic minorities often have of traditional mental health services, there has been strong minority representation in the population served in the studies that report this information (Kaufmann, 1995; Mowbray & Tan, 1993; Segal et al., 1995). This stands in contrast to mutual support groups, whose membership predominantly has been white. Perhaps since consumers share common experiences of discrimination with ethnic minorities, they are more sensitive to these issues and therefore design services that are more acceptable to these communities. Future research should assess this hypothesis further.

Second, regarding who refers to these services, referrals come mostly from informal sources (e.g., family, friends, word of mouth, self). Conversely, professional referrals ranged from one fifth to one third of the popula-

tions studied. Given that professionals seldom refer clients to mutual support groups (Black & Drackman, 1985; Katz, 1993), it is not surprising that the same would hold true for consumer-run services. Should consumer-run services prove to be effective for a broader range of clients, then professionals will need to be educated about their value (Black & Drackman, 1985; Chesler, 1990; Salzer, McFadden, & Rappaport, 1994).

Third, it is clear that consumer-run services need the support (especially financial) of local mental health systems. Almost all the services were funded by state mental health agencies, and Kaufmann et al. (1993) found that services which developed relationships early on with provider systems remained viable, while services that were not able to do so failed. Finally, although the degree to which consumer-run services embody the principles and contributions of mutual support has yet to be determined, they do provide persons with serious mental illness constructive roles beyond their status as mental patients and provide a viable route of access to peer role models for those not as far along in their own recovery.

Methodological Limitations

Although some of the results from the studies examining consumer-run programs are promising, most of the studies reviewed here have not employed rigorous empirical methods. Among the six studies reviewed, only one used random assignment and assessed consumer outcomes (Kaufmann, 1995). The other studies collected either quality assurance data (e.g., finding that one consumer drop-in center averaged over 150 persons a month for 12 months and had high client satisfaction), descriptive data on drop-in center users, or attitudinal self-report data without a control group. The one study that was more rigorous (i.e., random assignment, sufficient sample) examined the differences between a consumer-run employment center and traditional vocational services and found few differences on several employment variables.

CONSUMERS AS MENTAL HEALTH PROVIDERS

Despite their feasibility and potential usefulness, consumer-run programs remain largely dependent on the self-referrals of like-minded consumers, and continue to be a relatively limited resource for the general population of people with severe mental illness. The more recent development of hiring consumers for staff positions within conventional clinical and rehabilitative settings may provide a more expedient way to provide visible role

models and peer support on a broader basis and for larger numbers of people recovering from serious mental illness (Bledsoe Boykin, 1997; Mowbray et al., 1997). To the degree that this initiative permeates the mental health system, it also may be more successful in bringing about reforms in the ways in which mental health services are designed and delivered (Bevilacqua, Gettys, & Cousins, 1997; Davidson et al., 1997).

As with consumer-run services, the use of consumer providers has the potential to offer many of the benefits of mutual support, involving individuals intentionally in voluntary relationships with their peers to gain exposure to hope, information, and coping and problem-solving skills in a supportive, accepting, and empathic milieu. As these services are provided within the context of conventional clinical and rehabilitative settings, however, the question of the mutuality of these relationships is most likely less ambiguous, and more likely to be guided by conventional definitions of therapeutic boundaries—although this issue has yet to be systematically explored. Perhaps more so than in the case of consumer-run services, consumers who are employed as providers within conventional clinical and rehabilitative settings also may be able to benefit directly from the provision of a structured and supportive milieu. A number of strategies have been devised to accommodate some of the needs such employees bring to the workplace and to maximize the unique contributions they have to offer based on their first-hand knowledge of the territory. We have referred to these strategies as “supported” peer support to indicate that these individuals have been provided with training, supervision, and environmental accommodations to facilitate their provision of peer support to others (Davidson, Stayner, Rakfeldt, & Tebes, 1995). In this section we discuss the feasibility and outcome studies conducted on this more recent approach to service delivery.

Feasibility Studies

Initial credit for foreseeing potential value in employing consumers as providers goes to the Colorado Division of Mental Health, which in the spring of 1991 developed a program to train and employ individuals with psychiatric disabilities to provide case management services to their peers (Sherman & Porter, 1991). Similarly, Stoneking and Greenfield (1991), Mowbray et al. (1996), and Lyons, Karver, and Slagg (1996) addressed the issue of feasibility of this approach. As shown in Table 2, these studies suggest that although consumers may provide services

Table 1. Consumer-run services

Study	Sample	Program Description	Method	Conclusions
Mowbray, Chamberlain, Jennings, & Reed (1988): projects funded by the Michigan Dept. of Mental Health (DMH)	25 clients transitioning from the hospital to the community 10 psychiatric clients	Project Ease Out: Four consumers visited clients while inpatients and provided support after discharge. Companions Program: Consumers were paired with clients to practice social skills.	<i>Feasibility study:</i> surveyed program clients, calculated costs per client <i>Feasibility study:</i> assessed matches and productivity, calculated costs per client	Five clients no longer required services; no client dropouts and one client readmission; high client satisfaction; one consumer was rehospitalized; cost = \$1.67/day/client. Most matches lasted beyond the 6-month target; few terminations of matches; cost = \$2.25/match/week.
	Psychiatric clients at risk of hospitalization	Project Stay: Ex-patients provide a support network and develop life skills, enhancing community tenure.	<i>Feasibility study:</i> assessed productivity, level of contact, and turnover rate; calculated costs per client	Ex-patients maintained high amounts of contact and productivity despite high turnover; cost = \$.21/day/client.
	Over 1800 consumers, most with previous mental health experience, desiring mutual support	Daybreak Drop-In Centers: An unstructured setting that included recreational, cooking, housing assistance, and employment activities.	<i>Feasibility study:</i> surveyed program clients, tracked attendance, calculated costs per month	Averaged over 150 persons a month for 12 months; high client satisfaction; cost = \$470/month.
Nikkel, Smith, & Edwards (1992): the Community Survival Program	30 patients (mix of schizophrenia, bipolar & substance abuse) with long psychiatric histories	Consumer staff emphasize 1. bond between providers and program participants 2. use of coping skills found to be effective. 3. examining meaning of symptoms, 4. living in the community, 5. peer support to address substance abuse, and 6. role modeling.	<i>Outcome assessment:</i> Tracked client hospitalizations	Preliminary data suggest this approach has potential impact on rate of hospitalization rates; authors concluded more objective outcome data are needed.

<p>Mowbray & Tan (1993): self-help group called the Justice in Mental Health Organization (JIMHO) received Michigan DMH funds</p>	<p>120 clients (82% had used inpatient services) from the six centers</p>	<p>The centers were designed to provide a safe, supportive, normalizing, and accepting community environment; promote feelings of self-worth, dignity, and respect; and increase knowledge of the community by learning from each other.</p>	<p><i>Feasibility study:</i> conducted structured interviews using the Group Environment scale, Community Oriented Program Environment scale, and the Client Satisfaction Questionnaire</p>	<p>Most clients believed they had input into center operations, felt supported, learned from one another, were encouraged to be independent, and participated more in positive activities and less in negative activities; 80% reported being more confident in several life domains; 75% perceived the centers more positively than other mental health services in the area.</p>
<p>Kaufmann, Ward-Colasante, & Farmer (1993)</p>	<p>478 consumers (psychiatric patients, excluding substance abusers, homeless) across nine centers during a 6-month period (average of 28/day for all centers)</p>	<p>Centers provide social support (through social gatherings and celebrations) and employment services.</p>	<p><i>Feasibility study:</i> conducted interviews and focus groups with clients, tracked attendance</p>	<p>Clients liked the "relaxed atmosphere," being with similar people, having a place to go; clients wanted more equitable enforcement of rules, support, and expanded hours and activities; components of a successful center: participatory management, strong volunteers, relationships with other provider systems, resources, social activities, and special events; ongoing recruitment; cost = 243/consumer for 6-month period.</p>
<p>Kaufmann (1995)</p>	<p>146 clients with serious mental illness</p>	<p>Self-Help Employment Center: Vocational services based on self-help principles; consumers collaborated with clients, allowing them to take much of the responsibility.</p>	<p><i>Outcome assessment:</i> clients were randomly assigned to the two groups and were assessed at baseline, 6, and 12 months on % working, % in new jobs, hours worked, time to present job, and time in present job</p>	<p>Not many significant differences on employment variables; center clients were significantly more improved on an ordinal scale of vocational status created by the author at 12 months.</p>
<p>Segal, Silverman, & Temkin (1995)</p>	<p>310 clients participated for at least 3 months (twice during the past week)</p>	<p>Four consumer-run self-help agencies.</p>	<p><i>Feasibility study:</i> Goal was to characterize typical users: surveyed a randomly selected group of clients from the total population on service utilization, psychiatric history, functional status, symptoms, diagnosis, and health issues; interviewed the consumer staff and volunteers.</p>	<p>Typical center users were poor, African-American, and homeless and had a serious mental illness; centers first engaged clients informally with material services, then developed a counseling relationship and linked them to additional services later; a division of labor exists between self-help agencies that provide material (basic needs), psychosocial, and some counseling services, vs. community mental health centers that provide mostly medical and psychotherapeutic services.</p>

Table 2. Consumers as providers

Study	Sample	Program Description	Method	Conclusions
Sherman & Porter (1991)	25 persons who met the Colorado Division of Mental Health criteria for chronic mental illness	Recruits received extensive classroom and supervised on-the-job training in basic clinical and case management skills.	<i>Feasibility study:</i> tracked training completion rates, employment rates, hospitalization rates of the case managers, and conducted verbal surveys assessing productivity and satisfaction <i>Feasibility study:</i> SCs, of the SC-CM pairs, were compared to trainees not chosen (OT) on level of functioning (Ohio Level of Functioning scale) and symptomatology (Hopkins Symptom Checklist-40)	18 completed the training and became gainfully employed; the case managers had a total of only two hospitalization days for the entire sample in over 2 years of employment; supervisors and case managers were highly satisfied; in general, case managers performed duties for which they were trained.
Stoneking & Greenfield (1991)	Eight Consumer Support Service Coordinators (SCs) (persons with a history of mental illness and hospitalizations)	22 mental health consumers completed training to be consumer case managers (SCs). Eight were chosen to work in a Case Management Service agency, paired with nonconsumer case managers (CMs), and served about 80 clients; SCs used a self-help framework to help clients develop their social networks, use their strengths to live in the community, use community resources, obtain and maintain housing, use public transportation, and obtain benefits.		Few differences existed between the CMs and the OTs on functioning and symptomatology: the CMs decreased their amount of social activities after 3 and 6 months of employment; CMs had more social activities than OTs before and after training and after 3 and 6 months of employment.
Lyons, Cook, Ruth, Karver, & Slagg (1996)	Four consumer providers (history of hospitalizations and medication use)	A Mobile Assessment Unit (MAU) in Chicago provides crisis intervention and referral services on a 16 hr/day basis.	<i>Feasibility study:</i> dyads formed naturally at the beginning of each shift; job performance of consumer dyads (either one or two consumers present) was compared to nonconsumer dyads	Despite serving essentially the same clients, the consumer dyads did more mobile outreach and were less likely to be dispatched in an emergency; authors conclude consumers can be a valuable addition to the MAU.

<p>Mowbray, Moxley, Thrasher, Bybee, McCrohan, Harris, & Clover (1996)</p>	<p>Nineteen Peer Support Specialists (PSSs), who all had significant psychiatric histories</p>	<p>WINS (Work Incentives and Need Study), funded by the Center for Mental Health Services to increase vocational opportunities for clients already receiving services from case management teams.</p>	<p>Authors concluded that PSSs performed the activities necessary for vocational services; sharing a common bond enhanced the relationship between the PSSs and their clients; PSSs demonstrated job sophistication and professional skills; and PSSs experienced significant role confusion (e.g., "Am I a friend or a clinician?") and did not feel adequately compensated for their work.</p>
<p>Felton, Stastny, Shern, Blanch, Donahue, Knight, & Brown (1995)</p>	<p>104 clients with serious mental illness</p>	<p>Clients were served by one of three teams: (1) nonconsumer case managers only, (2) nonconsumer case managers plus nonconsumer paraprofessional assistants, and (3) nonconsumer case managers plus peer specialists, who performed case management services using a model similar to the model of Stein & Test (1978), including 24-hr availability, assertive outreach, advocacy, and a rehabilitation orientation.</p>	<p>All clients improved over time on quality of life and on symptoms, but clients of team 3 were more satisfied with their living situations and finances and reported fewer life problems (assessed perceptions and objective indicators) compared to the two nonconsumer groups; client contact by team 3 remained steady over the 18 months but decreased for teams 1 and 2; perhaps because the consumer providers may have affected their nonconsumer teammates positively, there were no differences between teams 1 and 2, which led the authors to suggest the contributions by the consumer providers accounted for the differences in client outcomes.</p>
<p>Solomon & Draine (1993, 1994a, 1994b, 1995a, 1995b, 1995c, 1995d, 1996)</p>	<p>96 clients with a major mental disorder and histories of hospitalization</p>	<p>Two case management teams (one made of all consumers, the other made of nonconsumers) provided intensive case management services based on Stein & Test (1978), including 24-hr availability, assertive outreach, advocacy, and providing services in the clients' natural environments.</p>	<p>No differences generally were found between the two groups on nondisposable income, social network size, days hospitalized, symptoms, attitudes toward medication compliance, quality of life, interpersonal contact, social functioning, satisfaction with their treatment from their team, working alliance, and family member satisfaction; Solomon & Draine conclude that consumers can provide case management services as well as nonconsumers; some studies did not have adequate power, however.</p>

differently from nonconsumers, they are able to perform their jobs adequately.

Other early reports of such efforts, based on anecdotal evidence from experiences with programs that have hired consumers as providers, have identified both the roles for which experience with serious mental illness would be an asset, and the potential benefits for hiring consumer providers (Besio & Mahler, 1993; Curtis, 1993; Davidson et al., 1997; Dixon, Krauss, & Lehman, 1994; Mowbray & Moxley, 1997a; Mowbray et al., 1997; Paulson, 1991; Shepard, 1992; van Tosh, 1993). Services for which consumer providers might be well suited include "advocacy and mediation; mentoring and role modeling; peer support, education and counseling; and assistance with meeting needs of daily living, such as housing and work" (Davidson et al., 1997, pp. 439–440). Additionally, these authors have suggested that consumer providers may be more able to empathize; to access social services; to appreciate clients' strengths; to be tolerant, flexible, patient, and persistent; and to be aware of and responsive to clients' desires (Davidson et al., 1997; Mowbray & Moxley, 1997b).

Effectiveness Studies

Since the success of these programs, consumers have been hired across the country to work in a variety of clinical and rehabilitative roles, and a few empirical outcome assessments have been conducted. Studies that employed the use of consumers as service providers (*not* in consumer-run services) are reviewed in Table 2 and were identified by key word searches on the Medline and Psyc-Info databases. Whereas Solomon and Draine (1993, 1994b, 1995b, 1995c, 1995d) found consumer treatment to result in essentially equivalent outcomes as compared to nonconsumer treatment, Felton et al. (1995) found that having consumers on a case management team yielded significantly better client outcomes compared to teams with no consumers.

Methodological Limitations

As with consumer-run services, the studies examining consumer providers also were not rigorously conducted. Of the six studies reviewed here, only two used random assignment, and only one of those assessed outcomes of the clients served by the consumers (the other examined the effect of employment on the consumer providers themselves). Again, the remaining studies either were

descriptive, suffered from small samples and low power, were naturalistic studies (i.e., no random assignment), assessed quality assurance data from service activity logs, or used focus groups. One of the more rigorous studies of consumer providers (Solomon & Draine, 1995d) randomly assigned clients to a case management team either made of all consumers or made of all nonconsumers and found no differences on a variety of standardized measures of functioning and symptoms over a 2-year period.

Despite the lack of methodologically sound studies both of consumer-run services and of the employment of consumers as providers in clinical and rehabilitative settings, a consistent finding from all the studies has been that consumers can adequately provide services to others with serious mental illness, demonstrating their ability to occupy important roles beyond their status as mental patients. Beyond this conclusion, however, the effectiveness of using consumers to provide peer support to other consumers in these settings remains unclear. These types of peer support are still relatively new, and therefore more rigorous studies are needed to assess the potential demonstrated by this group of mostly descriptive research.

PARTICIPATION IN PEER SUPPORT

The above discussion of the range of potential benefits to be derived from peer support suggests that it is a resource that might be welcome by most persons recovering from severe mental illness. Social support, positive social roles, coping and problem-solving skills, all typically are seen as lacking in people who are disabled by these disorders and who occupy largely stigmatized and isolated roles in a community to which they often do not feel they belong. Yet we have noted that these resources are used currently by only a minority of individuals with psychiatric disabilities. In addition, several studies of professionals' attitudes toward mutual support suggest that many professionals are reluctant to refer their clients to these groups, and that some professionals perceive these groups as potentially detrimental to their clients (Chesler, 1990; Salzer et al., 1994). Although, as Kyrouz and Humphreys (1996) have noted, low rates of utilization are not uncommon among other mutual support groups and voluntary organizations, there may be issues specific to persons with severe mental illnesses that impede their broader use of these options as well. Through our own attempts to foster the development of mutual support groups, consumer-run services, and the use of consumers as providers within our local

service system, we have identified a series of issues confronted both by consumers and by providers that appear to limit access to, and utilization of, each of these three forms of peer support. We review each briefly below.

First, despite the fact that it has been over 20 years since Strauss, Harding, and their colleagues in the United States (Harding, Brooks, Ashikaga, Strauss, & Breier, 1987a, 1987b; Strauss & Carpenter, 1972, 1974, 1977) and Bleuler, Ciompi, and their colleagues in Europe (Bleuler, 1974, 1978; Ciompi, 1980) began to publish rigorous longitudinal studies that showed that many people with serious mental illness can in fact improve over time, the longstanding Kraepelinian view of a chronic and deteriorating course continues to predominate the field. Beliefs such as that "once you are a mental patient, you always will be a mental patient" (Harding & Zahniser, 1994) are common not only to the lay public and to mental health providers, but also to consumers themselves.

Such beliefs impede the development and use of peer support in a number of ways. Perhaps most important, the acceptance of such beliefs on the part of people with psychiatric disabilities—what has come to be called "internalized stigma" within the MHCM (Davidson, Stayner, & Haglund, 1998)—can contribute to an immobilizing sense of demoralization, apathy, despair, and helplessness experienced by many people with serious mental illness (Davidson, Stayner, Lambert, Smith, & Sledge, 1997). Feeling that there is little they can do to improve their own situation, many individuals with psychiatric disabilities find little appeal in mutual support groups or in programs run by their peers. Believing that there is little chance for recovery in others as well as in themselves, they are skeptical that their peers would have much to offer them and see little point in coming together with a group of individuals with similar problems to share their troubles. Similar beliefs on the part of providers make them skeptical of the value of mutual support groups or services provided by consumers, as the peer support leaders or providers continue to be perceived primarily within the role of mental patient. As a consequence, the rate of referral to these resources continues to be low, as does the level of formal support for such resources within most state mental health systems.

Second, in addition to beliefs about prognosis in serious mental illness, there is the devastation of the illness itself and its impact on functioning. There is increasing evidence from psychiatric rehabilitation that some dis-

orders can be delimited to specific domains of functioning that leave other domains intact, allowing the person to achieve a sense of mastery over his or her condition (Anthony & Liberman, 1986; Bachrach, 1992). Depending on the severity of the disorder, however, many individuals with serious mental illness do experience significant impairments in multiple domains of functioning that can make participation in mutual support and in some consumer-run services extremely difficult, if not impossible—at least in the early, more active phases of illness (Davidson & McGlashan, 1997).

It may be useful in addressing the roadblocks posed by the disability itself to consider the role that the provision of supports and environmental modifications may play in assisting some individuals with psychiatric disabilities to participate in peer support. An example of the potential role of supports and accommodations in this area can be taken from the vocational area. Impairments in intellectual, emotional, or social spheres no longer need to pose as much of an obstacle to a person's chances at success on the job since the advent of "supported employment" and "supported education." With these advances in psychiatric rehabilitation, modifications can be made to the person's work or school environment, and supports can be provided "in vivo," to assist the person in compensating for his or her disabilities. Similar approaches have been explored in the context of consumer-run services and may be needed for those individuals who remain significantly disabled by their conditions if they are to participate in peer support. As mentioned above, we have referred to the range of strategies that might be employed to support individuals in participating in peer support activities under the rubric of "supported peer support." It remains for future research to evaluate the utility of these strategies, and to see if their implementation attracts more people to these activities.

Finally, despite cross-cultural studies in the developing world (Davidson & McGlashan, 1997; Lin & Kleinman, 1988) and studies of the effectiveness of paraprofessionals (Christensen & Jacobson, 1994; Durlak, 1979) showing that people can make significant improvements in the absence of professional intervention, the mental health system continues to be based on a belief that serious mental illness can be ameliorated only through the highly technical procedures of professionals. Whether through pharmacologic intervention, focused attention to developing a therapeutic relationship, or even highly specified

modules of behavioral training in psychiatric rehabilitation, there continues to be a sense that improvement will come about only through intensive efforts on the part of the professionals involved. Such an exclusionary investment in professional role and identity allows little room for peer support in facilitating recovery from prolonged disorders (Chesler, 1990; Salzer et al., 1994). Even when conceptualized as playing only one part in the context of a comprehensive approach to the treatment of people with serious mental illness—alongside of medications, rehabilitation, and clinical case management—the potential value of peer support can be diminished significantly by the prevailing medical and clinical paradigms used in the settings in which most care is provided. This medical/clinical emphasis has been all the more heightened by the introduction of managed care into public sector mental health, with its foci on medical necessity for the authorization of services, credentialed providers, and utilization management. Even though consumer-run services are often less expensive than conventional services, and mutual support is most often free, proponents of peer support are increasingly concerned about the appeal of these services to managed care organizations, their chances for capturing reimbursement, and the impact of credentialing and liability issues that may need to be addressed if they are to survive.

In our own experience with our local mental health system, we have seen these last two issues played out on at least two different levels. On the programmatic level, we have seen consumer-run services undergo a process of “professionalization” in becoming integrated elements of the formal mental health system. This process involves what had been less formal services, based on such values as flexibility, autonomy, and consumer choice, becoming more structured and more driven by their needs to attract and justify funding. To the degree that such a service comes to resemble a more conventional provider agency, it also potentially begins to lose its unique character and role within a system of care.

On the more personal level, we have seen consumer providers undergo a similar process of “professionalization” in becoming staff within conventional clinical and rehabilitative programs (Davidson et al., 1997). In our training and supervision of consumer providers, we have been impressed by the power of the prevailing clinical culture and the “seduction” of higher status activities such as psychotherapy in constantly threatening to pull consumer

providers away from their task of providing peer support. At least to an equal degree to the impact consumer providers have had on changing the systems of care that employ them, these same systems have “co-opted” consumer-run services and consumer providers to their own values and perspectives (Davidson et al., 1997). This not only has the effect of diminishing the value of peer support and leading consumer providers to want to become psychotherapists, but also has the effect of leading some individuals with psychiatric disabilities to reject the notion of peer support and to refuse to work with consumer providers because they are not credentialed clinicians. As one consumer advocate expressed it, “I don’t want other mental patients taking care of me when I get sick. What could they know—they’re not doctors.” A healthy tension between the clinical and consumer perspectives, while perhaps optimal, appears hard to achieve and maintain when the clinical paradigm is so well established.

IMPLICATIONS FOR MENTAL HEALTH POLICY, RESEARCH, AND PRACTICE

The disabling nature of serious mental illness, beliefs about a chronic and deteriorating course, and investments in the role of professional interventions pose formidable challenges to the development of peer support among people with severe psychiatric disorders (Estroff, 1982). For these and perhaps other reasons as well, peer support is neither well known nor well accepted by providers and consumers alike. The empirical evidence that exists to date, although preliminary and limited, suggests that both consumer-run services and the employment of consumer providers within conventional mental health settings have become additional routes to offering opportunities for peer support among individuals with serious mental illness. In addition, there are increasing numbers of people like Pat Deegan (1992, 1993), Dan Fisher (1994, 1996), Fred Frese (1993), Con Keogh (1979), and Kay Jamison (1995) who have recovered to a significant extent from their own disabilities and are becoming visible sources of inspiration, hope, and support to their peers, offering precisely the kind of role models Deegan would have valued in her own recovery. It is unclear at this time, however, to what degree any of these developments are having an impact either on the awareness or acceptance of peer support among individuals with serious mental illness or their clinicians.

With few exceptions, the empirical literature reviewed in this area consists mostly of quasi-experimental studies, qualitative reports, and anecdotal accounts of innovative programs, as opposed to randomized trials. This may in part be due to the difficulty in studying peer support using random invitation designs and high levels of experimental control, a process that may be so antithetical to the values of this approach that the phenomenon under investigation may no longer be indicative of peer support (Humphreys & Rappaport, 1994; Tebes & Kraemer, 1991). For the use of mutual support, consumer-run services, and consumer providers not to be merely the latest fad in community mental health, however, larger and better controlled studies will be needed that document their effectiveness and cost-effectiveness in facilitating recovery. Such studies will be important in securing for peer support a valued and enduring role in the comprehensive mental health systems of the future (Leff, Campbell, Cagne, & Woocher, 1997).

In addition to needing more information about the effectiveness of these approaches in promoting recovery, several questions remain about the differences between these three routes to peer support. First, there is the question of the degree of reciprocity between staff and clients both in consumer-run programs and in settings that employ consumer providers. Would the absence of reciprocity, should it not be present in these settings, also negate the operation of the "helper-therapy principle" (Riessman, 1990)? Second, consumer providers often experience confusions about their role, as they are torn between being a friend and the expectation of their setting that they "act like professionals" (Dixon et al., 1994; Manning & Suire, 1996; Mowbray et al., 1996; Solomon & Draine, 1996; Stoneking & Greenfield, 1991). Questions remain regarding how much room can be created within the conventionally boundaried practice of such settings for an appreciation of the common humanness, and shared experiences and concerns, between peers that is at the core of mutual support (Davidson et al., 1997).

Third, compared to clients receiving services from conventional mental health programs, participants in both mutual support groups and consumer-run services may play a more active role in creating their own environments, an aspect of these settings that in and of itself is thought to promote recovery (Kaufmann et al., 1993; Mowbray & Tan, 1993). While there is some evidence

that consumer providers have been able to affect changes within the mental health settings in which they work (Bevilacqua et al., 1997; Davidson et al., 1997; Felton et al., 1995), their influence on these settings is most likely less than that of their counterparts in consumer-run services and mutual support groups. It remains to be determined whether or not clients in the conventional mental health settings that employ consumer providers have been able to move beyond the passive role of "mental patient" to other, more socially valued and positive roles (Corrigan & Garman, 1997).

Finally, consumer providers in conventional mental health settings have the potential to engage more individuals into receiving services, and to have access to more individuals, than would ordinarily seek out mutual support groups or consumer-run programs, especially given the limited professional utilization of such resources (Black & Drackman, 1985; Katz, 1993; Salzer et al., 1994). This fact alone suggests the value and merit of integrating access to peer role models into clinical and rehabilitative settings. A remaining question in this area, however, is the degree to which the programs studied, and ones to be developed in the future, incorporate an explicit recognition of the consumer staff member's personal history of disability and recovery into his or her work (Davidson et al., 1997). Although such programs may have shifted successfully from viewing a person's experience with severe mental illness as a detriment to viewing it as a valuable job qualification, little attention has been paid thus far to the ways in which these experiences are integrated into the consumer's role and direct work with clients. It may represent progress for consumers to be hired into conventional clinical roles, for in doing so they may already function as successful role models for their clients. But does Fred Frese, for example, function primarily as a peer or as a psychologist, and Dan Fisher primarily as a peer or as a psychiatrist—under what circumstances, and for whom? What remains to be explored is whether or not hiring consumers to be providers is an effective way to combine the strengths both of mental health services and of peer support. To what extent do mental health services provided by consumers, and programs that employ them, come to embody the characteristics of mutual support described above? This direction may provide a promising area for future research.

This review of the feasibility and usefulness of peer support among individuals with serious mental illness sug-

gests that people with serious mental illness may constitute a promising but little utilized resource in the recovery of their peers. Such studies of the relative effectiveness of this approach, while clearly important, nonetheless tap only one dimension of the issue of the role of peer support in recovery from serious mental illness. Other dimensions of this issue—which were implicit in our discussion of the possible roadblocks to participation in peer support—are evident in the far-reaching repercussions of increasing the public visibility of, and access to, those role models for whom Pat Deegan had been searching. Infusing the mental health workforce with people who are coping successfully with their own psychiatric disabilities may not only provide direct effects on the level of individual client outcomes, but may also affect the lingering stigma surrounding people with mental illness that continues to permeate the mental health system and the broader culture (Bevilacqua et al., 1997; Davidson et al., 1997; Reidy, 1994). There may perhaps be no more powerful or direct way to bring about such changes in beliefs about mental illness than to have as colleagues people who have been personally effective in busting apart old stereotypes, and who in so doing provide positive role models both for our clients as well as for ourselves.

NOTE

This is a revised version of an invited address presented to the Preconference Institute on Self-Help/Mutual Assistance of the 6th biennial conference on Community Research and Action, May 1997, Columbia, SC.

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