Peer Support/Peer Provided Services Underlying Processes, Benefits, and Critical Ingredients

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The article defines peer support/peer provided services; discusses the underlying psychosocial processes of these services; and delineates the benefits to peer providers, individuals receiving services, and mental health service delivery system. Based on these theoretical processes and research, the critical ingredients of peer provided services, critical characteristics of peer providers, and mental health system principles for achieving maximum benefits are discussed, along with the level of empirical evidence for establishing these elements.

Ever since the development of the Community Support System in the late 1970s, peer support has been recognized as an essential component of a supportive network for persons with severe psychiatric disorders (Stroul, 1993). The Community Support Program (CSP) promoted peer support and peer provided services and was a major precipitant in the further development and expansion of these formal and informal services. The fact that the state of Texas Department of Mental Health and Mental Retardation selected peer support/peer provided services as one of six targeted psychiatric rehabilitation domains in their rehabilitation benefit design initiative speaks to how far these services have come to be viewed by providers, policy makers, families, and people with severe psychiatric diagnoses as acceptable and beneficial to a mental health service delivery system.

In 1989, when we submitted a grant to the CSP of the National Institute of Mental Health for an evaluation of consumer delivered case management service, we were unsure of the possibility of funding for fear that the reviewers would not be convinced that it was feasible for individuals with severe psychiatric diagnoses to deliver such a service. In order to make the intervention more palatable to the review committee, we designed the team to include one member without a psychiatric diagnosis. However, in the course of implementation, the team eventually became an all consumer team. During the past decade and a half, a number of peer provided services have been implemented and legitimized. Although we have clearly made progress in this arena, we still have a long way to go, as many communities and states are not as progressive as Texas on this issue.

The purpose of this article is to lay out the principles of peer support/peer delivered services that emerge from the literature. This article will begin with defining peer support and the various types of peer provided services; the psychosocial processes that underlie these services; the benefits derived from these services; and lastly, the critical ingredients of these services, as well as the critical characteristics for those delivering the services, and the essential system principles of these peer support/consumer provided services. An assessment of the level of evidence for these critical ingredients is made, along with a summary of the research supporting the assessment.

Definition of Peer Support

Peer support is social emotional support, frequently coupled with instrumental support, that is mutually offered or provided by persons having a mental health condition to others sharing a similar mental health condition to bring about a desired social or personal change (Gartner & Riessman, 1982). Mead, Hilton, and Curtis (2001) have further elaborated that peer support is "a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful" (p. 135). Through the process of offering "support, companionship, empathy, sharing, and assistance," "feelings of loneliness, rejection, discrimination, and frustration" frequently encountered by persons who have a severe psychiatric disorder are countered (Stroul, 1993; p. 53). Peer support may be either financially compensated or voluntary. A peer in this context is an individual with severe mental illness who is or was receiving mental health services and who self-identifies as such (Solomon & Draine, 2001).

Defining and Delineating Categories of Peer Support

Peer support, for purposes of this assessment, is delineated into six categories: self-help groups, Internet support groups, peer delivered services, peer run or operated services, peer partnerships, and peer employees. Each will be defined and discussed.

The oldest and most pervasive of peer support types is *self-help groups*. Katz and Bender (1976) defined self-help groups as "voluntary small group structures for mutual aid in the accomplishment of a specific purpose...usually formed by peers who have come together for mutual assistance in satisfying a common need, overcoming a common handicap or life disrupting problem, and bringing about desired social and/or personal change." Although there are groups that cover just about every mental health related problem, the most noted ones that are relevant to the present topic are GROW, Recovery, Inc., Schizophrenics Anonymous, National Depressive & Manic-Depressive Association groups, double trouble groups for individuals with a mental illness and substance abuse problem, and Emotions Anonymous.

In some instances, providers may assist in the start-up of a self-help group and facilitate the group until a leader emerges. Up to very recently these groups were required to be face-to-face (Gartner & Riessman, 1982). However, with the expansion of the Internet, *Internet online support* groups have come into existence, which lack this face-to-face element (Perron, 2002). Communication in Internet support groups is frequently conducted through e-mail or bulletin boards, while with specific software live interface with other group members is possible. These Internet support groups

are frequently public and open, where anyone can join. Some are closed or private and require an individual to make an application to the owner of the group (Perron, 2002). Internet support groups offer a high degree of anonymity, where confiding in others occurs without any social repercussions, given the lack of in-person contact among members (Davison, Pennebaker & Dickerson, 2000).

The Internet support groups are very similar to warm lines, where peers offer support via the telephone. However, *warm lines* are one-on-one support, rather than having the group aspect of self-help groups. Also, warm lines may lack continuity with the same individual provider, therefore, limiting the ability to establish a relationship between peer and peer provider.

Peer delivered services are services provided by individuals who identify themselves as having a mental illness and are receiving or have received mental health services for their psychiatric illness, and deliver services for the primary purpose of helping others with a mental illness. Within the realm of peer provided or delivered services are peer run or operated services, peer partnership services, and peer employees.

Peer run or operated services are services that are planned, operated, administered, and evaluated by people with psychiatric disorders (SAMHSA, 1998; Stroul, 1993). Individuals without psychiatric disorders may be involved in the service program, but their inclusion is within the control of peer operators (Solomon & Draine, 2001). These service programs are based on the values of freedom of choice and peer control. These programs have some paid staff and a significant number of volunteers. Generally, these services are embedded within a formal organization that is a freestanding legal entity. These pro-

grams vary greatly in terms of the size of the organization and they differ with regard to the nature of the services provided. Examples of peer operated services include drop-in centers, clubhouses, crisis services, vocational and employment services, compeer, where volunteers are individuals with severe psychiatric disorders, psychosocial educational services (BRIDGES), and a peer support program such as Friends Connection in Philadelphia, where individuals with dual diagnoses are matched with peers in recovery.

Those service programs that are not freestanding legal entities and share the control of the operation of the program with others without psychiatric diagnoses are categorized as *peer partnerships*. Therefore, the fiduciary responsibility for the service program lies with a non-peer organization, and the administration and the governance of the peer program are shared mutually between peers and non-peers, but the primary control is with the peers (Solomon & Draine, 2001). In order to reflect the lack of total control by peers, these programs are categorized as partnerships (SAMHSA, ND). This is similar to the distinction between autonomous and hybrid types of peer support organizations or self-help groups. Hybrid self-help groups are where professionals have a major role in the group (Powell, 1985).

Peer employees are individuals who fill designated unique peer positions as well as peers who are hired into traditional mental health positions. When peers are hired into existing mainstream positions, to be considered a peer employee, the individual must meet the requirements of a peer as in the definition specified above which includes publicly identifying as an individual who is receiving or has received mental health services. Frequently, designated peer positions serve in

capacities adjunctive to traditional mental health services, such as a case manager aid position. Examples of specially designated peer positions are peer companion, peer advocate, consumer case manager, peer specialist, and peer counselor. The term prosumer has also come into use. It refers to a person who is both an individual with psychiatric disorder and a professional, such as a trained psychologist, but must self identify as an individual with a severe psychiatric disorder (Frese & Davis, 1997). Others see it as having varied meanings, including paraprofessional or volunteers (Manos, 1992, 1993).

Underlying Psychosocial Processes of Peer Support

Why peer support has been considered to be beneficial to individuals with a severe psychiatric diagnosis has been explained by a variety of psychosocial processes that are theoretically based. Salzer and his associates (2002) describe five theories that underlie peer-delivered services, which include social support, experiential knowledge, helper-therapy principle, social learning theory, and social comparison theory. These theories have been inferred rather than empirically tested within the domain of self-help groups. The lack of testing within this context is due to the culture of self-help groups that make traditional research methodologies difficult to employ (Kingree & Ruback, 1994). This section will describe each of these theories in relation to peer support.

Social Support is the "availability of people on whom we can rely: people who let us know that they care about, value, and love us" and are willing to assist us to meet our resource and psychosocial needs (Sarason, Levine, Basham & Sarason, 1983). Research has demonstrated that these support-

ive relationships help to contribute to positive adjustment and to buffer against stressors and adversities, including medical as well as psychiatric problems (e.g., George, Blazer, Hughes & Fowler, 1989; Gottlieb, 1981; Ell, 1996; Walsh & Connelly, 1996). The primary types of supports that are discussed are emotional support (offers esteem, attachment, and reassurance), instrumental support (offers material goods and services); and information support (offers advice, guidance, and feedback). Peer support/peer delivered services help to enhance the number of individuals that a person with a psychiatric disorder can turn to for support and assistance, offer a sense of belonging and positive feedback of a person's own self-worth.

Another psychosocial process that underlies peer provided service is *experiential knowledge* that is specialized information and perspectives that people obtain from living through the experience of having a severe psychiatric disorder (Borkman, 1990). Experiential knowledge tends to be unique and pragmatic, and may be specific to one's circumstances. However, when the information is combined with others who share a similar problem, common elements regarding both problems encountered and their resolution emerge (Shubert & Borkman, 1994). This experiential process is viewed as a more active approach to coping with the illness, promoting "choice and self-determination that enhance empowerment," as opposed to the passivity engendered by "participation in services with a hierarchical structure" (Salzer & Associates, 2002, p. 6). Through relating to others with psychiatric disorders concerning their illness, individuals with psychiatric disorders may obtain validation of their approaches to problem resolution and gain increased confidence in their

working relationships with mental health service providers.

The experiential theory dovetails with *social learning theory* in that peers, because of their experiences as individuals receiving or having received mental health services are more credible role models for others with psychiatric diagnoses, and therefore, interactions with peers who are successfully coping with their illness are more likely to result in positive behavior change on the part of other peers. Peers who interact with peers with positive outcomes enhance their own sense of self-efficacy in dealing with their illness, its ramifications, and with the treatment system. Peers who have confidence in coping with their illness are more hopeful and optimistic about their future (Salzer & associates, 2002).

Social comparison theory also offers an understanding of the mechanisms of how peer support service provision benefits individuals who are receiving or have received mental health services. Social comparison theorizes that individuals are attracted to others who share commonalities with themselves, such as a similar psychiatric illness, in order to establish a sense of normalcy for themselves (Festinger, 1954). By interacting with others who are perceived to be better than them, peers are given a sense of optimism and something to strive toward. This upward comparison is considered to provide other peers with an incentive to develop their skills and to offer them hope. In contrast, downward comparison to those who seem so much worse off than themselves puts in perspective how bad things could be for themselves (Salzer & associates, 2002).

Peer support services afford individuals the opportunity to benefit themselves from helping others. This phenomenon has come to be called the *helper-therapy principle* (Riessman,

1965; Skovholt, 1974). Skovholt (1974) summarized the personal benefits derived from effectively helping others: 1) the helper feels an enhanced sense of interpersonal competence from making an impact on another's life; 2) the helper feels that she/he has gained as much as she/he has given to others; 3) the helper receives "personalized learning" from working with others, and 4) the helper acquires an enhanced sense of self from the social approval received for those helped. With this positive feedback and affirmation of themselves, they are in a better position to help others.

Benefits Derived from Peer Support/Peer Provided Services

Peer support/peer provided services have resulted in benefits to peer recipients, peer providers, and to the mental health service delivery system. In this section, these benefits will be delineated and discussed.

Benefits to Individuals who Receive Mental Health Services

Research reviews, including systematic, meta-analytic reviews of research on comparing the effectiveness of professional psychotherapists' to paraprofessionals' (i.e., individuals with post-bachelors clinical training in professional mental health programs) interventions, have concluded that there are no differences in outcomes, or in a few instances, the outcomes favor the paraprofessional (Christensen & Jacobson, 1994). In addition, when self-help was compared to therapists, the research again found no difference between the two (Gould & Clum, 1993). Furthermore, Gould and Clum concluded that self-help had better outcomes when addressing skill deficits and diagnostic problems, such as depression, than habit problems like smoking and drinking. Although the studies are limited in number and scientific rigor,

most effectiveness studies of self-help have found positive outcomes for participants (Christensen & Jacobson, 1994).

Reviews of peer support/peer provided services specifically for persons with severe mental illness have also come to positive conclusions, but somewhat more tentative given the infancy of the research area (Davidson et al., 1999; Solomon & Draine, 2001; Simpson & House, 2002). Based largely on uncontrolled studies of self-help groups for persons with severe mental illness, Davidson and his colleagues (1999) concluded that self-help groups seem to improve symptoms, increase participants' social networks and quality of life. Specifically Galanter (1988) evaluated Recovery, Inc., Kennedy (1989) evaluated GROW, and Kurtz (1988) evaluated National Depressive & Manic Depressive Association with regard to hospitalizations, and all found reductions in hospitalizations and, in one instance, shorter hospitalization when consumers were hospitalized (Kennedy, 1989). In addition these studies along with Raiff's (1984) study of Recovery, Inc. determined that members had improved coping, greater acceptance of illness, improved medication adherence, lower levels of worry, and higher satisfaction with health. Further, in a study by Powell and his associates (2001), self-help participation resulted in improved daily functioning and improved illness management. Furthermore, longer-term participants have better outcomes (Raiff, 1984; Rappaport, 1993) and outcomes are better when participants are involved in the group as opposed to their being just an attendee (Powell, Yeaton, Hill & Silk, 2001).

With regard to peer provided services, these services have been found to be as effective as non-peer provided services (Solomon & Draine, 1995a&b;

Chinman, Rosenheck, Lam & Davidson, 2000) or more effective. Two Level 1-type studies (most rigorous studies, employing experimental or quasi-experimental designs) have found reduced use of hospitalizations and/or crisis services (Clarke, et al., 2000; Klein, Cnaan & Whitecraft, 1998). In Klein and her colleagues' study, recipients of the peer delivered service also had improved social functioning, reduced substance abuse, and improved quality of life. Two other Level 1 studies found that having a peer on a team resulted in more positive outcomes. One randomized study used a peer to assist in post discharge network services and found that individuals assigned to this condition had fewer and shorter hospitalizations and functioned in the community without utilizing mental health services (Edmunson, Bedell, Archer & Gordon, 1982). The addition of a peer specialist to an intensive case management team as compared to a non-peer specialist resulted in improved gains in some aspects of quality of life, fewer significant life problems, improved self-esteem and social support (Felton, et al., 1995). Other less rigorously designed studies also found fewer hospitalizations for those served by peers (Chinman, Weingarten, Stayner & Davidson, 2001; Nikkel, Smith & Edwards, 1992). A peer employment program evaluated by a Level 1 type study resulted in higher rates of employment, higher earnings, and a tendency toward greater vocational rehabilitation status outcome (Kaufman, 1995). Similarly, recipients of a peer operated employment program maintained employment longer (Miller & Miller, 1997). In summary, there was a very high level of support for peer providers regarding positive outcomes for service recipients.

Benefits to Providers
A similar positive outcome to recipients was a reduction in hospitalizations for peer providers (Sherman & Porter, 1991). Based on qualitative research methods such as in-depth or narrative interviews, researchers have indicated a diversity of positive outcomes for providers. Being a peer provider offered these individuals personal growth in terms of increased confidence in their capabilities, ability to cope with the illness, self-esteem, and sense of empowerment and hope. With improved self-efficacy comes the power for individuals with psychiatric diagnoses to combat feelings of stigma (Salzer, 1997). Providers were also offered the opportunity to practice their own recovery, to engage in self-discovery, build their own support system, learn positive ways to fill time, and engage in professional growth including building job skills and moving toward a career goal (Gottlieb, 1982; Humphreys, 1997; Manning & Suire, 1996; Mowbray et al., 1996; Mowbray, Moxley & Collins, 1998; Salzer & Shear, 2002). Peer employees also have been found to have an improved quality of life (Armstrong, Korba & Emard, 1995; Mowbray et al., 1998).

Benefits to the Mental Health Service Delivery System
One of the major benefits to the mental health service delivery system is the potential cost-savings that is likely to result to the system from peer provided services. Given the consistency of the findings of decreased hospitalization or shortened length of hospital stay for both peer provided services and peer providers themselves, there is a translation of financial savings to the system, as hospitalization is one of the most expensive of mental health services. Also, self-help groups generally do not cost the system very much in terms of dollars or resources, and therefore, any savings to the system are a total dollar savings. Furthermore, self-help programs may reduce the utilization of the traditional mental health

services, and as such may further reduce cost to the mental health system (Segal, Gomory & Silverman, 1998). But one caution, dollar savings should not come to the mental health system from hiring individuals with psychiatric diagnoses into existing positions and paying them less for the same job.

There is also evidence that peer providers have an impact on altering negative attitudes of mental health providers (Cook, Jonikas & Razzano, 1995; Dixon, Hackman & Lehman, 1997; Dixon, Krauss & Lehman, 1994). All too frequently, mental health providers only see individuals with psychiatric diagnoses at their worst, when their symptoms are exacerbated or when they are in a powerless relationship to the providers, as opposed to seeing them function in effective social roles. Peer providers give mental health providers the opportunity to see peers successfully functioning in productive, "normal" social roles. Peer providers further offer mental health providers the opportunity to relate to individuals with psychiatric diagnoses as peers. These types of situations help to combat societal stigma of persons with severe mental illnesses.

Peer support/peer provided services proffer a mechanism for serving individuals in need of mental health services, but who are alienated from the traditional mental health system (Segal et al., 1998). For example, persons who are homeless or others who have had negative experiences with traditional mental health services or, for whatever reason, are opposed to using the traditional mental health system may find these peer provided services more acceptable. Persons who have experienced similar situations as these peers may be far more effective in engaging these individuals into mental health services or peer providers may be more effective in working with these individ-

uals (Segal et al., 1998). For example, Lyons and his colleagues (1996) found that peer staff of a mobile crisis service was more likely to do street outreach. Everly (2002) noted that peer counselors were effective in conducting community outreach. Powell and associates (2000) found that peers engaging in referral to self-help groups were more effective in having other peers follow through on referrals than when referrals to self-help groups came from professionals. Hodges and colleagues (2003) found "support for the idea that the use of self-help services encourages appropriate use of professional services" (p. 1161).

Research has also found that when peers are added on to teams, or when peer services are coupled with traditional mental health services, the outcomes for recipients are enhanced and thus, are a significant added value (Felton, et al., 1995; Edmundson et al., 1982; Klein et al., 1998; Kaufman, 1995). Evidence indicates that peer provided services can improve the effectiveness of the traditional mental health delivery system.

Furthermore, peer support/peer provided services enhance the ability of the mental health service delivery system to meet the mental health needs of the community. Christensen and Jacobson (1994) noted that only a portion of those with diagnosable mental disorders receive treatment and that professional therapists cannot begin to meet the extent of the need. Therefore, "these alternative formats might be useful adjuncts to professionally administered approaches" (p. 12).

Critical Ingredients of Peer Provided Services and Level of Evidence

Based on the psychosocial processes, the research on peer support/peer pro-

vided services, and the literature on peer provided services, the critical ingredients in peer delivered services, critical characteristics of peer providers, and system principles for maximizing benefits from these services will be discussed, along with the nature and level of evidence. These critical ingredients fall into three categories: service elements, peer characteristics, and system principles. The numbering of the ingredients does not imply priority rankings.

Service Elements

1. Use of experiential learning process

Having personal experience with serious and persistent mental illness is a primary aspect of being able to relate to others with psychiatric disorders, especially to individuals who shun the traditional mental health system. Peers in the process of recovery are excellent role models and have much experiential knowledge of dealing with common concerns and problems to offer other peers. Peer providers are particularly adept at negotiating the diversity of systems and agencies on behalf of others, due to their own experiences and encounters with societal and system barriers (Stephens & Belisle, 1993). There is a high level of evidence for this element, achieving Level 1 category, as there have been four randomized studies (Edmundson, Bedell & Gordon, 1984; Kaufman, 1995; Paulson et al., 1999; Solomon & Draine, 1995a&b); 3 quasi-experimental designs (Felton et al., 1995; Klein et al., 1998; Chinman et al., 2000) where peer delivered services as compared to essentially the same service delivered by non-peer resulted in the same or better outcomes. Since the major distinction was who delivered the service, peers were using themselves as an instrument for change. This experiential process is a major component of self-help groups and the evidence provided by self-help

research provides further support for beneficial outcomes. The self-help research includes 3 quasi-experimental studies (Galanter, 1988; Raiff, 1984; Kennedy, 1989) and one descriptive study (Kurtz, 1988).

2. Use of mutual benefit

Those who help other peers also gain from this experience as much as they give. This is the primary premise of self-help groups. Powell and colleagues (2001) interpreted their finding that greater involvement in self-help for patients with mood disorders resulted in improved illness management as evidence of mutual benefit of helping others helps one's self. There is a relatively high level of support for this critical ingredient, achieving a Level 2, as the four self-help studies noted above provide evidence for this mechanism. Also, one pre-post test study by Sherman and Porter (1991) found a reduction in hospitalizations after serving as consumer case manager aids. Further, qualitative research noted benefits to peer service providers (Mowbray et al., 1998; Salzer & Shear, 2002).

3. Use of natural social support

Natural social support is essentially an inherent element of peer delivered services, much like experiential learning process. A qualitative assessment of a Compeer program with volunteers with and without psychiatric histories found that those assigned to peer volunteers were more comfortable with these volunteers and had fewer concerns, but participants benefited from the social and recreational activities, regardless of the volunteer's status. In addition, participants aspired to be like the peer volunteers who were further along in their recovery (Davidson et al., 2001). Research on a Welcome Basket Program by peers was found to reduce rehospitalization and was

thought to be effective as it helped to expand participants' social network and reduce their isolation (Chinman et al., 2001). Since the contributions of social support and experiential learning processes can't be easily unbundled from the peer provider as the intervention in and of itself, the same evidence elaborated in empirical support of experiential learning applies here as well, resulting a high level of evidence for this ingredient.

4. Voluntary nature of the service

Choice and self-determination are key philosophies of the consumer movement, which then carry over into the consumer service arena. Individuals who do not want peer service provision will be unlikely to attend these services. For example, a study where individuals with psychiatric disorders were randomized to a self-help group was unsuccessful due to fact that only 17% of those assigned to self-help actually attended (Kaufman, Schulberg & Schooler, 1994). There are some individuals with psychiatric disorders who have been noted to feel that services delivered by their peers are less than those of professionals. Such individuals are less likely to benefit from such peer provided services. Research has found that long-term participants have better outcomes, even when these members do not differ from other entrants (Raiff, 1984; Rappaport, 1993). The level of evidence is limited by virtue of a lack of research and by not very rigorous research due to this methodology being antithetical to this service element.

5. Primary control of service by individuals with psychiatric disorders

Peers need to remain in control of peer provided services, even when the services are partnerships; otherwise these services lose the advantage of the peer element (Davidson et al., 1999). Lotery

and Jacobs (1994) noted that as many as 80% of self-help groups have professionals involved in these groups and that as long as they do not dominate the group or attempt to dominate they can add to the effectiveness of the group. Furthermore, Lotery and Jacobs stated that self-help members "retaining control over the functioning, goals and ultimate destiny of the group, is central to the successful functioning of these groups" (p. 280). Peer provided services need to be peer driven, otherwise peers feel disempowered. If peer service providers feel disempowered, their effectiveness is undermined (O'Donnell, Roberts & Parker, 1998). When peers determine the job responsibilities and working conditions for peer positions, this avoids "setting consumers up to fail in positions in which unreasonable demands have been placed upon them" (O'Donnell et al., 1998, p. 878). Ultimately, control needs to be in the hands of people with psychiatric disorders, otherwise "many of the essential characteristics of a true consumer-run approach are absent" (Salem, 1990). This critical element is based on investigators' observations and interpretation of their results, rather than on direct empirical evidence. Further, it is not always possible from the write-ups of research to determine the degree of control that peers have over the intervention, therefore, a determination can't be made as to whether greater control of peers resulted in better outcomes. Consequently, the level of empirical evidence for this element is limited.

Characteristics of Peer Providers
6. Experience with mental health service delivery system

Support for this comes from observations by researchers who have evaluated peer provided service interventions. For example, Dixon, Krauss, and Lehman (1994) report that the impor-

tance of peer team members' knowledge, street smarts, and personal experience with mental health treatment and homelessness was essential to engaging individuals with psychiatric disorders in treatment and to the resulting approach to service. Therefore by the criteria of randomized designs the level of evidence is essentially non-existent.

7. Stable and in recovery

Since peer providers function as positive role models and serve as upward comparisons of functional status for others to achieve, peer providers need to be stable or in a state of recovery. Support for this characteristic comes from qualitative research and the experience of conducting interventions studies, consequently, there is weak evidence for this (Dixon et al., 1997).

8. Not current substance abuser or dependent

Peer providers cannot be current substance abusers, for they do not offer a positive role model for others. Furthermore, abuse of substances is likely to interfere with meeting their job responsibilities and successful social functioning (Mowbray, Moxley & Collins, 1998). The evidence is limited, based on observations of researchers in terms of the successfulness of implementation of their interventions.

Characteristics of Mental Health Service Delivery System
9. Diversity and accessibility of types/categories of peer provided services

A given community needs a fair number of each of the types of peer services, that are geographically dispersed such that they are easily accessible to most people with severe psychiatric disorders. Peer tokenism is not a very effective approach to hiring people with psychiatric disorders, as these individuals will feel isolated and this likely will reduce their effectiveness

(Barrett, Pratt, Basto & Gill, 2000). Chinman and colleagues (2001) noted the "potential utility of peer support in improving person-environment fit and decreasing of the subsample of people who continue to have difficulty in establishing viable footholds in the community..." (p. 215). These latter statements imply a need for a greater diversity of peer services to improve outcomes for those receiving mental health services, but there is no direct evidence to support this critical ingredient.

10. Reflect cultural diversity of the community

Peer-provided services need to represent cultural diversity, as research on self-help groups has found that the group context and the characteristics of the group members influence whether someone will return after their initial attendance. Those who perceive a better fit between themselves and other group members are more likely to continue to attend (Luke, Roberts & Rappaport, 1993). It may be important for peer support/peer provided services to focus on specialized or specific populations, such as the homeless, or minority groups, or be gender specific.

Since the needs of persons with severe mental illness are multiple and complex, it is better to offer a diversity of these service options. A service system in general is able to adapt to needs of the population served by mirroring the demands of the service environment. Similarly, the peer-provided services need to take the heterogeneity of the population into account (Salem, 1990). The evidence is limited and based on observations and interpretations of researchers.

11. Availability of adjunctive and alternative peer provided services

Peer provided services function as an alternative to traditional mental health services by serving individuals who might not otherwise receive mental health services. Consistent with this are observations by researchers that peers do well at engaging individuals with mental illness who are homeless into mental health services (Dixon et al., 1994). Peer providers added to a team or peer provided service as an adjunct to traditional mental health services enhances the benefits to service participants (e.g., Felton et al., 1995). The evidence for this critical ingredient is inferred from research findings as opposed to direct empirical evidence.

Conclusions

The strongest evidence for the critical ingredients of peer provided services is for those service elements that are not antithetical to the employment of randomized designs, whereas characteristics of peer providers and system principles rely heavily on observations of investigators of peer provided service interventions. Regardless of the lack of evidence, there is strong support that everyone benefits from the provision of peer support/peer provided services. To benefit from peer provided services necessitates implementation of these critical elements. These services can effectively fill some of the gaps in the mental health service delivery system. Whether these services function as adjuncts or alternatives to the traditional mental health services should be left up to the individual to decide how they will use them (Salem, 1990). But this then requires enough options available in the system for choice to occur and to meet the needs of this heterogeneous population.

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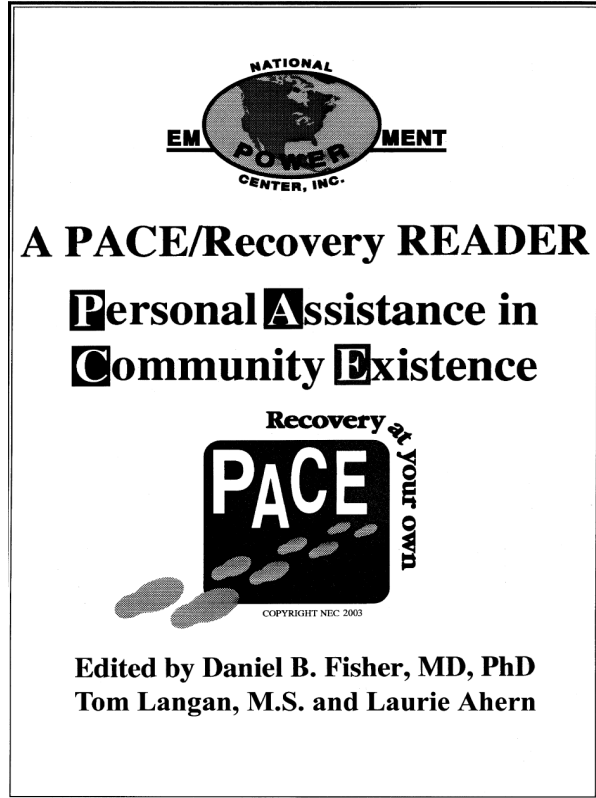
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