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Peer Support and Homelessness

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by

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ABSTRACT

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Those who have been socially excluded face extreme consequences—such as a higher chance of premature death (Aldridge et al., 2018). Homelessness services utilise peers to engage this population in the UK, but with little evidence. Current definitions are too broad and lack differentiation between types of peer support. Therefore, there is a need to clarify underlying concepts within peer interventions to influence practice and for future research. This thesis aims to identify and define the underlying change mechanisms involved in peer interventions for those who are homeless and the feasibility of testing the effectiveness of this intervention. Using the Medical Research Council guidance on developing complex interventions, two literature reviews and three empirical studies were completed.

Chapter 3 reports a review of the literature exploring the effectiveness of peer interventions and evaluates included articles for potential common elements in peer interventions, from 13 articles. Chapter 4 describes qualitative interviews with 29 participants providing and/or receiving this support to understand potential change mechanisms. Interestingly, it was found that participants were describing a mentorship-type of peer support, suggesting further clarification is needed. Therefore, a second literature review was conducted, in Chapter 5. This realist review focused on the mentorship-type of peer support, terming it intentional, unidirectional peer support (IUPS). The iterative literature search resulted in 71 articles from several sources (e.g. empirical and theoretical literature). Chapter 5 provides a detailed description of IUPS from multiple health areas and suggests change mechanisms that can transcend contexts.

To test these concepts in a homeless context, Chapter 6 reports a Q Sort study; a mixed methods design that has never been used within this topic, where a by-person approach to factor analysis is used to generate understanding of shared viewpoints. Forty participants (20 peers and 20 professionals) involved in the delivery and/or facilitation of peer interventions for a homeless population were recruited. Peers and professionals ranked general statements describing peer interventions. Results found support for the developed change mechanisms in Chapter 5 and further evidence the need for peer interventions to be clearly defined in practice and research. To aid this, Chapter 7 reports IUPS as an evidence-based intervention that can be used to inform practice and future research. Additionally, this intervention definition was utilised in the final empirical study in Chapter 8, where the feasibility of testing IUPS across multiple homeless organisations through a controlled cohort study was conducted. Five organisations (two in treatment group and three in control group) participated. Through qualitative interviews and quantitative data, a number of recommendations are suggested to ensure the success of future research.

The work in this thesis provides an identification of emerging issues within peer interventions that are worthy of investigation, creating new understanding of a previously poorly defined peer intervention. The main contribution of knowledge that this thesis provides is the clarity on types of peer interventions, and illuminates new avenues to further our understanding of this important topic.

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Academic Thesis: Declaration of Authorship

I, STEPHANIE LOUISE BARKER, declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

Peer Support and Homelessness

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
5. I have acknowledged all main sources of help;
6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
7. Parts of this work have been published as:

    Barker, S. L., Maguire, N., Bishop, F. L., & Stopa, L. L. (2018). Expert viewpoints of peer support for people experiencing homelessness: A Q Sort study. *Psychological Services*. doi: 10.1037/ser0000258

    Barker, S. L., Maguire, N., Bishop, F. L., & Stopa, L. (2018). Critical elements of peer support and the experience of peer-supporters helping the homeless: A qualitative study. *Journal of Community and Applied Social Psychology*, 1-17. doi: 10.1002/casp.2353

    Barker, S. L., & Maguire, N. J. (2017). Experts by experience: Peer support and its use with the homeless. *Community Mental Health Journal*, 53(5), 598-612. doi:10.1007/s10597-017-0102-2

8. Parts of this work have been disseminated in oral and/or poster format as:

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Barker, S.L. (2017). Peer Support Models: How to involve them in your projects successfully. Presented (oral) at the International Street Medicine Symposium, Allentown, USA, October 19-21

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Barker, S.L. (2016). Peer Support and Homelessness. Presented (oral) at the University of Southampton's 3 Minute Thesis Competition, Southampton, UK, March 4

Barker, S.L. (2016). Peer Supporters Aiding the Escape from Homelessness. Presented (oral) at the Faculty of Homelessness and Inclusion Health regional Meeting, London, UK, July 6

Barker, S.L. (2016). Peer Supporters Aiding the Escape from Homelessness. Presented (oral) at the University of Southampton's Annual PGR Conference, Southampton, UK, June 23-24

Barker, S.L. (2015). Experts by Experience. Presented (oral and poster) at the College of Medicine's 360 Degrees of Health conference, Norwich, UK, September 4-5

Barker, S.L. (2015). Experts by Experience. Presented (oral) at the University of Southampton's Postgraduate Conference, Southampton, UK, June 18-19

Signed: .....

Date: .....

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Abbreviations

AA	Alcoholics Anonymous
AUDIT	Alcohol Use Disorders Identification Test
AMSTAR	A Measurement Tool to Assess Systematic Reviews
CMO	Context Mechanism Outcome
CReDECI	Comprehensive Reporting in Developing and Evaluating Complex Interventions
CD-RISC 2	Connor-Davidson Resilience Scale
CG	Control Group
CINAHL	Cumulative Index of Nursing and Allied Health Literature
DUDIT	Drug Use Disorders Identification Test
DERS	Difficulty in Emotions Regulation Scale
GDPR	General Data Protection Regulation
GSE	General Self Efficacy Scale
IBPS	Intentional Bidirectional Peer Support
IPS	Intentional Peer Support
IUPS	Intentional Unidirectional Peer Support
MEH	Multiple exclusion homeless
MEDLINE	Medical Literature Analysis and Retrieval System Online
MMAT	Mixed Methods Appraisal Tool
MRC	Medical Research Council
NHS	National Health Service
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
PTSD	Posttraumatic Stress Disorder
PCR	Peer-Client Relationships
PPS	Primary Peer Support

Abbreviations

RCT	Randomised Control Trial
SMR	Standard Mortality Ratio
SAMHSA	Substance Abuse and Mental Health Services Administration
TAU	Treatment as Usual
TB	Tuberculosis
TG	Treatment Group
TIDieR	Template for Intervention Description and Replication
UK	United Kingdom
WAI	Working Alliance Inventory
WEMWBS	Warwick-Edinburgh Mental Well-Being Scale

Chapter 1 Introduction

1.1 Defining Homelessness

Take a walk down a high street of any major city in the United Kingdom (UK) and you are most likely to see someone who would be labelled as homeless. These occurrences provide us with a daily reminder of this visible problem. Rough sleeping is the most obvious form of homelessness; however, there are multiple forms of homelessness and existing literature reflects an inconsistency in defining homelessness (Fitzpatrick, Kemp, & Klinker, 2000).

Part VII of the Housing Act 1996 sets out the statutory definition of someone who is homeless. A person is homeless if they have no accommodation available for occupation, in the UK or elsewhere, no legal right to occupy an accommodation, or their accommodation is unreasonable for them to occupy (House of Commons, 2005, p. 9). Inappropriate accommodation can include occupying a vehicle, leaving accommodation because of violence or health reasons, or living with friends (i.e. sofa surfing). Being classified as homeless can also include those in transient housing or hostels. Thus, the term 'homeless' is applied to a diverse group of people, by where they may, or may not be found (Maguire, 2017).

This definition can include multiple types of homelessness. Rough sleeping includes people sleeping outside and is the most extreme type of homelessness (Shelter, 2018). Those who constitute the 'hidden homeless' are those who may be living with friends or family, sofa surfing, or in overcrowded accommodation (Shelter, 2018). The hidden homeless are often not engaged with services, and therefore are not counted in official statistics. Those who are engaged with services provided by their local councils are termed 'statutory homeless' (Shelter, 2006, 2018). Fitzpatrick, Bramley, and Johnson (2012) define a form of 'deep social exclusion', known as multiple exclusion homelessness (MEH), where people are homeless and have also experienced at least one other form of deep exclusion, such as institutional care, substance misuse, or participation in street culture (e.g. begging, sex work).

1.2 Policy

The Homelessness Act (2002) stipulated that each local authority must conduct a review of homelessness in their area and provide a strategy for prevention and support those affected by homelessness. Generally, each local authority has a duty to provide housing and temporary accommodation for people who are deemed in priority need (e.g. children, pregnant women, and

vulnerable people), and those not intentionally homeless (e.g. left provided accommodation, failed to comply with certain rules/regulations) (Department for Communities and Local Government, 2002). Although this policy helped a number of people, it failed to help everyone. Reports of gatekeeping and pressure to keep the recorded numbers of homeless low have led to people being rejected and excluded from services, creating distrust and animosity between service users and providers (Wilson, 2013).

In the last year, the Homelessness Reduction Act (2017) sought to reduce these issues by placing new legal duties to each local council (Ministry of Housing, 2017). The Act (2017), which came into full effect on April 3, 2018, seeks to enable everyone who needs support regarding housing and preventing homelessness to access care, as long as they are eligible for assistance. Under the Act (2017), local councils are expected to provide free advice and support to prevent homelessness, secure accommodation, and information on the rights of those who are homeless (Shelter, 2018). This is achieved through an extended period of support (from 28 days to 56 days) and focusing on prevention and relief. This process is summarised in Figure 1. National homeless charities, such as Shelter, supported the development of the Act (2017) and express hope for the coming changes to homelessness support (Shelter, 2018).

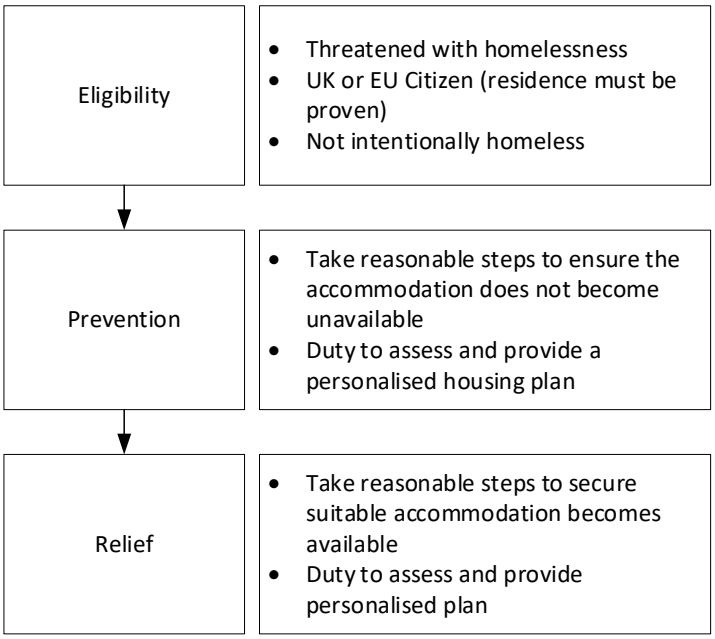


Figure 1. Process of Local Council Homelessness Duty

1.3 Prevalence

The Ministry of Housing, Communities, and Local Government releases England's homelessness statistics quarterly. In March 2018, their report stated that there were 26,880 housing applications in 2017, a 4% decrease from the last calendar year where 29,340 housing

applications were received (Ryan, 2018b). Housing applications are accepted if applicants are found to be unintentionally homeless and identified as in priority need. Of the applications that were assessed, 13,640 (51%) were accepted, 6,540 (24%) were found not to be homeless, 4,550 (17%) were found to be homeless, but not in priority need, and 2,160 (8%) were judged as intentionally homeless and in priority need (Ryan, 2018b, p. 5). The Ministry of Housing, Communities, and Local Government also reported that there was an estimated 4,751 rough sleepers in 2017, a 15% increase from 2016 (Ryan, 2018a).

These numbers do not include those who comprise the hidden homeless and anyone who is in need but not seeking services. Further, the number of housing applications received is derived from the housing applications that were assessed and does *not* include everyone who approached the council (Ryan, 2018b). The prevalence of homelessness in the UK is much higher than the numbers presented by the government. Shelter (2017) reports that more than 300,000 people are homeless in Britain, a number derived from compiling official rough-sleeping, temporary accommodation, and social services figures.

Regarding the local area, the report by Shelter (2017) found that the South East of England has a high rate of homelessness; for every 327 people in the South East at least one person is homeless. This figure is closer to the highest rates in London (1 in every 53), than it is to the lowest figures reported in Yorkshire and Humber (1 in 1,127). The report shows that the South East has:

- 23,547 people living in temporary accommodation
- 956 people rough sleeping
- 3,108 people in single homeless hostels and social services
- Totalling 27,611 people experiencing homelessness (Shelter, 2017)

According to statistics released by the Ministry of Housing, Communities, and Local Government, the typical demographic profile of a homeless person whose housing application was accepted in 2017 is between the ages of 25-44 (58%), a lone female parent with dependent children (47%), and of white ethnicity (62%) (Ryan, 2018b, Table 771, 780, & 781). Therefore, from these figures, it can be discerned that those who are not supported by government initiatives are single males. For example, Two Saints, a homeless charity that provides support across the South of England reported that in 2017 that 63% of their clients were male and single (Two Saints, 2017). Homelessness is a rampant issue and those who are likely to need the most support are single males.

1.4 Impact

Those who are homeless represent the 'hardest-to-reach' population, or, perhaps, the easiest population to ignore (O'Carroll, 2015). People who are homeless usually represent individuals who have the most complex issues that often cause breakdown in relationships, with family, friends, and support services alike (Maguire, Johnson, Vostanis, & Keats, 2010). Not only is this group disproportionately affected by health inequality (Hart, 1971), the homeless are more likely than the general population to suffer from multiple issues. In fact, compared to their domiciled counterparts, people living in temporary or emergency accommodations are eight times more likely to suffer from mental illness, while those who sleep rough are eleven times more likely to have a mental illness (Fitzpatrick et al., 2000). Those who suffer from chronic homelessness are more likely to have severe issues—for example, it is estimated that 31% of the homeless have a diagnosis of schizophrenia and about 70% have personality disorder diagnosis (Fazel, Khosla, Doll, & Geddes, 2008). Homelessness subjects a person to isolation and feelings of worthlessness, leading to depression and loneliness (La Gory, Ritchey, & Mullis, 1990). This population is also at risk for developing serious physical issues, such as tuberculosis, HIV/AIDS, hepatitis, and other infectious diseases (Fazel et al., 2008; Fitzpatrick et al., 2000). There is an increased prevalence of alcohol and drug abuse/misuse in this population (Fitzpatrick, et al., 2000). Taken together, these factors leave this population very vulnerable.

Those who are MEH are much more likely to have complex issues and worse outcomes than those who are not MEH (Fitzpatrick et al., 2012). With over 1,200 responses, Fitzpatrick et al. (2012) found that almost half of their participants experienced all four domains of MEH (i.e. homelessness, institutional care, substance misuse, and participation in street culture). Additionally, it was also found that being male, aged between 20-49, experiencing childhood abuse/neglect, and those who had problems at school were likely to have more complex issues while MEH (Fitzpatrick et al., 2012).

A recent review examined the impact of health inequalities for those who are socially excluded using standardised mortality ratios (SMR) (Aldridge et al., 2018). SMRs are a unit of measurement to compare the mortality rate of a population to the number of expected deaths in the general population, where 1.0 is equivalent to the general population. The study found that males have an SMR score of 7.9 and women have an SMR score of 11.9 (Aldridge et al., 2018). Those who experience social exclusion often suffer additional problems to those experienced by clinical populations, evidencing the most complex, multi-morbid conditions requiring significant resource to engage in health interventions. Thus, this population needs our attention and interventions need to be assessed for their effectiveness in reducing these likely and extreme outcomes.

1.5 Aetiology

Homelessness is caused by both structural and individual factors. Structural causes include poverty, unemployment, housing policies, lack of affordable housing, and housing rights (House of Commons, 2005; Shelter, 2006). Further, low income, unemployment, and poverty are direct factors that contribute to recidivism back into homelessness (Anderson, 2001). Individual factors that influence homelessness include lack of social support, behavioural issues, low academic qualifications, debt, poor health, and family conflict (e.g. domestic violence) (Quilgars, Johnsen, & Pleace, 2008; Shelter, 2006).

Main (1998) attempted to unite these two competing ideas about causes of homelessness and developed a theory of homelessness that examines the interplay between structural and individual factors, such as loss of affordable housing and economic conditions combined with individual factors including mental illness, substance abuse, and lack of social support as primary causes of homelessness. Main (1998) asserts that homelessness results from the unique mixture of these factors, calling for more investigation on this topic.

Recently, Maguire (2017) proposed a model explaining repeat homelessness, emphasising the link between individual and structural factors and the mediating role of psychological factors (see Figure 2). A psychological approach to understand the interaction of multiple factors is useful—people attribute meaning to others' behaviour, influencing how they react, which then shapes their environment, in an attempt to make the world more predictable (Maguire, 2017). Therefore, the model identifies contextual factors that can be impacted by understanding of psychological factors. If we understand predisposing and maintaining psychological factors to homelessness then we can develop policy and support around those ideas to prevent and treat homelessness.

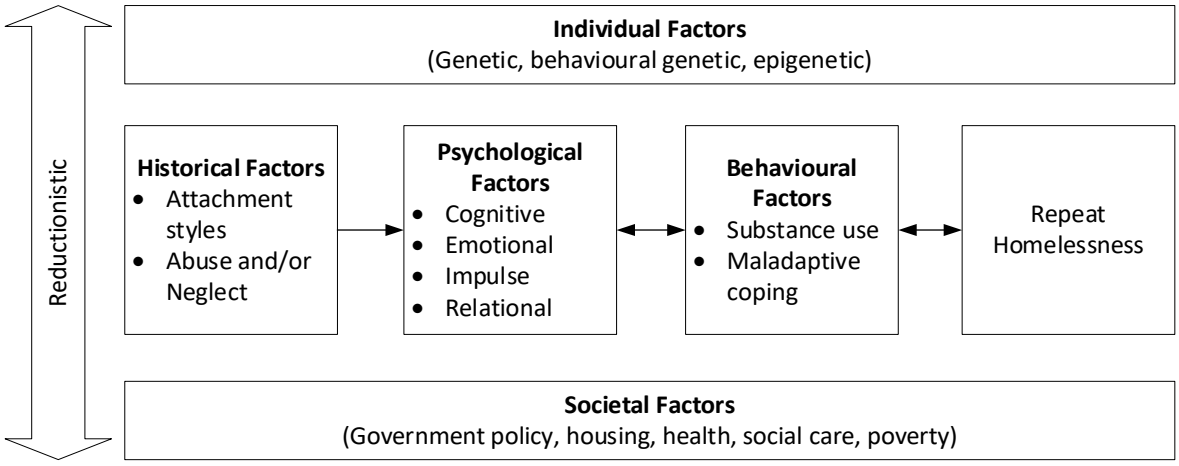


Figure 2. Maguire's (2017) Model of Repeat Homelessness

For example, experiences of childhood abuse manifest in adulthood as disordered functioning akin to personality disorders (impulsive and self-destructive behaviours, emotional dysregulation), described by Herman (1992) as 'complex trauma'. The experience of complex trauma can have an impact on the development of attachment and, therefore, how the person relates to others as an adult. Where an attachment figure has been avoidant or unpredictable, a child may grow up to feel that other people are not a source of safety (avoidant attachment) or that they will not be reliable (anxious attachment) (Mickelson, Kessler, & Shaver, 1997). These attachment systems then influence interpersonal relationships as adults, and result in the absence of a sense of safety and belonging, as well as fostering distrust of others. Further, this may influence fundamental cognitions about the self and how others may behave towards the individual (Maguire, 2017). This can result in people functioning in ways that collide with support services, resulting in loss of tenancy and repeat homelessness. Research supports these assertions; for example, experiencing childhood physical abuse, neglect, or homelessness increases risk of MEH in later life (Fitzpatrick et al., 2012). Further, childhood abuse and neglect are related to a decreased ability to regulate emotions, which results in an increase in maladaptive behaviours that contribute to evictions (Maguire, Greene, & Willoughby, 2012, manuscript in prep). These findings, and the model developed by Maguire (2017), enable interventions to target specific psychological and behavioural factors to help reduce the effects of homelessness and reduce recidivism of homelessness.

Further, Fitzpatrick et al. (2012) found that a pattern of adverse events can lead to MEH. Routes into MEH have been broken down into four broad phases. First, if substance abuse occurs at all, it

tends to be earliest in the MEH pathway. Secondly, becoming anxious or depressed, engaging in survival sex work, sofa surfing, and being in prison can lead to transitions into street lifestyles. Thirdly, sleeping rough, begging, and injecting drugs are events that confirm street lifestyles. Fourthly, official homelessness is characterised by tangible events, such as being evicted, applying to the council, and staying in hostels. This pathway can be used to help explain where someone is on the homelessness spectrum and be used to develop interventions and prevent the individual's situation becoming worse.

1.6 Treatment

The treatment of homelessness logically builds from the causes of homelessness and should include structural changes and support to individuals to help overcome psychological and behavioural aspects that originally contributed to homelessness. As described above there have been some recent changes to the policy and support provided by the government. The following section examines treatments that focus on helping the individual escape homelessness.

1.6.1 Treatment First

Traditionally, a treatment first approach has been used to help those who experience homelessness. This approach involves providing support for issues prior to housing the individual. Stipulations around housing include demonstrating sobriety and stability (Tsemberis & Asmussen, 1999). This type of treatment focuses on other issues experienced, providing treatment for addictions, mental illness, and physical ailments. Key workers or case managers do provide tangible support regarding housing assistance, as long as clients demonstrate that they are 'housing ready' (Tsemberis & Asmussen, 1999). To be housing ready, clients need to prove they have appropriate skills to live in a house—knowing how to pay bills, clean, cook, etc. Proponents of this approach argue that without these skills, people are being set up to fail (Kertesz, Austin, Holmes, Pollio, & Lukas, 2015; Tsemberis & Asmussen, 1999). This model treats the fact that these people have unstable housing as a secondary problem, potentially ignoring that homelessness could be the cause of addiction, mental health issues, and physical ailments.

1.6.2 Housing First

Housing first is a relatively recent treatment approach. The basic premise is that housing should be viewed as a right, not a privilege (Bean, Shafer, & Glennon, 2013). Current schemes of this initiative attempt to house the individual and then provide optional (but assertively promoted) support regarding mental health, addiction support, and other services (M. Brown, Jason, Malone,

Srebnik, & Sylla, 2016). Housing is not incumbent on sobriety or treatment. This approach has been well received; there are numerous housing first schemes across the UK, Canada, America, Australia, Finland, and France (M. Brown et al., 2016). Although research has supported this approach (e.g. M. Brown et al., 2016), it does require significant resources. Bean et al. (2013) report that Housing First is a valuable treatment approach, showing that combined with other treatments, it reduces drug/alcohol use and increases quality of life. Housing First is a welcome addition to tackling homelessness, but unless underlying psychological issues are managed, relapse into homelessness is very likely. Indeed, simply housing someone is not enough (Maguire et al., 2012, manuscript in prep).

1.6.3 Social Exclusion Treatment

Considering the various causes of homelessness, the approach to treat must be as flexible and complex as the problem itself. Homelessness results from a number of structural and individual factors and therefore, a comprehensive solution needs to consider these as well. Recently, Luchenski et al. (2017) conducted a review of interventions that work for those who are socially excluded. Authors identified multiple effective interventions, including pharmacological interventions for drug misuse, psychosocial interventions, case management, disease prevention, housing, social determinants (e.g. occupational therapy and supported work placements), and gender-specific interventions. Hewett (2017) asserts that a key component to effective interventions for excluded groups is peer involvement but Luchenski et al. (2017) calls for more research on this topic to understand client and peer outcomes. Peer interventions (described below) lack conceptual clarity and given that both government and third sector funds are used to support this approach, there is a clear need to provide clarity on this topic (Faulkner, 2013).

Further, research has found that social support is vital to health—weak or non-existent social ties is a risk factor for death, comparable to smoking (Holt-Lunstad, Smith, & Layton, 2010). Peers have a unique ability to access those who are socially excluded (Pilote et al., 1996) and more homeless services are utilising peers (e.g. Shelter in Birmingham, Ashford Place and Groundswell in London, UK). Therefore, there is a need to understand this topic and inform further service development.

1.7 Peer Support Interventions

1.7.1 Brief History

Peer support refers to the system whereby individuals with lived experience of a particular difficulty provide support to others. Peer support has a long history in the mental health arena and has become integral to health systems (Faulkner, Basset, & Ryan, 2012). Peer support stems

from the mental health recovery movement that began in the 1970's, which rejected the medical model for mental health treatment (Mead, Hilton, & Curtis, 2001). The medical model was criticised as being outdated and stigmatising—defining wellness as absence of symptoms and a focus on illness, not health. People with mental health issues wanted to have reform on hospital procedures for someone in mental health crisis, acknowledgment of the social factors that contribute to distress, and value of the lived experience (Faulkner et al., 2012). Indeed, shared experience spurred the movement for people to identify as 'survivors' of the mental health system (Faulkner et al., 2012).

This movement was seen as a threat to the scientific community, as activists conceptualised their shared experiences as 'experiential knowledge', a term historically found in the self-help area, to validate and give power to their voices (Borkman, 1976). Experiential knowledge is comprised of two elements: information on which the knowledge is based and the individual's attitude towards that knowledge (Borkman, 1976). Information includes the whole experience of a phenomenon, but it is the individuals' attitude towards their experience that determines whether this 'knowledge' is useful. Experiential knowledge allows the person to claim power in their own and their peers' story (Faulkner et al., 2012). The recovery movement values a holistic approach to mental health; there is emphasis on mutual empowerment, shared experiences, sense of belonging, and the ability to recover regardless of diagnosis (Mead et al., 2001).

The prevalence of this type of intervention is demonstrated by its presence in numerous organisations and international guidelines for multiple health issues, for example, in 2003, Wallcraft and colleagues identified over 700 programs that involve peers/consumers in England (Wallcraft, Rose, Reid, & Sweeney, 2003). Further, researchers in Australia developed recommendations for the use of peer support within high-risk environments and Canadian advisory groups developed national guidelines of including those with lived experience in homelessness services (Creamer et al., 2012; National Lived Experience Advisory Council, 2016).

1.7.2 Defining Peer Support

Peer interventions are those that are utilised to help the wellbeing of someone experiencing negative effects of a phenomenon. The idea that peers can help others through specific struggles is utilised in homelessness services, the rehabilitation of offenders, addiction treatment, and mental and physical health services (Adair, 2005; Chinman et al., 2014; L. Davidson, Chinman, Sells, & Rowe, 2006). Peer support interventions fall within a continuum of different helping relationships, shown in Figure 3 (L. Davidson et al., 2006).

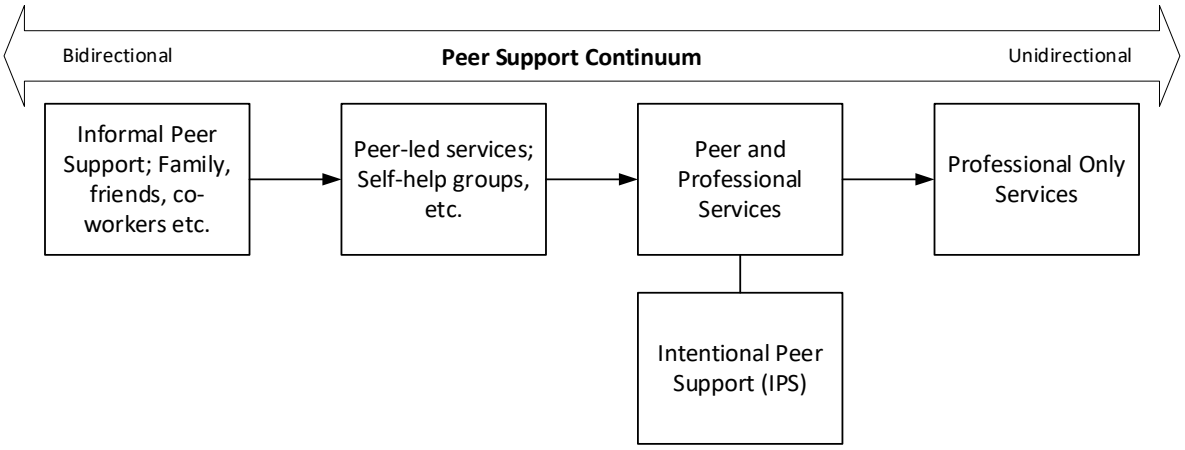


Figure 3. Continuum of Helping Relationships

In America, the Substance Abuse and Mental Health Services Administration (SAMHSA) define peer support as "services [that] are delivered by individuals who have common life experiences with the people they are serving", and that peers "have a unique capacity to help each other based on a shared affiliation and a deep understanding" of specific experiences (SAMHSA, 2015, para 1). SAMHSA's broad definition would suggest that the distinguishing factor in peer interventions is the fact that peers have a shared lived experience; however, this definition fails to capture other elements that differentiate one type of peer intervention from another.

Bradstreet (2006) clarifies by discussing three types of peer support: informal (naturally occurring), participation in peer-led services, and intentional peer support (IPS). IPS involves creating specific roles within organisations filled by those with lived experience of the phenomena (Bradstreet, 2006). This type of peer support is fostered and developed by organisations, and occurs frequently in mental health and addiction services (Wallcraft et al., 2003). IPS can be delivered as mutual/bidirectional support (peers are at the same level of recovery) or mentorship/unidirectional (one peer is at an advanced level of recovery and mentors the newcomer) (Faulkner & Basset, 2012). While this definition is helpful in developing our understanding of peer support, it lacks clarity in specifying the interventions that clients are receiving, which limits the conclusions that can be drawn from effectiveness studies. Unsurprisingly, there is inconsistency in the literature regarding the effectiveness of peer support. For example, Repper and Carter (2011) found positive evidence for peer support effectiveness within mental health services in their review; in contrast, there was little evidence for this intervention in a systematic review on IPS and severe mental illness (Lloyd-Evans et al., 2014).

Traditionally, research and practice use the general term 'peer support' to refer to any intervention that involves peers, including informal peer groups, informal peer mentoring (similar to one that occurs in Alcoholics Anonymous (AA)), intentional peer groups, IPS interventions, and

IPS mentoring interventions. Additionally, there is variation in the terms used depending on the setting; for example, within criminal justice services peers can be referred to as 'wounded healers', whereas within mental health peers may be identified as 'consumer survivors'. Within homelessness, peers are sometimes known as 'peer advocates' (Bowgett, 2015; Cook & Jonikas, 2002; Finlayson, Boleman, Young, & Kwan, 2016; Heidemann, Cederbaum, Martinez, & LeBel, 2016)

In this thesis, primary peer support (PPS) is used to describe peer support in general—how it has been known, but to differentiate it as a term that lacks clarity and can bring about assumptions in readers. To be clear, within this thesis, PPS is equivalent to peer support. The aim in defining peer support as PPS is to help readers differentiate between old terms that are obscure and loaded with assumptions about the intervention and its processes. There is a need for clarity in this area to define the different types of PPS to ensure that future research and practice are certain about the effectiveness of specific peer interventions.

1.7.3 Theory of IPS

Although IPS is utilised to support recovery from multiple phenomena, little is known about critical elements underpinning IPS that effect cognitive, behavioural, or emotional changes in recipients and/or providers. There are no known reports exploring these elements of change and the experiences of those providing/receiving IPS within the homeless population. Dennis (2003) developed the only known model regarding processes of IPS, reporting how IPS fits into a continuum of supportive social networks within the context of healthcare (similar to Figure 3). The model provides a conceptualisation of IPS, citing emotional, appraisal, and informational social support as its defining attributes. Peers aid interpretation of positive reinforcement, provide opportunities for vicarious and observational learning, act as role models for social comparison, disseminate coping strategies, and encourage cognitive restructuring (Dennis, 2003). This theoretical model is comprehensive in the context of nursing, but lacks explanation and evidence of IPS for homelessness. Further, Dennis (2003) does not differentiate the direction of the relationship within IPS. That is, this model is applicable to Bradstreet's (2006) definition of IPS, as it describes IPS that includes both bidirectional and unidirectional IPS, but has not examined asymmetrical peer-client relationships.

Whelan, Marshall, Ball, and Humphreys (2009) also found that sponsors in AA primarily provide emotional and instrumental social support. However, research has also found that the sharing of "experience, strength, and hope" is critical to reducing substance abuse (Blondell et al., 2001, p. 7). Genuine and honest motivations are important in building trusting relationships between

peer-supporters and clients; participants report distrust for AA members visiting from the community, suggesting they were motivated by needing to do their 'service work' as outlined by the twelfth step (Rayburn & Wright, 2009).

Literature from mental health also asserts the importance of relationships between peer-supporters and clients. The main components in these relationships are 1) shared experiences, 2) role-modelling, and 3) provision of support (Ahmed et al., 2012; Campbell, 2008; Campos et al., 2014; Mead et al., 2001; Salzer, 2002; Solomon, 2004). First, shared experiences enable the development of mutually beneficial relationships, where both peer-supporters and clients experience increased sense of community (Bradstreet, 2006; Mead et al., 2001). Secondly, IPS involves social comparisons, namely that peer-supporters act as role models for clients. Recipients of IPS look up to their peer-provider as someone who has 'been there' and survived. Thirdly, acting as role models, peer-supporters use their experience and knowledge of health systems to mentor clients, providing them with different types of social support (Campbell, 2008; Salzer, 2002; Solomon, 2004).

Therefore, the literature suggests that there are specific components involved in peer interventions. Specifically, different types of social support (emotional; informational; tangible; appraisal; and companionship), social learning, social comparison, trust, experiential knowledge, and role modelling are all identified elements of IPS interventions. Literature also describes the importance of the peer-client relationship in effective peer interventions and suggests that these components contribute to an effective helping relationship (Salzer, 2002; Solomon, 2004)

Additionally, peers benefit from being in the helping role. Historically described as the helper-therapy principle by Reissman (1965), where non-professional helpers benefit from being in helping roles—experiencing an increased sense of interpersonal competence, knowledge, and social approval. Indeed, peer-supporters benefit from engaging in providing support—increased self-efficacy and enhanced sense of self through re-telling their story and creating new personal narratives (C. Anderson, 1993; Campbell, 2008; Croft, Hayward, & Story, 2013; Eisen et al., 2015; Mead et al., 2001).

In sum, there is a breadth of literature that describe how IPS is thought to work; however, these assumptions are largely atheoretical and conjecture. Further, the existing literature mainly focuses on those who experience mental illness. While the homeless experience high rates of mental illness, those who are homeless have complex needs and are qualitatively different from clinical populations who are not homeless. Currently, there is simply not enough evidence to make conclusions about how IPS interventions work with a homeless population.

1.7.4 Findings on the Effectiveness of IPS

As described above, there has been mixed evidence on the overall effects of IPS (in its current definition). There have been individual studies examining IPS interventions. The literature shows that peers are utilised to increase healthy behaviours (Dennis, 2003), reduce alcohol and drug use (Blondell et al., 2001; Galanter, Dermatis, Egelko, & De Leon, 1998), increase mental health recovery (Campbell, 2008; Salzer, 2002), and reduce impacts of homelessness (Finlayson et al., 2016). Studies have found that client outcomes, such as substance misuse, health, and social support are positively impacted by IPS interventions (Felton et al., 1995; Resnick & Rosenheck, 2008; Tracy et al., 2012; Tracy, Guzman, & Burton, 2014).

Research on the effectiveness of increasing health for homeless persons has found that peers are able to increase client engagement with health treatments (Connor, Ling, Tuttle, & Brown-Tezera, 1999; Deering et al., 2009; Fogarty et al., 2001; Pilote et al., 1996; Tulsky et al., 2004; Tulsky et al., 2000), and reduce barriers in accessing health services (Finlayson et al., 2016). Further, studies examining IPS on mental health outcomes found that peers improve clients' ability to cope with transitions from the hospital to independent housing (Weissman, Covell, Kushner, Irwin, & Essock, 2005), facilitate increases in social networks (Stewart, Reutter, Letourneau, & Makwarimba, 2009), and contribute to better overall outcomes for clients (Bean et al., 2013; Galanter et al., 1998; van Vugt, Kroon, Delespaul, & Mulder, 2012).

These results are encouraging; however, these studies have been conducted with varying types of IPS—those with and without unidirectional support. Therefore, we cannot draw conclusions about which aspects of IPS are actually influencing client outcomes. Thus, there is a need to understand the elements that positively impact client outcomes.

1.7.5 IPS and Homelessness

Given the popularity and effectiveness of IPS in mental health and addiction services, unsurprisingly, homelessness services have increased uptake of this intervention. However, as described above, those who experience homelessness suffer additional problems to those experienced by clinical populations. IPS schemes are becoming quite common in homelessness services, with new peer programmes gaining funding (e.g. Ashford Place and Riverside in London, UK,). Yet to be reflected in published literature, IPS is a popular topic at prominent conferences (e.g. Street Medicine Institute Symposium 2016; 2017, The Faculty of Homelessness and Inclusion Health Symposium 2016; 2017; 2018). Further, international organisations have developed

standards and guidelines for involving those with lived experience into homelessness services (i.e. National Lived Experience Advisory Council, 2016).

While there is extensive literature on IPS in general, few studies focus on the potential change mechanisms that might underpin this intervention. Without a clear understanding of how IPS might work, research can neither prescribe best methods for delivering this intervention nor explain why effectiveness studies have mixed results. By establishing clarity about change mechanisms, organisations providing IPS for those experiencing homelessness will be better placed to improve their services and peer training to help their clients escape homelessness.

IPS interventions are aimed at promoting change within behavioural factors identified in the model by Maguire (2017) in Figure 2. However, IPS interventions can have an impact on both behavioural and psychological factors, such as challenging negative thoughts about the self or others, role-modelling impulse control, and increasing social support (Boisvert, Martin, Grosek, & Clarie, 2008; Felton et al., 1995; Tracy et al., 2012). Further, peers can help to access those who are MEH. Tulsky et al. (2000) found that peer-supporters are effective at increasing initial adherence to tuberculosis treatment and Deering et al. (2009) found that IPS increased adherence to HIV/AIDS treatment for homeless populations. Furthermore, recent research highlights the value of IPS for socially excluded populations, or those who are hard to find and hard to engage in change (see Finlayson et al., 2016; Luchenski et al., 2017).

IPS is most commonly utilised to assist health interventions for homeless populations, but peer-supporters also act as one-to-one mentors, informal supporters, group facilitators, and linking clients to professionals (Stephanie. L. Barker & Maguire, 2017). Peer mentors help clients to navigate complex health and social systems to access services. IPS schemes are being integrated into homelessness services at multiple organisations in the UK (e.g. Emerging Horizons, 2017; Finlayson et al., 2016; Luchenski et al., 2017).

One of the few reports examining IPS with a homeless population is a mixed-methods evaluation of a peer-advocacy programme from a homeless charity (Finlayson et al., 2016). Peer-supporters had a positive impact on clients experiencing homelessness by building relationships on “shared experience and ability to empathise and develop a mutual trust and understanding” and providing social support (p. 18). However, these authors were interested in the outcomes of IPS interventions, rather than the exploration of elements that contribute to effective IPS. Further, Croft et al. (2013) produced the only known qualitative report on the experiences of those providing IPS in a homelessness context, finding evidence that peer-supporters in educational roles benefitted from being a provider, experiencing empowerment and identity integration.

Although these authors used qualitative methods, they explored the motivation and outcomes experienced by peer-supporters, and did not include recipients of IPS in their sample.

Work in this area is sparse and assumptions are largely atheoretical, lacking in explanations of how this intervention works (i.e. mechanisms of change). This thesis will show that, although these initial conceptualisations of IPS are useful, they are incomplete in fully explaining change mechanisms underlying effective IPS, reporting experiences of providing/receiving support, and clearly defining IPS as an intervention for those experiencing homelessness.

1.8 Research Question

Those who have been socially excluded face extreme consequences—various conditions and diseases, mental illness, psychological isolation, and a higher chance of premature death (Aldridge et al., 2018). Although there are existing policies and treatment available for this population, homelessness still occurs. Homelessness services employ peers to engage this population in the UK, but there is little evidence to support this practice. Further, there is a need to clearly define underlying concepts within IPS and create preliminary theory for future research to build upon. It is the aim of this thesis to explore what specific components comprise IPS and if it is a feasible treatment option for work with the homeless. The thesis' research question, therefore is: what are the processes and elements of IPS interventions for a homeless population and what is the feasibility of assessing outcomes related to homelessness, mental health, addiction, and physical health? In order to answer this question, the following objectives have been identified:

1. Examine the current evidence base for the effectiveness of IPS with a homeless population.
2. Add to the evidence base by exploring what participants' identify as critical elements of IPS.
3. Add to the evidence base by ascertaining participants' experiences of providing and/or receiving IPS.
4. Model process and outcomes in the development of a 'middle-range theory' of mentorship peer interventions that transcends contexts.
5. Evaluate a model of IPS with a homeless population.
6. Add to knowledge on this topic by explaining relationships between identified elements of IPS.
7. Describe the intervention in detail for researchers and practitioners developing or improving IPS interventions.
8. Assess the feasibility of testing the effectiveness of the defined IPS intervention on outcomes through methodologically rigorous means.

1.9 Outline of the Thesis

Due to the complex nature of evaluating IPS, the Medical Research Council's (MRC) guidance on complex interventions has been used to aid the development of this programme of research, organising the research in the first two phases (development and feasibility/piloting) as stipulated by Craig et al. (2008). A visual depiction of the literature reviews and empirical studies is shown in Figure 4.

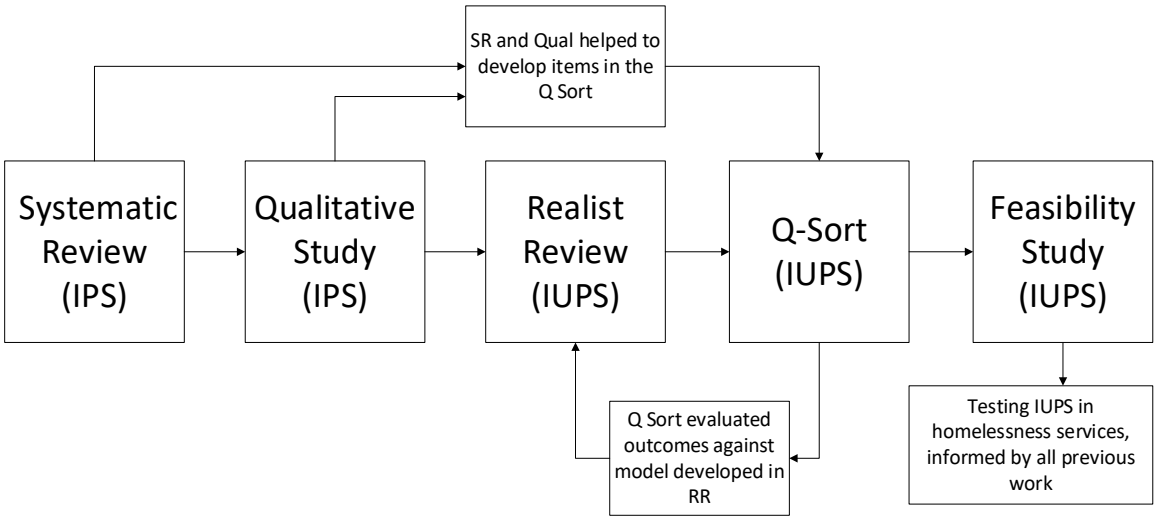


Figure 4. Visual Depiction of Work in the Thesis

1.9.1 Chapter 2: Thesis Methodology

This chapter describes the methodology of the overall thesis, using the complex interventions framework (Craig et al., 2008). The thesis satisfies the first two phases of developing and piloting a complex intervention, by investigating the theoretical and empirical evidence base, developing a model, and exploring the feasibility of evaluation. Further, this chapter includes sections discussing multiple paradigms in research and clarification of epistemological perspectives.

1.9.2 Chapter 3: Systematic Review of the Literature on the Effectiveness of Intentional Peer Support within Homeless Populations (Objective 1)

This chapter provides a systematic review on IPS and homelessness that aims to examine the current evidence on the effectiveness of IPS interventions. This review bolsters the rationale for subsequent work on this topic through assessing current literature and identifying existing gaps. The review found limited and methodologically weak literature on the effectiveness of IPS. However, included reports highlight significant outcomes of IPS as an intervention on outcomes related to quality of life. Current literature lacks clearly defined concepts and types of IPS used. Consequently, this review sought to use the included studies as a starting point, analysing the

textual data of the articles for common justifications, explanations, and uses of IPS to develop a preliminary identification of common elements in this intervention. The review search was re-run in June 2018 and updates of recent literature have been included.

1.9.3 Chapter 4: Intentional Peer Support Critical Elements and Experiences of those Supporting the Homeless: A Qualitative study (Objectives 2 & 3)

This chapter presents findings from a qualitative study exploring the critical elements of IPS as voiced by those who provide and/or receive this intervention. Twenty-nine participants were interviewed, and their transcribed data analysed using thematic analysis. Thematic analysis allows exploration of under-researched areas and can be used to build theoretical understandings of a phenomenon (Braun & Clarke, 2006). The 28 peer-supporters described providing a unidirectional type of IPS. Critical elements identified in this chapter include role-modelling recovery, providing continuity through never giving up, providing social support, and increasing motivation. This chapter adds to the development of a complex intervention by identifying critical elements of IPS.

1.9.4 Chapter 5: Identifying Change Mechanisms in Intentional Unidirectional Peer Support and Homelessness: A Realist Review of the Literature (Objectives 4 & 5)

Given that participants from Chapter 4 appeared to be describing a unidirectional type of IPS, this chapter provides an in-depth theoretical review of the literature to understand and define unidirectional IPS. Using realist methods, this review identifies important aspects that contribute to successful unidirectional IPS across populations, seeking to understand which mechanisms of unidirectional IPS are vital to a successful delivery of this intervention in various contexts. The chapter delivers a model of how unidirectional IPS is thought to work, according to a breadth of empirical and theoretical literature, building testable concepts and direction for future research on this topic. Findings support and extend results from previous chapters and existing literature.

1.9.5 Chapter 6: Expert Viewpoints of Critical Elements in Peer Interventions for People Experiencing Homelessness: A Q Sort (Objectives 5 & 6)

This chapter tests the model developed within the previous chapter and explores how critical elements of unidirectional IPS relate to each other through a Q-Sort study. Q Methodology is a unique mixed-methods design, developed by Stephenson (1953). This is done by statistically and qualitatively assessing communications surrounding a topic of interest (Stephenson, 1953). A set of items are developed from previous work in this thesis and existing literature, then are ranked by participants into a hierarchy by how much they agree or disagree with the relevance of each statement. Results found three perspectives that describe different types of PPS: one based on

strong peer-client relationships, one based on role modelling and mentoring, and one based on a mutual/bidirectional type of support. This chapter supports findings from the model developed in the previous chapter and suggests that unidirectional IPS is appropriate for homeless populations.

1.9.6 Chapter 7: An Evidence-Based Intentional Unidirectional Peer Support Intervention (Objective 7)

With guidance from the complex interventions literature (Hoffmann et al., 2014; D. Moher et al., 1999), this chapter presents a manual of unidirectional IPS; providing a procedural definition of how unidirectional IPS is conducted with a homeless population. This chapter acknowledges the development of the research programme, therefore guidelines are outlined around training components, delivery, and supervision requirements, concluding with an example from a London-based homeless charity. This chapter satisfies the first phase of the MRC guidance, where the intervention has been defined, modelled, and tested with a homeless population.

1.9.7 Chapter 8: The Feasibility of Conducting Research on the Effectiveness of Intentional Unidirectional Peer Support with a Homeless Population (Objective 8)

This chapter focuses on the second phase of the MRC guidelines for developing and testing complex interventions, and describes a feasibility study using a controlled cohort design to assess the effectiveness of unidirectional IPS with a homeless population through comparison of treatment and control groups. By assessing current programmes and utilising a feasibility approach, this chapter assesses for contextual factors, participant opinions, the potential for randomisation, and the possibility of comparable control groups. This study design was informed by previous chapters, such as the inclusion of outcome and process measures outlined by the systematic review. There were a number of barriers to conducting a cohort study across homeless organisations, which include recruitment, retention, gatekeepers, and resources. This chapter provides specific recommendations for future research on this topic to further the development of the research programme.

1.9.8 Chapter 9: Discussion and Conclusion

This chapter discusses results from the three studies and two literature reviews in this thesis by summarising findings and critically evaluating the work. Further, this chapter synthesises the thesis and note its strengths and limitations as a whole. In addition, this chapter identifies the thesis' original contributions to knowledge and practical implications of the findings. Suggestions for future research relate back to the findings, signifying areas to build upon, highlighting how future work can overcome identified limitations.

Chapter 2 Thesis Methodology

The following chapter describes complex interventions and introduces the complex interventions guidance, which is the chosen methodological paradigm to address the research question and objectives presented in Chapter 1. The chapter then considers philosophical underpinnings and the chosen epistemological perspective. Lastly, this chapter outlines the methods used for data collection, presented in accordance with the complex interventions guidance, and will discuss how an iterative process of multiple methods was used to explore the use of IPS interventions for a homeless population.

2.1 Complex Interventions

An intervention is defined as any action taken by someone in a helping position to increase the wellbeing of those with health and/or social care needs (Richards & Hallberg, 2015). This is a simple definition, but when one considers the actions that comprise an intervention, such as IPS, one can see how complex the process becomes. There are several interacting components, such as the type of support provided, the needs of the client, the frequency of support, the attitudes and influence of supporting staff, the context support is provided in, and the amount and types of outcomes experienced by both clients and peers. Arguably, no intervention is simple and requires consideration of complexity (Richards & Hallberg, 2015).

There is a need for careful scientific evaluation of IPS interventions to enable accurate recommendations for policy makers, practitioners, and future research. Richards and Hallberg (2015) argue that compiling previous research is not enough to inform practice and does not outline change mechanisms that underlie effective interventions. It is important to accumulate a body of evidence that explains the specific mechanisms responsible for behaviour change (Craig et al., 2008). This project set out to understand the underlying change mechanisms involved in IPS interventions for those experiencing homelessness. The MRC's guidance on developing and evaluating complex interventions was used to aid the development of this programme of research (Craig et al., 2008; Richards & Hallberg, 2015). The MRC's guidance provides a framework that enables researchers to systematically develop comprehensive interventions that can inform practice. The guidance stipulates four phases in the research process, to develop, test, evaluate, and implement a complex intervention, shown in Figure 5 and described in detail later. The MRC systematic framework is the most comprehensive resource to achieve the thesis aims and objectives of this project.

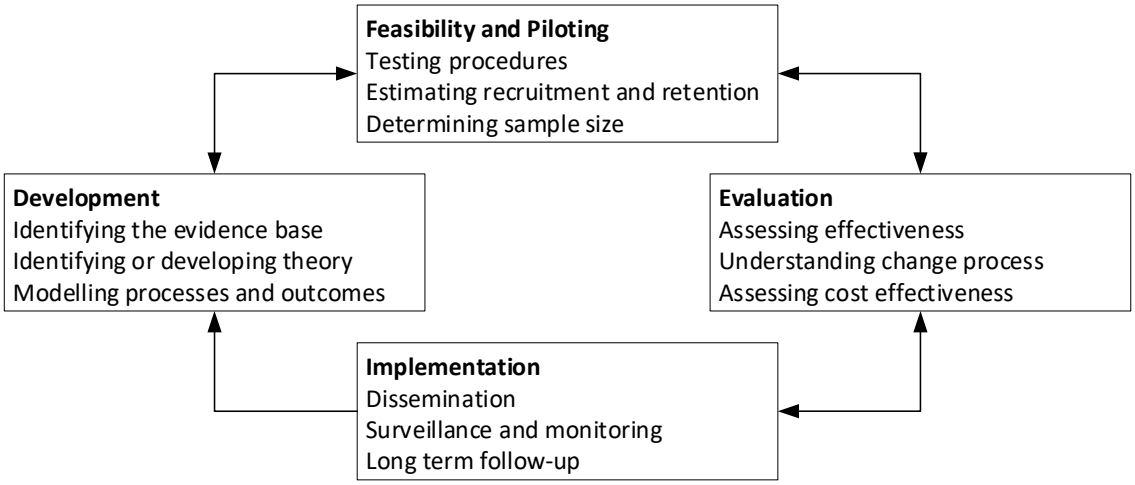


Figure 5. Complex Interventions Framework

Reprinted with permission from Craig, P., Dieppe, P., Macintyre, S., Michie, S., Nazareth, I., Petticrew, M., & Medical Research Council, G. (2008). Developing and evaluating complex interventions: the new Medical Research Council guidance. *British Medical Journal*, 337, a1655. doi:10.1136/bmj.a1655. Copyright 2018 by Copyright Clearance Center.

2.2 Philosophical Considerations

Guba and Lincoln (1994) define research paradigms as "the belief system or worldview that guide the investigator" in fundamental ways (p. 105). These belief systems dictate how a researcher interprets the world, guiding practice—from the development of research questions to specific methods used within research. There are three philosophical questions of knowledge that enable characterisation of each paradigm: ontology, epistemology, and methodology (Guba, 1990). Ontology concerns the nature of reality, epistemology regards knowledge and the nature of our relationship with knowledge, and methodology concerns how knowledge is discovered (Guba, 1990; Guba & Lincoln, 1994).

Two opposing paradigms, which exist on a continuum, are positivism and constructivism (see Table 1). Positivism is driven by the belief that there is one reality driven by natural laws (Guba, 1990). Scientific enquiry in positivism aims to understand cause and effect—"the true nature of reality and how it truly works" (Guba, 1990, p. 19). Thus, positivists are concerned with predicting and controlling phenomena. Positivists avoid bias by using highly controlled methodologies. Positivism is traditionally associated with quantitative methods such as experiments (Creswell, 2014).

Conversely, constructivism asserts that individuals develop meaning from their own subjective experiences and these lead the researcher to look for complexities (Creswell, 2014).

Constructivists rely on participant views, using open-ended questions and discussions to understand an individuals' reality, situated within context and culture. Constructivists embrace the role of the researcher, acknowledging how their own personal experiences influence interpretation (Creswell, 2014). Constructivism is usually associated with qualitative methodologies.

Positivism and constructivism represent each end of a continuum, there are multiple types of each that represent different degrees to one end of the continuum or the other, each with its own limitations. While positivism reduces complexity and can assert causal statements, it ignores contextual constraints and real-world settings that contain multiple variables, affecting ecological validity (Scotland, 2012). Additionally, while constructivists account for contextual factors, positivists argue that results cannot be generalised and are not re-producible (Scotland, 2012).

There is an attractive alternative to these two opposing paradigms, critical realism (one of the most common forms of post-positivism) (Danermark, Ekstrom, & Jakobsen, 2005). Critical realism sits between positivism and constructivism, combining factors from both, acknowledging the external reality and the socially constructed world (see Table 1). Indeed, critical realism aims to determine "what is real and what is subjectively accepted as truth" (Taylor, 2018, p. 217).

Critical realism asserts that our knowledge of the world only represents a portion of what actually exists, that our knowledge of the world will always be partial, but it can build over time (Fletcher, 2016; Sayer, 2000; Wong, Westhorp, Pawson, & Greenhalgh, 2013). Critical realism distinguishes itself through its focus on causation, where explanation of reality depends upon the description and understandings of causal mechanisms, which are "underlying entities, processes, or structures which operate in particular contexts to generate outcomes" (Wong et al., 2013, p. 5). Critical realism seeks to understand causal mechanisms—how they work, how they are activated, what outcomes they influence, and what circumstances will cause the mechanisms to behave in particular ways (Bhaskar, 2013; Sayer, 2000). This means that an exploration of what works for whom, and under what contexts, is ideal from this perspective (Pawson, Greenhalgh, Harvey, & Walshe, 2005).

Table 1. Philosophies of Research Paradigms

	Positivism	Critical Realism	Constructivism
Ontology (What is reality?)	Realist assumption of one 'true' reality, which is comprehensible.	Realist assumption of reality, but is stratified into the empirical, actual, and the real. It is imperfectly understandable.	Relativist assumption of multiple individually constructed realities.
Epistemology (What can be known?)	Objectivist assumption of knowledge	Objectivity in knowledge is ideal, but subject to falsification and inevitable bias	Knowledge is subjective, meaning is constructed through interpretations of realities
Methodology (How do we acquire knowledge?)	Quantitative methodology, such as experimentation	Knowledge can be acquired through both quantitative and qualitative methodologies, usually in natural settings	Qualitative methodology, including dialogue between researcher and participants

In critical realism, reality is stratified into three levels: the empirical (events that are observable and experienced), the actual (occurring events that we do or do not experience), and the real (where casual mechanisms exist and act upon the empirical level of reality) (Fletcher, 2016). Indeed, it is the primary goal of critical realism to identify and explain social processes through the 'real' level of reality to explain change mechanisms and their effects (Fletcher, 2016).

Reality can be understood through research, through in-depth exploration and understanding of how a mechanism works and enacts change in social systems. Knowledge can be acquired through extensive and intensive research methodologies (Sayer, 2000). Extensive research methods include traditionally quantitative methods, ascertaining the prevalence, impact, and patterns of a phenomenon and intensive research methods include those that attain qualitative data, such as interviews (Sayer, 2000; Fletcher, 2016). As shown in Table 2, the two methods can complement one another; intensive methods enables identification of change mechanisms, which can then be tested in large-scale extensive research studies. Indeed, the work in this thesis adopts that view—beginning with intensive methods and then building into a mix of both intensive and extensive methods to answer the research question. A critical realist approach and the work in this thesis aims to understand the causal relationships between IPS interventions and their outcomes, while accounting for contextual factors at play (Danermark et al., 2005). The following work is conducted with the understanding that good evidence is embedded within the context of social interaction and theory is an accurate description of how a meaningful phenomenon is generated and sustained (Neuman, 2006).

Table 2. Intensive and Extensive Research within Critical Realism

Adapted from Sayer (2000, p. 21)

	Intensive	Extensive
Research Question	How does a process work? What produces change?	What are the patterns? How widely are processes distributed?
Results Produced	Causal explanations	Descriptive generalisations
Methods	Interviews, qualitative analysis	Large-scale survey, statistical analysis
Limitations	Limited generalisability	Lacking explanations

Critics of critical realism suggest that this view provides researchers a middle approach to interpret data and "maintain an illusion of objective reality" (Taylor, 2018, p. 218). Additionally, critics argue that critical realism's use of interpretation to identify causal mechanisms can lead to errors. However, this approach allows the researcher to explore elements that account for contextual aspects and involves multiple methodologies, striving for objectivity, resulting in a comprehensive account of the issue being studied (Taylor, 2018).

2.3 Methods of Data Collection

Guidance from the MRC suggests that the development and assessment of complex interventions be divided into phases, enabling a comprehensive answer to research questions (Craig et al., 2008). This framework was used to develop a programme of research to answer the research question and objectives developed in Chapter 1. The study objectives and design for each phase are depicted in Figure 6. The following sections provide an outline of the phases and discussion on the chosen study design, limitations, and advantages of each.

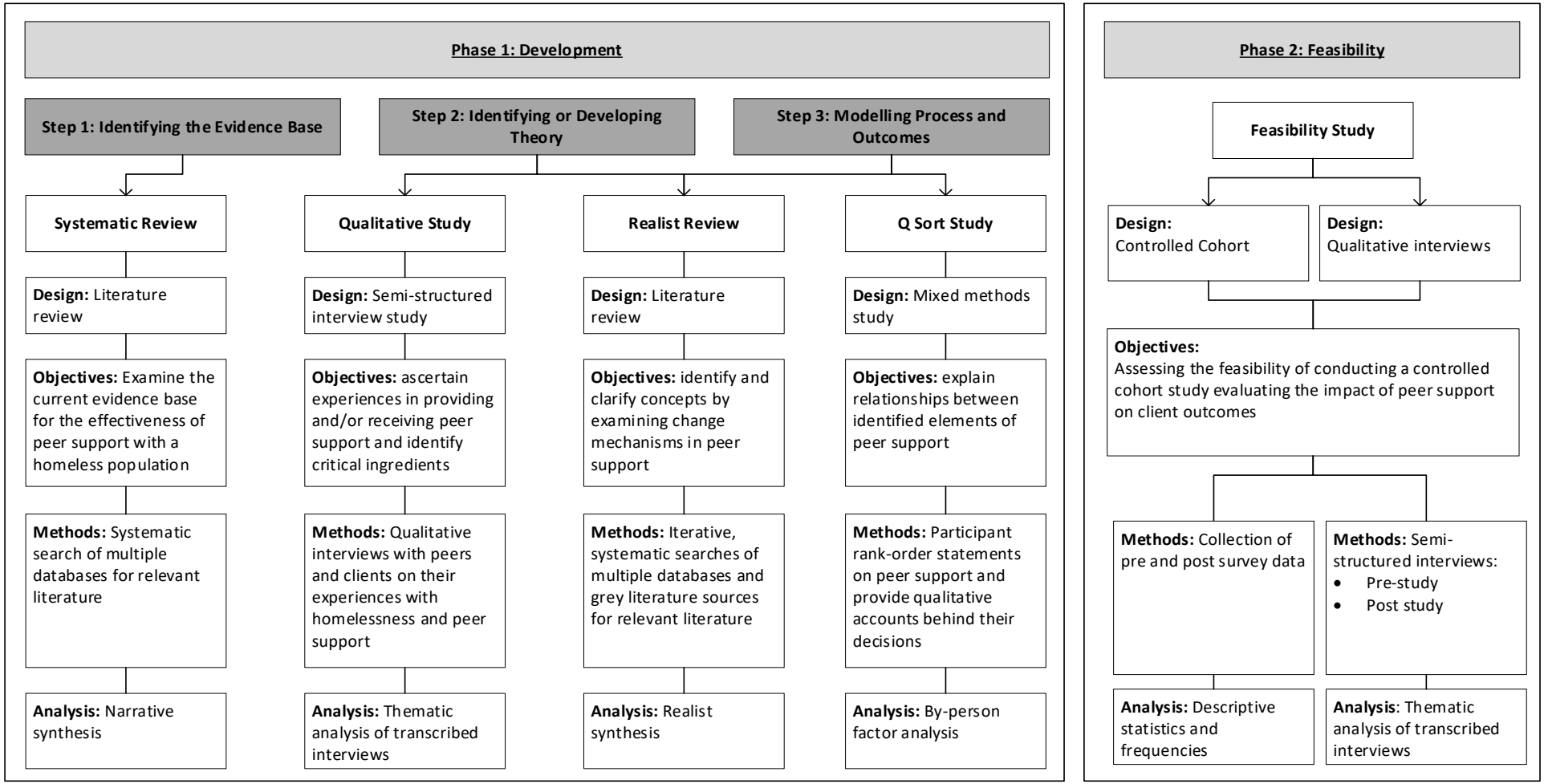


Figure 6. Study Design and Objectives

2.3.1 Phase 1: Development

Step 1: Identifying the Evidence Base

The development stage of complex interventions focuses firstly on identifying the existing evidence base. It is imperative to examine existing literature to ascertain if the intervention already exists, what outcomes have already been found, and justify moving forward (Richards & Hallberg, 2015). This can be achieved through a systematic review of the literature. Traditional systematic reviews adopt a meta-analytic approach to analysis, but this is not appropriate for complex interventions with multiple study designs and outcomes (Akers, 2009).

A review of the literature needs to be conducted, however it also needs to include wider questions, to understand if the intervention works and how it might work (Petticrew, 2015). This includes not restricting the inclusion of articles based on study design or methodological rigour. The integration of diverse study methods enables identification of change mechanisms and an in-depth understanding of the intervention in different contexts (Petticrew, 2015). Narrative synthesis is an established alternative to meta-analysis and allows the researcher to explore the data in a meaningful way, and can accommodate studies with diverse methodologies (Popay et al., 2006).

As discussed in Chapter 1, there is minimal research assessing IPS with a homeless population. Therefore, the first stage in the development of this research programme was to examine the current evidence base for the effectiveness of IPS with a homeless population in a systematic fashion (Chapter 3). The review adopts a narrative synthesis approach, as it includes a diverse set of studies (Popay et al., 2006). Additionally, the systematic review endeavoured to examine why IPS was being used as an intervention for this population, to begin the process of developing theory and identifying change mechanisms within IPS interventions.

Step 2: Identifying or Developing Theory

Developing a complex intervention requires researchers to examine underlying theory that explains the intricacies of the intervention. A thorough understanding of how an intervention works includes the identification of potential change mechanisms. Richards and Hallberg (2015) suggest that it is feasible that there will not be sufficient theories that explain the intervention of interest, thus “some empirical work may be required, often of a qualitative…nature” (pg. 8).

Following the systematic review, intensive research was required to understand what peers and/or clients identify as critical elements of IPS through qualitative interviews. Thematic analysis was chosen to enable an inductive development of understanding of potential change

mechanisms and contribute to developing theory (Braun & Clarke, 2013). Thematic analysis is a flexible qualitative method "for identifying, analysing, and reporting patterns" in data (Braun & Clarke, 2006, p. 6). Thematic analysis is useful to explore under-researched areas and is used to build theoretical understandings of a phenomenon (Braun & Clarke, 2006). It also uses a lower level of interpretation than other qualitative methods, such as grounded theory (Vaismoradi, Turunen, & Bondas, 2013). Thematic analysis allows for the inclusion of contextual aspects to be gathered from the participants, unlike content analysis, which aims to quantify the occurrence of codes, therefore potentially missing important aspects of why a peer would share their story with a client, for example (Vaismoradi et al., 2013). This study, reported in Chapter 4, adds to the evidence base, ascertains participants' experiences of providing and/or receiving IPS, and provides a foundation for further developing theory.

Additionally, Richards and Hallberg (2015) recommend complementary literature reviews to identify contextual factors and mechanisms of change. Realist reviews are one method to understand how an intervention works and develop a preliminary model of processes and outcomes. Realist reviews approach the evidence base from a different theoretical stance; under a realist view questions about 'what works' transform into "what is it about this programme that works, for whom and under what circumstances" (Pawson & Bellamy, 2006, p. 22). The realist review method enables understanding of the complexities in an underdeveloped intervention, permitting the researcher to identify and develop theory about how the intervention influences client outcomes.

In realist reviews, the assumption is that we cannot separate outcomes from their contexts, that is, in order to infer a causal relationship between two events, one needs to understand the underlying change mechanisms (M), which are influenced by the context (C) of the interventions delivery, possibly enacting different mechanisms with different contexts. Thus, the exploration of the review uncovers outcomes (O) of an interventions' change mechanisms, in different contexts (Pawson et al., 2005). While realist review methods are relatively new, it is a useful method for answering different queries about how an intervention works—using existing literature and experts in the field to develop a thorough understanding of interventions through these type of 'CMO' interactions. This method of exploration also enables the development of 'middle-range theories', that is, theories that involve abstraction, but can provide an avenue for empirical testing (Wong, Greenhalgh, Westhorp, Buckingham, & Pawson, 2013). Mid-range theories are helpful for psychology, where most (if not all) programmes are complex and require deep understanding of the contextual aspects that might influence outcomes, as middle range theories offer "an approach to linking findings from programme to programme and from policy to policy"

(Wong et al., 2013, p. 12). Indeed, it is the goal of a realist review to provide a useful middle range theory. Therefore, this thesis includes a realist review (Chapter 5) that enables development of the theory and satisfies the third step in developing a complex intervention, outlined below.

Step 3: Modelling Process and Outcomes

The MRC guidance suggests that it is important to model the process and outcomes of an intervention before implementation and is the last stage in the development phase (Sermeus, 2015). A model should describe the active components, how the components relate to one another, and any theoretical and empirical evidence that explains identified pathways (Sermeus, 2015).

The realist review results in a modelled middle range theory with testable concepts and descriptions of the components and their relationships (Wong, Westhorp, et al., 2013). Stages of the synthesis, in Chapter 5, are 1) assess theoretical literature, 2) assess empirical literature, and 3) combine models developed from both, resulting in a comprehensive model of IPS. The realist review utilised evidence from other contexts (such as mental health and addictions) to assess the theoretical model. Following recommendations of developing theory, I conducted a consensus building study, where experts ranked items describing the different components of IPS (Richards & Hallberg, 2015).

Chapter 6 describes a Q sort study—a mixed methods design utilised to test concepts developed in the realist review. Q Methodology, developed by Stephenson (1953), aims to objectively assess subjective viewpoints. This is done by statistically and qualitatively assessing a 'concourse', or communications surrounding a topic of interest (Stephenson, 1953). A set of items are developed that broadly represent the concourse. Items can be derived from multiple sources (in this case interviews and previous research), then are ranked by participants into a hierarchy by how much they agree or disagree with the relevance of each statement. Statements are organised into a Q sort, a pre-determined grid that forces participants to respond to each item in relevance to all the other items. Individual Q sorts are compared and contrasted, through a by-person approach to factor analysis to identify shared viewpoints (Watts & Stenner, 2005). Factors are then interpreted by the researcher using a holistic approach (Stephenson, 1953), where the whole factor configuration is interpreted by examining statement positions within the Q sort (Watts & Stenner, 2005).

A Q sort is preferred over a simple survey design, for one key feature—the forced distribution. As participants are required to rank items in relation to each other, participants are forced to

consider their placement of an item, while accounting for all other items (Watts & Stenner, 2005). A Q sort design allows researchers to explore relationships between different themes and permits a holistic interpretation of viewpoints, a feat unachievable with traditional questionnaires (Watts & Stenner, 2005). Additionally, this method seeks clarity within a complex topic. Through intentional recruitment of participants with relevant experience, Q methodology produces a taxonomy of expert viewpoints on elements involved in effective IPS for those experiencing homelessness.

The last task to complete the development phase of the MRC guidance is to clearly outline the intervention and how it will be operationalised in practice (Richards & Hallberg, 2015). Therefore, Chapter 7 reports the evidence-based IPS intervention that has been informed by all previous work in the thesis. This chapter utilises criteria developed by Möhler, Bartoszek, Köpke, and Meyer (2012) to report complex interventions. Additionally, this chapter will outline the intervention according to the Template for Intervention Description and Replication (TIDieR) checklist (Hoffmann et al., 2014). The development phase concludes with researchers having clarity about the theoretical base, existing evidence, and be able to clearly outline the interventions procedures (Richards & Hallberg, 2015).

2.3.2 Phase 2: Feasibility Testing

The second phase in the MRC framework examines the planning of the research evaluation, through a feasibility or pilot study (Richards & Hallberg, 2015). Whilst some argue that the terms ‘feasibility’ and ‘pilot’ are synonymous (Thabane et al., 2010), they are two different study designs (Arain, Campbell, Cooper, & Lancaster, 2010). A pilot study may assess the feasibility of some concepts, such as recruitment, randomisation, and follow-up, but in essence, it is a smaller version of a larger study. Pilot studies may be done to identify errors in the study design to maintain financial best practice (Leon, Davis, & Kraemer, 2011). In comparison, feasibility studies are pieces of research that precede a main study, and are primarily used to estimate parameters of the main study (Arain et al., 2010). Feasibility studies are flexible designs that can be used to assess participants willingness to be randomised, number of eligible participants, acceptability of the measurement tools, and follow-up rates (Arain et al., 2010).

Given that the intervention is clearly defined in Chapter 7, a feasibility study is appropriate. Chapter 8 will describe a feasibility study using a controlled cohort design to assess the effectiveness of IPS with a homeless population through comparison of treatment and control groups across homeless organisations. By assessing current programmes and utilising a feasibility approach, the researcher can assess for contextual factors, participant opinions, the acceptability of randomisation, and the possibility of comparable control groups. Assessing the feasibility of

existing IPS interventions has high ecological validity and will enable future research to evaluate this intervention. The feasibility phase of the MRC framework permits researchers to identify methodological and procedural barriers and the solutions to address them (Richards & Hallberg, 2015). This phase concludes with reasonable certainty that the intervention can be delivered and evaluated successfully.

2.3.3 Phase 3: Evaluation

The main aim of any intervention evaluation is to determine causality between the intervention and outcomes (Richards & Hallberg, 2015). Researchers should aim for the most rigorous method possible that is practical within the topic. Randomisation may not be possible and alternative ways to establish causality must be considered (Richards & Hallberg, 2015). A second aim of the evaluation phase is to establish clear understanding of the change process that occurs in the intervention.

Process evaluations aid understanding in how to assess a complex intervention, with its focus on identifying change mechanisms and assessing the intervention through experimental methods (Craig et al., 2008). Guidance on process evaluations direct the researcher to explore how the intervention works, by employing various methods to answer specific contextual questions (Moore et al., 2015). This method is appropriate for assessing existing programmes, exploring how an intervention works, but does so in the context of evaluating an intervention. The final aim of this phase is to assess the financial cost of evaluations, which can be achieved through an economic evaluation (Richards & Hallberg, 2015).

While the completion of this phase is outside the scope of this project (due to lack of resources, such as time), the work done in this thesis undoubtedly sets up future studies to complete the framework. Specifically, recommendations from the feasibility study in Chapter 8 can be used to design and conduct a full-scale controlled cohort study assessing IPS interventions across homeless organisations. The realist review reported in Chapter 5 also provides a foundation for a simultaneous process evaluation to be conducted.

2.3.4 Phase 4: Implementation

Implementation refers to the embedding of the intervention into routine social systems (Richards & Hallberg, 2015). Implementation is a highly active process that requires attention to multiple aspects to integrate the intervention into services. These actions go beyond dissemination and include the need for researchers to include long-term planning to monitor the implementation process (Richards & Hallberg, 2015). Researchers need to be clear about how much adaptation or

changes would be acceptable during the implementation phase (Craig et al., 2008). Additionally, continual monitoring of the implementation will reduce the chance of significant adverse events and can provide opportunities for identification of further intervention development (Richards & Hallberg, 2015). Completion of this phase is also outside of the thesis' scope. However, following guidance developed by Richards and Hallberg (2015) will enable future research to be conducted in the implementation phase of IPS interventions.

2.4 Chapter Summary

This chapter outlined the methodology chosen for each subsequent chapter. The researcher's epistemological view was also discussed, where a critical realist approach is adopted. Critical realism suits the MRC development of complex interventions well. There is a focus on identifying change mechanisms and clearly defining the intervention to ensure successful implementation of IPS within homelessness services. Additionally, both critical realist methodology and the MRC guidance will enable development of the programme of research and serve to answer the research question and achieve the identified objectives.

Chapter 3 Systematic Review of the Literature on the Effectiveness of Intentional Peer Support within Homeless Populations

3.1 Introduction

As outlined by the MRC guidance, the first step on developing an intervention is to conduct a review of the literature to ensure that the intervention has not already been created, identify the possible outcomes, and justify furthering the research programme. As described in Chapter 1, IPS interventions with the homeless are currently being utilised, but with limited literature to support it. Further, existing literature on IPS and homelessness has not been systematically reviewed. This review intends to begin filling in that gap by systematically exploring the effectiveness of IPS with a sample of young adults and adults who are street dwelling and/or engaged with homeless services. Therefore, this chapter examines the current evidence base for the effectiveness of IPS with a homeless population.

3.1.1 Objectives

Due to the lack of literature on homelessness and IPS, the initial aim was exploratory in nature: attempting to understand what the literature reveals about IPS and homelessness. Specifically, the review explored how IPS is currently being used with the homeless, the landscape of practice, outcomes of practice, and if IPS is a feasible option for work with heterogeneous populations. The main research objective assesses the effectiveness of IPS with a homeless population. That is, peers *are* the intervention, not only delivering it. The following objectives were explored during the search, as reflected in the search strategy terms:

Objective 1: How is IPS being used with those experiencing homelessness?

Objective 2: How effective is IPS with those experiencing homelessness?

3.2 Methods

The review protocol (found in Appendix A) was developed by the primary researcher and reviewed by two researchers. Studies that fulfilled one or more of these targets were considered:

1. Test the effectiveness of IPS with an adult and/or young adult homeless population.
2. Display common ingredients of IPS with a homeless population.
3. Evaluate IPS programs with a homeless population.

Studies that were not eligible had the following characteristics:

1. Testing the effectiveness of IPS with severe mental health, addictions, and/or health concerns in a non-homeless population.
2. Examining the cost effectiveness of peers in the workforce.
3. Examining outcomes without IPS.
4. Are not in English.

These criteria were selected because of the vast amount of research dedicated to IPS in sectors that prioritise issues that many homeless people face, but lack focus on treating homelessness. Literature found in the search lacked focus on homelessness, therefore, I included studies that had a primary intervention of IPS and its effects on those experiencing homelessness, with a minimum of 30% of the participants identifying as homeless. During the search process, it became clear that this arbitrary threshold needed to be added to the inclusion criteria, given that there is a breadth of evidence examining IPS within other contexts that, by chance, had participants experiencing homelessness in their sample. If a 40% threshold was chosen, four studies that otherwise met criteria would have been excluded (e.g. Resnick & Rosenheck, 2008; Tracy et al., 2012; Tracy et al., 2014; van Vugt et al., 2012). One study considered for inclusion, as it met other criteria, had only 6% of its participants identifying as homeless and was excluded based on this threshold (Fukui, Davidson, Holter, & Rapp, 2010). Thus, the intention of this cut-off is one of precision regarding the impact of IPS with a homeless population.

The search process refined the research objective to examine the effectiveness of IPS with a homeless population. The search also revealed that IPS is currently being used with the homeless for various health interventions: TB, HIV, overdose prevention, and Hepatitis (Gabrielian et al., 2013; Tulsky et al., 2000; Wright, Oldham, Francis, & Jones, 2006). Further, peers are currently aiding the homeless with health management, medication regimes, and acting as buffers for professionals (Deering et al., 2009; Gabrielian et al., 2013; Pilote et al., 1996; Rice, Tulbert, Cederbaum, Barman, & Milburn, 2012; Tulsky et al., 2000).

The review searched Medical Literature Analysis and Retrieval System Online (MEDLINE), Cumulative Index of Nursing and Allied Health Literature (CINAHL), psycINFO, and Web of Science

databases using keywords found in Table 3. Search terms were derived from keywords of relevant articles, consultation with a psychologist, and local homeless charities. Synonyms of PPS included terms such as 'consumer' and 'service user' to accurately reflect terminology used in mental health and addiction services. This review attempted to account for publication bias by searching published, unpublished, and grey literature extensively (Song et al., 2010). The grey literature search was performed through Google Scholar, local and national charity publications/reports, and reports from conferences (full search strategy can be found in Appendix B).

Table 3. Search Terms

Operator	Definition
1. Keywords: Population	adult OR over 18 OR older adult OR young adult
2. Keywords: Population	homeless OR homelessness OR homeless person(s) OR rough sleeper OR rough NEAR/3 sleepers (specific to Web of Science)
3. Keywords: Intervention	peer support OR peer OR service user OR consumer participation OR social support OR consumer OR peer counselling OR recovery
4. Keywords: Outcome	effectiveness OR efficacy OR outcome OR impact OR treatment outcomes
5. Boolean Operator	1 AND 2 AND 3 AND 4
6. Language Limit	English
7. Selection	Removal of duplicates followed by PRISMA guidelines of article sifting: title sift, abstract sift, full-text sift, review reference lists and articles citing.

Note. PsychINFO via EBSCOHOST interface, 1944-2015; CINAHL Via EBSCOHOST interface, 1944-2015. Web of Science, 1950-2015; MEDLINE via OvidSP interface using all databases, 1946-2015 search conducted 02/10/15-02/28/15.

The search was systematic, in two major stages, with the priorities of objectivity, transparency, and minimisation of bias (Akers, 2009). In the first stage, I surveyed titles and abstracts against the defined inclusion criteria to identify relevant studies to be reviewed in full. The second stage consisted of retrieving the full-text papers of the selected studies. I documented study exclusions and reasons for exclusion at this stage. This process was also conducted in conjunction with one member of the supervisory team (NM), who examined 10% of included studies and those which were excluded, to ensure reliability.

3.3 Results

After the duplicates were removed, over 4,000 articles were identified for further review. Detailed information of this process is shown in Figure 7, using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flowchart (D Moher, Liberati, Tetzlaff, & Altman, 2009). The search was re-done in June 2018, to acquire relevant articles published since the

original search date and subsequent publication of this review. The sifting procedure of the updated search is also reported in Figure 7. The two articles that were found have been integrated into the results and associated tables/figures.

Thirteen articles reporting on 12 studies were included. Two articles reporting on the same data set were combined for the purposes of this review. Table 4 shows data extracted from the included studies that contain general information regarding the study participants and procedures. Data was also extracted specific to the research question including IPS definition, peer characteristics, how peers were utilised, and theories cited.

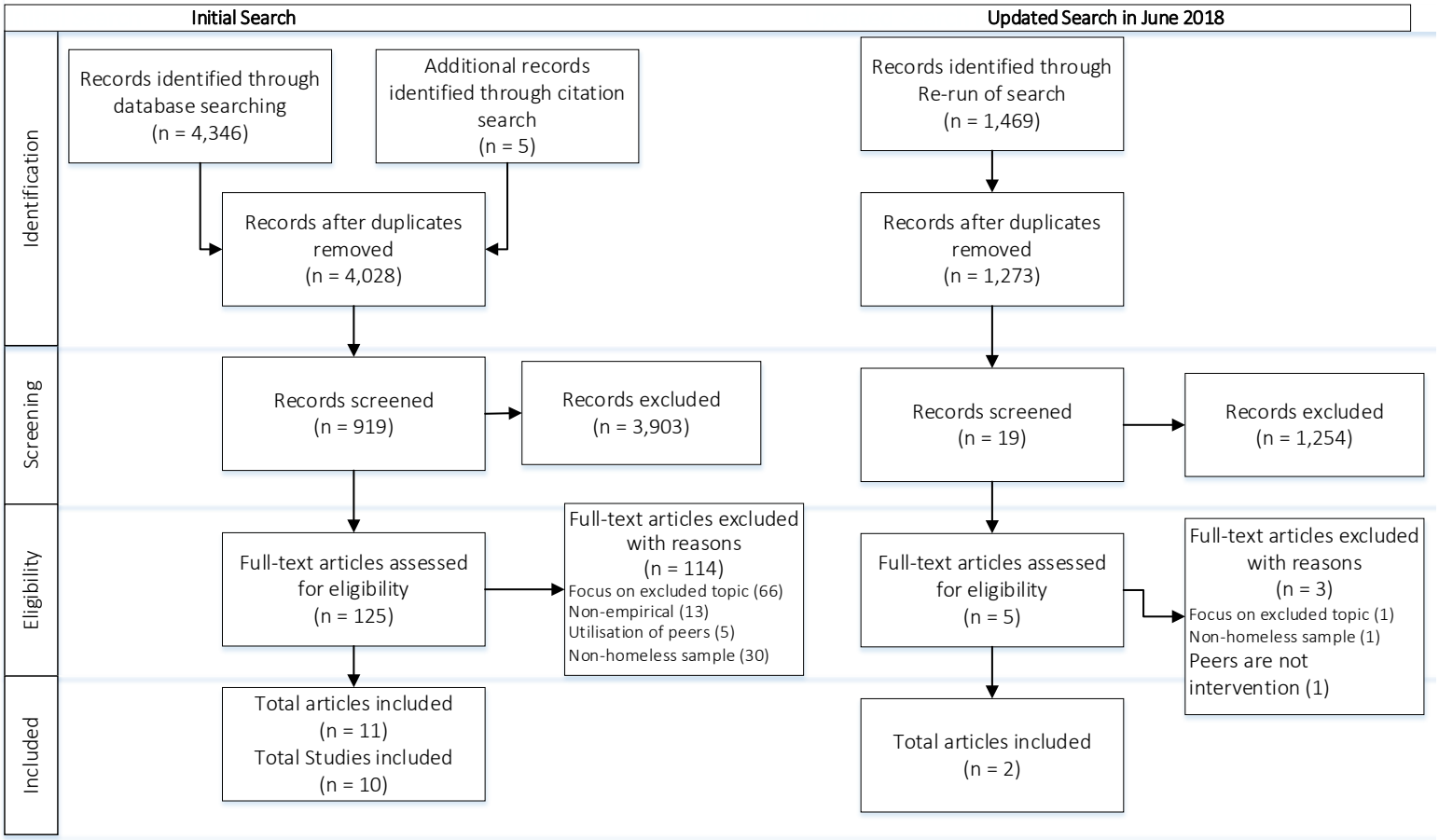


Figure 7. PRISMA Flowchart: Screening of Articles to be Included

Ten studies were completed in America (Boisvert et al., 2008; Corrigan et al., 2017; Felton et al., 1995; Fors & Jarvis, 1995; Galanter et al., 1998; Nyamathi et al., 2015; Resnick & Rosenheck, 2008; Tracy et al., 2012; Tracy et al., 2014; Weissman et al., 2005). One was completed in Canada (Stewart et al., 2009) and the last study was from the Netherlands (van Vugt et al., 2012).

The review found that there was a wide variety of measures used by the 12 studies. Most used standardised assessments and they were accurately reported in the articles. Although, two studies lacked in their reporting: Tracy et al. (2012; 2014) and Boisvert (2008) did not provide references or vital information about their measures, therefore outcomes are interpreted with caution. However, three studies used the same quality of life measure and their outcomes can be directly compared against one another (Felton et al., 1995; Resnick & Rosenheck, 2008; Weissman et al., 2005).

Included studies show baseline data for 2,241 participants and complete data for 1,881 participants; a loss of 505 or 23% of participants which is, overall, surprisingly low but this attrition affected some studies and confidence in their results drastically. For example, Weissman et al., (2005) excluded the data from their control group, as they had little to report. None of the included studies examined adults experiencing homelessness exclusively; all incorporated some other identifying factor. The most common population drawn from was adults experiencing homelessness and dependent on substances: 494 participants from four studies (Boisvert et al., 2008; Felton et al., 1995; Galanter et al., 1998; Resnick & Rosenheck, 2008; Tracy et al., 2012; Tracy et al., 2014). The second most frequent population included adults who are homeless and diagnosed with mental health issues, with 425 participants. Homeless veterans comprised 313 participants, while 459 medically vulnerable homeless persons were the focus of three studies. Lastly, there were 277 homeless youth/young people in this review. As some studies had complex sample populations, reflecting the complex needs of this population, participants may fall into one or more of the above categories, e.g. tri-morbidity—individuals who are homeless, substance dependent, have mental health problems, and physical ill-health (Hewett & Halligan, 2010).

Table 4. Data Extracted from Included Studies

Authors	Design	n	Methods	Tools	Interventions	Age	Sex	Race	Results	PPS definition	How PPS is used	Peer traits
Bean et al., (2013) USA	Longitudinal	104	surveys at baseline, 6 and 12 month	WHOQOL[1], arrest data	Housing first and PPS	56.06	72.2% Male	60% White 20% Black 15% N. American	Sig. change in quality of life score	NA	Part of housing intervention	Ex-homeless, mental illness, recovery
Boisvert et al., (2008) USA	Longitudinal	47	Interviews, pre/post (baseline and 9 months), and surveys	QOLR[2], MOS-SSS[3], VQ[4]	Peer support community program	NA	NA	NA	Sig. change in relapse rates, mental health & functioning, perceived support/affiliation	"global change in lifestyle and identity that occurs in the social learning context …emphasizes beliefs and values essential to recovery"	To develop a socially responsible recovery community--everyone is expected to contribute	Role models who have sustained recovery
Felton et al., (1995) USA	Longitudinal	221	Baseline and 3 six month intervals	RSES[5], PSMS[6], BHS[7], CAARS[8], ICMES[9], ISEL[10], QOL[11], LPI[12], CSI[13]	Peer supporters added to intensive case management vs case managers only and case managers + paraprofessionals	17% <30; 65% 30-50; 18% 50+	60% Male	43% Black 42% White 15% Other	Peers equal to case-managers. Sig. outcomes in quality of life, social support, self-image, and community tenure	Make unique contributions that enhance service effectiveness, role modelling, provide empathy, sharing practical info. and coping strategies, and strengthening social supports	In conjunction with case-managers	Ex-consumers, with 8 weeks of training in counselling and self-help
Fors & Jarvis., (1995) USA	Quasi-experimental; non-random	296	Survey at pre/post	Developed questionnaire	Peer led/adult led/ and non-intervention group	15	NA	NA	Peer-led groups were most effective, especially with younger sample	Mentors, prosocial aspect of life	Mentor, teacher	NA

Authors	Design	n	Methods	Tools	Interventions	Age	Sex	Race	Results	PPS definition	How PPS is used	Peer traits
Galanter et al., (1998) USA	Longitudinal	56	Urinalysis test for drugs of abuse 3 times over 4 months.	Urinalysis tests	Peer and professional led group therapy	NA	60% Male	58% Black 41% White 32% Hispanic	69% achieved 3 clean urine tests	NA	Conjunction with professionals (peer led groups etc.)	NA
Resnick & Rosenheck (2008) USA	Quasi-experimental; non-random	321	Two cohorts: one treatment (n=78) and one control (n=218). Measured 3 times over 9 months.	[14]RAQ, [15]MHCS, [16]MDS, [17]RAS, [18]ADLS, GAF, [19]ASI, [20]BPRS, PTSD - Checklist-S, [21]TLEQ, [22]QOL, [23]Participation	Vet-to-Vet; an addiction treatment delivered by peers compared to standard non-peer treatment	NA	95% Male	66% White	Treatment group improved on empowerment, confidence, functioning, and alcohol use.	Benefit from interacting with people who have experiences similar life circumstances.	In a program; delivering services	NA
Stewart et al., (2009) Canada	Cross-sectional	17	Within subjects	[24]SPS, [25]R-UCLA-LS, [26]DS, [27]PCI, [28]HBS	4 Support groups/1:1 groups by peers and professionals	19	54% Male	60% N. American 27% White 13% Other	Sig. decreased loneliness. Qual. Results show increased support and coping	Peers as part of social support network by providing info, modelling, and encouragement.	Part of group and 1:1	Ex-homeless youth
Tracey et al., (2012; 2014) USA	Cross-sectional	40	Clinical interviews, focus groups, training	[29]SCID I, Designed fidelity measure	10 mentors with 30 mentees for 12 weeks	50.3	62% Male	40% Black 38% White 22% Hispanic	Alcohol/drug use decreased; No predictive factors of abstinence found (e.g. gender homelessness etc.)	Abstinence based relationship, role model, hope.	Direct mentors	In recovery, 6 moths min. sobriety.

Authors	Design	n	Methods	Tools	Interventions	Age	Sex	Race	Results	PPS definition	How PPS is used	Peer traits
Van Vugt et al., (2012) Netherlands	Longitudinal	10	With/without consumer providers, fidelity study, baseline and 9 months	Demographic, DSM-IV, [30]HoNOS, [31]CANSAS, [32]WAS, [33]DACTS	Consumer-providers impact on clients over time	41.6	71% Male	NA	Sig. mental state and functioning, un/met needs with personal recovery, and homeless days. Inverse relationship for hospital days (could be attuned to illness/needs)	Consumers as mental health professionals	Direct with clients/as their service workers	NA
Weissman et al., (2005) USA	Longitudinal	340	Support delivered 1 hr/week with each participant baseline, 4, 8, and 12 months	Log books, [34]Interviews	Peer supporters providing support on transitions, mentors, socialisation over 12 months	48	100%	75% Black 13% Hispanic 9% White 3% Other	Participants with peer mentors were more likely to follow-up in treatment and increased socialisation	"by virtue of their street smarts, engagement skills, peer support, positive role modelling, fighting stigma, and education of co-workers"	Peer mentors	Knowledge about recovery, prior group work experience, people skills + inclusion criteria

Note. [1]WHOQOL (World Health Organization Quality of Life), [2]QOLR (Quality of Life Questionnaire). [3]MOS-SSS (Medical Outcome Study Social Support Survey—Focus on subscales: EIS (Emotional/Informal support), AS (Affectionate), TS (Tangible)), [4]VQ (Volitional Questionnaire). [5]RSES (Rosenberg's Self-Esteem Scale), [6]PSMS (Pearlin and Schooler's Mastery Scale), [7]BHS (Beck Hopelessness Scale), [8]CAARS (Client attitudes About Recovery Scale), [9]ICMES (Intensive Case Management Engagement Scale), [10]ISEL (Interpersonal Support Evaluation List), [11]QOL (Quality of Life Interview), [12]LPI, (Life Problems Inventory), [13]CSI (Colorado Symptom Index). [14]RAQ (Recovery Outcome Questionnaire), [15]MHCS (Mental Health Confidence Scale), [16]MDS (Making Decisions Scale), [17]RAS (Recovery Assessment Scale), [18]ADLS (Activities of Daily Living Scale), [19]ASI (Addiction Severity Index), [20]BPRS (brief psychiatric rating scale), [21]TLEQ (Traumatic Life Events Questionnaire), [22]QOL (Lehman Quality of Life Scale), [23]Participation in Vet-to-Vet. [24]SPS (Social Provisions Scale), [25]R-UCLA-LS (Revised. UCLA loneliness, Depression Scale), [26]DP (Depression Scale), [27]PCI (Proactive Coping Inventory), [28]HBS (Health Behaviour Survey). [29]SCID I (Structured clinical interview for DSM IV Axis I disorders). [30]HoNOS (Health of the National Outcome Scales), [31]CANSAS (Camberwell Assessment of Need Short Assessment Schedule), [32]WAS (Working Alliance Scale), [33]DACTS (Dartmouth Assertive Community Scale). [34]Interviews on employment status, housing, and substance use, overall QOL, social inclusion perception, social acceptance, symptoms of depression and anxiety.

Table 4. Continued: Data Extracted from Updated Search in June 2018

Authors	Design	n	Methods	Tools	Interventions	Age	Sex	Race	Results	PPS definition	How PPS is used	Peer traits
Corrigan et al (2017) USA	Longitudinal	67	Comparing peers as health mentors to regular treatment	Tabulation of Appointments	Assessing peer impact on adherence to health appointments over 12 months	NR	39% Female	100% African American	Clients with peer mentors adhered to more appointments and this change was maintained	NA	Peer mentors	Trained peers with homeless experience
Nyamathi et al (2016) USA	RCT	345	Comparison of peer with nurses; peers only; and regular treatment	[36]Vaccine completion:; Sociodemographic; Situational factors; Personal factors (TCU; General health; BSI; CES-D); Societal factors (MOS; CBC)	Assessing difference between groups on uptake of hepatitis vaccine for homeless parolees	42	100% male	51% African American 31% Latino 18% Other	All three groups had positive vaccine uptake, indicating no difference between the groups	NA	Peers as health coaches	Trained former parolees who successfully completed residential treatment

Note: [36] TCU (Texas Christian University Drug History Form); BSI (Brief Symptom Inventory); CES-D (Center for Epidemiology Studies Depression Scale); MOS (Medical Outcomes Study Social Support Survey); CBC (Carver Brief Cope)

All studies had peers as part of their intervention. Three studies had peers as mentors and assessed the impact on participants (Corrigan et al., 2017; Tracy et al., 2012; Tracy et al., 2014; Weissman et al., 2005). Two studies included IPS as part of larger interventions. For example, in Bean et al. (2013) the combination of IPS, harm reduction, and housing first were assessed, while IPS was assessed in a community programme in another study (Boisvert et al., 2008).

Five studies compared peers to various groups. Felton et al. (1995) added peers to case manager teams, comparing outcomes from case managers only and case managers with paraprofessionals. Similarly, Nyamathi et al. (2015) added peers as health coaches and then compared peers paired with nurses, peers only, and treatment as usual (TAU) on the uptake of a vaccine for hepatitis. Fors and colleagues (1995) also compared three groups: peers, adults, and a control group on the delivery of a harm reduction programme for homeless/runaway youth. Resnick and Rosenheck (2008) compared a peer-run, peer education programme to a control group and van Vugt et al. (2012) compared outpatient services with or without peers. The diversity of peer-programmes shows the complexity of this intervention, however, all programmes involved peers in a mentoring/unidirectional or mutual/bidirectional support approach, providing IPS to clients.

Two studies had peers working adjunctively with professionals/delivering services. These studies were still included as they were testing the effectiveness of peers within an IPS framework (i.e. unidirectional support). One study tested a specialised clinic run by peers and professionals, through urinalysis outcomes on drug use (Galanter et al., 1998) and the last tested a peer-run and delivered peer education programme compared to treatment as usual—that is, treatment without peers (Resnick & Rosenheck, 2008). These studies mirror how IPS is currently being used with a homeless population, reflecting a realistic climate of IPS and homelessness.

All studies had positive effects from IPS as an intervention; however, they vary in the size and confidence in those effects. Three studies found that outcomes with peers were comparable to the outcomes found with clinician-only groups (Felton et al., 1995; Nyamathi et al., 2015; Resnick & Rosenheck, 2008). Further, two studies had results that suggested peers were better than treatment as usual (Fors & Jarvis, 1995; van Vugt et al., 2012).

The studies in the review show nine areas on which IPS has an impact: overall quality of life, social support, physical and mental health, addiction/drug and alcohol use, life skills, homelessness, criminality, employment/finances, and attendance/interest. These areas are synthesised through the outcomes of each study. Each area found significant positive changes and/or nonsignificant changes relating to various outcomes, suggesting that further testing in this area is warranted. Significance values are reported here, when available, as per narrative synthesis guidance of ‘vote

counting' (Popay et al., 2006). The general results of each area are reported below followed by an analysis of the quality of studies and the implications of each for the effectiveness of peers with homelessness.

3.3.1 Overall Quality of Life

Four studies have results pertinent to this area (Boisvert et al., 2008; Felton et al., 1995; Resnick & Rosenheck, 2008; Weissman et al., 2005). Quality of life was assessed through standardised measures for three studies and the fifth study used an unpublished measure. Quality of life in this category is defined as the overall satisfaction with life; being "mostly satisfied" or "pleased" with life. Significant results relate to a reduction in life problems (p <.05), increased satisfaction with living (p <.01), and a modest change to being mostly satisfied/pleased with life. Nonsignificant changes are also recorded for satisfaction with life overall from another study (p=0.24), and on the unpublished measure used (Boisvert et al., 2008).

3.3.2 Social Support

Social support is a common outcome measure; peers provided different types of support, increasing social relationships and social esteem. The randomised control trial (RCT) reported that perceived social support was a reinforcing factor for increased adherence to hepatitis vaccines (Nyamathi et al., 2015). Four studies report a significant increase in aspects of social support, including increased belonging (p <.01), decreased loneliness (p <.05), increase in social relationships (p <.05) and general social support (Bean et al., 2013; Felton et al., 1995; Stewart et al., 2009; Tracy et al., 2012; Tracy et al., 2014).

Five types of social support (i.e. emotional, informational, tangible, appraisal, and companionship) (Tardy, 1985) are documented as being impacted positively by peer interventions. Specifically, three studies found that emotional and informational support increased: two with quantitative measures (p <.01 for both) and one through qualitative interviews (Boisvert et al., 2008; Fors & Jarvis, 1995; Stewart et al., 2009). Three studies report an increase in tangible support through peer interventions (Boisvert et al., 2008; Felton et al., 1995; Fors & Jarvis, 1995). Appraisal and companionship support (p <.05) had significant outcomes from two different study results (Boisvert et al., 2008; Felton et al., 1995). Lastly, social esteem, or confidence in social worth, significantly increased after the peer intervention for one of the studies (p <.01) (Felton et al., 1995). This review also found that there were nonsignificant changes in the results related to social support. Three studies reported no changes regarding size/composition of social network, perceptions of social inclusion, social acceptance, and social relations after the peer intervention (Felton et al., 1995; Stewart et al., 2009; Weissman et al., 2005).

3.3.3 Addiction/Drug and Alcohol Use

Common within a homeless population (Hewett & Halligan, 2010), many of the participants reported dependence on drugs and/or alcohol. The samples had high rates of substance use and it was generally found that a peer intervention reduced harm related to addiction. Half of the included studies report positive outcomes in reducing drug and alcohol use (p <.05; p <.01), and reducing relapse rates (Bean et al., 2013; Boisvert et al., 2008; Galanter et al., 1998; Resnick & Rosenheck, 2008; Tracy et al., 2012; Tracy et al., 2014). Two studies found nonsignificant changes related to addiction; specifically, the amount of money spent on drugs and the amount of days using drugs or alcohol (Bean et al., 2013; Resnick & Rosenheck, 2008).

3.3.4 Physical and Mental Health

Physical health is shown to improve for participants across five studies. Participants reported an overall increase in health (p <.01) on quantitative measures from three studies (Bean et al., 2013; Felton et al., 1995). Qualitative interviews show that participants felt that they had increased their health promoting behaviours resulting from peer interventions (Stewart et al., 2009). One study showed that hospitalisations increased during the intervention, which could be interpreted negatively, but researchers speculated that this increase was due to peers' advocating and highlighting participants' health needs (van Vugt et al., 2012). Another study found that peers were able to increase attendance at health appointments, undoubtedly increasing participants' overall physical health (Corrigan et al., 2017). There are nonsignificant positive changes related to hospitalisations, A&E visits, inpatient admissions, and days spent in inpatient for two studies (Bean et al., 2013; Felton et al., 1995).

Concerning mental health, four studies saw an increase in overall functioning, psychological health (p <.05), and a reduction in psychiatric symptoms (p <.01) on quantitative outcomes (Bean et al., 2013; Resnick & Rosenheck, 2008; Tracy et al., 2012; Tracy et al., 2014; van Vugt et al., 2012). One study assessed mental illness symptoms through qualitative measures and participants reported a reduction in depression and stress after the peer intervention (Stewart et al., 2009). Three studies found nonsignificant changes in recovery needs, posttraumatic stress disorder (PTSD) and other psychiatric symptoms, and no change in perceived treatment of mental health (Bean et al., 2013; Resnick & Rosenheck, 2008; van Vugt et al., 2012).

3.3.5 Homelessness

Three studies report outcomes related to homelessness: decreases in the number of homeless days (p <.01), reduced relapse to homelessness, and reports of an overall improvement in

environment (p <.01) (Bean et al., 2013; Boisvert et al., 2008; van Vugt et al., 2012). One study, however, did report that there was no significant change in homeless days and housing stability (Felton et al., 1995).

3.3.6 Life Skills

Life skills developed as a concept for the outcomes from the studies referring to internal processes that contribute to recovery and were reported from half of the studies. For example, empowerment significantly increased (p <.05) from working with peers as mentors and educators (Resnick & Rosenheck, 2008). Self-esteem improved from peer interventions on two studies—from qualitative and qualitative measures (Boisvert et al., 2008; Stewart et al., 2009). Peers also facilitate acceptance of illness and recovery, increasing efficacy, social skills, and coping as reported in three studies (Felton et al., 1995; Stewart et al., 2009; van Vugt et al., 2012). Lastly, there are nonsignificant changes related to recovery attitudes, empowerment over illness, and confidence as reported by one study (Resnick & Rosenheck, 2008).

3.3.7 Criminality

This area developed from two study results regarding arrests and contact with police; one study found a significant decrease in arrests (p <.01), another found non-significant changes in arrests and crime victimization (Bean et al., 2013; Felton et al., 1995).

3.3.8 Employment/Finances

Employment is an outcome measure for three studies, with two significant results related to increased rates of employment and satisfaction with finances (p <.01; Felton et al., 1995; Weissman et al., 2005). The third study found a nonsignificant change in the number of days worked after the intervention (Resnick & Rosenheck, 2008).

3.3.9 Attendance/Interest

Six studies found that higher participation in treatment was a significant result of the peer intervention in each study. One report explicitly examined the adherence to health appointments with and without peers, finding that those in the peer intervention were more likely to attend their appointments and maintain adherence over time (Corrigan et al., 2017). Tracy and colleagues (2012; 2014) found that higher rates of participation in the mentorship meetings/programme was significantly related to a reduction in drug and alcohol use (p <.01).

One study found that their peer/professional intervention had high rates of attendance and another found that participants stayed in contact with professional services as a result of peer intervention (Felton et al., 1995; Galanter et al., 1998). Nyamathi et al. (2015) also found that

peers were just as good as professionals to keep ex-parolees engaged in a residential treatment service and attain vaccinations. Lastly, a qualitative outcome reports that participation and engagement were a central theme to the peer intervention (Boisvert et al., 2008).

3.4 Discussion

3.4.1 Study Quality

Utilising the Downs and Black (1998) Quality assessment tool, scores are allocated to each individual study. The assessment tool is commonly used in measuring study quality in systematic reviews with non-random studies and is a recommended tool by the Cochrane Collaboration (Downs & Black, 1998; Higgins & Green, 2008). The tool has high internal consistency (Cronbach alpha > .69) for all subscales, save for the external validity scale, which has medium internal consistency (Cronbach alpha = .54). Ensuring reliability, this review utilised a second reviewer to score 10% of the included studies. Normally, each study is given a score out of 30 (possible 35 if power is calculated). However, studies included in this review did not supply enough information for questions regarding power to be fully assessed, and thus each study was given a score of 1 or 0 if they had provided power information, resulting in a possible total score of 28.

The tool assesses studies for reporting quality, internal, and external validity. As the quality assessment was not used to exclude studies, the focus was on the score relating to validity questions. Sixteen questions evaluated bias associated with external and internal validity; these questions directed attention to the strength of study outcomes related to peer interventions with a homeless sample. Three items relate to external validity, which is the ability to generalise findings. Study bias is assessed by seven items, which examines bias in the intervention and outcome measure(s). Lastly, confounding and selection bias, which determines bias from sampling or group assignment, is measured by six items. In sum, each study was given a score out of 16 for its quality regarding generalisability, participant selection bias, and confounding variables, as reported in Table 5 (Higgins & Green, 2008).

Two studies had the highest validity score, a score of ten or 63%, indicating that these results can be interpreted with the most confidence in this review (Felton et al., 1995; Nyamathi et al., 2015). Felton et al. (1995) included a comparison of three treatment groups—case managers only; case managers and peers; case managers and paraprofessionals—on multiple outcomes for 104 participants over two years. This study is the most relevant in answering the research question by isolating peers and assessing their impact over a long period. The main significant outcomes assessed in this study include increased quality of life, social support, self-image and outlook, and

community integration (Felton et al., 1995). Similarly, Nyamathi et al. (2015) conducted an RCT comparing three groups: peer coaches plus nurses, peers only, on hepatitis vaccination uptake for homeless adults, with a 12 month follow-up, for 345 homeless male parolee participants. There were no differences found between the three groups, suggesting that peers alone are equally effective as peer plus nurses and TAU on weekly coaching sessions.

The next highest validity score is eight or a 50% validity score, which was awarded to one study (Corrigan et al., 2017). Corrigan et al. (2017) assessed the effect of peer health navigators on treatment adherence for 67 homeless African American participants, finding that those in the peer group were more likely to attend their health appointments and this behaviour was maintained over the 12 month period.

Five studies received a six or a 38% validity score, suggesting that their outcomes must be interpreted with some caution. The remaining four studies scored lower than six: two of them scoring a 5, or 31%, and two scoring a 3 or 19% validity score. These lower scores indicate that their outcomes must be interpreted with extreme caution. A description of these scores and pertinent information is shown in Table 5.

Table 5. Downs & Black (1998) Validity Scores

Author	Validity Items Score*	Effects size for Main Outcomes	Sample Size	Setting	Duration	Design
Felton et al. (1995)	10	Large	104	Inpatient	24 months	Longitudinal
Bean et al. (2013)	6	None Reported	47	Housing apartments	12 months	Longitudinal
Fors & Jarvis (1995)	6	Medium to Large	221	Shelters	0.5 months	Quasi-experimental
Resnick & Rosenheck (2008)	6	Medium to Large	296	VA Premises	9 months	Quasi-experimental
Stewart et al. (2009)	6	None Reported	56	Outpatient/ drop-in	5.5 months	Cross-sectional
van Vugt et al. (2012)	6	None Reported	321	Outpatient	9 months	Cross-sectional
Tracey et al. (2012; 2014)	5	Medium to Large	40	Outpatient	6 months	Longitudinal
Weissman et al. (2005)	5	None Reported	17	Outpatient	12 months	Longitudinal
Boisvert et al. (2008)	3	Medium to Large	10	Inpatient	9 months	Longitudinal
Galanter et al. (1998)	3	Small to Medium	340	Day treatment	4 months	Longitudinal
Additional Articles from Updated Search						
Nyamathi et al (2016)	10	No effect: groups equal	345	Inpatient	12 months	RCT
Corrigan et al (2017)	8	None reported	145	Outpatient	18 months	Longitudinal

Note. *Validity scores are out of a possible 16

3.4.2 Common Elements of IPS

As there is minimal literature in this area, this review was an opportunity to build an understanding of common elements within IPS. IPS schemes for homelessness services are quite diverse; organisations utilise peers as formal, one-to-one mentors, informal supporters, group facilitators, and to link clients to professionals (Finlayson et al., 2016). Therefore, identifying common factors within this complex intervention will serve to develop the research programme and help focus future research in identifying specific elements that are critical to homelessness IPS interventions.

Common factors reported from each included study are shown in Figure 8. Elements were synthesised from the textual data of the included studies. I assessed why authors of the included studies chose IPS, their explanation of outcomes, and identified components. The data was approached qualitatively, searching for themes and patterns, I then constructed ideas of the

common elements of IPS. This is a tentative development and subsequent work attempts to develop ideas further. Common factors of IPS described in the studies include shared experiences, role modelling, social support, and attendance/interest.

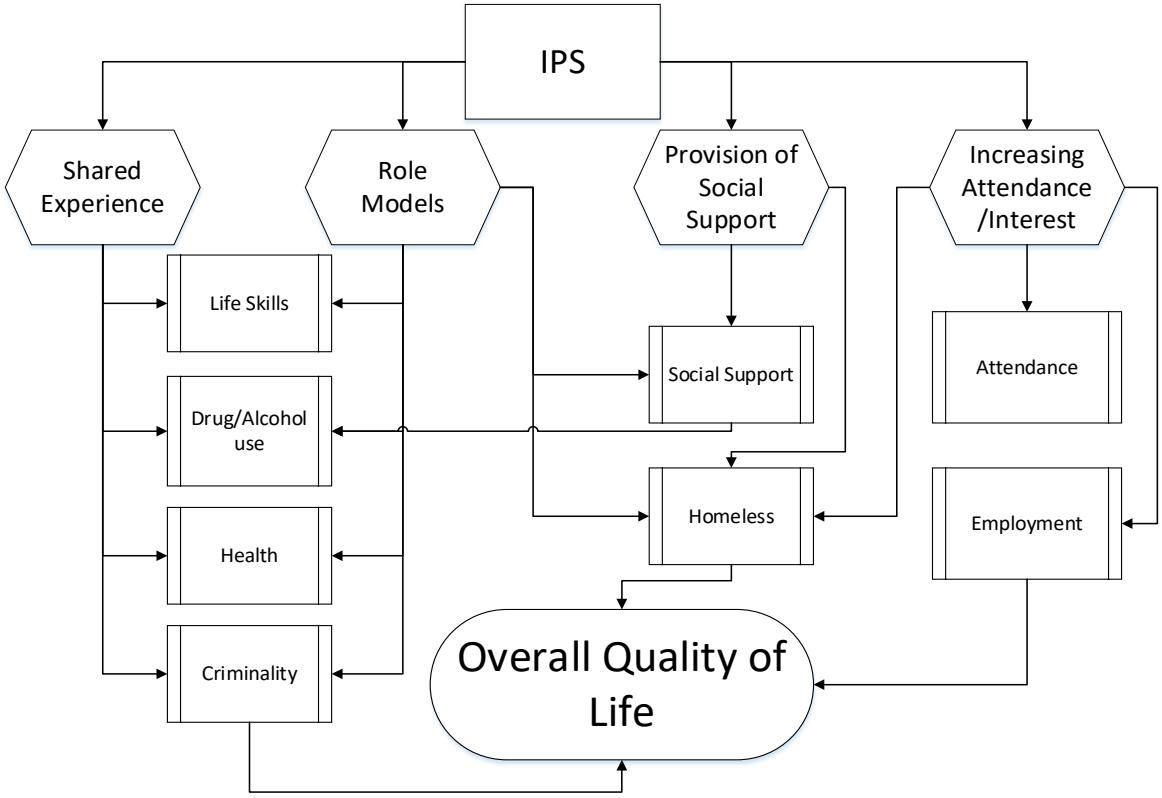


Figure 8. Common Elements of IPS

Articles discussed how peers influenced overall quality of life through shared experiences of homelessness, mental illnesses, and addiction. Five articles cite how shared experiences serve to build trust and rapport, building prosocial relationships to facilitate recovery (Boisvert et al., 2008; Weissman et al., 2005; Felton et al., 1995; Resnick & Rosenheck, 2008; van Vugt et al., 2012).

Another identified component of IPS includes role modelling; seven studies discuss the role of social learning and social comparison (Boisvert et al., 2008; Felton et al., 1995; Fors & Jarvis, 1995; Nyamathi et al., 2015; Stewart et al., 2009; Tracy et al., 2012; Tracy et al., 2014; Weissman et al., 2005). Mentors that possess similar traits are viewed as credible and provide a source of hope for clients to compare themselves, which enables motivation and self-efficacy for personal growth. Shared experience combined with role modelling is thought to improve life skills, reduce drug/alcohol use, increase health/healthy behaviours, and reduce criminality.

Three studies report that peers act as a source of social support and can impact participants' feelings of belonging, normalising, and integration into a community, which enable the individual to develop life skills, increase their social network, and reduce homeless days (Boisvert et al., 2008; Felton et al., 1995; Stewart et al., 2009). Lastly, the concept of attendance/interest was developed as an aspect of IPS from six studies as their attendance rates and participants' interest

in the peer interventions remained high (Corrigan et al., 2017; Galanter et al., 1998; Nyamathi et al., 2015; Stewart et al., 2009; Tracy et al., 2012; Tracy et al., 2014; van Vugt et al., 2012). Although attrition was an issue, authors mentioned that the control groups suffered more, and reported that, similar to previous literature, peers fostered interest in the intervention, facilitating retention (Pilote et al., 1996; Tulsky et al., 2000). Higher attendance and interest for treatment is hypothesised to be linked to a reduction in the number of homeless days and increased employment. These findings support previous research examining common elements of IPS; Salzer (2002) and Campbell (2008) also assert that shared experiences, role modelling, and social support are integral to IPS.

IPS is a complex process and the diverse outcomes reported suggest that it can positively affect various aspects of an individual's life. However, the available evidence proposes that there are significant change mechanisms involved. The MRC guidance states that only through careful understanding of the causal mechanisms involved in a complex intervention can it be applied to different settings and its effectiveness understood (Craig et al., 2008; Moore et al., 2015). One potential change mechanism involves the strength of the relationship between the peer and peer-supporter; just as the therapeutic relationship is vital to meaningful change in psychotherapies, the peer-client relationship is influential to developing behavioural and cognitive changes (Gelso, 2014). This dynamic relationship provides multiple types of support and role models that positively impact recovery from multiple issues. It is argued that homelessness experience is integral to effective IPS in homeless services. Rough sleeping and homelessness is a unique experience which involves exclusion from every aspect of society, that a shared experience of addiction or mental illness would not suffice in building the relationship between peers and clients in a homeless setting. However, more research into IPS and homelessness is required to assess if IPS interventions for homeless populations are qualitatively different than those with mental illness or addictions.

3.4.3 Limitations

Limitations of Included Studies

Most of the included studies had methodological issues; hence, the lower scores on the Downs and Black (1998) assessment tool (see Table 5 for detailed validity scores). For example, the most common limitation cited was the lack of randomisation. Only two of the studies were able to randomise participants to their interventions. Study authors discussed the impossibility of randomisation in the context of their study—participants were already assigned to certain staff or the study lacked comparison groups. One study that did randomise its participants recruited after they had completed a specific treatment and were piloting an IPS intervention and the other was a RCT (Nyamathi et al., 2015; Weissman et al., 2005). None of the studies blinded participants and

only one (Felton et al., 1995) blinded those measuring the outcome measures, but the rest did not avoid this potential scoring bias. In addition, only one of the studies reported power (Nyamathi et al., 2015). The individual studies reported their limitations on sample size, lacking control groups, attrition, and non-randomisation.

Limitations that I identified are described as follows: Boisvert et al. (2008) used a quality of life measure that was not cited in their references. Upon further investigation, it was found that this tool, the Quality of Life Rating Scale, is an unpublished measure and information about its validity and reliability were reported at a conference. This tool might be adequate but there was not enough information provided to have confidence in its outcomes.

Fors and Jarvis (1995) compared peers to adults in the delivery of a drug harm-reduction program; however, their comparison groups were extremely unbalanced. Indeed, the peer group had 173 participants while non-peers had only 34, and the control had 14. It is not surprising that the only group with significant results are peers. Unfortunately, the authors did not explain why there was such discrepancy between sample sizes. Lastly, Weissman et al. (2005) suffered such extreme attrition from their control group that they completely excluded that data from the report. The results of this study were lacking as there was very little reported.

It is possible that addressing these issues may show that the nonsignificant changes develop into significant ones; however, further work is needed to confirm that assertion. At a minimum, further testing would give greater confidence in the results. The presence of these limitations speaks to the complexity of completing research with this population, which is also represented by the lack of literature in this area. Despite these issues, all included studies had significant outcomes from their peer intervention on a homeless sample. This provides evidence that IPS can have an impact, but work must be conducted to support these results.

Limitations of Review Methodology

This review was limited by the threshold of including articles that had samples with at least 30% of them identified as homeless. While this criterion was used to ensure that articles that had a meaningful focus on homeless populations, it is an arbitrary proportion and limited the included studies in a way that may have been biased (e.g. focusing on variables already under scrutiny in the homelessness field, such as mental illness or addiction). To the best of the authors' knowledge, such a threshold has not previously been used and could have weakened the results in exploring IPS interventions with homeless populations; however, the threshold was required for the focus of this review. Further, the narrative synthesis of identifying common elements involved a level of abstraction. Therefore, the textual data could have been interpreted differently by another researcher. However, these common elements were firstly identified by frequency and then discussed and agreed upon with the contribution of two reviewers.

Although effort was made to include a second reviewer when possible, the search was completed by myself. The second reviewer was provided with articles selected for inclusion and exclusion to assess the inclusion criteria and to help focus the review. Further, the second reviewer was involved in assessing the quality of included studies. This also provided an opportunity to assess any ambiguous articles for inclusion. Having only myself complete the search could have biased the included studies, however the wide scope of the search helped to reduce this possibility. Lastly, this review was limited by available resources to include articles written in English, the inclusion of other languages could have strengthened the findings and resulted in a more global perspective of IPS with homeless populations.

3.5 Conclusions

This review found 13 articles describing 12 studies that examined the effectiveness of IPS with a homeless population; demonstrating limited evidence of IPS with a homeless population. Positive outcomes relate to the improvement of the participants' overall quality of life, specifically, the reduction of drug/alcohol use, improved mental/physical health, and increased social support. Results were grouped into eight outcomes related to quality of life, and each of these areas had conflicting results. Evidence in this area is underdeveloped and this was the first review to examine IPS with a homeless sample. The embryonic nature of this topic inherently suggests that more evidence is required, justifying further exploration in developing and defining this complex intervention. This review attempted to begin that process and inspire more research in this area, especially since services are currently using IPS in treatment for the homeless. Common elements of IPS were identified from the included studies suggesting that IPS works through components of shared experience, role modelling, providing social support, and increasing attendance/interest. Those four components are thought to moderate overall quality of life through the eight outcomes reported. These findings signify the value of creating prosocial and intentional relationships between clients and peers, and acknowledge the complexity and challenges of applying the appropriate IPS processes thus resulting in varying levels of successful outcomes.

3.6 Chapter Summary

This chapter was the first known report to explore the effectiveness of IPS as an intervention for treatment with a homeless sample through a systematic review of the literature. Positive evidence for this practice was found, however limited. This review is a vital element to this thesis; it provides some evidence for the use of peers and justifies further exploration of this phenomenon. The use of peers when aiding the homeless is a somewhat novel practice, regarding its representation in the literature, even though IPS is increasingly common in current services. This chapter is the first step of developing complex interventions as outlined by the MRC.

Further, a preliminary understanding of common elements involved in IPS was developed from the results and textual data of the included articles. Results of identifying common elements is a key aim of the first phase in developing a complex intervention towards developing understanding of change mechanisms (Richards & Hallberg, 2015). This review is the foundational work for the next chapter, where detailed explorations of the critical elements of IPS are reported. The next chapter contains a qualitative study, reporting interviews with those who provide and/or receive IPS and examining constructs outlined in the systematic review.

Chapter 4 Intentional Peer Support Critical Elements and Experiences of those Supporting the Homeless: A Qualitative Study

4.1 Introduction

The evidence reviewed in Chapter 3 was not large enough to develop a theoretical understanding of IPS, therefore this chapter reports an empirical study, as per MRC guidelines (Richards & Hallberg, 2015). This chapter aims to further ideas developed in Chapter 3, adding to the evidence base by exploring experiences of those providing and/or receiving IPS and ascertaining what they identify as critical elements within effective IPS for those experiencing homelessness. Croft et al. (2013) produced the only known qualitative report on the experiences of those providing IPS in a homelessness context. These authors explored the motivation and outcomes experienced by peer-supporters, but did not include recipients of IPS in their sample. Therefore, this chapter contributes original research to the field, by including aspects that have not previously been explored. Additionally, this work recruited peers and clients from a diverse sample, enabling further development of defining aspects of IPS.

4.2 Current Study

There are no known reports exploring the experiences of peer providers and recipients and their opinion of what makes IPS effective in homelessness recovery. In the absence of relevant evidence, the current study set out to identify putative mechanisms that might underpin successful IPS in homeless populations through an exploratory investigation of recipient and peer-supporter opinions. The aim is to understand what participants believe are the critical factors for effective IPS, through exploring participants' experiences of providing/receiving this support. Attitudes, feelings, and behaviours around recovery are examined through qualitative methods to ascertain experiences of people providing/receiving IPS in relation to homelessness. Often, participants are recipients of IPS before progressing into a peer-supporter role, thus experiences are reported from both perspectives of IPS providers and recipients.

4.3 Methods

4.3.1 Design

The researcher adopted a qualitative design, utilising semi-structured interviews to obtain an in-depth understanding of participants' experiences of IPS use within homelessness. Qualitative research examines individuals' experiences of a phenomenon, obtaining in-depth and rich

descriptions, while accounting for context in the individuals' world (Denzin & Lincoln, 2005). The research proceeded iteratively; interviews were transcribed and analysed as they were conducted, allowing later interviews to be informed by earlier analysis and identify when themes were approaching data saturation (Braun & Clarke, 2013). The research protocol can be found in Appendix C.

4.3.2 Setting

Four organisations that utilise peer-supporters in their homeless services were included; a brief description of each follows:

Organisation 1 strives to involve those with lived experience of homelessness to influence services directed to support homeless recovery. Utilising mentorship IPS, peer-supporters help clients overcome practical, personal, and systemic barriers in accessing healthcare. All peer-supporters have homelessness experience and go through a rigorous selection and training process. Volunteer peer-supporters are supported by the organisation to provide support through supervision and resources for personal issues.

Organisation 2 is a volunteer peer-led outreach service, targeting deeply entrenched rough-sleepers. Recruited peer-supporters have street homelessness experience and receive training on roles, boundaries, confidentiality, and safeguarding. The programme is supported by professionals—peer-mentors get supervision and support, but the work is completely peer-led.

Organisation 3 provides emergency accommodation to single people experiencing crises. Volunteer peer-supporters are integrated into services, with peer mentors helping clients navigate benefits, housing, job searches, and providing emotional support. Services are developed and delivered through collaboration between peers and staff. Peer-supporters are trained in pertinent homelessness issues. Peer-supporters are usually past clients who have homelessness experience, who show commitment, passion, and are motivated to help.

Organisation 4 is an emergency night shelter. Peer volunteers are available through a buddy system to help introduce clients to the facilities and normalise the client's experience. IPS in this setting is a mix of mutual/bidirectional and mentorship/unidirectional support. The organisation relies on mutual support (e.g. group activities) and more experienced clients or past clients to deliver IPS through the buddy system. Peer-supporters are past or current clients of the organisation who are reliable.

4.3.3 Participants and Recruitment

Participants were recruited if they were aged 18 and above, had experience with homelessness and provided and/or received IPS. All correspondence used the term 'peer support' to reflect current practice and access a variety of peer models. Participants were recruited through emails

and face-to-face meetings, where a brief description of the study was provided. Snowball sampling was utilised to supplement recruitment (Sadler, Lee, Lim, & Fullerton, 2010). Characteristics and experiences of all 29 participants are reported in Table 6.

Table 6. Qualitative Study Participants Characteristics

Characteristic	*n* (%)
Gender	
Male	23 (80)
Female	6 (20)
Age	
25-34	8 (28)
35-44	3 (10)
45-54	10 (34)
55-65	8 (28)
Homelessness Experience	
Homelessness	29 (100)
Rough Sleeping	21 (72)
Currently Homeless	0 (0)
Peer-Supporter Experience	
Provider of IPS	28 (96)
Recipient of IPS Only	1 (3)
Peer-Supporter Only	11 (38)
Recipient to Provider Experience*	17 (59)
Addiction Experience	
Drug & Alcohol Abuse/Misuse	12 (41)
Gambling Abuse/Misuse	1 (3)
Those in Recovery	12 (41)
*Note. **'*Recipient to Provider' refers to participants' reported experience of being a client before becoming a peer-supporter	

4.3.4 Interviews

Interview questions were derived from previous work in this thesis and relevant literature to explore participants' experiences of this intervention. A topic guide (Appendix D) was used with questions such as: "What is it like being a peer?", "If you were to hire a peer, what qualities would you be looking for?", and "What is important in peer-support?". I conducted single in-depth, semi-structured, face-to-face, active interviews at the participants' respective organisations. Interviews were done in a private room except for two conducted in an open communal space, interviews averaged 32.70 minutes (range = 18.13 - 54.10). Although peer-supporters and clients are included in this study, they were not considered as two groups and interview procedures were consistent across all participants.

4.3.5 Ethical Considerations

All participants gave informed consent prior to starting the interviews. With a-priori informed consent, all interviews were audio-recorded and transcribed verbatim. Some participants

displayed hesitancy regarding the audio recorder and spoke in depth once it was switched off, these instances were documented in field notes from post-recorded discussions and included as data in the analysis (Phillippi & Lauderdale, 2017). Participants received a £10 high street voucher for their time. In accordance with guidelines from the National Health Service (NHS) Health Research Authority, voucher amounts do not place any undue inducements; vouchers as payment for participants' time while involved in the study is not an excessively attractive offer that would lead them to participate when they otherwise would not (Health Research Authority, 2014). The Health Research Authority recommends that payments are calculated from a rate of £100 per 24 hours. This study asked for participants to complete tasks that take 45-60 minutes per interview. A debriefing form, including support and contact information, was provided to each participant once the interview concluded. The University of Southampton provided ethical approval on July 3, 2015 (ID: 13315, Ethics documentation can be found in Appendix E). All participant names have been changed and identifying details omitted.

4.3.6 **Analysis**

Thematic analysis was used to interpret the data, a flexible and active qualitative method for underdeveloped topics (Braun & Clarke, 2006). Coding was primarily inductive and an audit trail was maintained, including development of a coding manual, where each code was defined, negative cases identified, and participant quotes were extracted.

While familiarising myself with the interviews reading the transcripts, I began to note units of meaning and analysis, utilising an open coding method. Coding was not mutually exclusive, that is, one meaning unit (i.e. segment of talk) could be represented in more than one code. Initial open codes were clustered into preliminary themes, then refined for coherence, with a central organising concept defining each (Braun & Clarke, 2006). Nine preliminary themes were developed, and refined by conceptualising them within the context of the interviews. Themes were also judged using Patton's (1990) dual criteria for judging categories, that is, themes were unique but also related to the overall narrative. The research team discussed the themes to bring diverse perspectives to the analysis and avoid idiosyncratic interpretations. The analysis used the software package NVivo 10 (QSR, 2012).

A narrative rendering and a thematic map were developed to represent the findings. To illustrate the themes, I attempted to include quotes from every participant, choosing those that best exemplified each theme. To contextualise quotes, the results include a description of participants' IPS experience (i.e. provider only, recipient only, or recipient to provider).

4.4 Results

As can be seen in Table 6, most participants report being a provider of IPS. Participants' respective organisation all use mentorship to support homeless clients. Therefore, results are describing mentorship peer support, where the peer is more stable than the client and guides the client through services.

Participants understood unidirectional IPS to be gained through "*your experience. Getting to know the experience someone is currently going through."* As can be seen in the thematic map in Figure 9, six themes captured critical elements of successful unidirectional IPS, contributing to 'How peers help' and describing specific aspects of the unidirectional IPS process, which benefitted both recipients and providers. Results are described as they are presented in the thematic map.

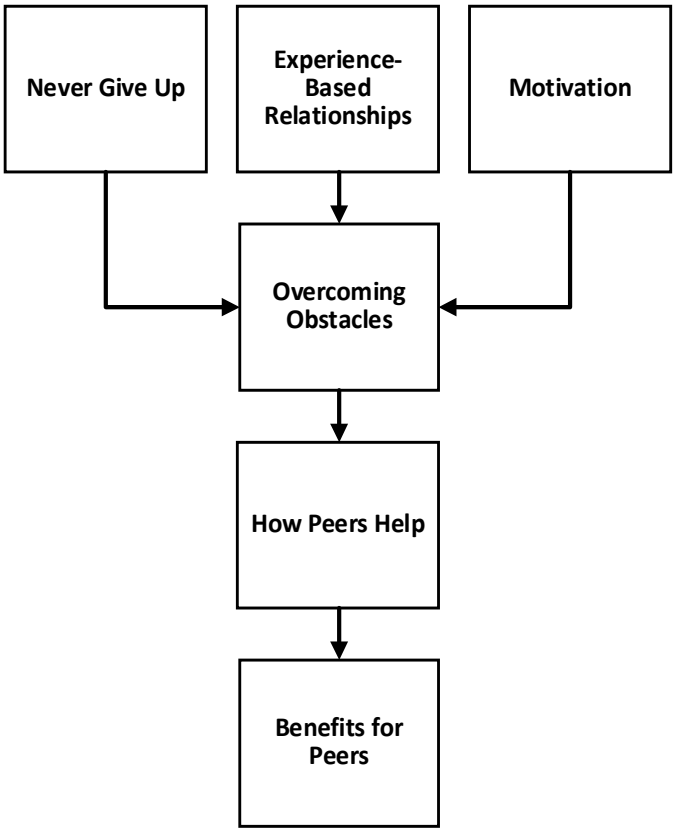


Figure 9. Thematic Map of Critical Elements and the Experiences of Providing Support

4.4.1 Never Give Up

Twenty-eight participants described how peer-supporters were persistent and committed to building meaningful and trusting relationships in order to help homeless clients. They felt such persistence was essential for unidirectional IPS to be successful.

> *"They kept pestering me and telling me to go in and I didn't want to go in then, but now I want to go in and I've got more help and understanding"—Andrea (recipient only)*

Almost all participants discussed how they had to be persistent in trying to support clients who had been labelled by professionals as 'resistant'. From their own experience of being on the streets, participants spoke about how they "*weren't ready for the help"* and it is a matter of not giving up on the client.

> *"I would go away, but they would still be in my mind. In my mind, I'm already preplanning, I'm coming back next week, I won't give up." –Fred (provider only)*

Participants spoke about the isolation that one endures when experiencing homelessness, rejected from all aspects of society and feeling a lasting sense of being unwelcome. Participants described how these events chip away at the individual's self-worth leaving them feeling suspicious of people who try to help. They understood how vulnerable people, like those living on the streets, often have to assess the intentions of other people to avoid being taken advantage of to keep themselves safe. In this position, participants described how those experiencing homelessness learn to trust their intuition:

> *"Like when you're homeless you pick up very well on certain things like vibes, energies, intentions, lies, you pick up very well on these things because more time you're on the receiving end of those things." –Muhammad (recipient to provider)*

However, their status as peer-supporters can help to reduce distrust or minimise the time to develop trust. Peer-supporters may have lived in a hostel recently, built a positive reputation with clients, creating a "*vibe"* or a feeling that they belong in this group and are trustworthy.

> *"[Being a peer] builds me in a link with the clients, because as soon as a couple of them start to trust you, you start to get everyone else in the hostel to know you."—George (recipient to provider)*

Once trust is established, maintaining it becomes vital. Otherwise, the clients can write the relationship off as another person or service who has let them down and pushed them further to the margins of society.

> *"You know you've got to gain their trust and if you don't gain their trust, you're wasting their time." –Peter (provider only)*

4.4.2 Experience-Based Relationships

All 28 peer-supporters discussed the value of shared experiences, which can be conceptualised as experiential knowledge, i.e., learning a truth from personal experience of a phenomenon (Borkman, 1976). Peer-supporters have intimate knowledge of homelessness, which contributes to the peer-supporters wisdom regarding treatment, barriers, and recovery. Participants discussed how attitudes towards their own experiences are important:

> *"You know there was a part of my life that for years, and years I was very embarrassed about. Quite ashamed, you know…that I had and I wasted so much of my life. And coming here, I realised well, actually it's not a waste, its qualifications…It's when you can stand up and say, well that's my experience…That is something you cannot be taught… I was out there and instead of looking at it like a waste of time and as a victim, actually what I was doing was gaining my qualifications" –Carl (recipient to provider)*

Peer-supporters' attitude towards their experience is key to differentiating peer-supporters from their informal counterparts. Through their positive attitude and outlook on how they impact the lives of others by using their experience, peer-supporters show personal growth:

> *"I am going to be better because I'm growing personally" –Oliver (recipient to provider)*

This growth also distinguishes them from informal counterparts; peer-supporters not only have training and organisational support, but they have a positive perspective on their experiences and use it in a beneficial way to help others and themselves.

> *"So, what I have learned from being homeless and what I've learned from here, I apply to myself and then it helps me to, uh, make sure that when I apply this knowledge that I help other people as well." –Muhammad (recipient to provider)*

Peer-supporters talked about how the relationship they build with clients becomes an important factor in helping people recover from homelessness. Peer-supporters come to the relationship as an equal to their client:

> *"Someone coming alongside, you know shoulder to shoulder, there's no kind of hierarchy, so to speak." –Rick (recipient to provider)*

Participants believe that the ability to connect as equals based on shared experiences makes unidirectional IPS unique and successful. In other words, peer-supporters bond with clients because they both have membership to a group that has endured marginalisation— they have experienced and survived the "*different world*" of homelessness. Peer-supporters use their common experience of homelessness to 'break the ice' with clients, telling their own story of homelessness to build a trusting relationship. Thus, it becomes an engagement tool to help break the cycle of homelessness.

Two participants disagreed, stating that having someone willing to help, no matter their life experience, is enough. Nonetheless, all participants agreed that peer-supporters' ability to have a unique understanding of the client's experience is what makes peer-supporters distinctive from professionals:

> *"So if someone gives them that (gestures to a piece of paper) that is the client. The client can come through the door and they could stand on their hands again the wall, for two*

hours, but [professionals] will always…be talking to this (paper) than the person…And that's where I am (gestures to wall) standing on my hands with this person. Having a chat. And this (gestures to a piece of paper) I can do later. If you train me how to do it, I'll do it later, but I'm not going to do it first." – Oliver (provider only)

4.4.3 Motivation

Peer-supporters' motivations were discussed in depth by 27 participants, where it was felt that those in helping roles should have genuine and clear motivations. They believed that peer-supporters should be doing this job for the *"right reasons,"*—a genuine desire to help someone. Participants felt that having intimate knowledge of surviving homelessness engenders a duty to help:

"When you get dragged into something like this, you have um, you've climbed out or in the process of climbing out of it. You have a deep inset feeling to want to help and it is a want to help people get out of it, so it's an overwhelming feeling that you get" –Glenn (recipient to provider)

Often, participants felt that status as volunteers would clarify peer-supporters' motivations and influence clients to interpret peer-supporters' intentions in a positive manner. Participants who had been recipients of unidirectional IPS spoke about how they used to question peer-supporters' motivations, but found that having and communicating a genuine desire to help could enhance the relationship:

"Why are they doing this, um, you know, what's the reason behind it? There must be some purpose behind it. But then with time I talk to them, there's really nothing… So it's completely utterly to volunteer and help other people. Rather than having other, you know, purposes" –Muhammad (recipient to provider)

Conversely, during most interviews, if the peer-supporters referred to their work as a job, they would quickly clarify: *"It's not a job, even though it is a job."* These comments about the role of a volunteer prompted more questions regarding being paid for their work and what changes, if any, would result.

"100% it would change because everything changes. It would change in maybe the way that is viewed…It would start to feel more like a job than something that you're doing because you want to do it." –Andrew (recipient to provider)

Some participants were unsure about consequences of being paid and worried it might negatively impact peer-client relations, but others felt that if they were paid they would feel more valued. However, there was a consistent view that the main difference between peer-supporters and professionals was that professionals are paid.

"We volunteer, they get paid"—Shane (recipient to provider)

Another motivation for entering into peer-work includes feeling the need to repay for the wrong they did in their past or repay kindness shown to them when they needed help. Participants felt that they needed to "*give back"* and unidirectional IPS provided that platform.

"We go out there and we try to give back to the community. Because before, when I was messed up myself, I wasn't giving a lot, I was taking a lot, because I was trying to support my habit. I wasn't working, I wasn't getting any benefits, so I had to revert to shoplifting, so I was always taking…So for once in my life, I'm happy to be able to be normal again and give back to people" –Fred (provider only)

Some motivations to become a peer-supporter overlap with the benefits that peer-supporters accrue, such as skill development that contributes to employability. Participants acknowledged that they are learning transferrable skills they can use in their own career development, which may involve moving into helping professions.

"It's a career I'm looking into it, with my courses and all that. So I'm hoping to go into the field, but come out with a different light and everything, but I've lived the life and to give something back to the community" –Jamie (provider only)

4.4.4 **Overcoming Obstacles**

Twenty-eight participants discussed numerous obstacles and challenges they encountered in fulfilling their role as a peer-supporter, including specific policies, their clients, maintaining their recovery, and certain professionals. Peer-supporters must meet certain criteria to become a peer, specifically the length of time in recovery from drugs and/or alcohol.

"Like I'm 13 years sober. Um…personally, I would say at least a year, at least a year. Obviously some people do it, 6 months, three months, so." –Harry (provider only)

Peer-supporter participants rely heavily on supervision and organisational support when they experience negative emotions.

"And yeah definitely, sometime there is a time when you share that information and try to um help each other where we raise our clinical supervision. And get out and talk, and um stressing feelings and emotions." –Jim (provider only)

Undoubtedly, key to the role of peer-supporting is coping with challenging client behaviour. While not an external obstacle, peer-supporters discussed client behaviour often, citing that managing rude or even aggressive behaviour is inherent in their role.

"Sometime they become even abusive, challenging behaviour, so if we just really, withdraw immediately because of that sort of abuse or behaviour or whatever, then definitely that

person is not going to get the help. So that I expect, I expect and I have to be mentally ready you know not um fail because of that. Because I need to support that individual. So the first step is to come back. You know that's, that's really important. So that person today, is not angry at me, but is angry at something that is not related to me" –Jim (provider only)

When dealing with challenging clients, peer-supporters discussed the need to know themselves, controlling their emotions and identifying triggers to maintain their recovery. Often, peer-supporters are faced with clients who are using drugs or drinking, and they need to be secure in their own recovery to be able to cope with any situation that occurs:

"Knowing your limitations for yourself…it's just knowing what you can do and what you can't do. Yeah, it's just them being aware of their own triggers…it's a hard one because you…you never…you don't know who you're going to meet." –Jamie (provider only)

Other individuals act as barriers to getting their clients care. These individuals include health care professionals, key workers, and hostel staff. Peer-supporters described receptionists as *"battle axes,"* a formidable barrier to getting help:

"If you don't get past the receptionist, you don't see the doctor" –Harry (provider only)

This is where peer-supporters discussed being able to help:

"If that's the case with my client, I'll tell them to go sit down first and then I will book him and, and so he's actually out of sight of the receptionist so they can say anything. Yeah talk to me like that, please do! (laughs)" –Jamie (provider only)

Peer-supporters can become a bridge between professionals and clients, helping clients get the treatment they need without experiencing any negative comments from professionals. Other participants spoke about how some hostel staff had been less than receptive to peer-supporters and it had taken time to build a relationship with the specific hostel in order for their work to be successful. A discussion about professionals being unwelcoming brought up an argument that some professionals feel threatened by peers, thinking that they might take their jobs, making them redundant. Peer-supporters felt that this contributes to some professionals' resistance to accepting unidirectional IPS models.

4.4.5 How Peers Help

Twenty-eight participants discussed four main ways in which they helped people: being role-models, breaking boundaries, providing individualised treatment, and social support. Peer-supporters help by representing someone who has gone through a similar situation and grown from that experience. Most peer-supporters saw themselves positively as role-models, able to *"inspire"* and model a life without the everyday struggles of being homeless. Participants felt that

peer-supporters acting as role-models might inspire clients to do better, or to feel that their goals are achievable, and that there is hope:

> *"There are a couple of people that, you notice are paying attention and they might feel stuck where they are at and they might start saying well you know. He was, like, in my position and he's moved on and he's moved on pretty quickly so maybe that could happen for me." –Rick (recipient to provider)*

Some participants, however, expressed their discomfort at being perceived as a role-model, as they did not want to seem *"different"* or *"better"* than their clients. Seeing themselves as similar to their clients, peer-supporters struggled with how to maintain professional boundaries, while still being supportive. Most participants discussed how keeping boundaries is vital to unidirectional IPS; to be invested in the experience-based relationship, without being drawn back into drugs, alcohol, maladaptive behaviours, or losing compassion.

> *"At first, I didn't quite understand the importance of having boundaries and um you know you're exposing yourself and that is, is um, can cause problems. So I know that, nowadays, I do know the importance of boundaries and I keep them at all times, it's easier." –Diane (recipient to provider)*

More experienced peer-supporters (those with more than two years as a peer-provider, $n = 9$) were more likely to share stories about how they had *"broken*,*"* or perhaps more accurately, adjusted, boundaries with their clients during specific circumstances. These included being available to clients after hours, giving clients cigarettes, or even buying their clients alcohol. These participants spoke about how peer-supporters would break boundaries when they felt the client needed extra support, such as helping a client avoid alcohol-withdrawal symptoms until they can get to a hospital, buying clients food or drink from their own money, and moving the client and all of their belongings. These peer-supporters felt that their boundaries are more fluid than those a professional might have in place. They did not take these situations lightly—and kept the best interest and safety of their clients in mind by getting appropriate professionals involved.

> *"If it's very important, I do cross boundaries sometimes… we've crossed so many boundaries just to get this person, you know thinking that, otherwise something more serious would have happened you know what I mean. At least I know I've actually helped someone" – Timothy (provider only)*

From their unique perspective, peer-supporters discussed how they adjusted treatment/support according to their clients' needs. Peer-supporters described being willing to go the extra mile for their clients, not only breaking boundaries (if needed), but ensuring that their client got support from other services. Indeed, a peer-supporter going the extra mile for their client connects to how peer-supporters will 'Never Give Up,' are persistent, and ensure that the job gets finished.

> *"He was going that extra mile for me you know and then I didn't realise that he was going the extra mile for me until I saw his relationship with other people" –Andrew (recipient to provider)*

Going the extra mile for clients involves providing social support, potentially in multiple contexts. Through their training and personal experience, peer-supporters provided informational support by signposting clients to cooperative services. There were also instances where peer-supporters would provide appraisal support, where peers encourage a client to take action and get feedback to solve a problem (Lakey, 2000), helping clients to self-evaluate, *"encouraging them to deal with the problem."* Likewise, peer-supporters gave advice, identified treatment options, aiming to *"steer them in the right direction."*

As might be expected, peer-supporters supply companionship support, where they help to increase clients' feelings of belonging and build their social networks. Participants constantly described how peer-supporters express empathy and care, supplying emotional support to develop deep bonds with their clients.

4.4.6 Benefits for Peers

Peer-supporters reported deriving a number of psychological benefits, which ranged from a general feeling of being "*happy to help"* to feeling that they are making a difference in someone's life, as described by 28 participants. Peer-supporters benefit from engaging with clients through emotional investment in the experience-based relationship, and this contributes to emotional satisfaction when they see that one of their clients is doing well:

> *"You see when you talk to someone and see that person changing, how do you think you're going to feel? Very happy!" –Fiona (recipient to provider)*

Most noteworthy are the internal benefits peer-supporters gained from being in a helping role; peer-supporters consistently reported increases in self-esteem, confidence, and self-efficacy. The work helps to further their own recovery; peer-supporters feel that they are useful, have purpose, lead meaningful lives, and this helps them stay sober.

> *"I felt valued and to have a purpose, to be able to work and felt capable of, you know how I felt, my self-esteem, made me feel better about myself, stronger." –Diane (recipient to provider)*

As reported in the 'Overcoming Obstacles' theme, participants felt that their respective organisations were extremely helpful and they expressed their gratitude for opportunities, support, and other external benefits that the organisation had provided:

> *"I mean it's not just that, we have action groups, we have forums, recovery groups…so if anyone of us at any time is struggling with the drink or drugs, you've got support. Can come*

here in the evening and get it off your chest and have feedback. You get so much from this place, it's unbelievable." –Fred (provider only)

Concrete benefits, also described under the 'Motivations' theme, include gaining employment references, skill development, and other work possibilities. Not only did peer-supporters report feeling more capable, they also felt that being part of an organisation helped them to make important decisions about their life path:

"You know that was a painful decision, but being a peer helped me realise that I needed to pick up on my education." –Philip (provider only)

Cumulatively, these benefits impact peer-supporters lives in a progressive nature, individuals move through the system first as clients, then receive help from a peer-supporter, and then they connect with services and are exposed to the opportunities associated with being a peer-supporter. Subsequently, peer-supporters are able to attend trainings and learn to help others, whilst simultaneously helping themselves:

"Those people who have been supported by us have now come into [the organisation] and really started supporting others, so. Yeah that's (making a circular motion) how it is. A cycle" –Jim (provider only)

Once out in the field, peer-supporters begin to help and develop their sense of purpose. Then, they further develop their skills and are able to add to their CVs, use support from other peers, the organisation, and their now-filled personal reserve of information and knowledge to help themselves get a paid job and move out of the homelessness cycle.

This progression out of homelessness also leads them to develop their identity in the transition from client to helper to worker. Peer-supporters transition from feeling hopeless, neglected by society, and taking from others (in some cases), then belonging to something that they view as bigger than themselves, which helps to develop their personal sense of worth. Their ability to move from being a victim of circumstances, to surviving, to thriving because of negative experiences helps them become better helpers. These benefits help peer-supporters to develop internally and to self-actualise:

"I can see myself. You know when you look back and you can see yourself growing." –Philip (provider only)

4.5 Summary of Results

The analysis resulted in six themes describing participants' experiences and opinions of key elements in unidirectional IPS. 'Never Give Up' describes how peers are persistent and committed in providing support to build 'Experience-based Relationships' which are comprised of experiential

knowledge. Participants also described the importance of peer-supporters having honest or genuine 'Motivations' to engage in peer work. Barriers to providing support are described in 'Overcoming Obstacles', such as policies, client behaviour, maintaining own recovery, and coping with difficult service staff. 'How Peers Help' outlines the methods peers use to support their clients—being role models, breaking barriers, providing individualised treatment and social support. The last theme describes the 'Benefits for Peers' from being in the helping role, most notably the impact on peer-supporters self-esteem, confidence, and identity.

4.6 Discussion

This chapter sought to understand the critical elements of support provided by peer-supporters to those experiencing homelessness and the experiences of those providing/receiving support. Participants defined mentorship IPS as an experience-based relationship built upon mutual understanding, empathy, and support, similar to previous literature suggestions (Mead et al., 2001; Salzer, 2002; Solomon, 2004). Participant reports of the vital aspects of unidirectional IPS were consistent with previous literature and extended upon results from the review in Chapter 3. They suggested that unidirectional IPS is successful because it operates through experience-based relationships and reflects peer-supporters' motivations. By being persistent and 'never giving up' on their clients, peer-supporters are able to access this 'hard to reach' population and increase engagement (Stephanie. L. Barker & Maguire, 2017; Odierna & Schmidt, 2009; Tulsky et al., 2000).

4.6.1 Contributions to Theory

Peer-supporters develop relationships with their clients based on their shared experiences of homelessness; they connect as equals and are distinct from professionals and informal peers because of their experiential knowledge of homelessness. These findings support previous research where authors theorised that the relationship and shared experience is vital to IPS in mental health (Campbell, 2008; Mead et al., 2001; Salzer, 2002; Solomon, 2004). Indeed, participants' emphasised mutual experience as one of the critical elements to successful unidirectional IPS, as it allowed for unique understanding and empathy to develop, supporting assertions made in Chapter 3. Similarly, these findings support results from Finlayson et al. (2016), in that peer-supporters develop a unique experience-based relationship, provide support, and act as a bridge between clients and professionals.

Regarding boundaries and self-disclosure, peer-supporters would frequently share their homelessness status with clients, to increase engagement and strengthen the relationship. Similarly, professionals self-disclose to build the relationship, help with engagement, and increase trust (Ham, LeMasson, & Hayes, 2013). Indeed, peer-supporters use their experiential knowledge

to promote engagement, role-modelling and inspiring clients, suggesting a possible mechanism within unidirectional IPS.

Boundaries were an interesting, and novel, topic during the interviews, as experienced peer-supporters reported that they were likely to break boundaries. These boundary crossings are a bit further than taking your client out for a walk to 'break the ice', these included buying their clients alcohol, 'moving' them and all of their possessions, and being available out of hours. Severe as they might seem, when understood in context, peer-supporters described they were making judgment calls on a case-by-case basis, also suggested by Mead et al. (2001). These peers, having more experience, felt more comfortable and able to take control of the situation, including getting their client a beer while on their way to the hospital to fend off delirium tremens or seizures. Therefore, it seems that peer-supporters conduct a cost-benefit analysis of their actions and maintain that they keep the best interests of the client at heart.

Previous research asserts that having a peer-supporter, or a committed, experienced, and compassionate person, involved in the clients' life helps decrease drug and alcohol use, and reduces relapses (Chapter 3, Stevens & Jason, 2015; Whelan et al., 2009). Stevens and Jason (2015) state that their findings of AA sponsor characteristics "may be informing for many relationships that involve initiating and maintaining a transformative process" (p. 381), thus, peer-supporters who are committed, persistent, caring, and trustworthy can develop strong experience-based relationships with those experiencing homelessness and help them escape it.

Further, Whelan et al. (2009) found results similar to the present study, in that peer-supporters provide multiple types of support, the most frequent being emotional support. The focus on emotional and instrumental support echoes assertions made in Dennis' (2003) model, where emotional support is regarded as a defining factor of IPS in healthcare, however in contrast to Dennis' (2003) model, current results do not favour one type of social support over another.

4.6.2 Impact on the Peer Supporter

Regarding the experiences of providing support, almost every participant discussed role confusion, expressing dissonance when referring to their work as a 'job'. Since honest or genuine motivations are interpreted to be important for client engagement, peer-supporters' role confusion is a noteworthy result. A report from Australia developed guidelines for IPS use within high-risk organisations also found this dissonance; professionals could not reach consensus regarding a statement that peer-supporters should be paid (Creamer et al., 2012; Varker & Creamer, 2011). Standards developed for the use of peer-supporters in organisations would stipulate that peer-supporters should be valued, and this could come in the form of payment (Faulkner, Basset, & Ryan, 2012; Faulkner et al., 2015).

The benefits peer-supporters receive exemplify the helper-therapy principle outlined by Reissman (1965), who observed that nonprofessional's own problems would diminish as they "benefit from their new helping role, they…become more effective workers and thus provide more help" (p. 28). Reissman's (1965) construct is demonstrated by the participants, through their cited improvements in self-constructs, increased feelings of purpose and meaning, and reported stability in recovery from their role as a peer-supporter.

Another internal process regarding identity seems to develop for peer-supporters as well; it involves moving from a 'taker/consumer/harmful' individual to one that 'gives/provides/helps'. Results of identity development supports assertions made by Mead et al. (2001), where peer-supporters and clients move away from an identity of 'less-than' to having meaning and purpose. Through active listening and re-telling their story, peer-supporters in this study experienced developments in their identity similar to those asserted by Mead et al. (2001). Anderson (1993) conceptualised identity transformations through extreme conditions, such as AA, as radical conversions. These radical conversions happen in contexts that promote identity transformations. Undoubtedly, unidirectional IPS provides a similar context, through the re-telling of their stories to clients and sharing with other peers, they engage in a reconstruction of their personal lives, and these likely aid developments in their sense of self. Further, as they create meaning in their lives and re-structure their autobiography, peer-supporters begin to attribute their experience of homelessness as a catalyst for the positive changes in their lives, possibly evidencing being in the peer-client relationship as a mechanism of change, as described in Chapter 3.

Some limitations of the present study must be acknowledged. I was responsible for conducting the interviews, coding and interpreting the data, which could result in different interpretations by another researcher. However, thematic analysis allows for inductive and data-driven coding and was conducted with the research team. Further, I conducted a full mini-analysis of the first four interviews to ensure methodological rigour and adherence to thematic analysis. Nonetheless, due to the nature of qualitative data, researcher bias may be present in the interpretation. Further, I am a female, viewed as a professional by participants, and never experiencing homelessness could have influenced participants' responses during interviews. For example, one participant changed his narrative while making a humorous comment about gender roles. He apologised to the interviewer and was assured that his comment was not offensive. Participants may speak about certain things according to their interpretation of what the interviewer may, or may not think, which impacts the kind of data we can gather. Lastly, many participants displayed hesitancy around the audio recorder and sometimes spoke in length when it was turned off, these instances were recorded as field notes, treated as confidential data, and included in the analysis, as recommended by Phillippi and Lauderdale (2017).

This study is the first to evaluate the experiences of IPS peer-supporters in homelessness, and to identify what these participants see as the key elements of support. This study expands upon previous literature by focusing on IPS use with a specific population and provides evidence for unidirectional IPS with homeless populations, while also identifying characteristics that may be especially helpful in a homelessness context. For example, this study supports findings that IPS interventions can aid services in reaching those who may be hard to find and hard to engage in change (Luchenski et al., 2017; Pilote et al., 1996). Peer-supporters have unique perspectives and develop trusting relationships with excluded populations to help them access services that would normally be unavailable to them. Peer-supporters are able to use their lived experience to find this population and increase engagement to help clients overcome barriers (Finlayson et al., 2016; Tulsky et al., 2000).

4.7 Conclusion

This study contributes to scarce evidence on unidirectional IPS with homeless populations. Twenty-nine participants with experience of providing and/or receiving IPS were interviewed to ascertain critical elements of IPS and their experiences of this intervention. Findings represent participant identified factors in mentorship IPS, not an exhaustive list, but theoretically consistent with previous literature.

Future research should evaluate the critical elements of unidirectional IPS by further exploring them with diverse and larger samples. Moreover, the identified elements in this study should be explored within theoretical literature to understand key ingredients in unidirectional IPS interventions across different populations. Additionally, researchers could evaluate the identity development that peer-supporters go through, further understanding how unidirectional IPS is a transformative context, and assess the impact on reducing recidivism back into homelessness (Anderson, 1993).

4.8 Chapter Summary

As participants reported experience with mentorship/unidirectional IPS, this chapter provides a qualitative account of potential change mechanisms involved in unidirectional IPS, furthering development and theory building of IPS with a homeless population. The identified elements support and build upon those found in the review reported in Chapter 3. Specifically, shared experiences can be conceptualised as the experience-based relationships described in this chapter, role-modelling and social support were described within the theme ‘How Peers Help’, and peers being able to increase client attendance/interest may be represented within peers ‘Never Giving Up’. These elements serve as foundation for the next chapter, where another review of the literature is reported. The subsequent review combines theoretical and empirical

literature to further the development and understanding of theory involved in unidirectional IPS interventions for those who are homeless, as outlined by the MRC guidance (Richards & Hallberg, 2015).

Chapter 5 Identifying Change Mechanisms in Intentional Unidirectional Peer Support and Homelessness: A Realist Review of the Literature

Given that Participants in Chapter 4 were found to be describing unidirectional IPS, this chapter aims to further define IPS and bring clarity to this area. This chapter defines a specific type of IPS that is explored throughout the rest of the thesis—the transition from exploring IPS to a mentorship-type of peer support: intentional, unidirectional peer support. This chapter also contextualises the rest of the work in this project within a review of empirical and theoretical literature to understand the change mechanisms involved in IUPS interventions, in accordance with the MRC's developing complex intervention guidelines. Achieved by providing a model of the different putative mechanisms and components underlying IUPS. The chapter concludes with a description of testable statements derived from the review.

5.1 Introduction

Chapter 1 defined IPS as providing either unidirectional support or bidirectional support (Bradstreet, 2006). While this definition is helpful in developing our understanding of peer interventions, it lacks clarity in specifying the interventions that clients are receiving. This is shown in Chapter 4, where peers and clients were recruited if they were providing/receiving IPS; however, 27 participants (93%) described being involved in a mentorship-type of IPS. This lack of clarity regarding the intervention is concerning and limits conclusions that can be drawn from research assessing IPS.

In Chapter 1, a continuum of the helping relationships was presented (Figure 3). The Figure combines IPS into one box, but findings in this work thus far suggest that it needs to be further unpacked. Proponents of peer interventions in mental health describe PPS as:

> *"Involving 1 (sic) or more persons who have a history of mental illness and who have experienced significant improvements in their psychiatric condition offering services and/or supports to other people with serious mental illness who are considered to be not as far along in their own recovery process" (L. Davidson et al., 2006, p. 444)*

L. Davidson et al. (2006) describes this relationship as unidirectional, where the peer provides the client with at least one type of support/service. This definition is clear and enables quality assessment and research to examine what type of peer intervention is being evaluated. However, there has not been uptake of this definition. IPS interventions are still commonly referred to as 'peer support' and as shown in the systematic review in Chapter 3, peer interventions vary,

leading to mixed and uncertain conclusions about effectiveness (e.g. Lloyd-Evans et al., 2014; Repper & Carter, 2010). Indeed, the key element in peer interventions *is* the lived experience of hardship; however, the inclusion of that element alone does not define this complex intervention.

To differentiate and clarify IPS that is currently being used in various services, I further define IPS into two types: intentional, unidirectional peer support (IUPS) and intentional, bidirectional peer support (IBPS). Whereas IBPS reflects the reciprocal and informal type of peer interventions, IUPS is a formalised, mentorship type of peer intervention where the peer is clearly more advanced and is mentoring the client in an organised fashion, similar to the definition provided by L. Davidson et al. (2006). This definition and new abbreviation are proposed with the aim of enabling clarity in future research, and the improvement and development of peer interventions. Therefore, the Figure has been modified to reflect these changes, shown in Figure 10.

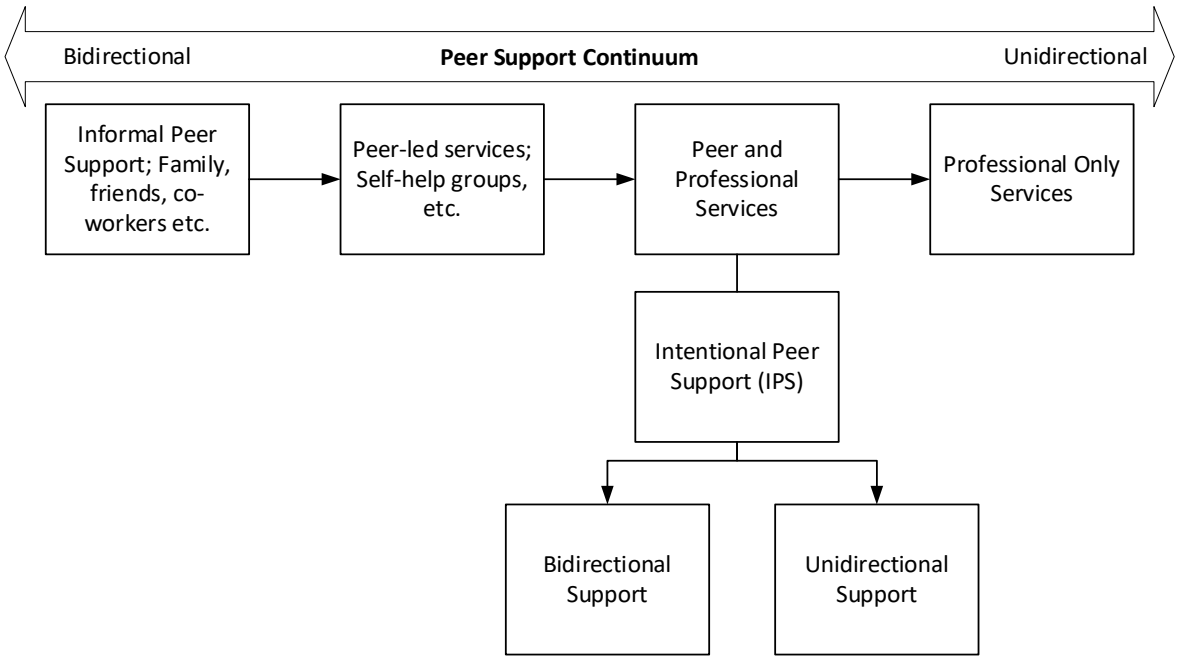


Figure 10. Modified Continuum of Helping Relationships

Additionally, to further clarify the nature of this intervention, this chapter aims to identify and define concepts within IUPS through a realist review of the literature. Realist synthesis is a theory-driven method embodying the critical realist epistemological perspective, which focuses on aspects of causation (Wong, Greenhalgh, et al., 2013). A realist review seeks to explore *how* a complex intervention works, attempting to answer the overall questions: what works, for whom, and in what contexts? (Pawson et al., 2005, p. 21). This is accomplished via a thorough, iterative process that involves developing a rough theory of how the intervention works. The rough theory is then edited by revision of included papers, and once completed, results in a detailed and strong middle range theory. Middle range theories involve abstraction, through careful consideration of evidence, but ultimately provide testable descriptions of change mechanisms that are responsible

for a particular set of outcomes in a given context (Pawson et al., 2005; Wong, Westhorp, et al., 2013).

As there is little research on homelessness and IUPS (study reported in Chapter 4 notwithstanding), this review considers literature across multiple health areas to identify change mechanisms that transcend contexts and can be applied to a homeless population (Wong, Westhorp, et al., 2013). This is not to suggest that context is unimportant, however. By identifying change mechanisms integral to IUPS, we can build interventions around identified core elements, given the needs of a particular population or specific aspects within each context (e.g. training topics, support settings). Therefore, this review is applicable to IUPS interventions within multiple health areas, not only homelessness.

Context specific mechanisms in IUPS have already been identified, and should be present to ensure IUPS' effectiveness (Moran, Russinova, Gidugu, Yim, & Sprague, 2012). The service should have a person-centred work environment, where peers are respected, accepted, and professionals are open to support the peer without judgement. Services need to be supportive for peers and be flexible when difficulties arise (Moran et al., 2012). Without this supportive culture, IUPS will be delivered in a context that hinders its effectiveness and will likely have negative consequences for both peers and clients. Therefore, the following identification of change mechanisms of IUPS is assumed to function within a person-centred work environment for the peer-supporters.

5.2 Aims and Objectives

This research aims to identify the important aspects that contribute to effective IUPS, seeking to understand which mechanisms are vital to a successful delivery of this intervention. Therefore, the primary objective of this literature review is to identify and clarify concepts by examining change mechanisms that are potentially transferable across health areas and applicable to services for those who experience homelessness.

This review will help to further knowledge about IUPS and multiple health areas and enable future research to be focused on critical elements, providing clarity in defining different types of PPS. It is the hope that this work will serve as a cornerstone for building testable concepts and processes, so that IUPS can be understood more fully and its nuances explored in detail.

5.3 Methods

As there is varied and unfocused literature exploring IUPS in multiple contexts, this review adopts a realist methodology. In accordance with guidelines for performing realist review (Pawson et al., 2005; Wong, Westhorp, et al., 2013), this work began with a known set of literature on IUPS

identified by my familiarity with the topic (e.g. L. Davidson et al., 2006; Dennis, 2003; Mead et al., 2001 etc.). The known set is comprised of research articles, theoretical literature, organisational reports, training materials, notes from meetings with various programme leads, interviews with peers and recipients of IUPS (from Chapter 4), and reports from governing bodies. The known set includes literature from different health areas, i.e. homelessness, addiction, mental health, physical health, and criminal justice areas.

Additionally, a detailed search of multiple academic databases was conducted to supplement the known set. The search included PsychINFO, PsycARTICLES, PubMED, MEDLINE, CINAHL, and Web of Science. The search strategy, reported in Appendix F, included synonyms of homelessness, adult/young adult, and change mechanisms. IUPS was not included in the search terms, as it is yet to be reflected in the literature, instead general terms around 'peer support' were included. Additionally, key word searches included 'homelessness' as it is of particular interest, however, titles were not excluded if they did not report on homeless populations. The known set of articles was also sifted. Figure 11, shows the sifting process, resulting in 71 articles included in the review.

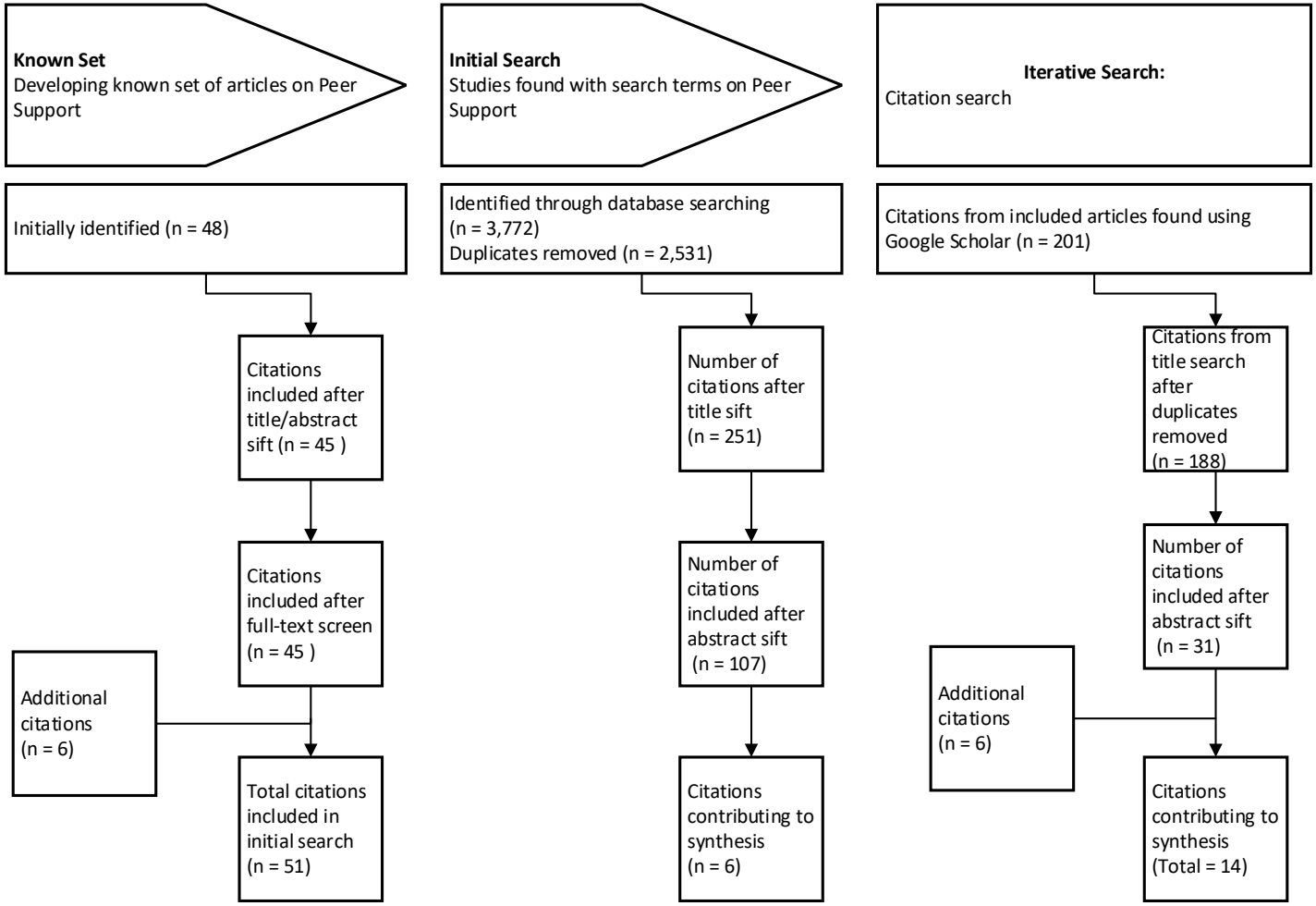


Figure 11. Document Selection Flow Diagram

(Adapted from Wong, Greenhalgh, et al., 2013, p. 7)

This review utilised broad inclusion criteria; articles were included if they discussed aspects that explain how and why IUPS works. Including:

- Articles that identify common elements in IUPS
- Articles that test common elements in IUPS
- Theoretical papers that potentially explain processes and common elements in IUPS
- Commentaries, perspective papers, and literature reviews on IUPS

Articles were excluded if they lacked focus on IUPS, reported on a topic irrelevant to the research aims, and/or were not in English. Once articles from the known set and the initial search were collected, I divided these into groups according to study type, similar to methods reported in McMahon and Ward (2012), specifically into theoretical papers, commentaries/perspectives, and empirical literature. Subsequently, pertinent data was extracted from each article (Appendix G). Relevant empirical articles were assessed for their rigour, and this was done using the Mixed Method Appraisal Tool (MMAT) and A Measurement Tool to Assess Systematic Reviews (AMSTAR; Shea et al., 2007; Souto et al., 2015).

The MMAT is particularly useful to assess the diverse types of studies included in this review, originally designed to assess mixed method studies (the MMAT can be found in Appendix H). However, this tool is used to assess single-method studies in this review. Currently the MMAT is the best and most comprehensive tool to assess study quality in multiple method types (Crowe & Sheppard, 2011). Using the MMAT, one tool was used to assess quality in the majority of the included studies. The MMAT assesses quality by assessing if the study has clear objectives and that data collection is appropriate in answering the research question (Souto et al., 2015). In subsequent steps, the researcher follows a set of questions that pertain to each study method. The AMSTAR was included to supplement the MMAT in assessing quality in papers reporting on literature reviews. The AMSTAR is an online 11-item checklist used to assess the quality of systematic reviews, with good face and content validity (Shea et al., 2007). This tool asks the researcher to assess quality through clear methods, comprehensive literature searches, and bias (the AMSTAR can be found in Appendix I).

The MMAT and AMSTAR provided justification on how much to weigh articles when considering the impact on the developed model, documenting the manner in which included articles influence progression. Further, the MMAT and AMSTAR are only applicable to empirical or systematic review studies, and given the diverse range of documents, I used the guiding principles of relevance and rigour as noted by Wong, Greenhalgh, et al. (2013). Each article is assessed based on its relevance to the research aims and if it has a clear line of argument, describes supporting evidence, and explores contradicting evidence (Wong, Westhorp, et al., 2013).

As recommended by Pawson and Bellamy (2006), the review process was iterative and required me to analyse the source documents in detail. Once data was extracted and quality assessed, I developed models for each included study. Because realist reviews are theory driven methods, I prioritised theoretical sources by dividing the analysis into two stages. Firstly, theoretical articles were examined to seek explanations of how IUPS works. Secondly, empirical articles were assessed for the same purpose but with a focus on explaining outcomes and evidencing identified pathways (shown in Figure 12).

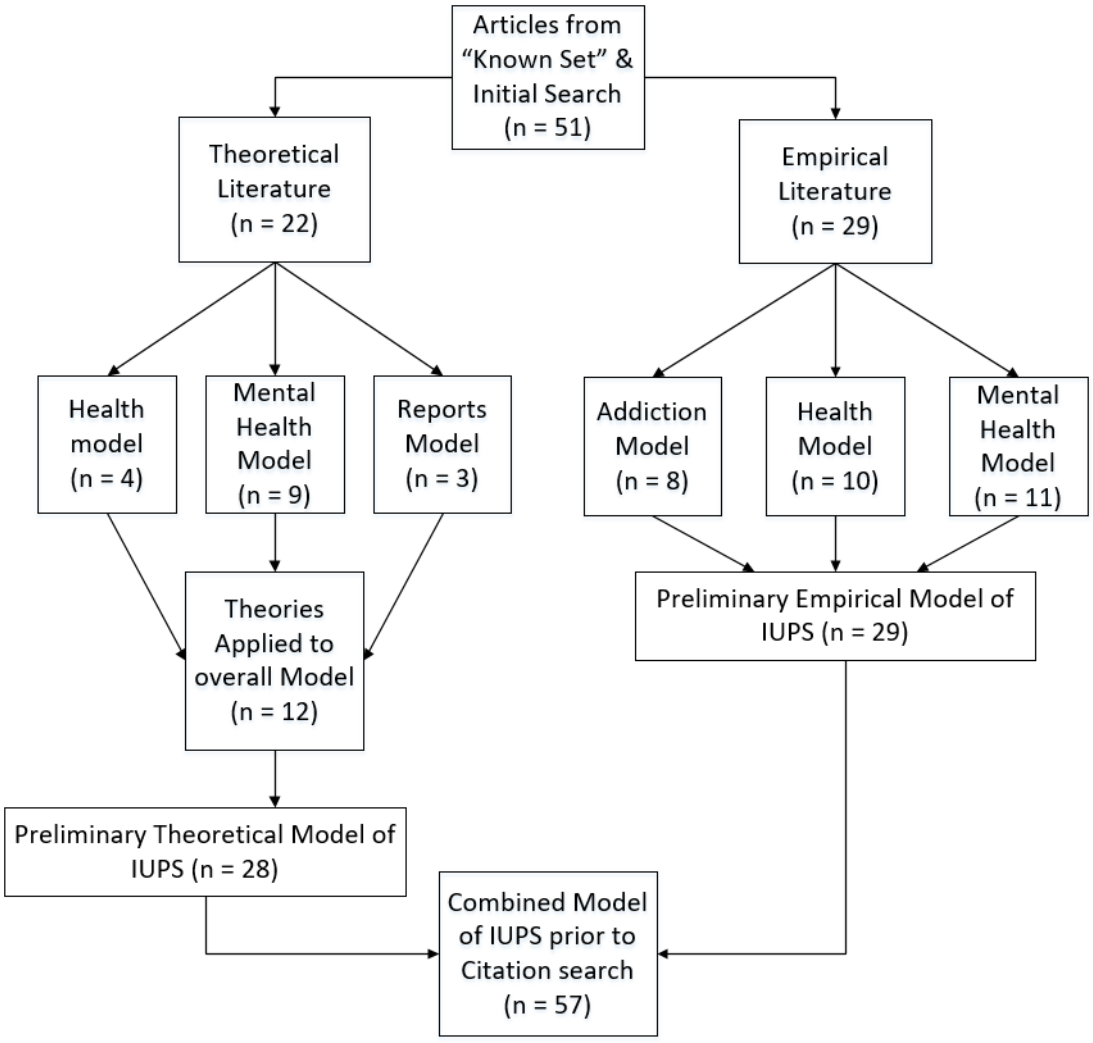
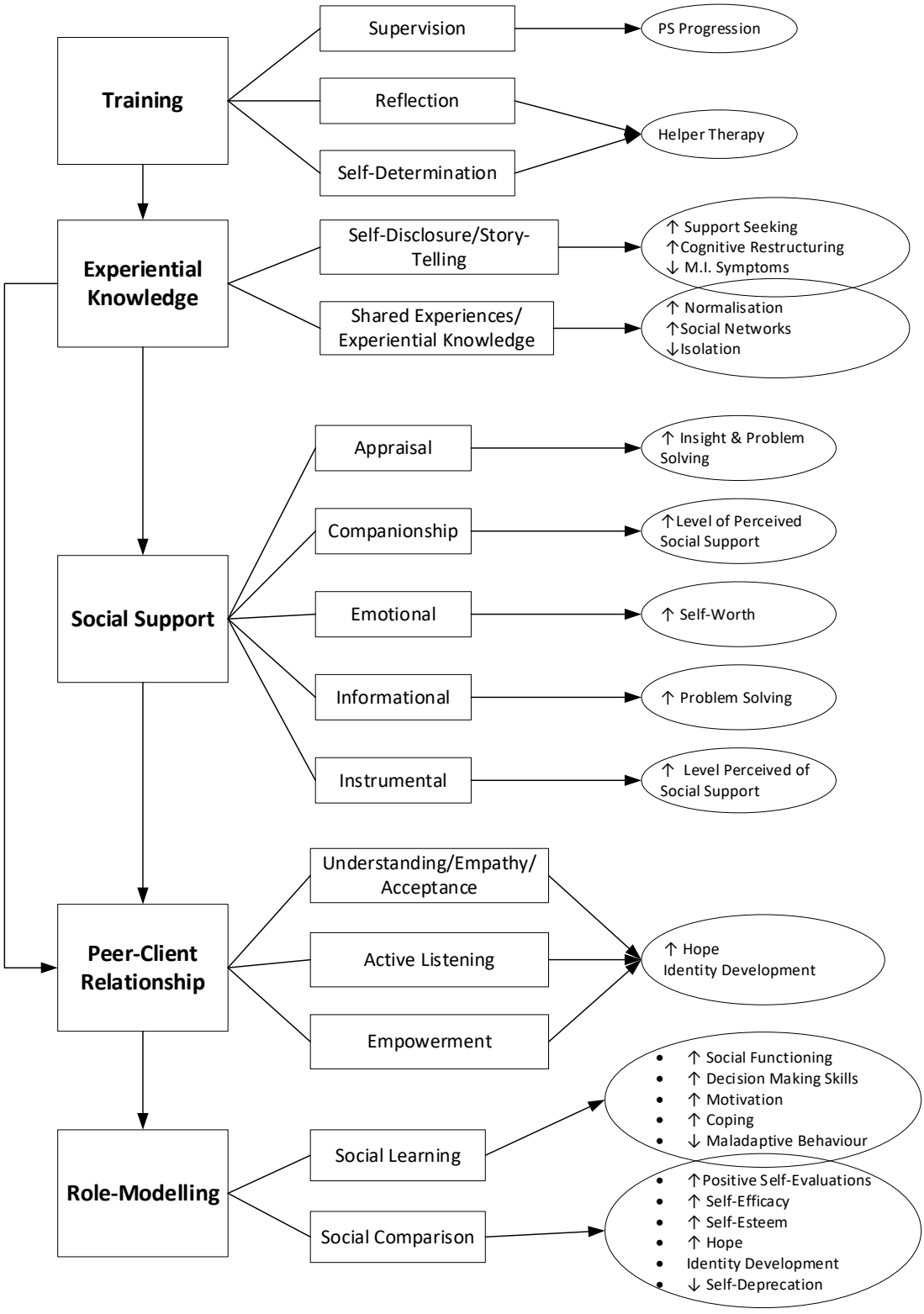


Figure 12. Model Development from Theoretical and Empirical Literature

5.3.1 Theoretical Literature

Theoretical literature was divided into specific contexts where formulations of the IUPS process were developed. Models of IUPS from mental health settings, physical health settings, and from organisational reports were combined into one overall model where theoretical literature was applied to each concept. During this stage, a citation search was conducted using Web of Science, PsychINFO, and Google Scholar. Six more articles were added to the theoretical literature set and applied to relevant concepts. This process resulted in data from 28 articles into developing a preliminary theoretical model of IUPS (Figure 13).



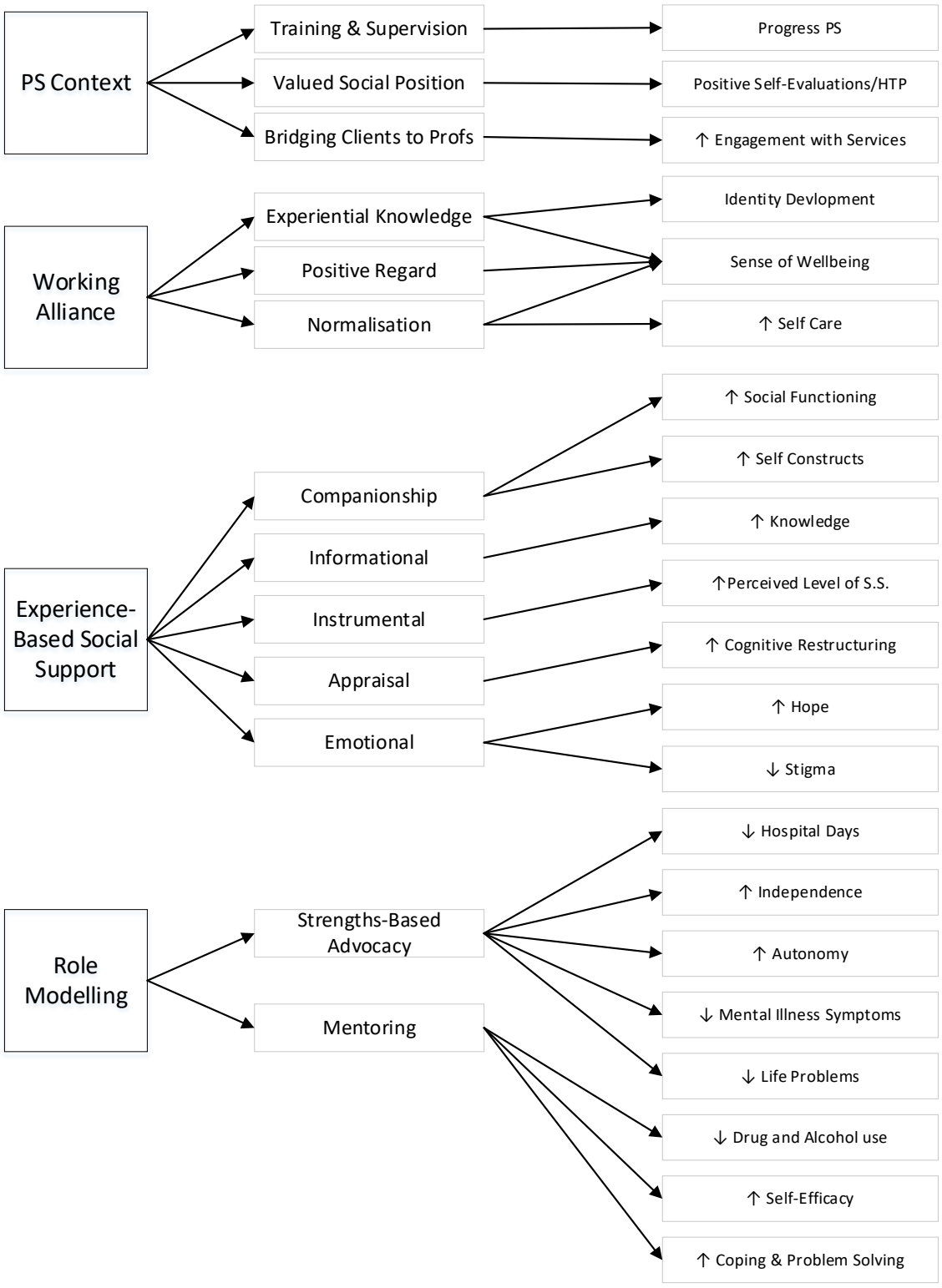
Note: ↑ = increases; ↓ = decreases

Figure 13. Preliminary Theoretical Model of IUPS

5.3.2 **Empirical Literature**

Regarding the empirical literature, a similar process was utilised. Articles were grouped into various contexts and models were made for each, resulting in a model for IUPS within addictions,

mental health, and physical health. Again, these models were combined into one overall preliminary empirical model of IUPS with data from 29 articles (Figure 14).



Note: ↑ = increases; ↓ = decreases

Figure 14. Preliminary Empirical Model of IUPS

5.3.3 Combining Theoretical and Empirical Literature

Once both preliminary models were developed, they were combined to create an overall model of IUPS. This process used the empirical articles to ascertain the strength of each pathway and edit the preliminary models. It became clear during this synthesis that peers and clients experience IUPS differently and that the final model needed to acknowledge this. Finally, in accordance with realist review methods, the iterative search process concluded with a citation search, which allowed relevant literature to be found that support and/or contradict the overall model of peer-support, resulting in an additional 14 articles. Changes to the model are described in the results section.

5.4 Results

The following results are described as they are read within the model, beginning with the client process, then detailing the process experienced by peers. It is important to note that while this model is presented as linear, with few entries and exits, in reality it is much more complex—clients and peers may enter or exit into any part of the model, thus the model outlines the typical pathway that clients and peers can take. The results are presented in the same manner as the pathway modelled in Figure 15, beginning with the typical pathway for clients receiving IUPS. Each mechanism is explained, outlining components involved, and concluding with a mechanism summary. The IUPS process for peers is presented similarly, before the discussion is presented.

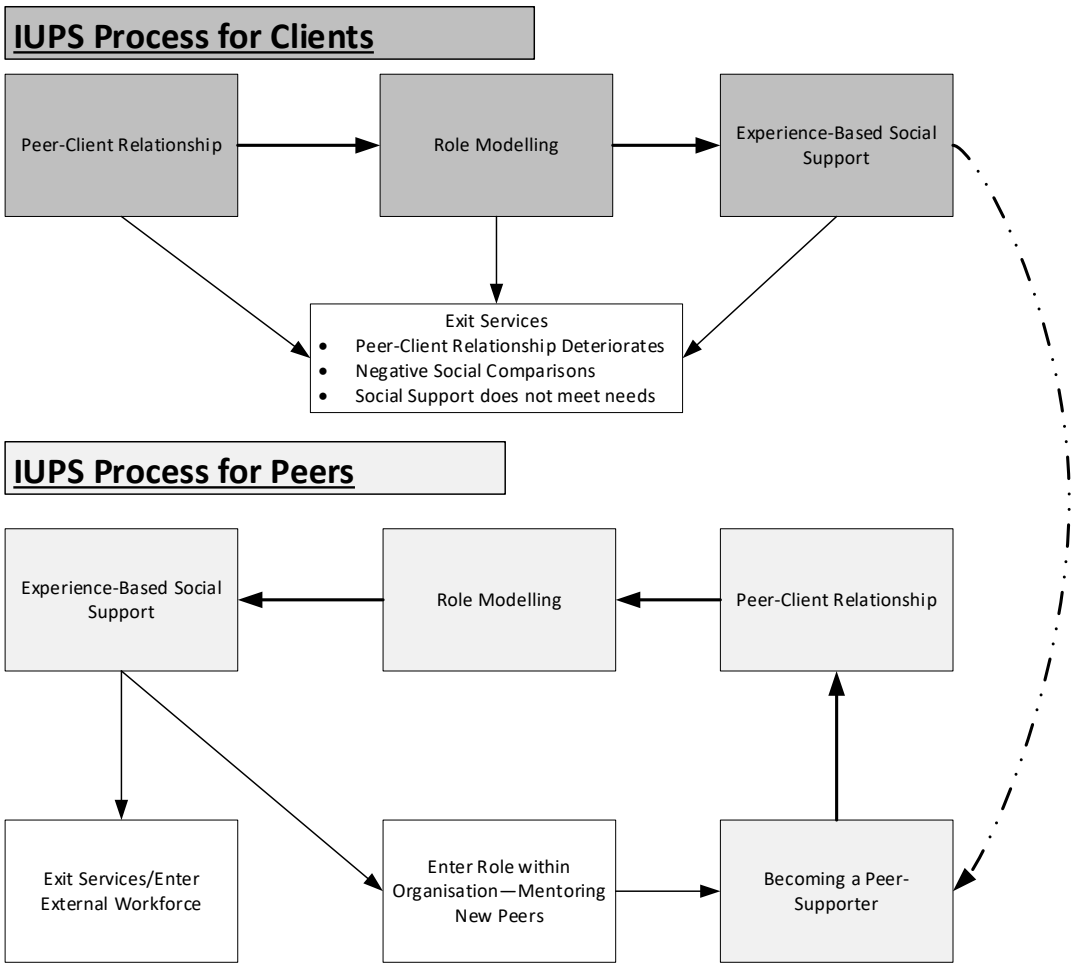


Figure 15. IUPS Pathway for Clients and Peers

5.5 IUPS Process for Clients

5.5.1 Peer-Client Relationship

Thirty-three of the included 71 articles mentioned relationships as the main mechanism for successful IUPS. Indeed, authors suggested the relationship is a critical ingredient to positive client outcomes, thus it is argued that the quality and strength of the peer-client relationship (PCR) will be directly related to client outcomes and marks the start of the model shown in Figure 15 (Goering, Wasylenki, Lindsay, Lemire, & Rhodes, 1997). Further iterative literature searches also identified the relationship between peers and clients as a change mechanism in the IUPS process (Hurley, Cashin, Mills, Hutchinson, & Graham, 2016; Solomon, Draine, & Delaney, 1995)

While many of the articles cited the importance of the PCR, very few provided detailed descriptions this element. Therefore, I used theoretical literature to support and describe the relationship between peers and clients. Gelso (2014) states that the "real relationship" (part of all human relationships) is the foundation of the working alliance that can develop in IUPS (p. 120). Horvath and Greenberg (1989) describe that a sense of bonding and agreement on the goals and collaboration comprises an effective working alliance. Research has shown that an increased

sense of working alliance can result in increased feelings of recovery (Moran, Mashiach-Eizenberg, et al., 2014). Additionally, Thomas and Salzer (2017) have found that strong working alliances increase service satisfaction and recovery outcomes in peer interventions. Peers endeavour to be genuine, accepting, and understanding in the PCR, and these elements are reflected by client-centred approaches (Campbell, 2008; Raskin & Rogers, 1989; Salzer, 2002). In summary, the literature suggests that a successful peer-client relationship (PCR) comprises experiential knowledge, positive regard, normalisation, and empowerment.

Experiential Knowledge

Thirty-six of the included 71 articles discussed some aspect of experiential knowledge, described as shared experiences, self-disclosure, or storytelling. Authors cited the importance of the relationship being built upon shared experiences and how peers will share their "experience, strength, and hope" with clients (Whelan et al., 2009, p. 7). It is apparent that the peer and client have a shared experience of hardship and a bond develops through that. Peers share their personal experience to engage with the client, connect the client to services, and provide support that will improve the client's sense of wellbeing, self-care, and help to develop their identity. Specifically, Solomon (2004) and Salzer (2002) suggests that the element of shared experiences impacts on increasing acceptance, normalising client's experiences, reducing isolation, and increases clients' social networks. Further, peers use storytelling and self-disclosure to increase cognitive re-structuring—giving clients a new perspective and opportunities to change their thought patterns based on peers as models (Adame & Leitner, 2008).

Positive Regard

Positive regard is conceptualised as the peer being able to understand the client's situation strengthened through experiential knowledge and thus providing empathy, understanding, and acceptance to build and foster the PCR. Thirteen articles asserted that a PCR, which entails high levels of empathy, understanding, active listening, and acceptance, leads to client outcomes such as higher levels of hope, autonomy, insights, and feeling understood (Chinman et al., 2014; Connor et al., 1999; L. Davidson et al., 2006; Gillard, Gibson, Holley, & Lucock, 2015; Repper & Carter, 2011). Further, peers are then trained in basic psychological skills (Creamer et al., 2012; Weissman et al., 2005), which enables them to effectively communicate empathy and acceptance.

Normalisation & Empowerment

The included studies identified normalisation and empowerment as integral aspects of IUPS, however, theoretical articles identified empowerment as an outcome, while empirical studies identified normalisation as a mechanism as it leads to feelings of empowerment (Repper & Carter, 2011). Here, they are presented together, as the concepts are linked and lead to similar outcomes for clients.

Empowerment is described as a mechanism of IUPS as it allows the client more freedom, control, and choices in their recovery from hardship. (Adame & Leitner, 2008; Cadell, Karabanow, & Sanchez, 2001; L. Davidson et al., 2006; Repper & Carter, 2011; Whelan et al., 2009). Adame and Leitner (2008) define empowerment as the degree to which a client has the ability to make choices about how to progress in their treatment and that these choices are made by the client about what is best for them. Having choices and volunteering to receive IUPS allows for the client to be more engaged with the service and the development of the PCR helps to solidify this.

Included articles describe peers developing strong PCRs with clients, where peers help the client to understand that their reactions to oppressive systems are normal, described as normalisation. This concept within mental health literature suggests that peers provide the validation of emotional responses that are often discouraged and seen as crises in traditional health care (Repper & Carter, 2011, p.398). That is, rather than normalising the act of being excluded, peers enable understanding of what may be considered abnormal or strange as a common experience, normalising the associated feelings and cognitions of exclusion (L. Davidson, Bellamy, Guy, & Miller, 2012; L. Davidson et al., 2006; Repper & Carter, 2011). Normalisation enables the client to feel more accepted and that they belong, perhaps increasing feelings of social support (e.g. emotional and companionship support). Through IUPS, clients experience personal empowerment, take active roles in their recovery, and are responsible for their actions (Campbell, 2008).

Changes to the Model and Summary of the PCR Mechanism for Clients

Further literature searches supported mechanisms described within the PCR as being vital to successful IUPS relationships; however, it is imperative that we acknowledge the possibility of these relationships being harmful. Coatsworth-Puspoky, Forchuk, and Ward-Griffin (2006) explored PCRs and found two types: one that was positive and developed and the other that was negative and deteriorated. Negative PCRs lacked trust, and left clients feeling that their peer was withholding support, engaging in detrimental behaviours such as gossiping, being controlling, and abusing their power. Methods of ensuring that the relationship progressed in a positive manner involved peers taking time to develop trust, being available, share power and control, and listening (Coatsworth-Puspoky et al., 2006). This literature changed the model to adding the exit from IUPS because of PCR deterioration.

Eight empirical articles asserted that through the unique PCR, peers are able to access and develop bonds with groups or subgroups that professionals inevitably fail to reach (Chinman et al., 2014; Felton et al., 1995; Finlayson et al., 2016; Galanter et al., 1998; Gillard et al., 2015; Pilote et al., 1996; Tulsky et al., 2000; Whelan et al., 2009). Peers encourage clients to attend to their health, resulting in fewer hospital days and missed appointments (Chinman et al., 2014; Finlayson

et al., 2016). Studies assert that peers are in a valued position that connected clients to other services that they otherwise may not have accessed (Felton et al., 1995; Finlayson et al., 2016; Galanter et al., 1998; Tracy et al., 2012; Tracy et al., 2014). Additionally, results of two RCTs suggest that peers are almost as effective as monetary incentives to encourage clients to attend treatment, but their effectiveness appeared to wane over time, suggesting the need for integrated care and options for clients to utilise different avenues in continuing their care (Pilote et al., 1996; Tulsky et al., 2000).

The PCR is the modality by which all the important aspects of IUPS are delivered—connecting with clients, providing social support, transmitting information through their experiential knowledge, and role modelling recovery. Consequently, it is the beginning of the IUPS process and leads to role modelling and the provision of experience-based social support.

5.5.2 Role Modelling

Many of the included studies discussed the importance of role modelling in IUPS, but very few gave in-depth descriptions. However, key theoretical articles suggested the role of social learning and social comparison in IUPS models (Salzer, 2002; Solomon, 2004). This prompted a thorough examination of original sources to explain processes occurring in IUPS. Social learning and social comparison theories are thought to underpin the role-modelling mechanism in IUPS, described below. Further, empirical literature often described that IUPS uses a strengths-based approach to advocating for clients and is added as a component in reducing stigma (Finlayson et al., 2016; Freddolino & Moxley, 1992; Gillard et al., 2015; Rowe et al., 2007; van Vugt et al., 2012).

Social Learning/Mentoring

Twenty articles discussed role modelling or mentoring and that it involves a stable and more advanced peer mentor the client through phases of treatment and provide support as clients progress. Social learning is a cognitive process that occurs within social contexts (Bandura, 1977). Clients learn from the peer during IUPS, and they are not passive in this process—they are learning and observing, being active in how they think about modelled behaviours from the peer, and are more likely to model behaviour when they perceive the model as similar to themselves. Peers can verbally impart information to clients. However, learning can occur without any behavioural changes. Clients need to attend to the information, retain the information, be able to reproduce the behaviour, and be motivated to complete the behaviour (Bandura, 2010).

Mentoring involves peers using their experience to model specific behaviours and practices that help the client to gain traction in early recovery. Peers transfer knowledge through various types of social support (i.e. informational, emotional, and appraisal) and this mentoring is a critical element of IUPS (Ahmed et al., 2012; Bradstreet, 2006; Campbell, 2008; Crawford & Bath, 2013; Gillard et al., 2015; Solomon, 2004).

Solomon (2004) suggests, “enhanced self-efficacy occurs as a result of interactions with peers” (p. 5). Higher motivation and social functioning results from reproducing behaviour modelled by peers and increasing interactions with pro-social individuals that peer-supporters introduce to the client, increasing clients’ self-esteem. Clients can learn how to behave pro-socially which results in increased decision making skills and reduced maladaptive behaviours. Role modelling/mentoring increases clients self-esteem, self-efficacy (Fors & Jarvis, 1995; Stewart et al., 2009), hope (L. Davidson et al., 2012; L. Davidson et al., 2006; Repper & Carter, 2011; Resnick & Rosenheck, 2008; Whelan et al., 2009), coping methods (Galanter et al., 1998; Resnick & Rosenheck, 2008; van Vugt et al., 2012), and reduces drug and/or alcohol use (Bean et al., 2013; Stewart et al., 2009; Tracy et al., 2012; Tracy et al., 2014; Whelan et al., 2009).

Social Comparison

Six included articles discussed how clients compare themselves to peers, viewing them as positive role models within the PCR (Ahmed et al., 2012; Bradstreet, 2006; Campbell, 2008; Crawford & Bath, 2013; Salzer, 2002; Solomon, 2004). Authors cited that social comparison is an important theoretical construct in explaining how clients benefit from IUPS. Social comparison theory (Festinger, 1954) centres on the belief that there is a drive within individuals to self-evaluate—that individuals evaluate their own opinions and abilities by comparing themselves to others in order to reduce uncertainty, and learn how to define the self. Comparisons can be upward; where one compares themselves to someone who is viewed as more advanced, or downward; where the comparison is done with someone who is less stable. It is theorised that clients are able to do more positive downward comparisons once they are affiliated with the peers—engaging in self-enhancement through belonging to a new and valued group. While upward comparisons for those with low self-esteem usually results in negative self-evaluations (Buunk, Collins, Taylor, VanYperen, & Dakof, 1990; Wills, 1981), in IUPS, clients’ desire to have a valued social position and be associated with the peers converts these upward comparisons into positive ones (Tracy et al., 2012; Tracy et al., 2014).

However, self-esteem and recent stressful experiences moderate the outcome of an upward comparison (Wills, 1981), therefore, the outcomes of these comparisons may depend on the client’s recent experience of stressors and level of self-esteem—which could lead to them exiting the service as shown in the model. Peers can help to circumvent this by developing a strong PCR and increasing the clients’ self-efficacy and self-esteem. Further, IUPS contributes to client identity developing a recovery narrative through peers’ modelled experiences (Campbell, 2008; Mead et al., 2001; Salzer, 2002).

Strengths-Based Approach

The final component of role modelling describes IUPS as a strengths-based approach, where peers advocate for clients and highlight their lived experience as a strength (Finlayson et al., 2016; Freddolino & Moxley, 1992; Rowe et al., 2007; van Vugt et al., 2012). Peers identify and break down barriers that clients often face in accessing services, developing and setting goals, reaching milestones, and generally, helping them to learn how to self-advocate to avoid becoming dependent on the peers (Finlayson et al., 2016; Fogarty et al., 2001; Rowe et al., 2007). When IUPS is recovery-oriented and values clients' strengths, it helps to develop the PCR and fosters positive outcomes. Strengths-based advocacy has been shown to lead to better outcomes for the clients, higher engagement with services (Finlayson et al., 2016), fewer hospital admissions and days (L. Davidson et al., 2012; Repper & Carter, 2011), increased autonomy (L. Davidson et al., 2006), and higher levels of hope (Bradstreet, 2006; Campbell, 2008; Lloyd-Evans et al., 2014; Solomon, 2004). Further, a strengths-based approach enables clients to challenge internalised stigma, increasing hope (Gillard et al., 2015).

Mechanism Summary for Role Modelling

Role modelling is an important element of IUPS and is presented as the second step in the linear model. Clients can learn various coping strategies directly or indirectly from their peer-supporters, improve their self-esteem by making downward or upward social comparisons, and feel that their life experience is valuable and can be used to help others. Conversely, clients can learn negative behaviours from their peer-supporters, make social comparisons that are damaging, and exit the service. Some of these potential undesirable outcomes are avoidable, given that the peer has adequate training and support to mitigate transfers of maladaptive behaviour (Tulsky et al., 2000).

5.5.3 Experience-Based Social Support

Eighteen of the 71 articles discussed types of social support. Articles varied on the types of social support provided by peers, but all five types were mentioned. Social support, as a general concept, was discussed by seven of the included articles, as a key process, as an outcome, or both. Social support is defined as "an exchange of resources between two individuals…intended to enhance the well-being of the recipient" (Shumaker & Brownell, 1984, p. 11). Shumaker and Brownell (1984) assert that an important aspect of social support involves self-disclosure, in the context of IUPS this is very beneficial as the type of information they are passing on may take the form of different types of social support. However, a few things need to be in place before this exchange will be beneficial for the recipient. They must have similar goals, similar modes of helping/receiving help, and recipients may lack the interpersonal skills to accept the support (Shumaker & Brownell, 1984). These issues are mitigated in the context of IUPS, however. Firstly,

peers work to develop relationships with the clients and thus will know what goals the client has, and they can work on them jointly. Secondly, peers are reflective in their practice and have training to deal with various types of people (described later in the 'Becoming a Peer' mechanism); this is also reinforced through their own lived experience. However, it must be noted that not all peers are going to be able to work with every client and that some flexibility in this regard is required. Thirdly, clients may lack interpersonal skills, but because peers have intimate understanding of the client experience, they are able to relate to the clients on deeper levels.

Informational Social Support

The most common type of social support provided by peers is informational support, which supplies recipients with useful or required information to help cope with challenging situations (Lakey, 2000; Solomon, 2004). Studies that highlighted informational support suggest that the provision of information regarding specific illnesses, treatments, or methods of coping lead to stronger PCRs (Goering et al., 1997), increased treatment adherence, knowledge, and problem solving skills (Deering et al., 2009; Finlayson et al., 2016; Fogarty et al., 2001; Repper & Carter, 2011).

Companionship Social Support

Companionship support includes linking the person to a social network, serving as a reminder that there is support there for them (Lakey, 2000; Salzer, 2002). Peers introduce clients to prosocial peers (through peer support organisations, AA for example) thus increasing their social networks and enabling clients to feel supported. Included studies cited that companionship support is provided by peers, helping clients to feel increased self-esteem, confidence, efficacy, belonging, social functioning, and increased social networks (Blondell et al., 2001; Chinman et al., 2014; Finlayson et al., 2016; Gabrielian et al., 2013; Rowe et al., 2007; Weissman et al., 2005; Whelan et al., 2009). Companionship support can lead to a stronger PCR and thus better outcomes for clients.

Emotional Social Support

Emotional support is the third most common type of social support reported by included studies. Emotional support serves to elevate someone's mood and help them to feel better about whatever situation they are in (Lakey, 2000). An example includes peers expressing how they understand how the client is feeling and showing empathy for their situation. This also helps build the PCR, developing trust and an emotional bond. Thus, social support acts as a process rather than an outcome alone. Peers communicate expressions of caring to clients and this enables clients to develop hope and to reduce stigma associated with homelessness, mental illness, addiction, and/or ill health, leading to increases in perceived levels of social support. Emotional

support is found to be critical for positive outcomes early in the PCR (Whelan et al., 2009) and leads to a stronger relationship (Finlayson et al., 2016; Goering et al., 1997).

Instrumental Social Support

Instrumental support involves the provision of tangible support, such as buying coffee, meals, supplying transportation, assistance completing paperwork, and locating services (Finlayson et al., 2016; Pilote et al., 1996) to help an individual to cope with an immediate need (Lakey, 2000). Through their respective organisations, peers have resources to help a client get to a doctor's appointment, meals, and find accommodation. These instances help to increase treatment adherence, strengthen the PCR, and increase perceived levels of social support (Finlayson et al., 2016; Goering et al., 1997; Pilote et al., 1996).

Appraisal Social Support

The final type of social support, appraisal support, encourages one to take actions and get feedback to resolve a problem (Lakey, 2000). Peers encourage clients to take action to change their situation, to go to the GP or sleep in a hostel, and then provide positive communication to assess the outcome of these actions. This results in clients engaging in cognitive restructuring their own self and their situation (Dennis, 2003; Finlayson et al., 2016; Whelan et al., 2009).

Mechanism Summary for Social Support

Experience-based social support comes last in the model, as it is the most diverse mechanism. Clients can experience increases of various types of social support at different levels of the IUPS model. As stated previously, the model is presented in a linear fashion, but is much more complex than the depicted process. IUPS provides multiple types of social support, based upon shared experiences. However, clients may also desire different support and drop out of the service as they feel their needs are not being met. This can be mitigated through the voluntary nature of IUPS, where clients are able to choose the type of support.

5.6 IUPS Process for Peers

5.6.1 Becoming a Peer

The next mechanism marks the beginning of the process for peers in IUPS. These are usually previous recipients of IUPS; however, it is not uncommon for peers to begin training as another step in their recovery without previously being a recipient of IUPS. This mechanism developed out of the nineteen articles that discussed the importance of training and supervising peers. Most described how peers are trained in various areas, where each training element varies according to context of IUPS delivery. Empirical literature identified that trainings should be delivered by professionals involved in the service (Pilote et al., 1996).

Authors cited that peers needed to be trained in order to be effective in the given context—evidenced by issues reported on the lack of training and support for peers. Tulsky et al. (2000) ran a peer-intervention where peers provided support to enable clients to gain access to tuberculosis treatment. Once the study was completed, peers and staff noted that peers struggled with their own personal issues regarding recovery and this inhibited their effectiveness, further, peers felt that they were not able to help with specific problem-solving and coping in real time. Authors suggested that proper training and supervision would have helped to alleviate these issues and helped to provide comprehensive support to clients (Tulsky et al., 2000).

Creamer et al. (2012) assert that peers should be given training in low-level psychological interventions, however this article reports on IUPS in high-risk organisations such as hospitals and the military. Nonetheless, authors suggest that peers should possess basic psychological skills such as active listening, psychological first aid, and information about referral processes. Thus, peers must be trained in the given context of the IUPS intervention and be sufficiently supported in their role (e.g. supervision from clinical professionals and opportunities for group supervison; Bowgett, 2015; Crawford & Bath, 2013; Faulkner et al., 2012; Faulkner et al., 2015; Mead et al., 2001).

Training and supervision is key to successful IUPS. Adequate training not only serves to parse out those who may not be committed to being a peer, but also provides the peers with sufficient knowledge and confidence to begin helping (Bowgett, 2015). Further, engaging with the organisation during training allows for the peer to develop prosocial relationships with other peers and professionals available to them (Moran et al., 2012). The support network for the peer is crucial to prevent harm to the peer while supporting clients. A supportive environment fosters peer growth, promoting peers to be self-reflective and self-determined (Moran et al., 2012). Further, training and supervision represents good practice—it would be negligent to send peers out to support clients without sufficient training and support (National Lived Experience Advisory Council, 2016).

Self- Reflection & Self-Determination

Included articles reported that peers should be reflective in their work and strive for personal growth (Ahmed et al., 2012; Campbell, 2008; Mead et al., 2001; Simoni, Franks, Lehavot, & Yard, 2011). While becoming a peer, peers should have opportunity and be encouraged to be reflective—helping to develop their sense of self as a helper and improving how they help others (Mead et al., 2001). Further, authors described how self-determination is involved in IUPS (Ahmed et al., 2012; Simoni et al., 2011). PCRs are built upon self-determination, respect, and shared responsibility. Peers are autonomously motivated. That is, they have intrinsic and extrinsic motivation that enables them to be effective helpers. Moran, Russinova, Yim, and Sprague (2014)

found that peers entered into IUPS because of internal motivations such as autonomy driven needs (aligning with personal values), relatedness needs (opportunity to connect to others), and competence driven needs (feeling confident and capable to help others). Participants also identified two external motivations: instrumental needs (e.g. seeking a job) and to escape their previous employment (Moran, Russinova, et al., 2014).

By being autonomously motivated, peers are able to support autonomy in others and are more likely to act pro-socially (Deci & Ryan, 2012). In addition, peers may have a higher prevalence of an autonomy orientation, as they may be more likely to integrate their past negative and positive identities with their current sense of self (Croft et al., 2013). This follows from peers developing their personal identities as people who experience personal growth are more likely to be autonomous and functioning better in their overall wellbeing (Croft et al., 2013; Mead et al., 2001; Moran et al., 2012). Personal growth aids their motivation orientation and can help them to become better helpers. Thus, peers' motivations are important to successful IUPS, as they can have a large impact on the relationship and essentially are *the* intervention—integral to the quality of the support clients receive. It has long been thought that helpers benefit from being in a supportive role (Reissman, 1965). Peer-supporters can experience an increased sense of interpersonal competence, increased knowledge, and social approval, which enables them to become better helpers, thus reinforcing the effectiveness of IUPS (Reissman, 1965).

Mechanism Summary for Becoming a Peer

Becoming a peer involves adequate training, support, supervision, and opportunity to be self-reflective—key elements within IUPS, as identified by 19 of the included studies. Peers have unique and valued lived experience, but it is essential that peers be adequately supported within their role to prevent harm to them and their clients. Further, peers should be reflective in their work and strive for personal growth, enabling them to become better helpers and develop their sense of self. Transitioning into a helping role supports a "synthesis of past experiences and movement away from professional support, building a sense of what the individual can achieve in his/her own right" (Croft et al., 2013, p.37). Thus, peer motivations are important to successful IUPS, as they can have a large impact on the relationship and are integral to the quality of the support clients receive.

5.6.2 Peer-Client Relationship

Experiential Knowledge

One aspect of experiential knowledge is experiential expertise, defined as competence in handling a problem related to one's experience and knowledge (Borkman, 1976, 1990). Using their experiential expertise, peers can enter into leadership roles, increase their status in the group, and be a source of authority (Borkman, 1990). A particularly important process in IUPS involves

the dialogue between clients and peers. The element of self-disclosing and telling life stories relates to how peers will volunteer information about their lives and their journey through recovery (Ahmed et al., 2012). Self-disclosures are thought to enhance the PCR by creating a bond between the peer and the client. Peers benefit from the process of sharing their story through a re-construction of their own personal narrative. Self-disclosure must be done safely, where the peer is trained to only share what they are comfortable with and perhaps be trained to identify which parts of their own history would be especially useful for their clients (Moran et al., 2012). By sharing their personal story, peers learn new ways to re-interpret their past and begin to develop their identity into feeling a sense of purpose and meaning (T. L. Anderson, 1993; Moran et al., 2012). Further, hearing the clients' story allows peers to be inspired by their clients' growth and serve as a point of reference to learn from others (Moran et al., 2012).

Positive Regard

Authors assert that the PCR is built upon mutual understanding, shared empathy, and acceptance (Ahmed et al., 2012; Mead et al., 2001). Peers (and clients) are able to tell their story and be listened to, which is the "cornerstone of peer-support, empowerment, and recovery" (Mead et al., 2001, p. 55). Peers engage with the client through active listening and use it to develop the PCR and build trust. Engaging in active listening creates a dialogue that pursues "a mutual commitment to personal and social improvement" (Mead et al., 2001, p. 138). Listening with the intent to help allows both clients and peers to develop a new sense of self (Crawford & Bath, 2013; Croft et al., 2013). It encourages the listener to get deeper with the client and their story, becoming engaged about the meaning of the story and the impact on the client—enhancing peers' helping skills.

Normalisation & Empowerment

Simoni et al. (2011) describe different potential models of IUPS and posit that empowerment is integral to advocacy-based interventions for excluded populations, given that they aim to reduce inequalities and increase health. IUPS is one such intervention, where power differentials are lowered and can keep clients engaged in the intervention. Thus, the focus is on how connected the client is to other people, and IUPS can provide an avenue to engage with social justice work and help to reduce social inequities and stigma. Additionally, training materials for peer-supporters working with a homeless population have a heavy focus on the role of advocating and empowerment for their clients (Bowgett, 2015). Thus, as reflected in current IUPS services, empowerment and advocating for excluded populations is a key element of IUPS (Moran et al., 2012). Peer-supporters, then, learn about how to advocate for their clients and to empower them. This enables peers to learn about coping with different stressors and teach lessons that

they can use in their own life. Peers inevitably learn about the methods that they teach to enhance coping strategies and can integrate their learning in their own lives (Borkman, 1976).

Mechanism Summary for PCRs for Peers

Both clients and peers experience the PCR, however, this mechanism was developed from 11 articles that highlighted the impact of the relationship on the peer. Peers benefit from being in a helping role; utilising their experiential expertise to help others encourages personal growth and identity development for the peer. While providing support, peers engage in safe self-disclosure, active listening, and advocacy. Peers not only gain in developing their sense of self, they also acquire valuable skills and interpersonal expertise—enhancing their prospects for employment. Peers may not always benefit from self-disclosure, however, and must be trained to avoid potential risks of harm through practice of telling their story, identifying elements that are especially helpful for themselves and others (Moran et al., 2012). Peer-supporters may be at risk for emotional burnout—where they overextend themselves by meeting high demands of the organisation and/or their clients, resulting in feelings of anxiety or hopelessness and may lead to withdrawal and/or avoidance (Moran et al., 2012). These risks can be mitigated through sufficient training, supervision, and self-reflection (Bassot, 2015).

5.6.3 Role Modelling

Social Learning/Mentoring & Social Comparison

While none of the included articles discussed potential impacts of peers as sources of social learning, some preliminary inferences can be made from interviews with peer-supporters, reported in Chapter 4. Interviews with peer-supporters found that role modelling and being able to 'inspire' clients led peers to feel that their work is beneficial (see Chapter 4). One empirical article reports that peers experience increased self-esteem, confidence, and become better helpers from role modelling (Moran et al., 2012), embodying the helper therapy principle (Reissman, 1965). Further, peers can conduct positive self-evaluations of themselves by comparing themselves to clients and informal peers, as they have a valued social position of being a peer, and live with meaning and purpose (Moran et al., 2012; Tracy et al., 2012; Tracy et al., 2014).

Strengths-Based Approach

Peers benefit from mentoring and helping, they have higher levels of quality of life and more independence (Croft et al., 2013; Eisen et al., 2015). Further, one peer from the interviews in Chapter 4 described that because he engaged in advocacy work, he became more attuned to the social injustices in the political and social sphere. This increased awareness may lead peers to participate in social movements to end injustices and become more involved within their

community. From interviews with peer-supporters, it was found that some peers had started community projects aimed at reducing stigma, protesting unjust laws and regulations, and became more involved within local community groups. Examples include starting a café for homeless individuals to work at, festivals for homeless artists, and fundraising events (Chapter 4). Thus, peers can become social justice advocates and contribute to ending social exclusion and inequality.

Mechanism Summary for Role Modelling for Peers

Being a role model for clients can help to increase peers' confidence, self-esteem, and self-efficacy. Peers benefit from being a source of hope for their clients; however, this may put pressure on the peers feeling as though they need to live up to impossible standards. Potential negative outcomes of being a role model again highlight the need for peers to have comprehensive support and training. Nonetheless, being a role model and engaging in strength-based advocacy work allows the peer to improve self-constructs and increase their skills to become better helpers and gain employment.

5.6.4 Experience-Based Social Support

The impacts of providing social support for the peers have not been fully explored by the included studies; however, I abstracted potential outcomes for peers, supported by included literature where possible. For example, providing instrumental support to clients, such as coffee or transportation, may help the peer to feel competent in their role as a peer. Further, when engaging in informational support, peers consolidate and find the limits of their knowledge of services, prompting them to seek out more information and increase their knowledge base. Undoubtedly, peers benefit from providing companionship and emotional support, they learn how to effectively communicate empathy and compassion and increase their social networks by linking clients to services such as AA (Creamer et al., 2012; Mead et al., 2001). Further, from their training, peers will have developed a self-reflective manner, and helping clients to do the same will compound benefits learned from their training (Mead et al., 2001).

5.6.5 IUPS Process for Peers Summary

Figure 15 shows how peers experience similar mechanisms, however, included studies have outlined that peers experience different outcomes from the helping role. There is also the potential for peers to exit the services and have negative experiences while being a peer. These instances are not represented in Figure 15 because as it is identified as a possibility; there are not enough accounts of peers exiting services for it to be depicted. However, peers may develop inappropriate relationships with clients which leads to relapses or romantic relationships that interfere with their work (Stephanie L. Barker, Maguire, Bishop, & Stopa, 2018). They may also feel overwhelmed and quit because they lack support to cope with the demands of the role.

These events can be alleviated with thorough training and support from organisations, again highlighting that necessity. However, peers can also exit the service in a positive manner—they may have gained external employment and are fully integrating back into society, or they may receive a promotion through their organisation and begin training new peers into the helping role. Overall, the IUPS process is one that helps both clients and peers to gain various skills and benefits.

5.7 Discussion

This realist review sought to identify the mechanisms that underpin effective IUPS for those experiencing homelessness by reviewing literature on IUPS in various contexts. The initial search resulted in 57 articles examining IUPS within homelessness, addiction, mental and physical illness, and criminal justice areas. In accordance with realist methods, synthesis began focusing on theoretical literature in developing a preliminary model of IUPS. Next, a second model for empirical literature was developed with an emphasis on evidencing identified pathways. The two models were combined and a final literature search was conducted, where an additional 14 articles were included in the review. Synthesis resulted in a final model of IUPS. This model outlines the process of IUPS for clients and peers. The model shows that both clients and peers experience mechanisms of PCRs, role modelling, and experience-based social support. However, clients and peers experience each of these mechanisms differently. Additionally, peers experience training and supervision when entering the peer role, shown in the 'Becoming a Peer' mechanism.

The literature that enabled the development of this model came from the areas of health, mental health, addictions, and homelessness. However, upon iterative literature searches, more support for these concepts and the overall model was found. Heidemann et al. (2016) examined the 'wounded healer orientation', whereby formerly incarcerated individuals mentor current prisoners and support them to make amends, give back to the community, and help others who have been similarly stigmatised. It was found that this support impacts positively on client's self-esteem and social support. This is done by mentoring, sharing past experiences to role model new coping behaviours, and plan a career in the helping profession. This model is arguably quite similar to the concepts explored in this review and supports the assertion that there are key mechanisms in IUPS that transcend contexts. Further, recent literature on IUPS in mental health by Gidugu et al. (2015), Proudfoot et al. (2012), and Gillard et al. (2015) identified mechanisms of IUPS that support those identified in this review. They cited the PCR, role modelling, social comparison, the helper therapy principle, social support, shared experiences, and boundaries as mechanisms in IUPS.

5.7.1 IUPS Process for Clients

Clients voluntarily enter into IUPS and gain from the PCR through experiential knowledge, positive regard, normalisation/empowerment, and bridging clients to professionals. The literature suggests that peers and clients bond upon their shared experience of hardship, and this enables a strong PCR to develop. This review highlights the importance and value of the PCR; if the PCR is strong then clients will have better outcomes overall (Gidugu et al., 2015; Solomon et al., 1995). That is, strong PCRs, characterised by shared experiences, empathy, acceptance, and understanding, result in the client experiencing increased hope, self-esteem, empowerment, treatment engagement, decreased hospital days, isolation, and fewer missed appointments (Cadell et al., 2001; Connor et al., 1999; Creamer et al., 2012; Felton et al., 1995; Finlayson et al., 2016; Repper & Carter, 2011; Weissman et al., 2005; Whelan et al., 2009).

Clients benefit from peer-supporters as role models—who they learn from, make positive social comparisons, and benefit from the overall strengths-based approach of IUPS. The synthesis shows that within strong PCRs, clients learn from peers as role models and this increases their self-efficacy (Campbell, 2008; Salzer, 2002; Solomon, 2004). That is, peers model recovery through social interactions and sharing their personal stories with clients as credible sources of reference for clients, which enables clients to feel as though they are able to achieve a similar lifestyle, leading to enhanced self-esteem, motivation, hope, coping methods, and positive self-evaluations (Finlayson et al., 2016; Freddolino & Moxley, 1992; Rowe et al., 2007; van Vugt et al., 2012).

Lastly, clients benefit from the social support that peers provide to them. This mechanism is quite diverse and comes last in the client model, as clients can experience various types of social support at any time during treatment. Clients may receive instrumental support such as transportation and a meal prior to a doctor's appointment, but this event also serves to develop the PCR and as an opportunity for the peer to share some of their own story and model recovery. Thus, while these mechanisms transcend contexts they are still a simplistic representation of the actual process of IUPS and the human relationships that develop. Similarly, clients can, and do, exit IUPS services at any point of this model—through the breakdown of a PCR, negative social comparisons, and mismatched support needs, for example.

5.7.2 IUPS Process for Peers

Once clients have progressed to a point of stability and recovery, they can positively exit the services or they can continue in the IUPS pathway and begin the process of becoming a peer, through training, self-reflection, and self-determination. The model identifies training and support for peers as a mechanism within IUPS. This assertion results from the synthesis of included studies that highlight the need for peers to be adequately trained and supported in their role (Finlayson et al., 2016; Mead, 2003; Mead et al., 2001; Tulsky et al., 2000). If peers are trained to be self-

reflective, on pertinent issues in the given context, and have access to clinical supervision and support, then they will be better able to provide effective IUPS and benefit the clients. Throughout this review, it has been highlighted that peers need training and support in order to fulfil their role and avoid harm.

There are a number of training needs for peers, regardless of the context of IUPS: self-reflective practice, boundaries, basic psychological skills, and problem solving. Self-reflective practice involves fostering an atmosphere where peers can reflect on their interactions with clients and examine their own beliefs, attitudes, and assumptions (Mead et al., 2001). This practice enables peers to become more sensitive to systemic issues and their own biases. Peers must be able to work in environments where they are able to critically reflect on issues that arise and have opportunity to experience growth.

Additionally, peers must have support to navigate boundaries with clients. Peers need a system of supervision and support in place to discuss any issues that they encounter when working with clients (Mead, 2003; Mead et al., 2001). For example, a peer in addiction recovery may become triggered if the client begins to use illicit substances in front of them. Further, because peers are invested into the PCR, they need support to ensure that they do not engage in maladaptive behaviours that negatively impact their own or the client's recovery (Finlayson et al., 2016). Additionally, training peers in basic psychological skills, such as active listening and empathy, enables them to be more equipped to navigate PCRs, enhancing IUPSs' effectiveness (Creamer et al., 2012). Lastly, while peers undoubtedly have a range of problem solving strategies, training them to handle problems in real time and to do so within the organisations policies on risk assessment and dealing with emergencies equips them with tools to be effective (Tulsky et al., 2000).

Returning to the IUPS pathway model, peers progress through the same mechanisms as clients, however, they experience different outcomes. Outcomes relate to how peers benefit from the helping relationship and develop their identity as a helper. For example, when peers share their own recovery stories with clients, they engage in a re-construction of their personal narratives. This encourages the peers to develop their identity and integrate their sense of self (Croft et al., 2013; Mead et al., 2001; Moran et al., 2012). Overall, peers benefit from the IUPS process, exemplifying the helper therapy principle (Reissman, 1965). By developing strong PCRs, being admired and respected by clients, working in organisations that value lived experience, peer-supporters undergo an increased sense of interpersonal competence and social approval, which leads to them becoming better helpers and experiencing an increase in confidence, self-esteem, and coping skills.

5.8 Limitations

The key limitation of this review is that it involved a significant amount of interpretation and arguably, other researchers could have reached different conclusions. To address this limitation, I have attempted to be as explicit as possible in describing the methods and included appropriate documents for readers to assess the progression of the synthesis in the appendices. Included studies have different strengths and limitations but were not excluded on quality assessment scores. Overall, quality appraisal scores were moderate to high. Only nine articles scored less than 50% on the MMAT. There were very few RCT's, however it was common for studies to have comparison groups. The main limitation was the lack of randomisation and accounting for bias in empirical studies.

Another limitation is that the literature search was conducted by a single researcher, although the supervisory team was consulted throughout the search and synthesis process. Further, as IUPS lacks distinct definitions, this review attempts to begin clarifying components and bring structure to future research on this topic. This impacted the review process by often requiring me to access the full report to understand if the report added to the review, increasing the time and resources needed for the review completion. Lastly, this review is limited to peer models that use IUPS. Thus, it cannot be generalised to interventions involving informal or IBPS.

This review is strengthened by the diversity and number of included studies that enabled the development of the IUPS pathway. This enabled the identification of mechanisms across contexts and which are found to be key elements of IUPS. Additionally, the use of a systematic and well-described method for synthesising diverse sources of evidence, i.e. realist synthesis (Pawson & Bellamy, 2006; Wong, Greenhalgh, et al., 2013), strengthens this review. Further, the search was iterative, covered multiple databases, and extracted information from multiple sources (i.e. interviews, organisational reports, and grey literature). Lastly, this is the only known report examining IUPS, with an in-depth exploration of mechanisms that are responsible for outcomes in this complex intervention.

Previous reviews have focused on the effectiveness of peer interventions and collectively, they have mixed or weak evidence for peer support (e.g. Stephanie. L. Barker & Maguire, 2017; Lloyd-Evans et al., 2014; Repper & Carter, 2011). Presumably, this results from the embryonic nature of IUPS in the literature and the lack of clarity and defined concepts. Thus, this review serves as a cornerstone for future work to research the underlying mechanisms of different types of peer interventions.

5.9 Conclusions

IUPS use with a homeless population exploration in the literature is lacking and this review identified mechanisms specific to IUPS by examining a diverse range of literature on IUPS and other populations. This review included 71 articles reporting on IUPS use with homelessness, addiction, mental health, physical illness, and criminal justice through an iterative search of multiple databases and various sources.

The proposed mechanisms are reported through a visual pathway model of how clients enter IUPS interventions and become peer-supporters. Clients develop a relationship with their peer-supporter, whom they learn from and compare themselves. Peers are role models for clients and provide them with various types of experience-based social support throughout their work. Peers benefit from entering into a helping role by experiencing identity development that integrates their sense of self and improves their self-esteem, confidence, and knowledge. Future research should use rigorous methods to explore assertions made in this review. Specifically,

1. The quality and strength of the PCR has a direct impact on both client and peer outcomes
2. Through social learning and comparison, clients learn behaviours modelled by peers, which impact client outcomes
3. Being a role model has positive and negative impacts on peer outcomes
4. Peers provide all five types of social support, each having impacts on client outcomes and enhancing peers' effectiveness
5. Training, supervision, support, and opportunities to be self-reflective are directly linked to peer-supporters' effectiveness.

5.10 Chapter Summary

This chapter described a realist review of theoretical and empirical literature, providing a model of IUPS interventions and testable concepts. This was the first review to examine IUPS and identify underlying change mechanisms that potentially transcend contexts. Additionally, this review satisfies the MRC's developing and modelling theory guidelines in complex interventions. This Chapter also satisfies the first part of the research question; to understand the processes and elements involved in effective IPS, and achieved objective four (model processes and outcomes in the development of a middle range theory).

The review highlights a number of processes involved in IUPS, including PCRs (experiential knowledge, positive regard, normalisation, and empowerment), role modelling (social learning, social comparison, and strengths-based approaches), and experience-based social support. This work further progressed ideas that were developed in Chapter 4, where it was found that

participants were describing a mentorship or unidirectional type of peer support. By further exploring the specific elements involved in effective IUPS, this review permits future research to determine the specific elements involved in a type of peer intervention that is being utilised with homeless populations within the UK. This review provides foundation for the next chapter to test these concepts with an expert population specific to peer interventions within homelessness.

Chapter 6 Expert Viewpoints of Critical Elements in Peer Interventions for People Experiencing Homelessness: A Q Sort Study

Chapter 5 outlined a model and the underlying elements within IUPS interventions through a realist review of the theoretical and empirical literature. This chapter aims to empirically test concepts that have been developed with experts in IUPS interventions within homelessness. Using a novel methodological approach, this chapter identifies expert viewpoints of potential change mechanisms in effective IUPS. This chapter utilises a Q sort method, where expert participants are asked to rank a number of statements describing IUPS and homelessness. All statements were derived from previous work in this thesis and relevant literature. Because organisations do not currently differentiate between the different types of IPS in practice, the general term 'peer support' was used in all correspondence and study materials. However, this was done with the aim of testing what expert participants thought were the underlying change mechanisms of IUPS, to support or contradict findings from Chapter 5. However, as described in Chapter 1, the term PPS will be used here in replacement of 'peer support'. This work further defines IUPS and our understanding of how IUPS may work within a homeless context. Further, this work solidifies the concepts that have been developed throughout this thesis and allows for a concrete description of the intervention (reported in Chapter 7) as outlined by Richards and Hallberg (2015) in the MRC guidance.

6.1 Aims & Objectives

By using the general term 'peer support', this chapter aims to test concepts developed in Chapter 5. In order to do this, expert participants are presented with statements that describes multiple aspects of IPS and IUPS. Therefore, the aim is to discern which elements are relevant to a homelessness context, by understanding what peers and professionals believe are the most and least important elements of effective PPS for those experiencing homelessness. Investigation into viewpoints from the entire participant group will further our understanding of potential change mechanisms through comparisons to previous literature, including components in the model developed in Chapter 5.

The following objectives were to; 1) assess viewpoints held by peers, 2) assess viewpoints held by professionals, and then 3) combine the factors from each group to assess similarities and differences in viewpoints across both groups. These objectives were achieved by asking experts (i.e. peers and professionals) involved in the facilitation and delivery of peer interventions to

participate by ranking statements that described various features of PPS. I used an approach called Q Methodology, described below, to help identify potential change mechanisms. See Appendix J for the study protocol.

6.2 Method

6.2.1 Brief Introduction to Q Methodology

Q Methodology is a unique mixed-methods design that aims to objectively assess subjective viewpoints by statistically and qualitatively assessing a concourse (Stephenson, 1953). Researchers develop a set of items derived from multiple sources (e.g. interviews, previous research) that broadly represent the concourse (S. Brown, 1980). Participants with topic-expertise then rank the items hierarchically by rating how much they agree or disagree with the relevance of each statement. The Q sort is a pre-determined grid that forces participants to make a relational judgment about each item by considering their rankings of other related items (see Q sort example for 43 statements in Figure 16). Forced-choice distributions compel participants to be thoughtful regarding item placements in relation to other items. The forced-choice distribution used in the Q sort reduces bias, as it is difficult for participants to create socially desirable distributions (Watts & Stenner, 2005).

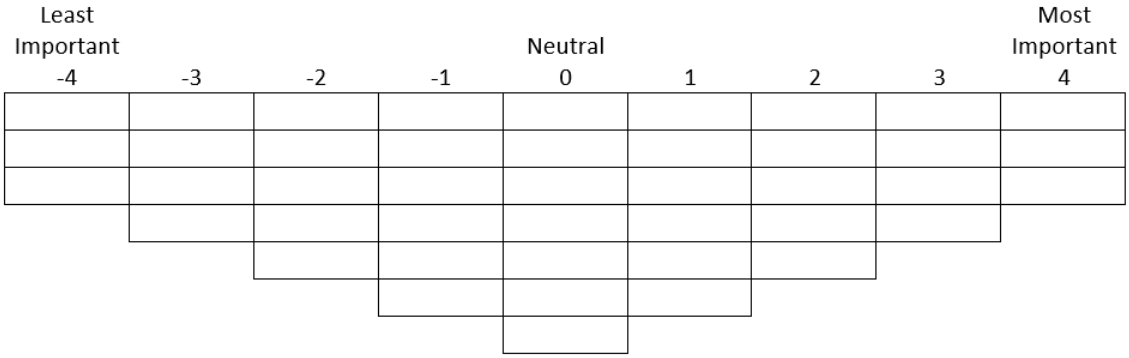


Figure 16. Q Sort Forced Distribution Grid

Individual Q sorts are compared and contrasted, through inverted factor analysis—a by-person approach rather than by-variable approach—to identify shared viewpoints (see Watts & Stenner, 2005). Factors are then interpreted by the researcher. Interpretation is guided by statistical analysis, participant demographics, and interrelationships of items, resulting in a holistic understanding of a shared viewpoint on a particular topic (Stephenson, 1953; Watts & Stenner, 2005).

6.2.2 Statement Development

The statements chosen for the Q sort in this study were drawn from primary and secondary sources that included relevant populations (Du Plessis, 2005). To create statements, I examined

results from extensive literature reviews and from interviews with 28 peer supporters (Chapters 3, 4, and 5). Results from sources indicated five themes (as outlined by results from Chapter 4) that describe potential change mechanisms in IUPS and homelessness. Additionally, I examined Creamer et al. (2012) and Varker and Creamer (2011), as they reported consensus statements in developing guidelines for IUPS interventions with high risk organisations (e.g. hospitals and the military). After requesting additional material from the authors, I identified statements that were not represented in literature search or interviews, that could be further examined in the current study (Varker, 2016). Therefore, I included ten adapted statements in the Q Set (statements 34 - 43) from their important work. Forty-three statements that broadly represent elements of IUPS and homelessness were developed from themes and included literature that emerged from the reviewed literature and qualitative interviews. Table 7 shows the statements and their corresponding themes.

Table 7. Q Set Statements and Corresponding Themes

Theme	Statement Number	Q Set Statement
Experience-Based Relationships	10	Peers' unique ability to understand where the client is coming from because they have been homeless too
	15	Peers knowing specific people or services that help
	14	Peers' positive attitude toward their experience of homelessness
	43	Peer support works because peers have been homeless too
	11	Peers connecting to clients as equals
	12	Peers being different from professionals
	13	Peers being different from other people experiencing homelessness through their training and connection to supportive organisations
Peer Motivations	16	Peers being committed to their clients
	17	Peers' motivations for helping are genuine, rather than for money
	18	Peers are paying back for the wrong they did
	19	Peers repaying for the kindness that was shown to them
Benefits for Peers	6	Peers know their own triggers
	7	Peers controlling their emotions around clients and professionals
	8	Peers using support from organisations to cope with struggles
	9	Peers maintaining their recovery
	20	Peers learn skills help them escape from homelessness
	21	Peers are actively living a lifestyle that clients can look up to
	22	Peers model recovery by representing someone who has gone through a similar experience and thrived
	33	Clients can compare themselves to peers

Table 7. Continued: Q Set Statements and Corresponding Themes

Theme	Statement Number	Q Set Statement
Peer Support Tasks	23	Peers respect boundaries
	24	Peers bend boundaries to fit the needs of their client in a particular situation
	25	Peers go the extra mile for their client
	26	Peers being available outside of normal professional hours
	27	Peers understand, and can help to adapt treatment for their clients' needs
	28	Peers advocate for their clients and help them learn how to self-advocate
	29	Peers provide important information
	30	Peers provide emotional support
	31	Peers are a source of friendship for the client
	32	Peers give advice to help
	34	Peers provide an empathic, listening ear
	35	Peers identify clients who might be at risk to themselves or others
	36	Peers facilitate connections to other services and help
	37	Peers help to increase psychological, health, and overall wellbeing of their clients
	38	Peers have training in psychological skills, such as listening skills
	39	Peers are a bridge between clients and professional help
	40	Peers have support from supervision and other peer supporters
	41	Peers respect confidentiality
	42	Peers reduce stigma around homelessness, mental illness, and addiction
Peers' Never Giving Up	1	Peers being persistent and clients help, taking time to develop trust.
	2	Building trust based on experience of homelessness
	3	Developing trust with clients
	4	Peers being adaptable to clients' needs
	5	Peers being adaptable to clients' personalities and behaviours

6.2.3 Participants

Organisations and individuals that provide PPS interventions to homeless populations were identified through internet searches, conferences, publications, and authors' personal contacts. Participants were recruited through emails, online social media posts, and face-to-face meetings, where a brief description of the study was provided. To supplement initial recruitment, I utilised snowball sampling (Sadler et al., 2010). Participants represented eight different organisations across England. One was a University and seven organisations provided PPS to those experiencing homelessness. In addition to homelessness services, four of these organisations provided support for addiction, mental health, and physical health. Clients of these organisations cover the wide range of homelessness issues, from those who are deeply entrenched on the streets, to those who require assistance for acute homelessness.

Participants were purposively recruited if they were aged 18 and above and had organisationally defined experience in the facilitation and/or delivery of peer interventions to a homeless population (Trochim, 2006). By recruiting experts in Q Methodology, S. Brown (1980) argues that large sample sizes are rendered unnecessary. This study recruited 40 participants: 20 peers and 20 professionals. Professionals were from homeless charities and organisations, and had been working in the homeless sector for longer than 6 months. Peer supporters were defined as peers by their organisations and usually had homelessness experience. Peers were currently working with clients to provide support to homeless persons at various stages of recovery from homelessness. I did not impose a limit on peer supporter experience as PPS interventions with homeless people is relatively novel. Previous work with this population indicated that such limits would have significantly limited the potential participant pool (e.g., participants in the qualitative study had varying experience in PPS). Additionally, peers have often experienced PPS as recipients before progressing into a peer supporter role, so their relevant experience does not begin at the moment they become formal peer supporters (Stephanie L. Barker et al., 2018). In this sense, time as a peer is somewhat arbitrary, but some measure is useful in analysis. Participant characteristics are reported in Table 8.

Table 8. Q Sort Study Participant Characteristics

Characteristic	*n* (%)
Gender	
Male	21 (52)
Female	19 (47)
Age*	
20-30	10 (25)
31-40	10 (25)
41-50	10 (25)
51-64	8 (20)
Professionals Experience (*n* = 20)	
Work Experience	
Up to 1 Year	4 (20)
Up to 2 Years	0 (0)
Up to 3 Years	5 (25)
Up to 5 Years	3 (15)
More than 5 Years	2 (10)
More than 10 Years	2 (10)
More than 15 Years	4 (20)
Homelessness**	7 (35)
Addiction	6 (30)
Peer supporters Experience (*n* = 20)	
Work Experience	
Up to 1 Year	9 (45)
Up to 2 Years	6 (30)
Up to 3 Years	1 (5)
Up to 5 Years	2 (10)
More than 5 Years	1 (5)
More than 10 Years	1 (5)
More than 15 Years	1 (5)
Homelessness***	19 (95)
Addiction	9 (45)

Note. *Two participants did not disclose their age. **Professionals with homeless experience were found to have a range of professional experience: 1 = up to 1 year; 4 = up to 3 years; 1 = up to 5 years; and 1 = up to 10 years. ***One peer participant reported that they did not have homelessness experience however, they did report addiction experience and had been working with a homeless population as a peer for up to 3 years. It was decided that their experience as a peer warranted their inclusion into the study.

6.2.4 Procedures

Statements were given to participants in a random order, then participants were instructed to sort according to how much they agree or disagree that the individual statement is important to peer intervention with a homeless population. Participants organised the statements into the pre-determined grid where they had to allocate a statement to every available space. As can be seen in Figure 16, there are limited spaces in each column.

This study utilised two methods of data collection: online and face-to-face. Research has shown no difference in the reliability or validity of online (or by mail) compared to face-to-face data collection (Reber, Kaufman, & Cropp, 2000; Stephenson, 1953). For online data collection, FlashQ (Version 1.0) was utilised (Hackert & Braehler, 2007).

Participants, who took part in the study online, were instructed to sort all the numbered statements into three different piles: ones they disagree with, ones they find neutral, and ones they agree with. Participants were then instructed to sort the statements into the grid (Figure 16), and given the opportunity to revise their sort. Next, participants were asked to provide their reasoning for the placement of items in the highest (+4) and lowest (-4) positions. Finally, participants had the option of providing additional explanatory comments.

In-person procedures followed the same format as online; however, not all participants sorted the statements into three piles. Participants reported being overwhelmed with the number of statements that they agreed with and most proceeded by laying out all the cards and then placing them into the grid.

6.2.5 Ethical Considerations

All participants gave informed consent prior to starting the Q sort. Non-waged participants (i.e. peer-supporters) were compensated a £5 voucher for their time (as in Chapter 4), given that the task would take between 30-45 minutes. Professionals were not compensated under the justification that participation in research studies relevant to their work falls within their wages. Participants who completed the Q sort in person were handed the £5 voucher and asked to sign a form confirming receipt of the voucher. Those who completed the Q sort online were provided space to supply their mailing address, so the £5 vouchers could be mailed out, with a form confirming their receipt of the voucher and a prepaid envelope so they could return the form to the researcher. All participants were supplied with a debriefing form reiterating the study aims and support contacts, should they be required. Ethical approval was granted by the University of Southampton on April 27, 2016 (ID: 19942). See Appendix K for ethics documentation. Participant names have been changed.

6.2.6 Analysis

Given the study objectives, the analysis was completed in three stages: 1) analysis and interpretation of factors from the peer supporters, 2) analysis and interpretation of factors from the professionals, and 3) a second-order factor analysis combining factors from both peers and professionals to understand common and differing viewpoints across both groups.

Steps in Q Methodology analysis include the following: 1) factor creation, 2) factor rotation, 3) factor extraction, 4) the creation of factor arrays, and 5) interpretation of factors. Participant Q sorts were entered into the computer software PQMethod (version 2.35, Schmolck & Atkinson, 2012), where Q sorts are inter-correlated and factor analysed. Factors are rotated through Varimax rotation; this analysis involves including as many sorts as possible to maximise saturation (Du Plessis, 2005).

Factors were extracted to ascertain the smallest number of factors that accounts for the most study variance. As the current study is testing factors identified by work done in Chapter 5 and relevant literature (e.g. Creamer et al., 2012), the best method of analysis for this study was Principal Component Analysis (PCA). Using the best possible mathematical solution allows for the researchers to evaluate ideas developed in previous studies by making use of statistical methods (Watts & Stenner, 2005). PCA is preferred over the other extraction method permitted by PQMethod, centroid factor analysis, where factors are extracted based on theoretically informed criteria (Watts & Stenner, 2005). Indeed, centroid factor analysis was not chosen because this work aims to test the model developed in Chapter 5, where the theoretical basis for IUPS was identified.

This study stipulated two criteria for factor extraction; the Kaiser-Guttman criterion and a three-or-more rule (Schmolck, 2017; Watts & Stenner, 2005). Factors were extracted if they had Eigenvalues > 1.00 and three or more significantly loading Q sorts (Schmolck, 2017). In Q methodology, significance level is calculated by the number of items in the Q set (see Equation 1) , therefore factor loadings of 0.39 or above were significant at the p = 0.01 level (Watts & Stenner, 2005). Q sorts that significantly load onto more than one factor are said to be confounded and should not be included in the analysis (S. Brown, 1980). That is, confounding variables are those that could also explain the target response, diluting the perspective of each factor that it significantly loads onto, weakening the analysis and limiting conclusions that can be drawn about each factor (Watts & Stenner, 2005).

Equation 1. Significance Level Calculation

$$2.58\ x\ \frac{1}{\sqrt{Number\ of\ items\ in\ Q\ Sort\ Set}}$$

$$2.58\ x\ (\frac{1}{\sqrt{43}})$$

$$p < .01 = .39$$

The creation of factors leads to the development of factor arrays—a distribution of the Q set items that demonstrate the shared viewpoint from participants that contribute to that factor. Factor arrays are created by merging factor exemplars through weighted averages, where Q sorts that have higher factor loadings are considered representative of the factors' viewpoint and therefore given more weight in the averaging process (Watts & Stenner, 2005).

A factor array is a diagram that represents an overall gestalt of the data, presented in the same format as a Q sort (i.e. Figure 16). Factor arrays serve as the foundation for interpretation. Through a careful and holistic examination of the patterns of items in the factor array, we are able

to understand what elements participants prioritise in effective PPS for those experiencing homelessness (Stephenson, 1993).

Each factor is described below, including brief demographic data of the participants that comprise that factor. Further rankings are included, for example, (25: +3) indicates that item 25 was ranked in the +3 column. Distinguishing factors, or those statements that were ranked in a significantly different way than other factors, are marked in each factor summary with an asterisk. Distinguishing statements assist interpretation of the factors, ascertaining particular viewpoints about the factors. Conversely, statements that did not differentiate between factors are termed consensus statements because participants value them in similar ways and represent shared viewpoints (Watts & Stenner, 2005). As participants provided their reasoning for the placement of different statements, quotes are included to clarify viewpoints.

6.3 Results: First Order Analysis

Results are presented first with brief descriptions of the findings from the peer Q sort analysis and professional Q sort analysis. Factors from the peer and professional analysis provide the data for the second-order factor analysis, which is the focus of this chapter. Detailed description of the peer and professional results can be found in Appendix L.

6.3.1 Principal Component Analysis Results: Peers

Four factors were identified, rotated, and extracted, which accounted for 52% of the peer-study variance. The four factors were comprised of 16 Q sorts (four each); the remaining four Q sorts were confounded and therefore not included. Each factor produced a unique factor array; however, Factor 4 had a rank-tie for the +2 column (Schmolck, 2017). Consequently, an examination of the participant ("Shane") with the highest factor loading helped to determine statement placements (Schmolck, 2017). Shane loads onto this factor at .69 and was the most consistent with the overall factor array and therefore the viewpoint represented by this factor. Shane had rated statement #30 higher than the other Q sorts from column +2, it was decided to place #30 in the spare +3 position.

The peer analysis resulted in three consensus statements: 18. Peers are paying back for the wrong they did (-4), 38. Peers have training in psychological skills, such as listening skills (0), and 41. Peers respect confidentiality (+3). Across all peer participants, statement 18 was ranked quite low, 15 out of 20 peers placed this statement at -4. It is apparent that peers disagree with this statement; peers having negative motivations for embarking in peer-work does not contribute to effective peer interventions. Conversely, peers generally agreed that confidentiality is an important aspect for effective peer interventions. Peers having training in psychological skills were consistently ranked in the middle, highlighting that peers felt that training is important, but

not vital to effective peer interventions. Table 9 outlines the factors developed from the peer analysis.

Table 9. Peer Analysis Results: Factors

Details	Factor Summary
Factor 1: Reaching Overall Goals	
• Comprised of 4 Q sorts • Accounts for 16% of the variance • Three females and one male • Average age 36.25 (range = 30-42) • Three reported homelessness • Two reported addiction	• Peer interventions are effective when peers are increasing their clients' wellbeing and helping to reduce stigma • Positive outcomes achieved through trusting and confidential relationships • Peers are unique and can provide a different level of support than professionals or informal counterparts • Peers who have honest motivations (*17: +3), support from organisations (40: +3; 8: +1), and maintaining recovery (9: +1) are effective • Peers' experiential knowledge of homelessness (*10: -3; *2: 0) was not a vital element of effective peer interventions • Peers needed to focus on building trusting, confidential relationships with clients • Peers' lived experience has minimal impact on an effective peer-client relationship
Factor 2: Trusting the Lived Experience	
• Comprised of 4 Q sorts • Accounts for 12% of the variance • Two females and two males • Average age 51.35 (range = 47-55) • All experience reported homelessness • One reported addiction	• Effective peer interventions includes strong experience-based trusting relationships • Peers connect with clients as equals (11: +3), and persist even in significant difficulties (*1: +3) • Valued uniqueness of peers—different from both professionals (12: +2) and other people experiencing homelessness (13: +1). • Devalued clients comparing themselves to peers (33: -4) or peers breaking boundaries by being the clients' friend (*31: -4) • Peers should be at a stable level of recovery (9: +1) to provide effective support • Peers do not need to know their own triggers (*6: -3) to be effective o Only one of the peers reported experience with addiction, the term 'triggers' may be unfamiliar. Given that this group prioritised other elements of peer recovery and health (e.g. *7: +3; 8: 0; 9: +1), this is interpreted as a potential limitation in the study, where the statement used a potentially unfamiliar term

Table 9. Continued: Peer Analysis Results: Factors

Details	Factor Summary
Factor 3: Treatment Relationship over the Peer-Client Relationship	
• Comprised of 4 Q sorts • Accounts for 12% of the variance • Three males and one female • Average age 47.25 (range = 37-60) • All reported homelessness • Three reported addiction	• Minimised importance of 'peer' aspects, such as role modelling, peer recovery, and experiential knowledge • Prioritised the provision of practical activities of peer interventions • Developing trust is important (3: +4), but trust based on shared experiences of homelessness is not vital to effective peer interventions (*2: -3) • Clients comparing themselves to peers (33: -4), clients looking up to peers (21: -3), and peers' modelling recovery (22: -1) were not integral elements of effective peer interventions • Peers' recovery status is not as important to practical support in effective peer interventions (*9: -3; 8: -1)
Factor 4: Informal Support, Provided by Supported Peers	
• Comprised of 4 Q sorts • Accounts for 12% of the variance • All male • Average age of 36 (range = 25-47) • All reported homelessness • Two reported addiction	• Provision of social support as key in effective peer interventions • Prioritised support for peers—support from supervision and other peer supporters • Informal peer support—peers giving advice (32: +4), source of friendship (31: +2) and available outside of normal business hours (*26: +1) • Conflicting viewpoint: valued the informality of peer support, did not value peers connecting to clients as equals (*11: -4). o Acknowledge that there are power imbalances but actual provision of support operates within an informal relationship—potentially highlighting an element that is not represented within this study. Certainly, this factor and participant responses reinforce lack of clarity around PPS terms being clearly defined and understood

6.3.2 Principal Component Analysis Results: Professionals

Following the same procedure as the peer analysis, three factors were rotated and extracted and together accounted for 46% of the professional-study variance. The three factors are derived from perspectives of half of the professionals included in the study (*n* = 10). Three Q sorts were confounding and seven Q sorts generated factors that did not pass extraction criteria.

Professionals agreed on the ranking of 14 statements, specifically that effective peer interventions occurs when peers work to increase the psychological wellbeing of their clients, respect boundaries, have supervision, and have support from professionals and other peers. They also felt that it is important that peers are positive role models who provide emotional social support and create a bridge between clients and professionals. Conversely, professionals felt that peers should not risk-assess clients. Further, professionals did not feel that successful peer interventions depended on peers knowing specific services, having genuine motivations, or potentially overextending themselves. Additionally, peers controlling their emotions, using support to cope with struggles, and facilitating connections to services were seen as important, but not vital, to effective peer interventions. Table 10 shows the factors from the professional analysis.

Table 10. Professional Analysis Results: Factors

Details	Factor Summary
Factor 1: Experience-Based Relationships	
• Comprised of 5 Q sorts • Accounts for 17% of the variance • Three males and two male • Average age 41 (range = 35-44) • Two reported homelessness • Two reported addiction	• Peers develop unique experience-based relationships and are positive role models • Valued the shared life experiences—peer interventions work because peers have been homeless too (43: +4), allows for genuine understanding of the clients' perspective (*10: +4; *27: +1) • Peers help to reduce stigma, reducing barriers to services (42: +4) and help to increase client wellbeing (37: +2) • Support was less effective if peers were motivated by guilt (18: -4), if peers broke boundaries by becoming friends with the clients (31: -4), overextended themselves (25: -3), or bent boundaries (24: -3)
Factor 2: Healthy Peers, Healthy Clients	
• Comprised of 2 Q sorts • Accounts for 8% of the variance • Two females • Average age 38.5 (range = 38-39) • Both reported homelessness • One reported addiction	• Unique perspective from two Q sorts • Effective peer interventions starts with a healthy and supported peer; maintaining their recovery, seeking help for personal struggles, and are positively motivated • Peers need to maintain their recovery (*9: +4), know their triggers (6: +2), use support from organisations to cope with personal struggles (8: +1), and control their emotions around clients and professionals (7: 0) • Peers are living a lifestyle that clients can look up to (*21: +3). • This group ranked a statement on peer motivations significantly higher than the other factors (*18: +3), suggesting that peer motivations are complex and important • Skills developed from the peer role are not necessary for effective peer interventions (20: -4)
Factor 3: The Peer Role	
• Comprised of 3 Q sorts • Accounts for 12% of the variance • Two females and one male • Average age 40.33 (range = 23-64)	• Peers need training and supervision, build trust with clients, know their own triggers, provide clients with social support, respect confidentiality, be adaptive, and flexible—including working outside of normal professional hours (*26: +2) • Support is effective when peers are operating within a set of defined guidelines (e.g. training, goals, values) • Peers needed to be able to cope with various potentially stressful situations—proficiency in coping with triggers and challenging situations to preserve client and peer safety • Peers should not be providing treatment (27: -4), or giving advice (32: -4)

6.4 Results: Second Order Analysis

6.4.1 Principal Component Analysis Results

The second order analysis combines factors developed from the peer and professional analyses in order to statistically assess shared opinions between the two groups (Hathcoat & Montgomery, 2010). To achieve this, factors developed from the peer and professional analyses are treated as new data (Hathcoat & Montgomery, 2010; Watts & Stenner, 2005). That is, four factor arrays from the peers and three factor arrays from the professionals were entered into the PQMethod software as new Q sorts (version 2.35, Schmolck & Atkinson, 2012). For clarity, these factor arrays shall be referred to as Q sorts hereafter.

These Q sorts were analysed, rotated, and extracted to provide a solution. Three factors met extraction criteria and accounted for 67% of the total second order analysis variance. Extraction criteria at this level have been relaxed to allow different perspectives to be represented. Extracted factors meet the Kaiser-Guttman rule but do not have three or more significantly loading sorts (Watts & Stenner, 2005). If the >3 criterion were to be applied in this situation perspectives would be eliminated from two valuable groups: professionals who have experienced homelessness and peer supporters only.

One of the Q sorts was confounded, resulting in a final solution of three factors with six Q sorts loading significantly and uniquely onto them. Twenty-two of the possible 26 participants (12 peers and 10 professionals) fed into the results of the second order analysis.

Consensus Statements are shown in Table 11, where both professionals and peers agree that effective peer interventions involves peers developing trust with clients and respecting confidentiality. The whole group also felt that peers needed support from supervision and other peers in order to positively influence client outcomes. They also agreed that peers needed to be adaptable, committed, provide emotional social support, and listen empathically to clients in order to be effective. Both participant groups felt that peers did not need to have a positive attitude towards their own homeless experience. Professional and peer participants agreed that it was not helpful when peer-supporters are motivated by the need to repay a debt. Both groups agreed that there was no need for effective peers to provide information on specific services or people or to identify clients who are at risk to themselves or others. Both participant groups agreed that peers needed to control their emotions, use support to cope with struggles, and have training in psychological skills, but they did not consider these factors as vital to effective peer interventions.

Table 11. Consensus Statements from the Second Order Analysis

	Statement	Agreed Position
26	Peers being available outside of normal professional hours	-3
19*	Peers repaying for the kindness that was shown to them	-2
14*	Peers' positive attitude toward their experience of homelessness	-2
27	Peers understand, and can help to adapt treatment for their clients' needs	-2
33	Clients can compare themselves to peers	-2
17*	Peers' motivations for helping are genuine, rather than for money	-1
15*	Peers knowing specific people or services that help	-1
35	Peers identify clients who might be at risk to themselves or others	-1
7*	Peers controlling their emotions around clients and professionals	0
8*	Peers using support from organisations to cope with struggles	0
38*	Peers have training in psychological skills, such as listening skills	0
4	Peers being adaptable to clients' needs	+1
39	Peers are a bridge between clients and professional help	+1
30	Peers provide emotional support	+1
16*	Peers being committed to their clients	+1
40*	Peers have support from supervision and other peer supporters	+2
34*	Peers provide an empathic, listening ear	+2
5*	Peers being adaptable to clients' personalities and behaviours	+2
41	Peers respect confidentiality	+3
3*	Developing trust with clients	+4

All statements are Nonsignificant at p <.01; *Nonsignificant at p < .05

6.4.2 Factor 1: Trusting Peers' Experience While Providing Support and Structure

This factor accounted for 27% of the total study variance, and represented the dominant factor in the second-order analysis. Three factors from the first level of analysis loaded significantly onto this factor: Factor 2: *Trusting the Lived Experience* from the peers, Factor 1: *Experience-Based Relationships* and Factor 3: *The Peer Role* from the professional analysis.

In total, 12 participants (four peers and eight professionals), six males and six females (average age = 43.64, range = 23-64) from six different organisations contributed to this perspective. All of the peers and two of the professionals reported personal experience of homelessness. One peer and two of the professionals reported experience of addiction. Participants ranged between 1-15 years' experience working with a homeless population.

Participants acknowledge and value peers' uniqueness; their difference from professionals (*12: +3) and their ability to develop strong, trusting, experience-based relationships with clients (*2: +4). Both groups of participants thought that peers were especially able to approach clients on an equal level (*11: +3), and that they had a distinct ability to understand the clients' perspective based on their shared experiences of homelessness (*10: +4). Peers are able to develop trust with clients, and this is seen as a key ingredient of effective peer interventions:

> *"People who have been through the transition of homelessness as well as connected issues, and are now stable, can offer advice based on experience. This is valuable."—Rick (Professional)*

Further, the benefits that peers gained were prioritised, such as skill development from being in a helping role (*20: +2), from training in psychological skills (38: +1), and through support from their respective organisations (40: +2; 8: 0), plus skills to control their own emotions (7: +2).

> *"Gaining trust can be done well if you can listen and absorb, controlling your emotions, lets the client relax and feel confident to trust you"—Glenn (Peer)*

This group felt that peers are good role models for clients; peers were living a life that clients could look up to (*21: 0), and they modelled recovery (22: +1). As Pippa (Professional) explained: *"Homeless people frequently make reference to 'successful peers' and model some of the behaviours."* The above elements enable effective peer interventions to reduce stigma and breaks down barriers to services (*42: +3).

Further, this viewpoint asserts that peer interventions needs structured and defined roles in order to allow peers to be effective and avoid harming either the clients or the peers themselves. Participants felt that peers should not be negatively motivated. It is about "*wanting to help…because peers have experiences that could be useful to others*"—Lori (Professional).

Peers should respect boundaries that have been established by their role (23: +1). They should avoid becoming friends with clients (31: -4), and giving advice (32: -4):

> *"They aren't there to give advice, it's not their role. What works for one person won't work for another so advice is a dangerous ground"—Sarah (Professional)*

Boundaries need to be firm, and should not be bent to suit the client (24: -3). Participants agree that peers did not need to be available outside working hours (26: -2), or overextend themselves and risk burnout (25: -3).

In sum, this factor captures the viewpoint that peers need to value their lived experience as a tool to engage with clients and develop trusting experience-based relationships. According to this perspective, peers provide a different type and level of support that ideally operates within prescribed boundaries that maintain the safety of both clients and peers.

6.4.3 Factor 2: Healthy Peers, Healthy Clients

This second-order factor accounts for 20% of the study variance. It is an exact replica of Factor 2: *Healthy Peers, Healthy Clients* from the professional analysis. While proponents of the Q sort method would recommend against including a factor that has only one significant loading (S. Brown, 1980; Watts & Stenner, 2005), I decided to include this factor because it provides a unique perspective. It does so because it reflects a view of effective peer interventions from two women who have experienced it from all three perspectives - as clients, peer-supporters, and in the current study, as professionals.

In this viewpoint, peers' health and personal recovery is important. Participants felt that peers needed to maintain their recovery (*9: +4), know their own triggers (6: +2), use support from their respective organisations to cope with personal struggles (8: +1), and control their own emotions around clients and professionals (7: 0). Participants held the view that if peers are able to maintain their recovery, they will be more adept at living a lifestyle that clients can look up to (*21: +3).

> *"It is important for the peer to maintain their recovery because the clients see peer support as someone who is stable, they will usually model their life on [the peers]. Nobody will respect a peer who is in active addiction"—Julie*

Further, participants valued peers' lived experiences (43: +4), but they did not view experiential knowledge as vital to developing trust. That is, effective peer interventions occurs when trust is developed between peers and clients (3: +4), but trust can be developed without a shared experience of homelessness (*10: -2; *1: -3, *2: 0).

Peers who are healthy and supported by their organisations (40: +1) are able to provide effective social support. For example, peers can provide important information (29: +2), be an empathetic, listening ear (34: +1), provide emotional social support without being overwhelmed, and are able to manage challenging client behaviour (5: +2). Recovering peers can gain clients' trust through the provision of support and by being committed to the client (16: +1). Further, peers work to increase their clients' overall wellbeing (*37: +3), and help them learn how to self-advocate (*28: +3).

This groups' viewpoint diverges from other perspectives in how they described peers' attitudes and motivations. Participants felt that while their homeless experience *"was not positive"* being able to overcome the challenges has made them a better professional (Julie) (*14: 0). Also, participants ranked statement 18 ("peers are paying back for the wrong they did") at +3; significantly higher than the other factors. Perhaps participants felt some peers are paying back for wrongdoings, suggesting that peer motivations are complex.

Regarding breaking boundaries, participants felt that peers being available out of normal working hours (26: -4) is "*not professional*" (Molly). Further, being a source of friendship (31: -3) and giving advice (32: -4) were not prioritised in this factor. Participants also felt that skills developed in peer interventions (*20: -4) are not necessarily helpful for further career development:

> *"The skills you have may be different from the ones you need at work"—Molly*

Participants ranked statements that acknowledge peers' uniqueness and equal power with clients low (12: -2; 13: 0; 11: -3), as explained by Julie:

> *"Being a professional that came from lived experience is also about your abilities and passion for your job, not just because you were homeless"*

Consistent with this view, participants felt that peers should not be expected to perform tasks that are not expected of professionals, e.g. working outside normal business hours. Interestingly, this group felt that skills developed from the peer role are not necessary for effective peer interventions (20: -4).

In sum, this factor represents a unique perspective on elements involved in effective peer interventions from the perspective of those with a breadth of experience. This group felt that effective peer interventions starts with a healthy and supported peer; peers who are maintaining their recovery, seek help for personal struggles, and are positively motivated are good role models for clients.

6.4.4 Factor 3: You can Trust Us, We are here to Help

Two factor arrays from the first level of analysis contributed to this factor, accounting for 20% of the total variance: Factor 3: *Treatment Relationship over the Peer-Client Relationship* and Factor 4: *Informal Support, Provided by Supported Peers* from the peer analysis. The Q sorts from eight peers comprised this factor. All reported homelessness experience and five reported experience with addiction. These peers are from three different organisations and reported one to 15 years' experience working with this population.

Participants in this factor hold the viewpoint that effective peer interventions are built upon the provision of social support in a trusting relationship. Peers need to respect boundaries (23: +4) and confidentiality (41: +4), both of which foster the development of trust (3: +3). Trust can also be strengthened by the provision of multiple types of social support. Peers give clients advice (*32: +4) based upon their own experiences and knowledge of services (*10: +1). Effective peers provide important information (29: +3), emotional social support (30: +3), actively listen to clients (34: +3), and are a source of friendship for the clients (*31: +2). Effective peers know that the client is *"the most important person"*—Beth (Peer) and can work with them to provide the support that they require.

Peer support is most effective when peers are trained (38: +1) and are supported to do their work (40: +2; 8: 0). Peers' main function is to provide social support, but also to acknowledge their limits, by connecting clients to appropriate professional support (36: +2; 39: +1) and help their clients learn how to self-advocate to better care for themselves (28: +1).

Participants in this factor did not feel that peers' uniqueness from professionals (12: -2) and other people experiencing homelessness (*13: -4) is vital to effective peer interventions, as described by Shane (Peer):

> *"There are no difference between peers and other people experiencing homelessness because most peers were homeless and passed through the same path like other homeless…we're together in the struggle and we understand what you are going through but you have to understand that we can fight this together"*

Contrary to the other factors, this group felt that because peers are not different, they are not viewed as role models. Peers in this group worried about social comparisons negatively affecting the relationship between peers and clients. While this group acknowledged the value of their experiential knowledge in providing social support, they do not value it as a vital component to effective peer interventions (*43: -3). Peers are there to help the client and provide multiple types of social support and connect the client to professional services.

In sum, this factor captures the viewpoint that peer interventions are most effective when there is a focus on the type of support being delivered by trained and supported peers. Peers must be trustworthy and prioritise the clients' needs in order to be effective.

6.5 Discussion

This study aimed to understand what 1) peers and 2) professionals believe are the most and least important elements of effective peer interventions for those experiencing homelessness, with the overall aim of 3) identifying common viewpoints held by both peers and professionals as to which elements are critical in effective peer interventions for people experiencing homelessness.

6.5.1 Consensus across Peers and Professionals

As a group, peers and professionals agreed on a number of consensus statements, shown in Table 11. Peers and professionals agree that effective peer interventions are built upon trust and confidentiality, a finding that is consistent with previous literature in this thesis (Chapter 4 and 5) and elsewhere (Creamer et al., 2012). The foundation of a working alliance, such as one that develops between peers and clients, is trusting that the other person will act in accordance with our expectations, and be genuine and authentic in sharing experiences (Gelso, 2014; Gill, Murphy, Burns-Lynch, & Swarbrick, 2009). Another finding in line with previous work in this thesis (Chapter 4 and 5) is that participants agreed that the provision of emotional social support is important in effective peer interventions. Interestingly, peers and professionals in the current study did not reach consensus on any other type of social support.

The results suggest that aspects of training and supervision is a potential change mechanism; participants agree that peers need supervision and support to be effective. However, contrary to the model developed in Chapter 5, peers getting training in psychological skills was not felt by participants to be integral to peer interventions. As recommended in Chapter 5, the type of training must accurately reflect the context in which PPS is provided. Training can enable peers to be flexible and to effectively manage various situations. For example, receiving training in how to manage and understand challenging client behaviour may reduce peers from acting inappropriately. Further, helping peers to develop a reflective style to their supporting behaviour can help peers avoid relapsing into old behaviours and develop personally. Gill et al. (2009) argue that formal training concentrating on the peer role within the given context should be valued over specific training in mental health or addiction, for example.

Participants generally disagreed that effective peer interventions are influenced by peers being available outside regular business hours. This boundary crossing was developed from peer interviews in Chapter 4, but participants in the current study felt that it does not contribute to effective peer interventions—participants felt it was "*unprofessional*". A peer being available out of hours was also not prioritised by participants in Creamer et al. (2012).

Contrary to previous literature, participants did not feel that peers need to have a positive attitude towards their personal experience of homelessness (Borkman, 1976). Participants felt that even if the overall experience of homelessness was not positive, it could still be used to benefit others. The statement (14) lacks in describing a dimension of how peers may integrate their experiences into problem solving methods in experiential expertise (Borkman, 1976). Thus, this element needs further exploration to ascertain how these concepts do or do not overlap.

In the current study both peers and professionals agreed that peer motivations around money were not integral aspects to peer interventions. This idea had originally been developed from interviews with peers who had been recipients of PPS and who felt that peer motivations were key to establishing and maintaining trust (see Chapter 4). Therefore, this highlights another element that requires further investigation.

6.5.2 Differing viewpoints

Even though the analysis resulted in a number of consensus statements, three different perspectives emerged. Factor 1: *Trusting Peers Experiences while Providing Support and Structure* represents the dominant perspective from both peers and professionals. Factor 1 captures the viewpoint that effective peers value and use their experiential knowledge as a tool for engagement and in building experience-based relationships with clients. Further, peer interventions are a unique level of support, but must operate within a given set of guidelines and boundaries. Factor 2: *Healthy Peers, Healthy Clients* provides a unique viewpoint from

professionals who have experienced being a peer prior to their role as a professional. Factor 2 exemplars illustrate that peers who are active in their own recovery enable peer interventions to be effective and are appropriate role models. Factor 3: *You can Trust Us, We are here to Help* gives a distinct peer perspective, where exemplars demonstrate that peer interventions are effective when peers are supported, trained, and are actively trying to achieve PPS tasks. These differing viewpoints are discussed in terms of identified critical elements involved in IUPS identified from model from Chapter 5 (see Figure 15).

Experiential Knowledge

The points of view illustrated by Factors 1 and 2 support the assertion in Chapter 5's model that peers develop unique experience-based relationships, which become the foundation of peer interventions effectiveness. Peers are able to connect with clients through an intimate understanding of the homelessness experience, providing empathy, acceptance, and normalising the cognitions and emotions the client is feeling, as described in Chapter 5. By valuing statements on experiential knowledge, peers' ability to understand, and the provision of emotional social support, Factor 1 results support assertions made in previous Chapters. In Factor 2, participants value experiential knowledge, also viewing it as critical element to IUPS' effectiveness.

Role Modelling

Exemplars in Factor 1 and 2 illustrate peers' ability to model recovery and be a positive source of social comparison for clients. This provides support for the role-modelling element identified in the model developed in Chapter 5. Role modelling is suggested as key to peer interventions by other literature as well (see Chinman et al., 2016; Salzer, 2002; Solomon, 2004). Role modelling and mentoring enables peers to deliver multiple types of social support. It can improve clients' self-efficacy, feelings of hope, increase coping skills, and reduce drug/alcohol use (Bean et al., 2013; L. Davidson et al., 2012; Fors & Jarvis, 1995; Galanter et al., 1998).

However, the model developed in Chapter 5 also acknowledged that clients can learn negative behaviours from peers, a problem identified by participants in Factor 3. Participants felt that role modelling could result in harm to the client and/or peer, such as modelling inappropriate behaviours or creating power imbalances that diminish the clients' self-esteem.

The model suggests that peers adopt a strengths-based approach, where peers advocate for their clients, actively break down barriers to care, and help clients learn how to self-advocate for their own needs. This assertion was supported by viewpoints in Factor 1 and Factor 3, by participants valuing statements that describe this process. Research shows that strengths-based approaches can increase client engagement, feelings of hope, and result in fewer hospital admissions (L. Davidson et al., 2012; L. Davidson et al., 2006; Finlayson et al., 2016).

Peers' Motivations

Participant responses on peer motivations in this study are not consistent with the model in Chapter 5 and work from the qualitative study in Chapter 4, which suggested that peers needed honest and genuine motivations in order to be effective and be seen as different from professionals. Although participants in both Factors 1 and 3 placed statements describing peers' motivations low in the grid, Factor 2 participants ranked one particular statement (18) quite high. It appears that this group did not shy away from the blaming language in the statement. However, overall the results highlighted the fact that majority of participants are uncomfortable letting peers blame themselves and feeling that they need to make up for wrongdoings. The statement was developed as a direct quote from interviews with peers from Chapter 4.

Factor 2 views negative motivations and blame as a real element within peer support—some peers have colourful pasts and may feel that by engaging in peer-work, they are making up for past indiscretions. Peers in the interviews from Chapter 4 talked about peer motivations, stating that honest motivations were crucial to building trust. However, maybe it is not about having honest motivations but rather being honest *about* the motivations that drive them.

Recent research exploring peers' motivation for engaging in peer-work found that peers engaged for the benefits that they experience (Croft et al., 2013). Moran, Russinova, et al. (2014) found that peers entered into peer interventions to align with their own personal values, the opportunity to connect to others, and because they wanted to feel confident and capable of helping others. Given that research exploring if peers engage with peer-work to satisfy a need to repay and make up for wrongdoings has yet to be completed, we cannot be certain that this is not already occurring.

Social Support

Factor 3 illustrates a viewpoint that bolsters assertions that social support is key to peer interventions (e.g. Dennis, 2003). The literature proposes that social support is how peer-supporters effect change because different types of social support result in different outcomes (Chapter 5). Clients can feel emotionally supported, experience feelings of belonging, become better informed, and evaluate their own behaviours through social support, as reported in Chapter 5. Consistent with Chinman et al. (2016) participants in Factors 1 and 2 devalued the idea of companionship as a form of effective social support, because participants felt that peers being 'friends' with clients' is a boundary crossing. Participants in the current study valued emotional social support, as shown in the consensus statements. However, participants in Factor 3 consistently ranked statements on social support highly whereas Factors 1 and 2 did not. This discrepancy highlights the lack consensus about key elements in effective peer support. Professionals and some peers may feel that some types of social support (such as companionship

support) may breach boundaries, whereas other peers feel that these types of social support are integral to the care they provide.

However, this discrepancy could be explained by acknowledging that participants are describing different types of peer support, mentorship/unidirectional support versus mutual/bidirectional support. While there may be underlying common change mechanisms in peer support, such as the PCR, this result bolsters the assertion in Chapter 5 that IUPS should be differentiated in the literature and practice.

6.5.3 Defining IUPS

Overall, Factor 1 and 2 exemplars appear to reflect a view of PPS that is best aligned with IPS as described by Bradstreet (2006), where peers use their lived experience to build relationships with clients and provide support that is fostered and supported by organisations. However, as described in Chapter 1, IPS, in its current definition, can include different types of support. IPS can be multidirectional support, where both clients and peers are at the same level of recovery and both receive recovery-related benefits from the peer relationship. Indeed, this is indicative of mutual support (Bradstreet, 2006; Mead et al., 2001). Exemplars in Factor 3 appear to be describing mutual peer support—intentional support that embodies a mutually beneficial relationship where peers are not "different" or "better than" the clients (Chapter 4).

Factors 1 and 2 appear to be valuing a more formal, mentorship type of peer support, arguably a type of support that is not clearly defined in the current PPS literature, outside of this thesis. By combining different types of PPS in one study, we may be confounding our results. Therefore, I propose that IUPS must be defined separately from traditional types of PPS and explored independently to understand its impact on homeless clients. By identifying services that provide this type of mentorship support we can begin to unpack how different models of PPS impact on clients. Furthermore, by clearly defining this type of support, services would be able to identify what type of support they are providing and make appropriate improvements.

6.5.4 Strengths and Limitations

Limitations of this study include the collection of the demographic data ascertaining participants' level of experience working with a homeless population—the question did not clearly differentiate between formal peer supporting from informal. I identified the need for clearly defined terms in order to understand PPS as a specific intervention and avoid participant misinterpretation. It is notable that 45% of peer participants had less than one year of experience working with this population, which may have affected results. Peers with less experience working with this population may lack clear understandings of their role, leading to wide interpretations similar to current results. However, there was a breadth of experience represented through personal experience of homelessness, addiction, and of working with the population.

Nonetheless, it would be interesting for future studies to compare results with a peer population that is more experienced.

Additionally, I missed an opportunity to ask about participants' experiences as recipients of peer support. Fortunately, some participants volunteered this information, but the analysis would have been strengthened with this information. Accurately understanding participants' experiences would have allowed a deeper exploration into their viewpoints. Participant feedback indicated that some statements were not specific enough; participants noted the obscure wording of some statements. Watts and Stenner (2005) suggest that clarity in instruction and statements is imperative to successful Q studies. The statements were developed from attempts to bring clarity to an undefined topic. Due to limited resources, I did not pilot the statements to the target population prior to the full study. Future research could examine the statements and help to further refine them. Additionally, only 22 of the possible 40 participant Q sorts were eligible to be in the analysis. Clearly, the number of confounding sorts highlight the lack of consistency in defining this intervention.

This study has added to the literature on this topic by exploring critical elements in PPS within homelessness. Participant feedback suggested that the concourse was appropriately representative; however, further investigation into this topic may reveal items that are not yet represented in the literature. Q methodology is a unique and a rigorous method that results in useful collections of viewpoints on PPS and homelessness.

6.6 Conclusion

This Q sort study included 20 peers and 20 professionals who rank ordered 43 statements into a hierarchy to identify critical elements of peer interventions within a homeless population. The study analysis occurred in three stages, peers and professionals Q sorts were analysed as two distinct groups, followed by a second order analysis. The second order analysis combined viewpoints from the two groups, which resulted in three distinct viewpoints on key elements involved in peer interventions for those experiencing homelessness. The viewpoints support previous literature assertions on critical elements in PPS and identify areas for further exploration. Specifically, future research could examine developed statements, comparing with work from Chinman et al. (2016) to develop a context-specific psychometric test to assess effective peer support. Additionally, future research on PPS should take care to identify what type of peer intervention is being evaluated to ensure clear understanding of its effectiveness. Programmes delivering PPS can use these results to understand what type of peer intervention they are providing and tailor their peer training to focus on critical elements.

6.7 Chapter Summary

This chapter reported on a Q sort study which indirectly tested elements developed by the model in Chapter 5. It was found that expert participants described different types of peer interventions; however, the dominant perspective from peers and professionals aligned with elements describing IUPS. Further, the Q sort found support for multiple elements identified in Chapter 5, including experiential knowledge, role modelling, peer motivations, and social support. However, there was not consistency across all participants regarding these elements. Peer participants in Factor 3 were found to be describing informal or IBPS, and therefore did not support some elements in the IUPS model, including role modelling, peer motivations, but prioritised all types of social support. This supports the differentiation between the two types of PPS. Additionally, this was the first study to examine peer interventions for those who experience homelessness using Q methodology.

This chapter represents that last empirical work in the development phase of the MRC complex intervention guidelines (Richards & Hallberg, 2015). As this work evaluated concepts found in Chapter 5, it has allowed clarity on peer interventions for a homeless population and therefore a detailed description of IUPS for researchers and practitioners is presented in the next chapter.

Chapter 7 An Evidence-Based Intentional Unidirectional Peer Support Intervention

With guidance from the complex interventions literature, this chapter describes a manual of IUPS; providing a procedural definition of how IUPS is conducted with a homeless population. This chapter represents the last step in developing a complex intervention, where researchers have clarity on each aspect within the intervention (Richards & Hallberg, 2015). With guidance from Hoffmann et al. (2014), this chapter describes each element of IUPS, summarising the intervention based on previous work in this thesis and current IUPS programmes. This chapter concludes with an example of a current IUPS programme.

7.1 Reporting the Intervention

To fulfil the development phase of the complex interventions framework, comprehensive reporting of the intervention is crucial (Möhler et al., 2012). Research has found that adherence to the MRC framework has improved the quality of reporting, but this could be enhanced (Möhler et al., 2012). Hoffmann, Erueti, and Glasziou (2013) found that only 39% of non-pharmacological interventions were described adequately in the primary paper or supporting documents. Without a clear description of an intervention, services, policy makers, and researchers cannot replicate or build upon it (Hoffmann et al., 2014).

Hoffmann et al. (2014) developed a checklist containing the minimum items recommended for describing an intervention, the Template for Intervention Description and Replication checklist and guide (TIDieR). This tool was developed through a consensus building study, with relevant experts in research. The TIDieR is useful across study designs, including trials, case-controls, and cohort studies. Hoffmann et al. (2014) describe the tool as a method to allow replication. Additionally, Möhler et al. (2012) developed 16 criteria for the comprehensive reporting of the first three phases in developing and evaluating complex interventions (CReDECI). This tool was developed, with experts, to complement existing reporting guidelines and to ensure that all aspects relevant to complex interventions are reported (Möhler et al., 2012).

As this chapter aims to provide readers with a manual of how to run an IUPS programme for a homeless population, both tools were used to provide an explicit description of the intervention. Therefore, the following headings are derived from both tools and their corresponding descriptions were informed by previous work in this thesis and examples of practice across homeless organisations in the UK.

7.1.1 Brief Description of Intervention

Intentional, unidirectional peer support (IUPS); where peers who have shared experiences of a particular difficulty, such as homelessness, have a more stable lifestyle, are trained and supported to deliver support to clients who are in an earlier phase of recovery or have less stable lifestyles.

7.1.2 Underlying Theoretical Considerations

Chapter 5 reviewed articles across disciplines and synthesised the results into concepts that have supportive evidence. Results showed that IUPS has three mechanisms:

1. PCRs
2. Role modelling
3. Experience-based social support

Peer-Client Relationships (PCRs)

The review assessed how IUPS works across various contexts found that PCRs were the foundation of this type of peer support. PCRs were conceptualised as being a unique relationship, built upon experiential knowledge (including shared experiences), positive regard (empathy, acceptance, understanding, and active listening), and normalisation/empowerment (where peers advocate for clients). Experiential knowledge was first conceptualised by Borkman (1976) where those with a more advanced level of recovery are able to mentor those in early recovery. In IUPS, the same principle applies; peers are those who have achieved a level of stability regarding their homelessness and they are able to guide clients through health and social systems.

The PCR has shared experience at its core; peer and clients bond and identify with one another given that they both have membership to a marginalised group. Once their initial bond is formed, peers are able to further develop the relationship and gain clients' respect and commitment, which allows for further work and progress to be made.

Additionally, the relationship is characterised by empathy, understanding, acceptance, and active listening. These allow for the relationship to strengthen and for various types of social support to be delivered to the client. Peers help to normalise client experiences and provide them with different options in attaining stability. Clients feel empowered and more able to take control back into their lives. Lastly, peers are able to connect clients to other services by acting as a bridge; liaising between the client and services to help the client overcome barriers and enable them to get treatment.

Role Modelling

Role modelling is perhaps the most theory-laden construct in IUPS. This process is comprised of social learning/mentoring, social comparison, and a strengths-based approach. Numerous sources

identified social learning as a main theoretical underpinning of IUPS (Campbell, 2008; Salzer, 2002; Solomon, 2004). Social learning posits that clients are able to learn from peer-supporters through the social context of their interactions; peers model specific behaviours when interacting with professionals, other peers, and other clients. This allows observational learning to occur for clients. Further, clients are active in this process; they are continuously taking in information about how a peer behaves, communicates, and interacts with the world around them. Peers being active in mentoring clients, by providing specific support to resolve problems, strengthens this process. Therefore, clients can learn from peers through informal interactions but also those where the peer is verbalising instructions to the client.

Regarding social comparison, Festinger (1954) suggested that people have an innate drive to evaluate themselves against others. Comparisons can be upward; where one compares themselves to someone who is viewed as more advanced, or downward; where the comparison is done with someone who is less stable. Suitable models to make these upward comparisons usually include someone who is perceived as similar, credible, and with a degree of power/influence. Within IUPS, the presence of a PCR provides the context in which these comparisons can occur. Further, while upward comparisons can lead to negative self-evaluations, peers are thought to be living an achievable lifestyle, reducing the psychological distance between peers and clients, resulting in positive self-evaluations. Tracy et al. (2012); Tracy et al. (2014) argue that mentors hold a "valued social position" (p. 42) and this can trickle into ensuring that social comparisons result in positive self-evaluations. Clients also have the opportunity to make downward comparisons—to other homeless people, perhaps those that are viewed as not being active in their recovery or progressing.

Lastly, IUPS has been identified by the literature as a strength-based approach. Organisations foster the value of lived experience into all aspects of their service, creating a recovery-oriented context for peers to work within. This then encourages peers to work by valuing their client's experiences and nurture their strengths. This also serves to strengthen the PCR and lead to better client outcomes.

Experience-Based Social Support

This concept is built upon theoretical literature that suggests different types of social support are provided by peers and the varying impact upon recipients (Shumaker & Brownell, 1984). This involves peers self-disclosing about their own experiences with the intention of normalising experiences, strengthening the PCR, and to enhance the overall wellbeing of the client (Shumaker & Brownell, 1984). Peers are able to provide all five types (informational, emotional, instrumental, appraisal, and companionship) of social support to clients, through their own experiences, support from their respective organisation, and personal network of contacts. These components

were identified by the literature across contexts. Further, because of their shared experience, peers are able to provide support that is tailored to their shared experience of homelessness.

7.1.3 Intended Interactions and Overall Aim of the Intervention

The model in Figure 17 shows that clients enter into IUPS and firstly develop the PCR, which enables role modelling and experience-based social support to occur. The model also shows components that comprise each mechanism. While clients can exit the service at any stage, the model shows that clients may exit to become a peer. Essentially, this model visually summarises the description of IUPS above. The overall aim of IUPS is to increase the clients' stability and functioning in a number of areas related to homelessness, mental health, addiction and physical health.

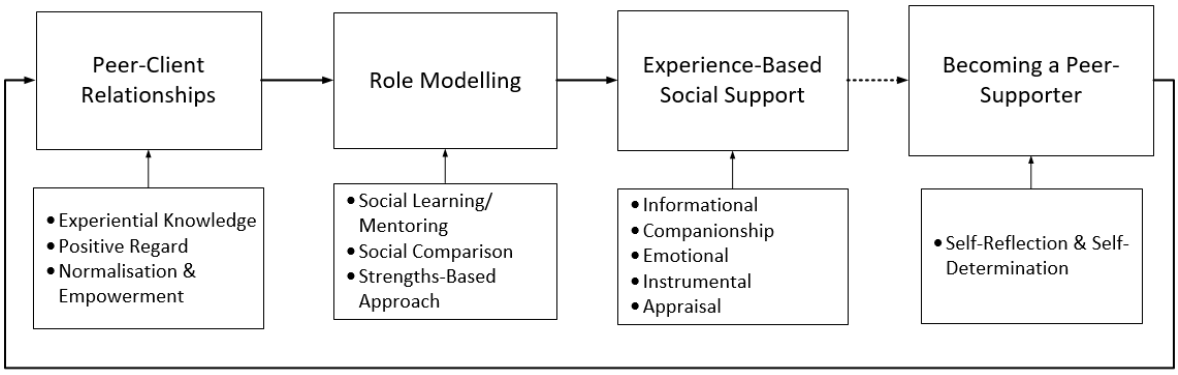


Figure 17. IUPS Process

7.1.4 Intervention Provider's Expertise, Background and Specific Training

Peers are the key to IUPS as they effectively are the intervention. In order to be classed as peers, firstly, they need to have experience of homelessness. Further, peers need to be reliable, show passion, and be motivated to help clients (Lawrence, 2018; Mullins-Downes, 2018).

Peers should receive training on the theoretical basis of IUPS, including self-reflection, self-determination, and how to safely self-disclose. The goal of these elements is to ensure the peer begins to understand themselves, their own biases, assumptions, motivations, and to be reflective on their work with clients. Peers also need training on homeless-specific issues, such as dealing with arrears, housing benefits, and how to utilise local social services (Lawrence, 2018). Additionally, peers should learn basics of confidentiality, mental health, addictions, managing challenging behaviour, and communicable diseases (Bowgett, 2015).

Professionals, who have experience with a homeless population, may need to be educated on client-centred principles and to truly value the lived experience that peers bring. This may require training for new IUPS programmes. Professionals need to be compassionate, empathic, and may need support to enable a culture shift for peers to be accepted and IUPS programmes to flourish (Emerging Horizons, 2017).

7.1.5 Physical or Informational Materials Provided to Participants for Intervention Delivery and/or Training

It is important to compensate the peers for their time. Study procedures in this thesis used £5 or £10 high-street vouchers to pay non-waged participants. Additionally, many UK-based IUPS programmes compensate their peer supporters (such as Birmingham Changing Futures, Groundswell, Ashford Place, Street Buddies, and Pathways).

Some IUPS programmes may have workbooks or paperwork to complete when meeting with clients (Bowgett, 2015; Lawrence, 2018). They can provide structure and space for peers to reflect on events that occur when supporting clients. These materials may be optional—research has yet to explore their importance.

7.1.6 Procedures, Activities, and Processes Used in the Intervention

Firstly, peers would need to be identified and trained. The training process may identify peers who are unsuitable, such as those who are unreliable. Next, peers would be matched to clients, which may be at random (i.e. the next client to enter the programme) or they may be matched on shared demographics, such as gender, age, or language. Interviews with peers and clients in Chapter 4 suggest that being matched on some criteria may be beneficial for the PCR, but this is yet to be explored fully in research. Programmes may choose to have one method above the other, but most likely, it would be a mix of the two.

Peers must be provided with supervision and support to maintain their role. These supervision meetings can be one-on-one and/or in groups, but they must occur regularly and have a reflective approach to them. Organisations that provide IUPS, such as Groundswell and Birmingham Changing Futures, have group supervision monthly and one-to-one as needed (Bowgett, 2017; Mullins-Downes, 2018).

7.1.7 Modes of Delivery

Peers can deliver support to clients in a number of ways. This may be in-person and one-to-one, but it could be over the phone, or use of internet messaging. Support can also be provided in groups, where one or two peers hold a group meeting to increase companionship support and link prosocial clients together. For example, one peer may take a few clients to a 12-step based recovery meeting or a peer and professional might meet with one client to discuss a treatment plan, identifying goals, values, and actions to be taken.

7.1.8 Contextual Factors and Determinants of the Setting

As described in Chapter 5, services should have a person-centred environment, where peers are respected, accepted, and professionals are open to support the peer without judgement. Services need to be supportive for peers and be flexible when difficulties arise (Moran et al., 2012).

The setting can depend on the type of population—deeply entrenched homeless, those who are engaged with services and staying at supported accommodation, or those who are being supported by the organisations' floating support. IUPS is flexible in this regard, peers can meet clients where they are to provide support. In fact, current models of this support utilise peers to accompany clients to health appointments to help them with transportation, dealing with professionals, or interpreting doctor instructions (Bowgett, 2017).

Conversely, peers can also meet with clients within supported accommodation to have informal discussions about their needs. For example, peers at Birmingham Changing Futures may go out to the supported accommodation to meet the client and bring them some food or clothing and then discuss what the client wants and how they may achieve their goals.

Some IUPS programmes might value advocacy and encourage clients to get involved in social justice activities to change systemic barriers that contribute to homelessness. For example, Pathways works with clients to help them engage with local leadership and influence policy decisions.

7.1.9 Intervention Delivery

This can vary by organisation and the specific homeless population. Peers who work with deeply entrenched homeless persons may aim to have contact with their client every fortnight and this may last for months or years (Simonsen, 2015). Conversely, clients who are engaged with services may see their peer on a more regular basis, such as once per week. Again, this could be for a few weeks or months. This shows how IUPS can be personalised to the client and the degree of support required.

7.2 An Example: Ashford Place

Ashford Place is a UK based community organisation, providing support for the North London community of Brent. This 30-bed emergency and transitional accommodation serves over 100 people per year. Ashford Place targets marginalised people experiencing crisis and struggling to access services. A strengths-based 'whole person' model combines lived experience with organisational expertise and resources to meet immediate needs, resolve problems, provide a platform of stability and support, and enable people to take control of their lives.

Through combined drop-in services and peer-support, Ashford Place aims to take people off the street into 24/7 emergency accommodation, prevent evictions, meet basic needs, address substance misuse, improve mental health, build resilience and skills, reconnect clients with support networks including family, peer support, and community groups, and help people to get their voices heard. Further, the project delivers weekly drop-in crisis intervention support (both on site and in other areas in the community), where those in need can get information and

referrals to housing supports, legal assistance, GP care, job matching, and benefits support, from both peer supporters and staff. Ashford Place has recently developed an IUPS programme, building upon their existing model where peer volunteers are integral to service delivery.

All peers are provided monthly training on relevant topics in housing and homelessness (e.g. universal credit, housing benefits, streetlink etc.). Their IUPS programme is an extension of their current peer model, where peers who have shown an interest in being a peer mentor are asked to attend a full day of training. The training consists of background to IUPS models, self-reflection, self-determination, and introduction to a workbook. The workbook is a tool for peers to help clients identify an area of their life that they would like to change or improve. Peers then meet with clients for a minimum of six sessions over the next few weeks or months to help the client achieve their goals. Peers meet with clients at the centre and usually on a one-to-one basis. Peers are supported with informal supervision as needed and a monthly reflective practice meeting with staff and peers to discuss any challenging events and/or provide feedback on the IUPS programme (O'Leary, 2018).

The integrated evaluation involves collecting data from the same participants over a period of time to evaluate the initial and long-term impact of an intervention. A battery of surveys over a 12-month period for each participant is collected. Specifically, participants are invited to complete surveys when they first engage with Ashford Place's services and again at two six-month intervals. Further, qualitative interviews with a sample of staff, clients, and peers are used, to contextualise quantitative results and ascertain client, peer, and staff experiences. Outcomes of interest to this project are: the impact on mental health, drug and/or alcohol use, overall wellbeing, self-efficacy, resilience, the impact of the PCR, and the incidence of various behaviours (e.g. arrests, hospital nights, A&E admissions, and nights spent in a police cell). Additionally, the evaluation examines the impact this programme has on the peer-supporters through measuring self-efficacy, mental wellbeing, job search satisfaction, and the PCR at two time points over three months.

7.3 Chapter Summary

This chapter clearly defines IUPS as a distinct and evidence-based intervention. All previous work in this thesis contributed to the development of this chapter. This chapter provides a framework for future research and practitioners interested in evaluating, developing, or implementing mentorship peer schemes. This chapter marks completion of the first phase of the MRC complex intervention guidance, the development phase. Additionally, this chapter defines the intervention to be assessed in the following chapter. Indeed, the next chapter presents a feasibility study assessing this intervention, as per MRC guidance (Richards & Hallberg, 2015).

Chapter 8 The Feasibility of Conducting Research on the Effectiveness of Intentional Unidirectional Peer Support with a Homeless Population

8.1 Introduction

Given the diversity of peer interventions used in practice, the complex social systems involved in homelessness services, and the embryonic nature of the topic, available research designs to evaluate this intervention are limited. The participant pool of various organisations implementing peer interventions are not using the same type of PPS; furthermore, the populations served are also quite diverse. For example, a number of homeless charities with peer schemes in London serve the homeless, but their aims vary: Groundswell seeks to reduce health inequalities affecting the homeless, Riverside connects entrenched rough sleepers to services, Ashford Place takes referred clients and helps them deal with crises, and St. Mungos is primarily a housing and support organisation. There is overlap between these organisations, but by no means do they provide the same services and they certainly do not utilise peers in the same manner. However, there are homeless organisations utilising IUPS with the same overall aim. For example, Groundswell, Shelter, and Riverside utilise IUPS to increase their clients' wellbeing in relation to their housing situation.

Due to the complex nature of evaluating peer-support, the MRC guidance on complex interventions has been used to aid the development of this programme of research, organising the research in the first two phases (development and feasibility/piloting) as stipulated by Craig et al. (2008). This chapter focuses on the second phase, and presents a feasibility study using a controlled cohort design to assess the effectiveness of IUPS with a homeless population through comparison of treatment and control groups. By assessing current programmes and utilising a feasibility approach, we can assess for contextual factors, participant opinions, the acceptability of randomisation, and the possibility of comparable control groups. Assessing the feasibility of conducting a controlled cohort study has high ecological validity, strengthening the confidence we can have that the study parameters will be feasible in a real world setting (contrasted with a laboratory setting). This does however limit the specificity of conclusions that can be drawn about outcomes.

8.2 Aims and Objectives

In attempting to further the development of the research programme, it is essential to understand the process of undertaking a controlled cohort study with the target population. This

feasibility study addresses the following research question: what is the feasibility of conducting a controlled cohort study assessing the impact of IUPS on those experiencing homelessness?

The objectives of the study are to:

- Explore professionals', peers', and clients' experiences of taking part in a controlled cohort study;
- Assess recruitment and retention rates;
- Assess the comparability of control and experimental groups;
- Evaluate the measurement tools, their appropriateness, and usability within a larger study;
- Identify any barriers and facilitators to IUPS.

8.3 Methods

8.3.1 Design

Feasibility studies are pieces of research that precede a main study, and are primarily used to estimate parameters of the main study (Arain et al., 2010). Generally, the focus is not on the outcomes measured, but on the process of implementing the main design. A feasibility design is appropriate for this topic, because it allows the exploration and understanding of practical issues such as recruitment, acceptability of randomisation, suitability of an outcome measure, and development of an outcome measure (Arain et al., 2010).

This study is a feasibility of a controlled cohort study, which involves evaluating a sample before and after receiving an intervention (Mann, 2003). This involves a defined group of people (those experiencing homelessness), followed over time to examine associations between different interventions received (treatment as usual vs IUPS) and subsequent outcomes. This is a prospective study—recruitment occurs before intervention and participants are followed over time (Higgins & Green, 2008). The protocol for this study can be found in Appendix M.

8.3.2 **Recruitment**

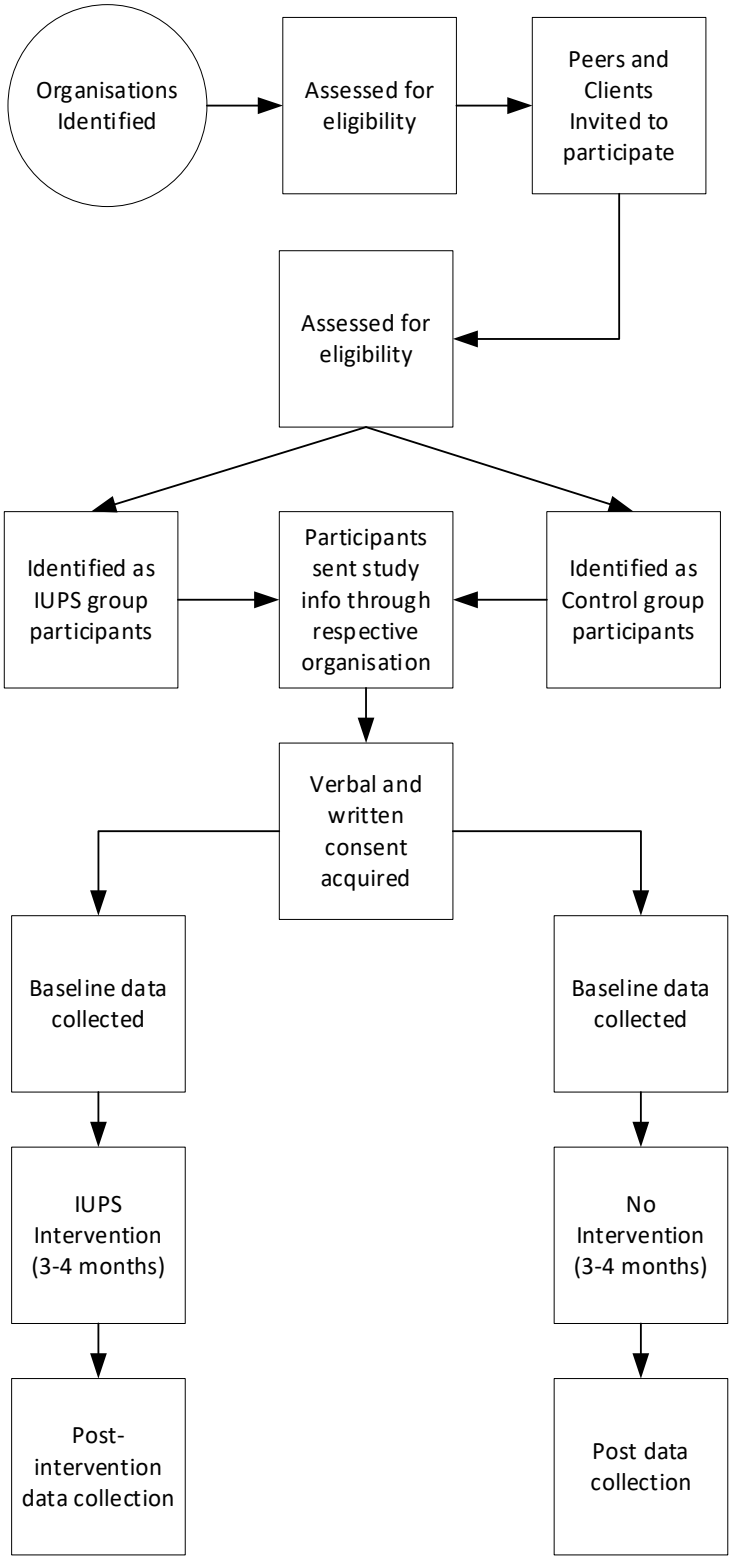


Figure 18. Feasibility Study Recruitment Outline

Participants were recruited at three levels: organisations, peers, and clients. Organisations were identified and assessed for eligibility (level 3). Within each organisation, we then recruited a manager who invited eligible peers and/or key workers to participate (level 2). Then, each peer-

supporter/key worker recruited their clients (level 1). Analysis occurs at level 1 where client outcomes are assessed.

Treatment Group:

Eligible participants for the treatment group are those who have experienced homelessness and IUPS. In order to identify possible participants, I used the outline depicted in Figure 18, by firstly assessing peer programmes delivered by local homeless charities to identify which meet the following criteria:

1. Provide services to a homeless population
2. Include those with lived experience in their services
3. Those with lived experience are trained in supporting clients
4. Peers actively work one-to-one with clients to increase general wellbeing (e.g. health, mental health, assistance with benefits, accompanying clients to appointments, etc.)
5. Peers are supported by professionals and/or group supervision

Once eligible organisations were identified, I approached them to ask for their participation in the feasibility study through emails, face-to-face meetings, and online advertising. Peers and clients were recruited from eligible organisations based on the following criteria:

Peers:

- Aged 18 and over
- Have personal experience of homelessness;
- Speak and read English fluently;
- Are engaged with IUPS provision;
- Have been providing IUPS for at least one month;
- If applicable, identify as being in recovery from drugs and/or alcohol;
- If applicable, identify as being in recovery from mental and/or physical illness

Clients:

- Aged 18 and over
- Are currently coping with homelessness;
- Mentored/working with a peer within a IUPS framework;
- Speak and read English fluently, or with assistance from their peer/the researcher

Criteria are identified as being integral to participating in the feasibility study and future cohort studies. The requirement for peers to speak and read English fluently is derived from the included measurement tools, which may or may not have been translated in to other languages and subsequently tested for their validity and reliability. Further, peers should have at least one month of experience providing support. This criterion is selected because the IUPS framework identifies peers as being more stable and further along in their recovery than their clients, thus they must have had time to attend training and become familiarised with providing IUPS.

Peers and clients were invited to participate via emails, face-to-face meetings, and through organisation managers using a short description of the study and what would be asked of them, using a study advert. Snowball sampling was utilised, where participants were asked if they know of others who would be interested in participating.

Control Group:

Control group participants were recruited using a similar process and inclusion criteria; where homeless organisations that *do not* have IUPS programmes were identified and then approached for their participation. Recruiting for the control group occurred simultaneously to treatment group recruitment. Control group clients were coping with homelessness and able to speak and read English fluently or with assistance. Control group organisations were viewed as TAU, whereas treatment groups were TAU plus IUPS.

Vouchers

Non-waged participants were informed of a £5 voucher for each session (i.e. each survey session and each interview) that they participated in. These are high street vouchers that have been used as compensation for the non-waged participants' time, as reported in Chapter 4. Voucher amounts and guidelines are outlined in Table 12.

Table 12. Voucher Amounts and Distribution

	Control		**Treatment**	
Data Collection Point	Clients	Professionals	Clients	Peers*
Baseline	£5	Not eligible as they are paid	£5	£5
Post-treatment data	£5		£5	£5
Qualitative data collection	£5		£5	£5
Total	£15	£0	£15	£15

*Note *peers were provided vouchers if they were not already compensated through their respective organisations*

Sample Size

Relevant literature evaluating peer interventions with homeless populations longitudinally is sparse, therefore, I drew upon existing literature to estimate sample size. For example, Fors and Jarvis (1995) included three arms in their longitudinal evaluation of peers with marginalised populations: 142 participants in the peer arm, 21 in the non-peer arm, and 14 in the control group. Similarly, Resnick and Rosenheck (2008) had 78 participants in their treatment group and 218 in the control group, within their assessment of peer interventions for a veteran population compared to TAU.

There are two known trials examining peers effectiveness in increasing homeless participants' treatment adherence in tuberculosis (TB) services (Pilote et al., 1996; Tulsky et al., 2000). These

trials had similar numbers in each of their groups: an average of 81 and 39, respectively (Pilote et al., 1996; Tulsky et al., 2000).

Billingham, Whitehead, and Julious (2013) assessed pilot and feasibility studies on health interventions in England and found that the average number of participants in 2-armed studies was 30 per arm. However, relevant literature on feasibility studies suggest that 12 participants per treatment arm is sufficient, therefore, this feasibility study aimed to recruit 12-20 client participants in each group (N = 24-40) (Julious, 2005).

8.3.3 Measurement Tools

The intervention includes an evaluation of the IUPS services that participants are receiving and this is tested through a battery of surveys. The surveys have been chosen to assess process and outcomes that have been identified throughout this thesis and by theoretical assertions by Maguire (2017). Specifically, the strength of PCRs was suggested to be integral to IUPS interventions by Chapter 5. As there is no existing tool to assess the relationship between peers and clients, I chose a tool traditionally used to assess the therapist-client working alliance. Further, Maguire (2017) suggests that emotional dysregulation is a psychological factor that leads to repeat homelessness, and therefore, a tool to assess levels of emotional regulation has been included. Work reported in Chapters 3, 4, 5, and 6 identified outcomes commonly associated with peer interventions. These include drug and alcohol use, mental health, resiliency, and self-efficacy (Blondell et al., 2001; Campbell, 2008; Galanter et al., 1998). Tools have been chosen to reflect these outcomes, described below (surveys can be found in Appendix N).

As feasibility studies are not primarily oriented to evaluating outcomes, this study will assess if the treatment and control groups are similar enough that conclusions can be drawn from comparison of the two groups and participant acceptability of measurement tools. Thus, the clients in each group were asked to complete surveys over a similar timeframe, with two data collection time points: at baseline (within one month of starting with IUPS/services) and 3-4 months later.

Demographics Form

Clients were asked to fill out a demographic form to ascertain their age, gender, ethnicity, mental health diagnosis, and mental health support. This information is required to assess the representation of the participant population to the rest of the homeless population and conduct comparisons between the treatment and control group. This information is kept separate from any other data collected in order to ensure participant confidentiality.

Behaviour Questions

These questions surround client behaviour to understand the representation of the sample to the rest of the homeless population. Participants can report their housing situation, frequency of

rough sleeping, tenancies, and evictions, in the last 6 months. Further, this form requests that participants report the number of times that they have engaged with various behaviours in the past 4 weeks, including violence against others, against property, threats to staff, threats to other service users, and theft. Lastly, we request participants identify the number of times they have been arrested, spent nights in a police cell, nights in a hospital, and A&E admissions, over the last 6 months.

Alcohol Use Disorders Identification Test (AUDIT)

To assess clients' alcohol use, the AUDIT was utilised (Babor & Caetano, 2006; Saunders, Aasland, Babor, De la Fuente, & Grant, 1993). This measure has been validated internationally through the World Health organisation (WHO), with various populations, including primary health care patients in six different countries (Saunders et al., 1993). The tool has good internal consistency (r = .86) and a high correlation coefficient (.78; Babor & Caetano, 2006). This measure has 10 items in total; eight are scored on a 5-point scale assessing the amount of alcohol use in a week, in one sitting, and over the past six months. The remaining two questions are scored on a 3-point scale assessing the impact of drinking on an individual's life, alcohol-related injuries, and other people being worried about the individuals' drinking.

Drug Use Disorders Identification Test (DUDIT)

To evaluate drug use, the DUDIT is used (Berman, Bergman, Palmstierna, & Schlyter, 2003). This 11-item measure was developed to accompany the AUDIT, in assessing drug use impact on an individual's life (Berman et al., 2003). Nine questions on the DUDIT are scored on a 5-point scale exploring the incidence of drug use and ability to stop once started. Questions 10 and 11 are scored on a 3-point scale, which examine drug-related injuries and if other people in the individual's life are concerned about their drug use. The tool has high convergent validity (r = .86) and a Cronbach's Alpha of .94 (Berman et al., 2003). The AUDIT and DUDIT are commonly used in conjunction with each other (Babor & Caetano, 2006).

Warwick-Edinburgh Mental Well-Being Scale (WEMWBS)

The WEMWBS assesses subjective mental wellbeing and psychological functioning through 14 items. The scale is scored on a 5-point likert scale and has been validated for use with UK populations, including the general population. Validation studies with the general population have shown the WEMWBS has a Cronbach's Alpha of .91 (Stewart-Brown, 2013; Stewart-Brown & Janmohamed, 2008).

General Self-Efficacy Scale (GSE)

The GSE examines participants levels of perceived self-efficacy, identifying coping and adaptation after experiencing stressors (Schwarzer & Jerusalem, 2010). This 10-item scale has a Cronbach's

alphas that ranges from .76 to .90, in samples from 23 nations, with the majority in the high .80s (Schwarzer & Jerusalem, 2010). The tool is scored using a 4-point scale.

Connor-Davidson Resilience Scale (CD-RISC 2)

The CD-RISC 2 is a two item scale assessing resilience and the ability to 'bounce back' after a stressful event (Vaishnavi, Connor, & Davidson, 2007). The scale includes two items, which were originally part of a larger scale assessing resilience. The tool has a Cronbach's alpha range from .67 to .85. Vaishnavi et al. (2007) validated this two-item scale on various populations and found that it is a valid tool for the general population, psychiatric populations, and those with health issues (J. Davidson & Connor, 2016).

Difficulty in Emotions Regulation Scale (DERS)

The DERS is a 36-item survey which assesses emotional dysregulation (Gratz & Roemer, 2004). The tool has six scales which all have a high Cronbach alpha (range .84-.89). The scales assess acceptance and awareness of emotions, impulse control, goal directed behaviour, strategies to cope with emotion, and levels of emotional clarity (Gratz & Roemer, 2004). The tool was developed with the general population and further tested with female participants diagnosed with borderline personality disorder.

Working Alliance Inventory (WAI)

The WAI is used to assess the strength and impact of peer-client relationships. This tool is traditionally used to assess relationships between clients and helpers (usually therapists). However, it broadly defines the working alliance as a collaboration characterised by mutual trust, commitment, and compassion (Horvath & Greenberg, 1989; Kokotovic & Tracey, 1990). With author permission, the tool has been modified to reflect the language of PPS (i.e. replacing "therapist" with "peer") (Horvath, 2016).

This 12-item tool assesses client's perceptions of the working alliance they have with peers/professionals on a 4-point scale (Hatcher & Gillaspy, 2006). The WAI-SR has three subscales assessing the goals, tasks, and bond (Hatcher & Gillaspy, 2006). These subscales all have high correlation coefficients (ranging from .85-.90) (Hatcher & Gillaspy, 2006).

8.3.4 Data collection and Analysis

Quantitative Data

Client participants completed the eight surveys on two occasions: Time 1 (baseline) and Time 2 (3-4 months later). This feasibility study aimed to assess three methods of survey data collection, outlined in Table 13. In all three methods, I was present, as the surveys required administration from an appropriately trained researcher. Furthermore, data that is collected in the field required

more than one researcher/person present, in order to comply with health and safety regulations outlined by the University. Completion of surveys took no longer than 45 minutes, but this timeframe varied, depending on the participants' literacy level (Range: 10 – 45 minutes).

Table 13. Survey Data Collection Methods

Pairs	Groups	In the Field
• Pairs of peers and clients, or • Pairs of professionals and clients • Invited to respective organisations • Participants complete surveys with researcher	• Groups of participants • Invited to respective organisations • Complete surveys with researcher present	• Researcher collaborates with peer or professional • Organises a meeting spot (e.g. participant home, café, community centre) • Participants complete survey with researcher

Quantitative data was analysed using the software programme SPSS 24 (IBM, 2016). Ideally, analysis would consist of a mixed methods ANOVA, with an adequate number of participants. However, within this small feasibility study a mix of independent and paired sample *t*-tests was used. Independent samples *t*-test are useful to examine differences across groups (e.g. to assess equivalence of demographic data across groups), while paired sample *t*-tests are useful to assess an individual over time (e.g. to assess client outcomes on survey battery from Time 1 to Time 2). However, if the data violates assumptions of normality (see Table 14), then nonparametric tests, such as the Wilcoxon Signed Rank test or the Mann-Whitney U Test can be used (Field, 2009).

Table 14. Assumptions of Parametric Data

Assumption	Description	How It is Identified
1. Normally distributed data	Data is distributed in a common bell curve	• Visually plotting data (e.g. P-P plots) • Examine standardised skewness and kurtosis values (greater than 3.29 indicates significance at p <.001)
2. Homogeneity of variance	Variance values should be similar across data	• Levene's tests assumes that variances across groups are equal, therefore, a significant Levene's test indicates that this assumption has been violated
3. Independence	Data from different participants are independent	• Participants across groups are unable to influence each other in relation to the study

Qualitative Data

Qualitative interviews allow a deeper understanding to the process of this feasibility study, thus all participants, including peers and professionals, were invited to contribute to the study through qualitative interviews (Braun & Clarke, 2013). Peers, clients, and professionals were informed of opportunities to provide feedback through interviews during initial quantitative data collection. Interviews were conducted within 30 days of Time 2 data collection.

Primarily, qualitative data was collected through one-to-one, semi-structured interviews, where participants can voice their experience of the study through informal discussions (Wilkinson, Joffe, & Yardley, 2004). Interviews followed a topic guide for each type of participant (see appendix O). Interviews focus on the experience of the study, their opinions on the measurement tools (length, language, etc.), possibility of randomisation, and the feasibility of conducting a larger study.

Each interview was audio-recorded with permission from participants. Interviews were transcribed verbatim, input into the data managing software NVivo 11, and analysed using thematic analysis (QSR, 2012). Thematic analysis is a useful, flexible method for handling qualitative data (Braun & Clarke, 2006). Further, thematic analysis is the best method of analysis to achieve identified research aims. The analysis seeks to understand participant experiences of the cohort design and identify any barriers to carrying out a full-scale cohort study. The analysis is coded inductively, following guidance developed by Braun and Clarke (2006), using participant words to identify issues with the research design and suggested changes. Additionally, as recommended by Phillippi and Lauderdale (2017), field notes were included as data in the analysis.

8.3.5 Ethical Considerations

This study received ethical approval from the University of Southampton ethics committee on 17/03/2017 (ID: 30373). All participants provided informed consent to participate in the surveys and/or interviews. All data is treated in accordance with University Data Policy and the Data Protection Act (1998) (Note that General Data Protection Regulation (GDPR) had not come into effect until after the study's conclusion). Participants were recruited through their respective organisations and were informed that their participation is voluntary, having no impact on the services that they receive. Each non-waged participant received a £5 voucher for their time while participating in the study. The decision to use a non-cash compensation is derived from a standard practice of conducting research with this population, as described in Chapter 4. Participant names have been changed and identifying characteristics removed. Ethics documentation can be found in Appendix P.

8.4 Results

Five organisations participated in the study, two in the treatment group and three in the control group. These resulted in 38 clients taking part in baseline data collection (treatment group = 12, control group = 26). All participants, including peers and professionals, were invited to participate in qualitative interviews. Additionally, professionals from organisations who did not participate were also invited to participate in interviews to ascertain reasons for nonparticipation. The researcher was also diligent in keeping field notes from meetings with potential participating

organisations, documented as informal interviews. Table 15 provides a summary of recruitment for interviews.

Table 15. Summary of Participation in Qualitative Interviews

Group	Participant Level	Invited	Participated	Informal Interview
Treatment	Client	12	1	0
	Peer	11	3	0
	Professional	10	4	6
Control	Client	26	5	0
	Professional	14	2	8

Fifteen interviews were conducted averaging a length of 14.19 minutes (range = 5.06 - 44.38). Eleven interviews and 13 informal interviews were conducted face-to-face. One informal interview and four interviews were conducted over the phone. The qualitative interviews focused on the participant experience of being involved in the study and the feasibility of conducting a cohort study in homeless organisations.

8.4.1 Feasibility of Conducting a Controlled Cohort Study across Homeless Organisations

Recruitment

This study aimed to recruit between 12-20 clients per participant group. While that aim was achieved, it was not without difficulties, as outlined below. Recruitment into the study was open for 11 months beginning in March 2017 and closing at the end of January 2018. Field notes and interview transcripts provide data on reasons for nonparticipation.

Treatment Group

Eleven organisations were contacted and invited to participate, five of these organisations replied to recruitment correspondence. Of the three organisations that declined to participate, one stated that their client group was not appropriate for the study as their peers work with deeply entrenched homeless and that *"within a month we are still trying to get them to accept a cup of tea"—Sarah, Professional Treatment Group (TG).* The second organisation stated that their current service was very chaotic at the moment and feared that the study would contribute to conflict, worrying about difficult behaviour resulting from some people getting vouchers and some not.

The third organisation utilises IUPS to help their clients attend health appointments and engage with services. There was initial hesitancy for the researchers to access clients, as they do not introduce paperwork to clients within a short time period and staff were worried about the size of the survey, unfamiliar faces, and types of questions, however, staff allowed me to come and speak with the peer supporters, leaving the decision up to them. This prompted a pre-study focus

group with eight peers to present the study, garner interest, and obtain reasons for hesitancy. During the focus group, I explained the study, highlighting that reducing interference with the PCR was a key priority. Most peers expressed reluctance, as they felt that the survey pack was too big and that it would be quite difficult to get their clients to do it within a month. One or two peers who did not feel that the study could be done with their clients appeared to influence the others.

Two organisations agreed to participate. One organisation has a peer who provides IUPS to all clients, focusing on helping them to overcome their personal issues, including homelessness and health. This peer uses his own personal experience of homelessness and navigating health systems to mentor his clients into stability and advocating roles within health services. The feasibility study recruited three clients from this organisation.

The second participating organisation provides IUPS, where peers and staff work to help their clients attend appointments, engage with services, and reduce crisis. Their peer mentors use outreach, referrals, and in-reach methods to access clients. The feasibility study recruited nine clients from this organisation.

Control Group

Six organisations were identified and invited to participate. One organisation informed me that they would be implementing an IUPS programme in the middle of the study, therefore, this organisation was not asked to participate. Two organisations did not reply to correspondence and their reasons for nonparticipation cannot be identified. The three organisations that did reply were very receptive to being involved in the study, but were concerned about the feasibility of data being collected at a second time point. The first organisation is a homeless hostel that provides short-term accommodation to those currently homeless. They provide a range of services primarily through a professional key worker. The feasibility study recruited 17 clients from this organisation. The second organisation is also a short-term accommodation service where professionals provide key work support to those experiencing homelessness. The feasibility study recruited five clients from this organisation. The third participating organisation is long-term accommodation where clients have their own tenancy in supported accommodation. These clients have moved through other short-term services and use this service as a stepping-stone to get back to having their own tenancy without support. Clients from the third organisation could be considered more stable and less chaotic than those in short-term accommodation. The feasibility study recruited four clients from this organisation.

Recruitment Rates

As can be seen in Figure 19, recruitment rates were generally low. For the treatment group, there was 88 clients that were possibly eligible for the study, however only 12 (13%) were recruited at baseline. Data collection for treatment group organisation 1 occurred on one day. Although

treatment group organisation 1 has 18 clients that could be recruited, on that data collection day, five were present and only three were interested in participating. Similarly, treatment group organisation 2 works with 70 clients who are potentially eligible for inclusion. Baseline data collection occurred over one week and many of recruited participants seemed to be there by chance (i.e. they happened to come into the centre). An additional barrier that impacted recruitment for treatment group organisation 2 included extreme weather; snow had caused the centre to close on the first day of data collection and staff suspected that many of their clients were not going to visit the centre while it was so cold. Peers and key workers at treatment group organisation 2 often go out to meet their clients (at hostels, charities, check-ins, prior to appointments etc.) and I went with the peer/key worker to five client appointments. Unfortunately, three clients were un-locatable and two were not interested in the study.

For the control group, baseline data was collected from 26 of a possible 108 clients (24%). Control group organisation 1 has experience of students coming to request client participation in surveys. I was at the centre for two consecutive days after the study had been advertised for the two previous weeks. These two days resulted in baseline data from 17 participants. For control group organisation 2 and 3, data collection occurred on one day. Both organisations had posted the study advert and I collected baseline data of nine participants. This study did not collect data on those clients who did not participate. Therefore, any reasons for initial client nonparticipation are unknown.

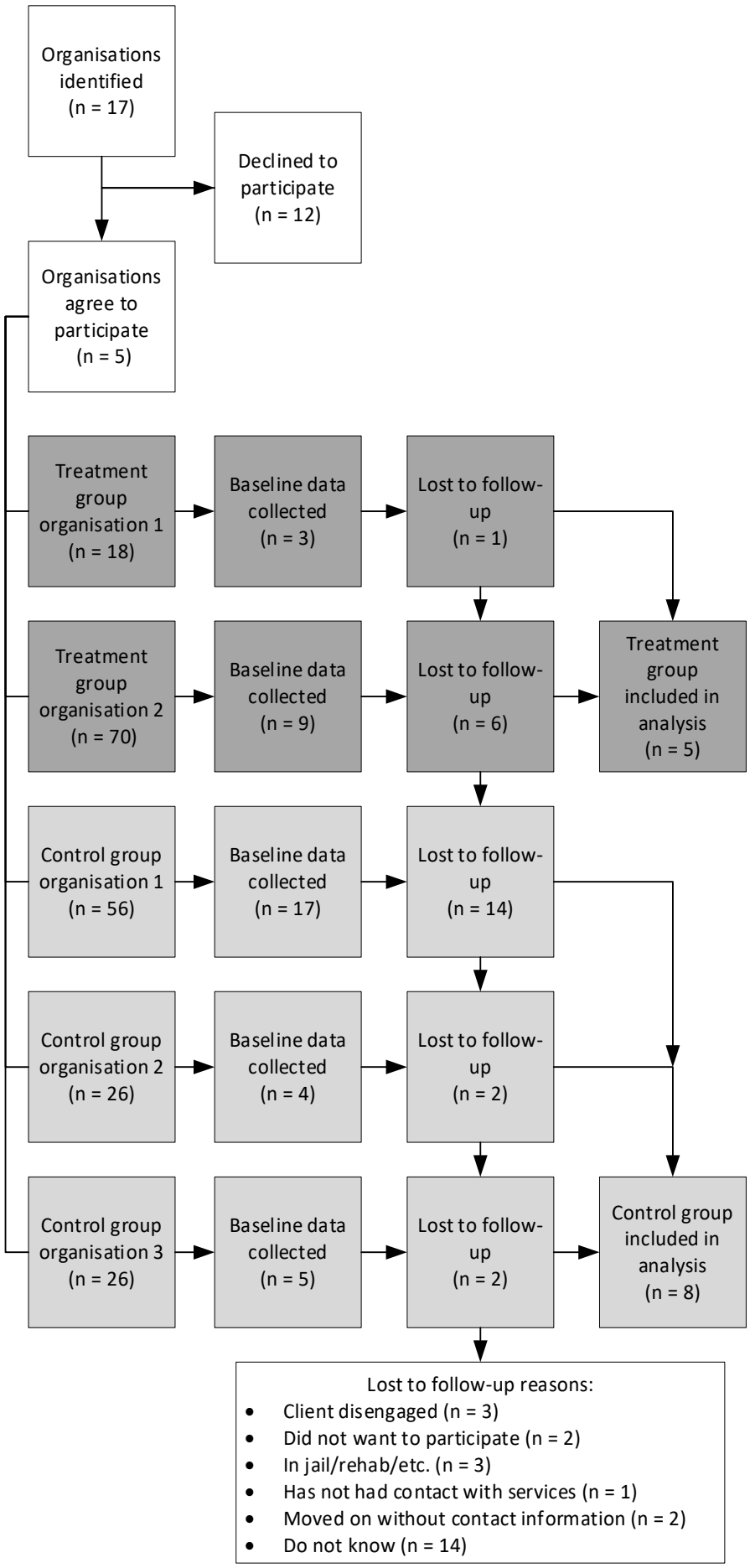


Figure 19. Flowchart of Client Participation

Comparison of Groups

Assessing the comparability of the two groups was conducted with SPSS 24 (IBM, 2016). When examining the data, I found that normality assumptions were violated. This is established by examining P-P plots, histograms, and assessing skewness and kurtosis values against a normal distribution (Field, 2009). Therefore, comparisons across groups are made through the Mann-Whitney U Test (Field, 2009).

The two participant groups were similar across demographic data. The mean age of treatment group participants at baseline is 42.83 (*SD* = 1.32) which was not significantly different from the control group (*M* = 37.79, *SD* = 10.25), *U* = 103.5, *p* = .177. Similarly, gender was distributed equally across both groups, *U* = 178.0, *p* = .505. Additionally, the two groups did not significantly differ in ethnicity (*U* = 112.5, *p* = .174).

Regarding most behavioural incidents and other items, the two groups do not significantly differ. However, the two groups significantly differed in their current housing situation, *U* = 66.5, *p* = .004. As can be seen in Table 16, most participants in the control group were residing in a hostel, whereas the treatment group shows a varied housing situation.

Table 16. Baseline Characteristics of Participant Groups

Characteristic	Treatment Group	Control Group
	n (%)	*n* (%)
Age		
19-30	2 (16.7)	7 (30)
31-40	4 (33.3)	7 (30)
41-50	2 (16.7)	7 (30)
51-64	4 (33.3)	3 (10)
Gender		
Male	10 (83.3)	18 (69)
Female	2 (16.7)	8 (31)
Mental Health Need		
Yes	9 (75)	19 (70)
No	3 (25)	7 (30)
Currently Getting Support	6 (50)	11 (40)
Current Housing		
Hostel	3 (25)	21 (80)
Rough Sleeping	1 (8.3)	-
Squatting	1 (8.3)	-
Supported Accommodation	4 (33.3)	5 (20)
Other	3 (25)	-
Nights Spent Rough last 6 Months		
0-36	9 (75)	19 (73)
37-71	1 (8.3)	2 (8)
72-107	-	1 (4)
108-143	-	1 (4)
144-180	2 (16.7)	2 (8)
N/R	-	1 (3)

Measurement Tools

Professionals who were interviewed expressed concern over the items relating to alcohol, drugs, and violence: *"I was worried that it could be a trigger"—Gwen, Professional TG*. However, participants stated that it is likely that clients are asked for this information on a regular basis:

> *"Those are the type of questions that you get asked all the time so when you're on drugs and that, do you know what I mean, so you just get used to it. Used to the questions"—Carol, Client, Control Group (CG).*

Generally, clients did not find the items too intrusive or difficult to answer. What did appear to be a problem for some clients was the level of literacy skills required to complete the surveys. While I was asked to read out the survey for only three clients, the need for clarity on specific questions occurred frequently—almost every participant needed assistance to complete the surveys, however minor (specific questions for item clarity, clarify meaning of words, etc.). This suggests

that although most participants are able to go through the survey independently, it is important to have someone available to answer questions and clarify items.

Participants were also asked for their feedback on the surveys, and suggestions for changes. These are shown in Table 17. When asked if they felt that the surveys captured behavioural and emotional changes they experienced, participants felt that the survey topics were appropriate, but one suggested that peer interventions are successful because of the emotional social support that they provide. This is an important point, as the work in this thesis suggests that social support is key in peer interventions, but was not included as one of the surveys. Therefore, future studies should include a measurement tool assessing perceived levels of social support as a process outcome.

Additionally, participants felt that the inclusion of more qualitative questions would help to contextualise their responses. Specifically, the type of drug used (classifying cannabis differently than heroin, for example) and the opportunity to explain how their life has changed over the three-month intervention period:

> *"So I could explain how my life was at the first to the second [time point]. Yeah, that would have been, would have been helpful. Helpful to yourself as well"—Carl, Client, TG*

Additionally, some professionals felt that the exclusion of qualitative questions on the surveys may not capture the 'soft outcomes' that clients achieve over a period of time:

> *"Those softer things, that happen in our lives. Which are significant, to who we are as individuals, and how we live our lives, choices that we make, and all of the things that are important to moving forward. You know, that's massive, I think!"—Mariah, Professional, CG.*

Table 17. Suggested Survey Changes

Survey	Participant Feedback	Suggested Change
Demographics Form	Participants were confused by "case management" and needed to be informed that it meant key work	Correctly use the term key workers and/or include a clearer description
Behaviour Questions	Participants may not be honest or *"might not also see their behaviour as violent or abusive or threatening"—Joan, Professional, TG*	Attain this data from the organisation, with consent from participants
AUDIT/ DUDIT	Some participants reported that they were recovering and were unsure of how to answer the questions	Inclusion of a sobriety date question
WEMWBS	Participants struggled with the word "opposes" in question 2 of this tool	Add clarification, e.g. "opposes, or disagrees…"
GSE	Participants needed clarity on how to complete this survey	Clarify instructions and have someone present to answer questions
CD-RISC	No feedback	
DERS	Text was too small and participants found it to be quite long, especially coming last in the survey pack	Make text larger and carefully consider the order of surveys, to help manage participant mood
WAI	Good questions to include, but has left blank spaces for participants to mentally insert the name of their peer or their client, which was confusing	Modify items, for example, item #3 is "I believe __ likes me", could be clarified to read "I believe my peer supporter likes me."

The baseline data was analysed for patterns in missing data. Little's MCAR test was run on all Time 1 variables to test if the data was missing completely at random (Field, 2009; IBM, 2016). This test was nonsignificant (Chi-Square = 740.00, *df* = 2511, Sig. = 1.000) meaning that the missing data is occurring at random.

However, given the exploratory nature of this feasibility study, frequencies and descriptors of missing data were examined, items with more than 5% of missing data were scrutinised. Notable missing data results are shown in Table 18. Mainly, missing data appears to be on the behavioural items, suggesting that participants could be uncomfortable answering these items. This further supports suggestions made by participants to ascertain this data from the participating organisation. Other survey items that are missing may be reduced by implementing the suggested changes from participants, reported in Table 17.

Table 18. Missing Data: Notable Items Missing >5% of Responses

Item	*n (%)*	*N*
WAI #9. I feel _____ cares about me even when I do things that he/she does not approve of.	4 (10.3)	35
WAI #3. I believe ___ likes me.	4 (10.3)	35
Incidents of theft	3 (7.7)	36
Violence against people	3 (7.7)	36
Number of evictions in least 2 years	3 (7.7)	36
Threats against other service users	2 (5.1)	37
Violence against property	2 (5.1)	37
Length of last tenancy	2 (5.1)	37
Nights spent rough sleeping past six months	2 (5.1)	37

Note. Full table can be viewed in Appendix Q

Data Collection

One of the aims of this study was to examine the preferred method of data collection. Participants were able to complete the survey in pairs, groups, or out in the field. Data collection methods seem to depend more on the group that was being recruited, as most of the control group was conducted in groups whereas the treatment group had a mix of in the field and in pairs. Results of data collection methods in the current study seem to reflect organisational preferences rather than specific client preferences. Therefore, for a larger study, this may have to be managed at the organisational levels—deciding which method may be best to enhance recruitment.

However, all interviewed participants were asked about preferences in regards to a larger study. Participants suggested that it depends on the particular client:

> *"I've got other clients who have never been to this office. And if they had been involved in this study I would have been saying to you, let's go to them. I think it's all client dependent"—Sarah, Professional, TG*

Both pair and group data collection are easily achievable and do not require extra resources. However, data collected in the field does require the researcher be accompanied. In the current study, I went out with staff/peers to collect data. An added benefit of in the field data collection is that if clients found the questions too intrusive, then they would have a supportive person whom they trust present. Participants reported that if researchers want honest responses, then there must be some trust developed with the client. This could be done through recruitment of peer researchers or internal staff. Although, it was generally agreed that in the field data collection, where the researcher accompanies a peer or staff member, could help to reduce dishonest answers. Therefore, although limited, this feasibility study suggest that a larger study could still

use any method of data collection, but should endeavour to remain flexible—to meet clients where they are.

Retention

As shown in Figure 19, only 13 clients participated in the second time point. Interviewed participants were asked about why follow-up was so difficult. Participants felt that the client group can be "chaotic" and untraceable at times:

> *"Sometimes they are just not contactable and they just go off the radar, it's just um impossible to see clients regularly. And to be honest, some of the time, I'm literally ringing around the pharmacy to see if they're picking up their methadone prescriptions and if they've picked it up, ok that means they're alive. Um, so yeah, when you're working with clients that are as chaotic as they are, that don't have a routine. It yeah. Trying to get them in, yeah. It is really difficult"—Sarah, Professional, TG*

Clients in this population can be transient and "*difficult to engage at the best of times"—Dwight, Peer, TG.* This is a common barrier in completing research with this population and one of the justifications for the current study.

To understand this more, participants were asked to give suggestions to overcome low rates of follow-up. Suggestions include having a firm date for Time 2 set, so it could be advertised from the beginning, reminders for clients in between (provided by their peers or key workers), and a larger incentive (such as £10) at the second time point. Participants also felt that if the researcher was a familiar face and could spend more time with the staff/peers, then it would give the clients opportunity to get to know the researcher and develop trust, they may be more willing to engage three months later. Another suggestion was to involve peer researchers, as they could connect with clients quickly and get the clients' buy-in to the study from the first. However, there were some reservations expressed about peer researchers. Some participants described their negative experience with peer researchers:

> *"They were hugely unreliable. They didn't turn up for their meetings, their trainings. You'd get everyone trained and this has happened so many times, get everyone trained finally. And then the research would be due to take place on the Monday and no one would turn up"—Gwen, Professional, TG*

Peer researchers might enable stronger retention, however, the current study did not have resources to evaluate that, therefore, this may be something to be re-examined through literature and/or through a larger study.

Another barrier to follow-up involved the professionals involved at one participating organisation. Staff turnover was an issue for follow-ups in the current study. I made multiple trips to the

organisation attempting to engage with clients for follow-ups with little success. After persisting, I was able to meet with two staff and re-explain the study and its aims, eventually gaining access to some participants. Staff attitudes towards the study can have an impact on data collection—if the staff do not value the study or there are instances of turnover, then staff may become barriers to its completion. This experience re-iterates how important it is to get buy-in from staff, and how important it is to get the study known around the centre so that if there is a staff change or other event, then the study can still continue and be valued.

Possibility of Randomisation

Participants held different views on randomisation, clients felt that a level of randomisation already exists—*"you don't get to pick your key worker"—Rick, Client, TG.* Clients did report that they have options to change key workers, if there is conflict or other issues—a design that could work within each treatment or control condition. However, professionals and peers had strong reservations about the practical implications. One of the treatment organisations began as an IUPS service with a comparative model design. They experienced many issues with this design, such as animosity between staff and peers, staff feeling they were denying clients a service that they believed was helpful, and a feeling of unfair division of labour as staff with a peer were more able to manage their caseloads. The staff reported that their service has already shown that IUPS models are superior to key work alone, so there is no need to randomise another intervention. It would be better to compare similar services with and without IUPS:

> *"We had a lot of unhappy staff for a long time. Um and that would have meant that we had unhappy clients. And then I think we should have made it comparative to other services like the NHS, where they didn't have peer support"—Gwen, Professional, TG*

Therefore, future research should maintain the controlled cohort design to assess the effectiveness of IUPS across homeless organisations rather than aiming to adopt a random design.

Quantitative Data Results

Although not an explicit aim of this feasibility study, I was interested to explore participant outcomes. As stated earlier, the data in the study was non-normally distributed; therefore, the use of parametric tests would be inappropriate. Data was analysed, instead, using Wilcoxon Signed Rank to assess any differences between groups over time (Field, 2009). The control group had a significant difference on their GSE scores from Time 1 to Time 2 ($T = 34.00$, $p = .024$, $r = .56$). There were no other significant findings. The increase of self-efficacy for the control participants may be the result of their continued stability and support provided by living within a hostel. All Time 2 control participants were living at the same hostel as Time 1. Whereas, the clients in the treatment group had much more variable living situations. This may further evidence that the two groups are qualitatively different from one another.

Closer examination of the treatment group reveals that all of the survey scores are changing in positive directions. That is, there has been improvements, but these changes are not statistically significant—unsurprising given the small sample size. The sample size could be considered as case studies rather than aggregated cases. All five participants improved on at least two measures, but there was not consistency across the participants. These results highlight the need for a larger study to examine client outcomes to assess the impact that IUPS has on clients.

8.4.2 Participant Experience of the Feasibility Study

Client Experience

Three clients felt that some of the questions were a bit difficult, such as the behaviour questions. The clients also report that if they had not progressed personally, then doing the questions again, would make them feel disappointed. Conversely, six clients (including two of those that discussed their negative experience) spoke about how completing the surveys was an overall positive experience for them. Clients enjoyed redoing the survey items and seeing their progression over the last three months:

> *"Last time I did, I was in a really bad place, do you know what I mean, and um like most of my answers to them questions were like ones and twos, I think. But like this time it's like mostly fours and fives, because I'm in a good place and off the drugs and that now, and everything"—Carol, Client, CG.*

Clients also felt that the survey questions helped them to get and understanding of themselves:

> *"Some of the things you would ask, in the forms, I wouldn't normally ask myself. So to think of that and think of the answer and think oh, well maybe I've got issues or something (laughs), but yeah it had a realisation to it"—Carl, Client, Treatment Group (TG).*

Overall, client participants (who were willing and available to participate in the interviews) reacted positively to the surveys and their comments suggest that it could become a tool for them to reflect on their own progress. Clients also reported that they appreciated the £5 voucher and that it was a good value for the amount of time put into completing the survey.

Peer Experience

Peers interviewed reported on their experience of the study. They felt that it was difficult to identify appropriate clients for the study, citing safety and willingness to engage as the main criteria to include clients. They did not report any reservations about the study design or its questions, stating that the topics were similar to topics that are addressed in treatment. After the study completion, peer participants stated that the workload was minimal—*"it's really nothing majorly added to my workload"—Dwight, Peer, TG*. Peers felt that the study was a positive experience for their clients and were not worried about them for the study duration.

Professional Experience

All organisations wanted to meet with the primary researcher prior to review the study and decide if they were willing to ask their peers and/or clients to be involved. Concerns were expressed about how the study may impact the safety of their clients, the PCR, and any breakdown of trust.

After I met with them, participating professionals were satisfied with the study procedures, including risk assessment procedures and how the primary researcher would handle any averse client reactions: *"I think after we had had our conversation, um I think it went quite smoothly. There was nothing to indicate that anyone was upset by anything. You know, so there wasn't any concerns"—Mariah, Professional, CG.*

There were some concerns about how the survey data was to be collected, but given the flexibility of the study, this reduced professionals' concerns:

> *"What was really good about your evaluation was that you were really flexible. And we've had some evaluators come several times in the past. But, we didn't have the flexibility. So, I did have some trepidations…if you were just sat in a room and expected everyone to come to you, then you wouldn't get the data that you needed. But none of that happened and you were going out and you were really flexible, so I thought it was really positive"—Gwen, Professional, TG.*

Overall, professionals found participating in the study was "*informative*" and were pleased to see their clients participating without issue. *"The fact that you have quite a significant number to start with, I think is a reflection on how it was managed, really and truly, in the sense that there were no difficulties and everyone was happy to engage" Mariah, Professional, CG.*

Some professionals saw using the study as a means to try to re-connect with their client who had disengaged completely. In sum, not only were professionals' concerns assuaged, but they were also pleased with the study overall and current procedures. This suggests that the feasibility study itself could be useful to potentially develop relationships with professionals and their organisations and therefore improve recruitment in any subsequent larger trial.

8.5 Discussion

The study aimed to explore participants' experience of and the acceptability of participating in a cohort study. Overall, participants reported that being involved in the study was a positive experience. Clients felt that they could use the surveys to see their own personal progression over the study period and few reported issues with the study as a whole. Peers and professionals expressed their reservations prior to the study commencing, but reported that their experience in

the study was also positive. This study also sought to understand the feasibility of conducting a controlled cohort assessing IUPS interventions across different homeless organisations. A number of recommendations for conducting a larger cohort study were found and are summarised in Table 19.

8.5.1 Recruitment

Recruitment methods used in this study (outlined in Figure 18) where I approached the organisation initially were found to be useful. However, 12 out of 17 organisations did not respond or declined to participate. This suggests that a larger study will need to account for a low recruitment rate of organisations. Interviews suggest that professionals had concerns about involving their clients in the study. Researchers providing a clear description of the study in advertisements, being proactive in anticipating professional concerns, and being willing and flexible to meet with organisations to describe the study could mitigate this. Previous research has shown that recruitment of vulnerable populations is more successful when the professional organisation is involved (UyBico, Pavel, & Gross, 2007).

Comparison of Groups

Cohort studies often struggle to control for all the factors that could make groups differ (Mann, 2003). This study found that the groups housing situations significantly differed. A larger study may circumvent this issue with larger sample sizes, but it does need to be considered as different housing situations could mean that the groups are qualitatively different and therefore cannot be compared to each other. Future studies may attempt to 'match' participants by demographic information prior to study inclusion (Creswell, 2014). In the current study, interviewed professionals were asked to identify organisations that provide similar services to a similar population group with or without IUPS. All treatment group professionals interviewed were able to identify comparable services. Recruitment of treatment organisations could occur first, utilising informal interviews to ascertain equivalent services that can function as control groups could be a method to increase the chance that groups will be comparable (Mann, 2003).

8.5.2 Measurement Tools and Data Collection

Prior to the study, professionals expressed apprehension about the items in the survey pack. Concerns were reduced through discussions involving explicit procedures to manage client emotion during data collection. Client participants reported that survey topics and questions are a normal part of their treatment, suggesting that the included tools are not overbearing or too intrusive. However, there were specific recommendations for the tools, described in Table 17.

Peers suggested that researchers could gain accurate data on client behaviours (specifically around violence) from the participating organisation, also described by Cohen et al. (1993) as

means to help increase follow-up and enhance data collection in research. This is easily achieved through an additional consent form for client participants to permit researchers access to this information. Furthermore, the addition of a measurement tool assessing levels of social support should be included in a larger study.

Given that recruitment initially occurs at the organisational level, it would follow that data collection procedures will need to be agreed upon by both researchers and the professionals. This may be dependent on how peers or professionals interact with their clients, whether it is in pairs, groups, or out in the field. Participants in this study generally felt that it should be flexible, depending on the client.

8.5.3 Retention

Follow-up rates for this study were poor, which is a common issue for cohort designs (Mann, 2003). Reasons for this include the complex needs of the population and organisational understanding and value of the study. Follow up rates for the two groups (30% for Control and 41% for Treatment) are consistent with previous literature (Cohen et al., 1993), however suggestions to increase follow-up rates were suggested and are outlined in Table 19.

Cohen et al. (1993) outlines five methods to increase follow-up rates in research with a homeless population: 1) Get all possible contact information and information of someone who knows the client, 2) collect records from organisations, 3) communicate with clients' social network, 4) have the same researcher conduct follow-ups, and 5) use incentives. While all of these methods were used in the current study, it is important that a larger study utilise and extend upon them. For example, researchers could develop a 'permission to contact' consent form which details contacts with organisations, social networks, and friends to find the client (Cohen et al., 1993). Additionally, researchers need to cultivate a relationship with each organisation to enhance follow-up efforts (Cohen et al., 1993). This could begin at the pre-study discussion where the researcher works to advertise the study, assuage professionals' concerns, and to increase buy-in from the organisations. Above all else, the researcher needs to be persistent and exhaust all leads (Cohen et al., 1993).

8.5.4 Possibility of Randomisation

Participants expressed a number of issues involved in randomising clients and key workers to different conditions, stating that the potential cost outweighs the benefits. A recent IUPS evaluation report utilised randomisation and peers were credited with increasing engagement and having more fluid boundaries that reduced boundaries in accessing care (Emerging Horizons, 2017). The report also described issues between staff and peers, echoed by participants in this study. It is recommended to use a cohort design instead of randomisation for subsequent

research. To conduct evaluations across organisations, researchers generally do not have the power to dictate what kind of treatment clients receive, thus a comparative cohort design is best.

However, cohort designs are susceptible to confounding effects, which can be mitigated by blinding participants and/or researchers to group membership (Mann, 2003). Within this study, blinding participants was impossible. However, larger studies should aim to blind researchers who are scoring the measurement tools.

8.5.5 Limitations

This study aimed to examine the feasibility of conducting a cohort study to assess IUPS interventions across organisations. However, the small participant sample limits the generalisability of results. Additionally, no data was collected to ascertain reasons for nonparticipation of potentially eligible clients or organisations that did not respond to correspondence. The findings are from those who did participate and may not be representative of the wider homeless population. Regarding measurement tools, the study did not include a social support measure, which was an oversight and clear limitation to assessing the feasibility of including one. However, this study does provide insight to conducting a cohort across homeless organisations and provides detailed recommendations for future research.

8.6 Conclusion

This chapter reports on a feasibility study of evaluating IUPS interventions across homeless organisations in the UK. There were a number of barriers identified, such as poor follow-up rates, staff turnover, organisational concerns about the surveys, and extreme weather. The model developed in Chapter 5 was represented well in this feasibility study; however an oversight led to a social support measurement tool not being included. Further, outcomes identified from Chapter 3, 4, and 6 enabled identification of appropriate measurement tools. Given the aims and objectives of this chapter, outcomes were not prioritised. However, outcomes were assessed and found no statistical difference between the treatment and control groups, most likely due to the small sample size.

Table 19. Recommendations for Future Research

Area of study	Issue	Recommendation
Recruitment	Organisational recruitment	Researchers need to engage with organisations to provide a clear description of the study, being proactive in anticipating professional concerns, and being willing and flexible to meet with organisations.
	Population sample	There is a need to ensure the groups are comparative. Researchers should ensure that recruitment is occurring across diverse living situations, perhaps through matching methods—by identifying a treatment organisation and then a similar service that does not provide IUPS
Measurement tools	Surveys	Measurement tools need to be edited to increase clarity and researchers should consider the order surveys are presented to help control participant affect (as described in Table 17). The addition of a social support measure to ensure all relevant concepts are included in an evaluation.
	Behaviour items	To ensure complete and correct data, researchers are encouraged to ascertain behaviour data from the relevant organisation. This will rely upon the relationship researchers have developed with the respective organisation and permissions granted by the client.
	Procedures	There is a need to ensure that a trained researcher is present while participants complete the survey pack, to answer questions and support participants through data collection.
Data collection	Different methods of data collection	There should be flexibility for this issue, and should be agreed upon by both researchers and the participating organisation.
Retention	Lost to follow up	There are a number of recommendations for this issue: o Set date for follow-up o Increase incentive at Time 2 to £10 o Reminders sent to peer/key worker and client o Spend more time at organisation to develop relationships with clients o The inclusion of peer researchers may be a possible aid in increasing follow-up.
	Staff buy-in/turnover	There is a need to develop strong relationships with organisations, which can help to increase staff buy-in and reduce issues at follow-up. Researchers should use face-to-face meetings with both staff and managers to highlight the value of the study and identify how the study may benefit the specific organisation.

8.7 Chapter Summary

This chapter satisfies the feasibility/piloting stage of developing a complex intervention (Richards & Hallberg, 2015). Following recommendations from this study and accounting for identified limitations, a larger cohort study can be conducted with reasonable confidence that it will be successful. This chapter marks the conclusion of empirical work in this thesis, however it sets up a clear line for future research to continue the development of this complex intervention for those experiencing homelessness.

Chapter 9 Discussion

9.1 General Discussion

Homelessness is a complex problem with extreme consequences for overall health (Aldridge et al., 2018). There are multiple types of homelessness, but people are generally defined as homeless by where they are or might not be found (Maguire, 2017). This means that those affected by homelessness can be a diverse group of people with varying experiences of the structural, behavioural, and/or psychological factors that resulted in their situation. Further, this group often has higher prevalence of both mental and physical illness and require a significant amount of resources to engage. Current homeless charities have begun to utilise peer interventions to help clients overcome structural and individual barriers. Peer interventions are increasingly being used to engage those who are homeless and affect client outcomes without much evidence to support this practice. Further, peer interventions are poorly defined, as IPS models can include both uni- and bi-directional support. It has been argued, throughout this thesis that research and practice need to differentiate between the two types of peer interventions in order to understand how and why peer interventions can be effective for those who are homeless. Therefore, the research aimed to understand what the processes and elements of effective IPS interventions are for those who are homeless and the feasibility of assessing outcomes on homelessness, mental health, addiction, and physical health.

Adopting a critical realist lens, the research aim was achieved through use of the MRC guidance (Richards & Hallberg, 2015). The focus of research from a critical realist perspective is causation through the identification of change mechanisms. The use of intensive/qualitative methods (as in Chapters 3, 4, and 5) enables understanding of change mechanisms, then subsequent extensive/quantitative research (such as the Q sort in Chapter 6 and a controlled cohort study following recommendations from Chapter 8's feasibility study) can test assumptions made. Given the focus on change mechanisms, the MRC complex intervention framework was the best and only comprehensive tool appropriate to furthering this programme of research and answering the research question. Through the MRC guidance, this thesis developed a body of evidence which systematically explored the processes and elements in IPS interventions (Richards & Hallberg, 2015). In this chapter, I summarise and integrate the findings of the present studies and place them within the context of literature examining PPS and its use with a homeless population. Next, I consider the wider implications of this research programme. I conclude by discussing directions for future research in this area.

9.2 Main Findings

The literature review in Chapter 3 demonstrated limited evidence of IPS with a homeless population, likely due to the poorly defined peer intervention leading to the review including different peer interventions within the same study. However, the review served as a starting point in developing an understanding of the common elements within IPS through synthesis of the textual data of the included studies. From this review, IPS was conceptualised through shared experiences, role modelling, provision of social support, and peers being able to increase attendance or client interest in the intervention. It was also asserted that strong PCRs and experience of homelessness are key for effective peer interventions with homeless populations. The review identified that peers have positive outcomes on clients' overall quality of life, specifically, the reduction of drug/alcohol use, improved mental/physical health, and increased social support. Even when the search had been updated (in June 2018), the review found a lack of literature for IPS interventions within homelessness, providing justification of this thesis and furthering development of the research programme.

Chapter 4 furthered findings, through qualitative interviews with those providing and/or receiving IPS. It was abstracted from participant reports of their experiences providing support that this participant group was describing unidirectional IPS, providing accounts of how elements identified in Chapter 3 align with asymmetrical PCRs. Therefore, shared experience came to be understood as experience-based relationships built upon mutual understanding, empathy, and trust. Further, role modelling and social support were found to be within the realm of how peers provide support, but still key to successful unidirectional IPS. Further, peers being able to increase attendance and client interest was conceptualised through how peers 'Never Give Up' and go the extra mile for their clients. Existing literature identifies 'attendance/interest' as an outcome, given that peers have been found to increase treatment adherence (Corrigan et al., 2017; Pilote et al., 1996; Tulsky et al., 2004; Tulsky et al., 2000). This shows that peers are able to cross boundaries and engage with those who are multiply excluded.

Contrary to results from Chapter 3, two participants disagreed that homelessness experience was key, citing that having someone willing to be involved and help the client was sufficient. Another novel finding related to peers defining their role as a job; many participants felt that being paid would negatively impact peer motivations. Additionally, this work examined the impact of being in a helping role for the peers, finding results similar to peer interventions in mental health, where peers undergo transformative identity developments (Mead et al., 2001). As they re-structure their autobiography through unidirectional IPS, peer-supporters begin to attribute their experience of homelessness as a catalyst for the positive changes in their lives.

Chapter 4 marked an important turning point in the thesis, it became clear that IPS is comprised of different interventions and the identification of this emerging issue needed to be further clarified. A peer who has achieved a level of stability, is able to mentor clients, and has received training is psychologically different than a peer who is at the same level of recovery as the client, leading to different processes and outcomes for clients. This prompted a realist review of the literature, in Chapter 5, to define an asymmetrical peer intervention: IUPS. Given that most peer participants in Chapter 4 were from a diverse group of UK based homeless charities currently providing unidirectional IPS interventions to their clients, I decided that it would be more useful to explore IUPS rather than mutual/IBPS. Examining IUPS not only reflects the current practice of peer interventions for those experiencing homelessness but it also indicates participants available for subsequent research. This is not to suggest that IBPS interventions are not valuable, rather that exploration of IUPS was more practical and justified given findings from Chapter 4.

Chapter 5 reported a thorough review of theoretical and empirical literature resulting in a developed model of IUPS and provides testable concepts. Specifically, it was found that IUPS is comprised of multiple components that underlie three main change mechanisms: the PCR, role modelling, and experience-based social support. These are the suggested change mechanisms that both clients and peers experience, however, peers not only experience these elements differently (i.e. from a helping perspective) but they also undergo an added change mechanism in becoming a peer through training and supervision to become self-reflective, resulting in the development of their identity.

To evaluate these concepts within a homeless context, a Q sort study was conducted, reported in Chapter 6. This study tested concepts through exploratory methods, using the general term ‘peer support’ and asking participants to identify which elements they thought were integral to effective peer interventions. This resulted in three differing viewpoints that aligned with both IUPS and IBPS. That is, two dominant perspectives from a group of peers and professionals felt that elements identified in IUPS were crucial for peer interventions, whereas a group of peers appeared to be describing elements within IBPS (i.e. prioritisation of companionship social support and devaluing role modelling).

Specifically, Chapter 6 found support for the role of experience-based PCRs as the foundation of effective IUPS interventions, whereby role modelling and the provision of experience-based social support can occur. However, contrary to previous work, most participants in this study devalued statements on peer motivations. While some participants felt that the statement referring to peers repaying for wrongdoings was important in peer interventions, it most likely reflects a limitation of the wording of the statement. This finding is elaborated on later in the critique and future research sections. Further, Chapter 6 re-examined the issue of homelessness experience being key in peer interventions finding that peers and professionals describing IUPS interventions

felt that this was a key component in establishing meaningful and effective PCRs, supporting concepts developed in the model and Chapter 3.

After assessing the conceptual model within a homeless context, the intervention was clearly defined and described within Chapter 7, serving to identify concepts and measurement tools to be used within the feasibility study, reported in Chapter 8. Specifically, psychometric tests identified from included literature in Chapters 3 and 5 were identified, Further, the use of the WAI to evaluate PCRs was adapted from therapist/client language to peer/client, with written permission from the original authors (Horvath, 2016). Since the completion of the feasibility study, this tool has been used to assess the PCR within mental health areas (see Thomas & Salzer, 2017), suggesting that there is consensus of the suitability of the tool for this use. Indeed, this thesis and work by Thomas and Salzer (2017) is a novel use of the WAI, setting up future research to further the development of this tool for evaluating the PCR within peer interventions.

The feasibility study marks another turning point within this work, as the intervention has been developed and a body of evidence now defines the intervention, the next stage within MRC guidelines stipulate that the parameters of successfully evaluating the intervention must be undertaken (Richards & Hallberg, 2015). Therefore, a feasibility study aiming to assess barriers to conducting a controlled cohort of IUPS across UK-based homeless organisations satisfies this next stage. A number of barriers were found, specifically, within recruitment, finding comparable control groups, follow-up rates, and staff turnover. A number of recommendations are made in the discussion section of Chapter 8. Specifically, the need to engage with staff, peers, and clients to ensure buy-in to the study across the organisation, ensure that suitable control organisations are found (i.e. variety of living situations), and follow specific recommendations to increase follow-up rates (e.g. increased time spent at organisations, reminders of study dates, and increased incentive amounts).

Therefore, the thesis' research question has been answered: effective IPS interventions need to be clearly defined (as IUPS or IBPS), and the processes and elements of IUPS are experienced-based PCRs that enable meaningful role modelling to occur, and experienced-based social support to be delivered for homeless populations. Further, it is feasible to assess outcomes of IUPS interventions across homeless organisations, however, future controlled cohort studies will need to account for identified barriers and follow prescribed recommendations.

These findings are similar to previous research on peer interventions in mental health, where peers develop experience-based relationships with clients and support is delivered through that relationship, as reported in Mead et al. (2001) and Faulkner and Kalathil (2012), for example. However, current findings suggest that IUPS for homeless people maintain that a shared experience of homelessness is integral to effective support (as reported in Chapter 6).

In contrast to the model of IPS within a nursing context developed by Dennis (2003), where emotional, appraisal, and informational social support are key, findings in this thesis suggest that emotional support is key in IUPS for homeless populations, but other types of social support (e.g. companionship) may be indicative of IBPS (as reported in Chapter 6). Therefore, social support is an important aspect of IPS but this work suggests that the type of social support may differ depending on the type of peer intervention being delivered.

As per suggestions by Luchenski et al. (2017) this work identified multiple outcomes for both clients and peers in IUPS. Clients can experience increased feelings of normalisation, relatedness, hope, and self esteem and peers can experience integrated identity development and increased self-esteem and confidence, for example (see Chapter 5). This work furthers our understanding of IUPS interventions and the various benefits (and challenges) that it can have.

9.2.1 Original Contributions

The work in this thesis provides an identification of emerging issues within peer interventions that are worthy of investigation, creating new understanding of a previously poorly defined peer intervention. The main contribution of knowledge that this thesis provides is the clarity on IUPS. Although, this thesis did not define a new type of peer intervention, it does provides clarity on existing concepts, arguing that IPS is composed of two different interventions that need to be acknowledged within practice and research. Bradstreet (2006) acknowledged that his definition of IPS included two different types of peer interventions and subsequent research did not adequately differentiate the two. Although L. Davidson et al. (2006) originally defined unidirectional PPS, there has not been uptake of this definition. Further, a recent meta-analysis found little evidence to evaluate in PPS and cited the lack of clearly defined models as a contributing factor to this (Lloyd-Evans et al., 2014). Therefore, the provision of the realist review in Chapter 5 is an essential piece of work. A further strength of this work is that the realist review was completed with theoretical and empirical sources from multiple contexts, resulting in a model that can transcend contexts and is useful for English-speaking researchers and practitioners across homelessness, mental health, addiction, and physical health IUPS interventions.

Additionally, Chapter 7 provides a procedural definition of IUPS within homelessness services, which was developed with the intention of specifying a framework for future research and practitioners interested in evaluating, developing, or implementing IUPS scheme. Therefore, the dissemination of this thesis work is crucial; nor researcher or practitioners will be equipped to adequately evaluate or implement peer programmes without this new and important work.

9.2.2 Critique of the Research

A main limitation within this thesis is the amount of abstraction involved. Every piece of work involved interpretation and this was limited by the development of my own thinking and

understanding. Thus, this work could be interpreted differently by another researcher. However, the use of multiple well-established guidelines, such as the MRC guidance, Centre for Reviews and Dissemination, Narrative synthesis guidance, realist methods guidance, and reporting criteria, and clarity in method strengthens this project.

Secondly, this thesis could have focused the research to identify the differences between IUPS and IBPS interventions. Bringing this clarity to the research programme would have furthered concepts and arguably would be useful to practitioners and researchers alike. However, this thesis indirectly identified the elements that are present within IBPS by identifying those that are not appropriate for IUPS models. Further, this work was developed in accordance with the research question and objectives, which did not focus on delineating the similarities or differences of IUPS and IBPS.

A third limitation of this thesis is the lack of peer involvement with the development of study procedures and materials. Although peers were recruited for input of materials in the feasibility study, both the studies reported in Chapters 4 and 6 did not recruit peers to review materials. Indeed, the involvement of peers for this purpose would have avoided issues experienced within the Q sort study in Chapter 6. Due to a lack of resources, the statements were not piloted. This led to participants potentially misinterpreting statements on peer motivations. Although the statements were developed with the research team, it would have been beneficial to pilot the statements with a sub-group of the chosen sample, and clarify the meaning of each statement to minimise confusion and ensure clarity. Peer involvement was originally planned in the protocol of Chapter 4 (Appendix C), where I planned to conduct a focus group with the participants on the findings of the study. However, due to lack of resources (i.e. time and funds to adequately compensate peers), this was not completed. However, subsequent work in this project evaluated the concepts developed in Chapter 3, minimising any potential negative implications of this. The importance of peer involvement in the development of peer programmes (Ahmed et al., 2012) should also be reflected in the evaluation of this intervention. Though it could be argued that future research can and should evaluate the findings and enhance our understanding of peer interventions.

This thesis has a number of strengths. The use of comprehensive guiding frameworks (i.e. critical realist and MRC) ensured that this work was conducted systematically, thorough in developing a coherent understanding of IUPS and enabled the intervention to be clarified and underlying concepts defined. This ensured a focus on change mechanisms and contextual factors in achieving an answer to the research question. The inclusion of clients, peers, and professionals ensured that all relevant groups were included in the research across the thesis. Specifically, Chapter 4 included both peers and clients in ascertaining their experiences of IPS, Chapter 6 involved both peers and professionals for a diverse range of viewpoints on effective peer interventions, and Chapter 8

encompassed all three participant groups in the feasibility of assessing IUPS interventions across homeless organisations.

Additionally, this work utilised multiple research methods, some of which for the first time within this topic (i.e. Chapter 6's Q sort). There was a progression of primarily intensive qualitative research methods to the use of mixed methods. Diversity in research methods allows for the topic to be examined through different means and substantiate concepts.

9.3 Practical Implications

Practitioners interested in developing an IUPS programme for homeless clients can refer to Chapter 7, where the intervention is clearly described, however, implications are summarised below. Findings suggest that peers can have a significant impact on a number of client outcomes, therefore organisations implementing IUPS programmes should tailor evaluations to focus their outcomes on the areas where peers are shown to have impact, such as reduction of drug/alcohol abuse/use, increasing mental and physical health, the strength of the PCR, and increasing social support. Additionally, organisations should examine the impact of delivering IUPS on the peer-supporters, by measuring their self-efficacy, mental wellbeing, and the strength of the PCR.

Moreover, training of peer-supporters should highlight the theoretical basis of IUPS, including self-reflection, self-determination, and how to safely self-disclose. The goal of these elements is to ensure the peer begins to understand themselves, their own biases, assumptions, motivations, and to be reflective on their work with clients. Organisations that include IUPS interventions can bolster the identity development of peer-supporters by adopting a reflective approach to supervision, that is, where peer-supporters are encouraged to explore their emotional reactions to clients and situations (Bassot, 2015). Peers also need training on homeless-specific issues, such as dealing with arrears, housing benefits, and how to utilise local social services (Lawrence, 2018). Additionally, peers should learn basics of confidentiality, mental health, addictions, managing challenging behaviour, and communicable diseases (Bowgett, 2015).

Given the mixed results on payment and valuing peer-supporters, each organisation should encourage discussion to assess any potential negative outcomes, specifically those affecting the PCR, to assess how peers may best be compensated for their work within each organisation. Regarding boundaries, organisations should provide guidance to manage specific situations, but endeavour to remain flexible. Specific recommendations on the role of boundaries is yet to be explored in the literature, thus until there are evidence-based recommendations, individual organisations should ensure that peers not only have the appropriate support to manage boundary crossings, but also an non-judgmental atmosphere to permit these discussions to take place.

9.4 Future Research

There are a number of potential lines of enquiry generated from this project. The main suggestion is for subsequent research to conduct a large-scale controlled cohort study, following on from the feasibility study recommendations in Chapter 8. However, there may be more work needed if researchers aim to include randomisation, such as a pilot study. Additionally, this project has been developing IUPS through the MRC guidance and the thesis only represents the first two phases. Subsequent research could complete the remaining phases of evaluation and implementation (Richards & Hallberg, 2015).

Regarding conceptual developments, future research could further understanding of the model developed in Chapter 5 through assessing the specific concepts. For example, the role of the PCR could be furthered in evaluations using the WAI and compare scores with identified outcomes. Similarly, the role of social learning, social comparison, social support and role modelling on client and peer outcomes could also be assessed. Future research could be conducted to assess the proposed elements that are key to peer-supporter training. Additionally, studies should be done to assess how peers maintain a strong and effective PCR, evaluating what happens when it deteriorates, building upon work by Coatsworth-Puspoky et al. (2006) and how training content, supervision, and support may help to avoid these instances.

The role of peer motivations in this work was mixed, future research could build upon this thesis and work by Moran, Mashiach-Eizenberg, et al. (2014) to explore if peers engage in IUPS to make up for past wrongdoings and/or identify other motivators. Further, work should be done to evaluate client outcomes on IUPS interventions compared to IBPS interventions. This will enable refinement of the two interventions and support or disprove findings within this thesis. Another interesting finding in this thesis relates to more experienced peers breaking boundaries in Chapter 4. More work should be done to explore if peers' experience levels have an impact on client outcomes. Additionally, work on peer experience levels could help to define a 'peer' in IUPS and subsequent recruitment procedures.

9.5 Community Based Dissemination

This work has been disseminated into current projects. For example, a participating organisation received an organisation-specific report of their peer and client results from the qualitative study in Chapter 4. This organisation used the report in the recent successful bid for continued funding of their project. Additionally, I have been working with Ashford Place, as described in Chapter 7, and have implemented the results of this work into the peer training and development of their IUPS programme. Further, this work has been shared with community partners and I have consulted with different organisations on the development and/or improvement of their peer

interventions (e.g. Lambeth in South London and Maudsley, Homeless health Team at Solent NHS in Southampton, and Second Step in Bristol, UK).

Current community dissemination with Basingstoke and Deane Borough Council has led to the development of an IUPS project and inclusion of those with lived experience into all levels of services. Continued work with partners is planned to ensure that this important work is shared and the principles are applied to current peer schemes in the UK.

9.6 Conclusion

This thesis described the work of two literature reviews and three empirical studies exploring the processes and elements of effective peer interventions for those experiencing homelessness. It was found that IPS interventions need to clearly define the direction of the PCR—as either IUPS or IBPS. It was also found that IUPS interventions are characterised by strong PCRs, role modelling, and experienced-based social support. This work suggests that the PCR is a crucial element in effective IUPS interventions and that role modelling and the provision of social support occurs through these relationships. Additionally, this thesis sought to understand the feasibility of evaluating IUPS across multiple homeless organisations, finding a number of barriers that need to be accounted for in future research. This work outlined practical implications, such as training and supervision recommendations and suggested avenues for future research in furthering the development of this complex intervention.

Appendix A Systematic Review Protocol

Background

Peer-support has a long history in the mental health arena; starting in the early 1800s and it has since flourished into our health system tremendously Peer-support stems from the recovery movement that began in the 1970's which rejected the medical model for mental illness (Mead et al., 2001). The recovery movement, also referred to as the consumer movement, values a holistic approach to mental health (Mead et al., 2001). There is emphasis on mutual empowerment, shared experiences, sense of belonging, and the ability to recover regardless of diagnosis (Mead et al., 2001). Mead and colleagues (2001) developed a definition that is consistently cited in recent literature:

> *"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. Peer-support is not based on psychiatric models and diagnostic criteria. It is about understanding another's situation empathically through the shared experience of emotional and psychological pain. When people find affiliation with others they feel are 'like' them, they feel a connection. This connection, or affiliation, is a deep, holistic understanding based on mutual experience where people are able to 'be' with each other without the constraints of traditional (expert/patient) relationships."(*Mead et al., 2001, 135).

This sharing of experiences is something that is being used all over the country, indeed it is found in the healthcare sector, mental health, criminal justice, addiction frameworks, and work with the homeless. In 2003, Wallcraft and colleagues identified 896 consumer/peer-support involved groups running in England with almost 80 percent of these groups using peers and/or mutual support (Wallcraft et al., 2003). The increased use of peer-support is reflected in the literature, specifically for mental health, health, and addictions, but lacking for homelessness.

Basset and colleagues (2012) describe three types of peer-support: informal, participation in peer-led services, and intentional peer-support (Faulkner et al., 2012). Informal peer-support is one that happens naturally, however, intentional peer-support can be ex-users who are employed in mental health settings. "[P]urposeful relationships…a process where both people (or a group of people) use the relationship to look at things from new angles", increasing awareness and finding different avenues of support as defined by the American National Coalition of Peer-support (http://www.ncmhr.org).

The lack of literature on peer-support in homelessness is concerning as there are numerous organisations utilising this in their everyday work (e.g. Streetbuddies, Groundswell etc.). Peer-support use within homelessness services will most likely only increase in the future thus

requiring understanding of the existing literature. Specifically, this review intends to systematically explore the literature to understand models of peer-support, the practice of peer-support with a homeless population, and relevant outcomes of its use.

Aims and Objectives

Due to the lack of literature on homelessness and peer-support the research aim is an exploratory one; attempting to understand what the literature reveals about peer-support and homelessness. Specifically, the review will explore theories and models that underpin peer-support and homelessness, together and as separate constructs, how peer-support is currently being used with the homeless, the landscape of practice, outcomes of practice, and if peer-support is a viable option for work with hard-to-reach populations

This will be done by attempting to answer the following objectives:

Objective 1: How is peer-support being used with the homeless?
Objective 2: What are the goals of peer-support with a homeless population?
Objective 3: How effective is peer-support with the homeless?
Objective 4: Do peer-supporters gain from the experience and who gains more?
Objective 5: What are the experiences of those who have had peer-support?

Review Methodology

Data derived from the review will be extracted into appropriate tables to highlight key features of each included article and to assess objectives. Quality will be assessed using the Critical Appraisal Skills Programme and the Mixed Methods Appraisal Tool to asses various methodologies.

As recommended by Popay and colleagues (2006) a narrative synthesis method will be utilised initially. The analysis will begin with the development of a theoretical model of change which will enable the researcher to refine the research question. Following guidance of Popay and colleagues (2006) allows for the researcher to evaluate the data and decide if there is a more appropriate synthesis method.

Study Eligibility Criteria

Studies that fulfil one or more of these targets will be considered:

1. Test the effectiveness of peer-support with an adult homeless population.
2. Display common ingredients of peer-support with a homeless population
3. Evaluate peer-support and/or peer led programmes with a homeless population.
4. Explore peer-support with a homeless population.

Studies that are not eligible will have the following characteristics:

1. Population sample under the age of 18.

2. Testing the effectiveness of peer-support with severe mental health, addictions, and/or health concerns on a non-homeless population.
3. Examining the cost effectiveness of peers in the workforce.
4. Examining housing outcomes without peer-support.

These criteria are selected because of the vast amount of research dedicated to peer-support in sectors that prioritise issues that many homeless people face but do not focus on homelessness. For example, a study found in an initial search through the Web of Science database included the keyword *homeless* where they explored the importance of family as social support but only included homelessness in one sentence displaying that it was included post hoc. Indeed, participants were excluded if they were homeless . An included study found in the initial search with keywords *homeless* and *peer-support* through the Web of Science database explores chronic disease management with a supplementary use of peer-support (Gabrielian et al., 2013). This study would be eligible as it explores how peer-support is used with a homeless population.

Types of Studies

As described in the background section, there is little information on this topic and to exclude a relevant study for its method could eliminate vital information from the review. Therefore, the review intends to include a broad range of studies, including randomised controlled trials; quasi-experimental studies including non-randomised, before and after, and interrupted time series; observational studies including cohort studies, and case studies, but anticipates a higher number of qualitative method studies. This review will include only studies published in English.

Types of Participants

The proposed review will select studies that examine homelessness and peer-support with male and female adults; aged 18 and over. These will be people who have experience with being homeless, giving support to homeless people, and/or both. Studies that include young people will be excluded; because of the range of programmes for homeless youth, potentially resulting in a review too broad for the available resources.

Types of Interventions

The interventions that will be inspected are any that relate to using intentional peer-support to reach entrenched homeless persons, as a buffer between staff and clients, and/or as a means to keep clients involved, for example. The review will also examine and document the different types of interventions that are being used with the homeless.

Appendix A

Search Strategy

The search strategy is a process that should be objective, explicit, and minimize bias (Akers, 2009). This will be ensured through an audit trail being completed by the researcher. It is very likely that a large amount of studies will be retrieved and the inclusion criteria must be sensitive enough to gather all relevant studies but specific to the research question to eliminate irrelevant studies. This process aids to reduce selection bias and will contribute to the reviews' transparency (Booth, Papaioannou, & Sutton, 2011).

The search will be systematic, in two major stages. The first stage will comprise of the researcher surveying titles and abstracts against the defined inclusion criteria to identify relevant studies to be reviewed in full. The second stage will consist of getting the full-text papers of the selected studies. The researcher will document study exclusions and reasons for exclusion at this stage. This process will also be done in collaboration with supervisors when there may be ambiguity.

The search strategy will also be piloted against a selected sample of papers to check the trustworthiness and clarity of the inclusion criteria. Thus increasing the review's transparency and replicability. The study selection will be documented using the PRISMA guidelines by Moher D, Liberati A, Tetzlaff J, Altman DG,(2009).

Databases

The review intends to use MEDLINE, CENAHL, psychINFO, and Web of Science.

Handsearches

Due to time and resource constraints, the researcher will conduct handsearches if relevant studies reference lists require it.

Grey literature

As much material on this topic has been explored by various organisations and subsequently written up, this review will include relevant material posted on related websites. For example, Groundswell has made a report available on their website that examines homelessness and ways to escape it with their peer researchers (Seal, 2011). If this review were to exclude grey literature, it would be a weak representation of what is current in this topic. Included organisational websites are Groundswell, St. Mungo's, Together UK, Mind, Homeless Link, Shelter, and all UK homeless and/or mental health charities.

Search Terms

The search terms will be piloted by using a sample of selected papers and evaluating if the search terms are appropriate (Akers, 2009).

- Homeless
- Homelessness
- Homeless persons
- Peer-support
- Peer
- Consumer participation
- Service user
- Effectiveness
- Social support

The search will utilise the AND function to combine topics of homelessness and peer-support, in their various potential terms. Once relevant studies have been found, the researcher will examine the references lists of included studies to ensure that all relevant literature has been found.

Managing references

The primary researcher is tasked with managing references and ordering inter-library loans. The researcher will utilise EndNote to aid in references management, finding duplicates, and documenting the search

Study Appraisal and Synthesis Methods

Data Extraction

Data extraction can help to minimise bias and improve validity and reliability (Akers, 2009). Data extracted will include study type, population, methods, interventions, results, and limitations (see Table 1). The sole researcher will conduct this, but seek consultation from supervisors and other relevant resources throughout. Authors will be contacted for missing data.

Table 1. General Study Information

Study number	
Authors	
Title	
Citation	
Type of publication	
Country/City	
Study type	
Population	
Methods	
Measurement tool(s)	
Type of analysis	
Interventions	
Results	

Limitations	

Table 2. Participant Information

Number of participants	
Recruitment procedure	
Inclusion criteria	
Exclusion criteria	
Mean age	
Gender percentage	
Co-morbidities	
Attrition	

Subsequent data will be extracted to gather further data specific to the research question, but also to assist in the synthesis stage of the review. As the review is conducted, these categories will remain flexible to reflect what the data describes.

Table 3. Research Objective Data Extraction

Peer-support definition	
How peer-support is used	e.g. Chronic disease management (Gabrielian et al., 2013)
Peer-supporter characteristics	
Values of peer-support	
Type of peer-support used	e.g. Intentional
Models/Theories cited	

Assessing Quality

Concepts in selected studies will be assessed for their "credibility, transferability, dependability, and confirmability" (Booth et al., 2011, p. 114). The review will utilise checklists developed by the Critical Appraisal Skills Programme for the various types of studies to ensure standardisation and quality work (Akers, 2009).

For mixed method studies, the researcher intends to use the Mixed Methods Appraisal Tool (MMAT), developed specifically for intricate reviews that examine various types of methodologies (Souto et al., 2015). The tool posits an initial two questions for every study and then follows up with four questions depending on the type of method employed. This tool has shown that it is valid and efficient, taking an average of fifteen minutes per study and is reliable (Souto et al., 2015).

Overall, the quality assessment intends to examine that the research aims and questions are clearly stated, study design is appropriate for the research question, detailed methods used, risk of bias assessed, and appropriate data is displayed to support results (Booth et al., 2011). If required, the researcher will combine quality assessment checklist questions that are deemed

appropriate for the review, under supervision, thus creating a specific quality assessment tool for this review.

Data Synthesis

Data will be analysed using narrative synthesis, which explores heterogeneity in a descriptive manner. Narrative analysis is chosen over meta-analysis as meta-analysis requires the data to be similar in its research question and methods (Booth et al., 2011). Anticipated studies will be much more diverse than a meta-analysis will allow. Popay and colleagues (2006) state that narrative analysis should be utilised initially to enable a decision to be made about subsequent data synthesis (Popay et al., 2006).

The narrative synthesis will be done through four stages; 1) developing a theoretical model for interventions, 2) preliminary synthesis, 3) examining relationships in the data, and 4) assessing the strength of the output (Booth et al., 2011). The researcher intends to organise the data through the use of data extraction in conjunction with narrative tools such as text descriptions and groupings or clusters (Popay et al., 2006). This will enable the researcher to examine the data and develop a theory of change to inform the review. The theory of change seeks to understand how, why, and for whom the intervention works; specifically, how and why peer-support works with a homeless population (Weiss, 1998). Ideally, the theory will be developed before the full analysis stage is undertaken, resulting in a refined research question (Popay et al., 2006).

The synthesis will then include the remaining stages of a narrative analysis, whilst the researcher, with supervision, evaluates if there is a more appropriate synthesis method, such as meta-ethnography (Popay et al., 2006).

Results and Conclusions

The review is intended to understand peer-support and its role with helping those who are homeless. The conclusion section will allow for results to be interpreted, identify strengths and weaknesses, place the review in the context of current knowledge, and identify any implications of the review.

Information will be disseminated through a written report. The researcher intends to write-up the report for a selected journal to be published. Potential journals include the Journal of Psychological Review and the Journal of Community and Applied Social Psychology.

Appendix B Systematic Review Search Strategy

MEDLINE was searched using the OvidSP interface on weeks of 02/10/15-02/28/15. Searched using all databases, 1946-2015.

1. Adult.mp. (10369548)
2. “Over 18”.mp. (2378724)
3. “Older adults”.mp. (153449)
4. 1 OR 2 OR 3 (12338342)
5. Homeless.mp. (29638)
6. Homelessness.mp. (18838)
7. “Homeless Persons”.mp. (8036)
8. “Rough Sleepers”.mp. (112)
9. 5 OR 6 OR 7 or 8 (37941)
10. “Peer-support”.mp. (12773)
11. Peer.mp. (312928)
12. “Service User”.mp. (5380)
13. “Consumer Participation”.mp. (15549)
14. “Social Support”.mp. (192662)
15. Recovery.mp. (1315393)
16. 10 OR 11 OR 12 OR 13 or 14 or 15 (1789132)
17. Effectiveness.mp. (1336946)
18. Efficacy.mp. (2490993)
19. Outcome.mp. (4138724)
20. Impact.mp. (2477199)
21. 17 OR 18 or 19 or 20 or 21 (8343413)
22. 4 AND 8 AND 14 AND 19 (4075)
23. Limit: English (4068)

Web of Science searched on weeks of 02/10/15-02/28/15, 1950-2015.

1. Adult (TOPIC) (9582021)
2. Over 18 (TOPIC) 665230
3. Older Adults (TOPIC) 946266
4. 1 OR 2 OR 3: 10,060,737
5. Homeless* (TOPIC) 31805
6. Homeless* (TITLE) 17012
7. “Homeless Person” (TOPIC) 9212
8. “Homeless Person” (TITLE) 443
9. Rough NEAR/3 Sleepers 36
10. 5 OR 6 OR 7 OR 8: 31,846
11. Peer (TOPIC) 319439
12. Peer (TITLE) 67664
13. Peer-support (TOPIC) 59507
14. Peer-support (TITLE) 1698
15. Peer NEAR/3 Support (TOPIC) 13691
16. Peer NEAR/3 Support (TITLE) 1336
17. Consumer (TOPIC) 549641
18. Consumer (TITLE) 107113
19. Consumer Participation (TOPIC) 23802
20. Consumer Participation (TITLE) 368

21. Consumer NEAR/3 Participation (TOPIC) 16374
22. Consumer NEAR/3 Participation (TITLE) 313
23. Service User (TOPIC) 446970
24. Service User (TITLE) 32483
25. Social Support (TOPIC) 479170
26. Social Support (TITLE) 26750
27. Recovery (TOPIC) 503928
28. Recovery (TITLE) 109657
29. 10 OR 11 OR 12 OR 13 OR 14 OR 15 OR 15 OR 16 OR 17 OR 18 OR 19 OR 20 OR 21 OR 22 OR 23 OR 24 OR 25: 1730909
30. Effective* (TOPIC) 9289191
31. Effective* (TITLE) 712045
32. Efficacy (TOPIC) 2865304
33. Efficacy (TITLE) 522048
34. Impact (TOPIC) 4733974
35. Impact (TITLE) 1119598
36. 27 OR 28 OR 29 OR 30 OR 31 OR 32: 15587885
37. 4 AND 9 AND 26 AND 33: 352
38. Limit: English (346)

CINAHL Via EBSCOHOST interface searched on weeks of 02/10/15-02/28/15, year range 1944-2015.

1. (MH "Adult") OR "Adult" (747408)
2. (MH "Young Adult") OR "Older Adult" (108525)
3. “Aged 18 and older" (119)
4. S1 OR S2 OR S3: (747, 431)
5. (MH "Homeless Persons") OR (MH "Homelessness") OR "Homeless" 6337
6. “Rough Sleepers" (22)
7. S5 OR S6: (6, 338)
8. (MH "Support, Psychosocial") OR (MH "Peer Counseling") OR "Peer-support" (45711)
9. “Peer" (22848)
10. (MH "Consumer Participation") OR "Consumer Participation" (12747
11. “Social Support" (12987
12. S8 OR S9 OR S10 OR S11: (81, 878)
13. (MH "Clinical Effectiveness") OR "Effectiveness" (66882)
14. (MH "Treatment Outcomes") (191445
15. “Efficacy" (79460)
16. “Impact" (121949)
17. S13 OR S14 OR S15 OR S16: (407, 996)
18. S 4 AND S7 AND S12 AND S17: (50)
19. Limits: English (50)

PsychINFO via EBSCOHOST interface searched on weeks of 02/10/15-02/28/15, year range 1944-2015.

1. Adults (350019)
2. Aged Adult (22221)
3. Elderly People (5042)
4. Young Adults (34774)

5. S1 OR S2 OR S3 OR S4: (354, 095)
6. MM “Homeless” (4550)
7. Rough Sleeper (10)
8. Homeless People (993)
9. Homelessness (3857)
10. S6 OR S7 OR S8 OR S9: (6420)
11. DE "Social Support" OR DE "Support Groups" OR DE "Peers" OR DE "Peer Counseling" (40142)
12. Peer-support (5014)
13. DE "Client Participation" (1451)
14. Service User (5995)
15. Consumer Participation (408)
16. S11 OR S12 OR S13 OR S13 OR S14 OR S15: (50, 642)
17. DE "Treatment Outcomes" OR DE "Treatment Effectiveness Evaluation" (42583)
18. Impact (228272)
19. Effectiveness (135068)
20. S17 OR S18 OR S19: (367, 700)
21. S5 AND S10 AND S16 AND S20: (13)
22. Limit: English (13)

Total (duplicates removed): 4028

1. **Title sift (919)**
    a. Including titles with keyword homeless and peer-support, also including titles that discuss HIV, TB, assertive community treatment, social support, housing outreach, barriers to treatment, housing, marginalised populations, frostbite, theories, RCT’s on homelessness.
2. **Abstract sift (165 total; 40 from grey)**
    a. Include
        i. How peer-support is used
        ii. Theory & Models
        iii. Effectiveness
        iv. Peer-supporters
    b. Exclude
        i. Under 18
        ii. W/O Peers
        iii. Not Homelessness
        iv. Other—Irrelevant topic, etc
    c. Ambiguous
3. **Full article (9; 2 from grey)**
    a. Organise into type of study: empirical (Qual/Quant/Mixed), Reviews (Meta/Systematic), and non-empirical (articles/thought/opinion/no participants)
    b. Review empirical first
    c. Reference list search to ensure comprehensiveness
    d. Include if intentional peer-support with </=30% homeless sample

Grey Literature Search

1. **Relevant websites:**
    a. Google search *“homelessness” England filetype:PDF* (285,000 results)
    b. Add *“Peer-support”* (81,100 results)
    c. Search using "homelessness" England filetype:pdf "Peer-support" with Google Scholar (1400 results)

2. **Title sift**
    - 90 found
3. **Introduction/abstract sift**
    - 40 included
    - Organise into type of study: empirical (Qual/Quant/Mixed), Reviews (Meta/Systematic), and non-empirical (articles/thought/opinion)
4. **Examine relevant websites:**
    - **Search: "agency name UK Homeless Peer-support" into google. Title/abstract sift relevant reports.**
    - E.g. "Groundswell uk "homeless" "peer-support" filetype:PDF"
        - Once a document was found (e.g. "The Escape Plan" (Seal, 2011)), the reference list and citing articles/reports were checked to search further.
    - **Pathways, Shelter, Crisis, Groundswell, together, homeless link, Mind, Centrepoint, Foyers, Salvation Army, The Big Issue, and YMCA**
5. **Conference materials/reports**
    - "PeerFest" November 21, 2014
    - "No Return to the Streets" December 11, 2014
    - "Homelessness, Social Exclusion, and Health Inequalities" March 4-5, 2015
    - Materials were picked up from each event and assessed for their inclusion.
6. **Full paper (2)**
    a. Reference list search to ensure comprehensiveness

Appendix C Qualitative Study Protocol

Peer-support has a long history in the mental health arena; starting in the early 1800s and it has since flourished into our health system tremendously (Faulkner et al., 2012). Peer-support stems from the recovery movement that began in the 1970's which rejected the medical model for mental illness (Mead et al., 2001). The recovery movement, also referred to as the consumer movement, values a holistic approach to mental health (Mead et al., 2001). There is emphasis on mutual empowerment, shared experiences, sense of belonging, and the ability to recover regardless of diagnosis (Mead et al., 2001). Mead and colleagues (2001) developed a definition that is consistently cited in recent literature:

*"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. Peer-support is…understanding another's situation empathically through the shared experience of emotional and psychological pain."(*Mead et al., 2001, 135).

This sharing of experiences is something that is being used all over the country, indeed it is found in the healthcare sector, mental health, criminal justice, addiction frameworks, and work with the homeless. In 2003, Wallcraft and colleagues identified 896 consumer/peer-support involved groups running in England with almost 80 percent of these groups using peers and/or mutual support (Wallcraft et al., 2003). The increased use of peer-support is reflected in the literature, specifically for mental health, health, and addictions, but lacking for homelessness.

The lack of literature on peer-support in homelessness is concerning as there are numerous organisations utilising this in their everyday work (e.g. Streetbuddies, Groundswell etc.). Peer-support use within homelessness services will most likely only increase in the future thus requiring an evidence base. Specifically, the proposed study intends to explore the role of peer-support with the homeless and what makes it helpful.

Aims & Objectives

The proposed study intends to contribute to the scarce evidence base on peer-support with the homeless by conducting qualitative interviews with current or ex-homeless individuals who have received and/or provided peer-support. The research aim is an exploratory one; attempting to understand the various aspects of how peer-support works and what participants felt were critical factors to its aid. Currently, a systematic review is being conducted on the relevant literature and this study will help to further understand evidence found. Another aim of the proposed research is to establish a group of individuals who will consult with the researcher over the course of the main research project. Increasingly, public involvement is encouraged in research and this study intends to keep consumers involved in the whole research process and keep values of peer-support (INVOLVE, 2012; Mead, 2001).

Appendix C

Methods

Participants

Participants will be aged 18 and above, have had experience with peer-support (either as a consumer or provider), and have experience with homelessness. The study aims to interview 30-35 participants to ensure data is robust. Participants will be identified through local and national charities and homeless shelters/hostels, where there will be an advert posted about the interviews/meeting(s). Potential participants will be given the researchers contact information through the advert resulting in emails or phone calls where their eligibility will be assessed. Once eligible participants are identified and show interest, the researcher will provide the participant information sheet, which outlines the research, possible risks, benefits, confidentiality, and contact information for support services. The researcher will read out the participant information sheet and then participants will be asked for their written consent regarding their participation, audio recording the interview, and consent to be contacted after the interview for a focus group. They will be informed of their right to discontinue at any time. Once verbal and written consent is acknowledged, the interview will commence.

Due to travel costs, some participants might be interviewed over the phone or by Skype. The procedure will be the same for individual interviews, but the researcher will ensure that the participant has a professional contact with them during the interview. This will be ensured through the initial contact—participants will be recruited through organisations and charities and phone/Skype interviews conducted only when the professional contact agrees to be nearby the participant. Consent for phone/skype interviews will be acquired by sending the participant the consent form with a pre-paid postage return envelope form the University. Phone/Skype interviews will not commence until this document is returned to the researcher and consent will be discussed over the phone/Skype to ensure understanding. Lastly, verbal consent will be acquired.

The study does not intend to use formal interview measurements, interview questions will ask about participant's experience of giving/receiving peer-support, what they believe is critical to its success, and how it can be implemented. Currently, the researcher has developed preliminary questions and prompts that explore peer-support and its use with the homeless population.Once the interview has been completed participants will be given a £10 voucher and a debriefing form which will be reviewed with the researcher. The debriefing form restates the purpose/aims of the research, confidentiality, support service information, and contact information—of both the primary researcher and the ethics Chair.

Once majority (about 5-7) of the interviews are completed, the researcher will begin organising a focus group. The focus group's purpose is to review the interview process and to get the group's

opinion and feedback of the research experience. The focus group will comprise of the same participants who were interviewed.

Again, participants will sign a consent form and receive an information sheet detailing the purpose of the focus group. Participants will be asked about their experience being interviewed, questions they would have liked to see, how they processed the interview afterwards, and other general comments on the interview process. The researcher also intends to ask about themes generated from the initial data analysis. The group will focus on participant's beliefs, views on how research is delivered, and input from the public on how peers are incorporated into work with the homeless. The focus group will end with the researcher providing another debriefing form.

Data Analysis/Results

Data will be analysed using a thematic approach, following steps outlined by Braun and Clarke (2006). The analysis will begin with transcription and inductively develop themes and relevant codes. The data will be arranged into a thematic map and disseminated into a report. The results of the study will inform subsequent research on this topic within the researcher's PhD thesis.

Discussion

The overall findings will be reported into a discussion section and the report written up into a chapter of a thesis and for publication. As this area is heavily lacking in research, it is vital that information collected be appropriately disseminated to relevant audiences. Also, the focus group will be documented and incorporated into the PhD thesis. The results of the consultations will be used to inform future research performed by the researcher—to ensure that procedures and methods are appropriate and that they have an opportunity to express areas or specific questions to be explored.

Appendix D Qualitative Study Interview Topic Guide

These are general questions and probes used:

- What is a peer to you?
    - What is peer-support to you?
- Have you had help from a peer in your experience of homelessness?
    - What was it like for you?
- How could peer-support help?
- What about peers is different than professionals?
- Do you think peers being more involved would help?
    - As a buffer between staff and clients?
    - As outreach workers?
    - Replacing professionals?
- What do you think it is like for the peer-supporters?
    - Do they gain from it?
    - Should we understand this more?
- What has not worked for you in your experience of homelessness?
    - What would have helped instead?
- What is important to you about peers and homelessness?
- How should researchers approach this subject?
- How can researchers be more sensitive?
- If you were to participate in another study, how much time could you give?
    - What would be adequate compensation?
    - What is the best way to communicate?
    - Do you have recommendations for me about how to continue in the research?
- Is there anything else you would like me to know about your experience of being homeless and/or helping those who are homeless?

Appendix E Qualitative Study Ethics Documentation

E.1 Participant Information Sheets

Researcher: Stephanie Barker **Ethics number**: 13315 **Date:** 16/06/15 (2)

Please read this information carefully before deciding to take part in this research. If you are happy to participate you will be asked to sign a consent form.

What is the research about?

I am a student at the University of Southampton and these interviews hope to get your opinion about peer-support and homelessness. I hope to find out what you think about peers and how someone who used to be homeless can help those who are currently homeless. We want you to be involved to help us understand how we can explore this topic with the people like you. Homelessness is an issue that many people face and can be very difficult.

Why have I been asked to come?

You are invited to take part in this because of your experience of being homeless and/or helping others who are homeless.

What will happen to me if I take part?

The meeting, held at the University of Southampton, should be no longer than 1 and a half hours and we will start with introductions, signing consent forms, and what we are doing. I will also take this time to explain that I will be audio recording the meeting. Once we are ready, I will ask you different questions related to peers and homelessness. You are asked to share only what you are comfortable with sharing. You are asked to come to one meeting, but are welcome to attend a follow-up focus group, and you will get an information sheet after the meeting is complete.

Are there any benefits in my taking part?

You may not benefit directly, but will be contributing to research that aims to help those who are homeless and adding to current knowledge. Your travel expenses, up to £20, will be reimbursed, with proof of travel claim.

Are there any risks involved?

There is the risk of emotional stress, depending on what is talked about in the meeting. Some questions may bring up a topic or story that triggers you emotionally and I will be active in making sure that you are comfortable. If you do feel troubled and would like to talk to someone not related to the study you can call these helplines:

Samaritans: 08457 90 90 90

Shelter's helpline: 0808 800 4444 freephone

Will my participation be confidential?

Any information gathered from the meeting will be stored under compliance with the Data Protection Act (1998) and the data policy of the University of Southampton; all data will be kept on a password protected computer. Confidentiality and privacy will be respected. All data will be anonymised and identifying information will be changed to protect your identity.

What happens if I change my mind?

You do not have to stay, you are volunteering your time and have the right to leave without consequence, at any time.

What happens if something goes wrong?

If there are problems or you have concern and/or complaints, you can contact Research Governance Manager (02380 595058, rgoinfo@soton.ac.uk).

Where can I get more information?

You are welcome to contact me for more details or if you have any questions about this meeting at 02380 594719 or S.L.Barker@soton.ac.uk

E.2 Consent Forms

CONSENT FORM (Version 2, 16/06/2015)

Study title: Peer-support and Homelessness

Researcher name: Stephanie Barker

ERGO Study ID number: 13315

*Please **initial** the box(es) if you agree with the statement(s):*

I have read and understood the information sheet (27/05/15/version 2) and have had the opportunity to ask questions about the study	☐
I agree to take part in this research project and agree for my data to be used for the purpose of this study	☐
I understand and agree that the session will be audio recorded.	☐
I understand my participation is voluntary and I may withdraw at any time without my legal rights being affected	☐
I agree to be contacted after the interview to participate in a focus group to discuss the research	☐

Name of participant (print name)……

Signature of participant……..

Date……

E.3 Debriefing Statement

(Version 2, 16/06/15)

The aim of this research was to find out your opinions on peer-support and homelessness. It is expected that peer-support will be viewed positively and this will help to direct future research. Your data will help our understanding of how to continue on in this area of research. Once again results of this study will not include your name or any other identifying characteristics. The experiment/research did not use deception. You may have a copy of this summary if you wish and you may have a copy of the research project once it is completed.

If you have any further questions please contact me, Stephanie, at 02380594719 or S.L.Barker@soton.ac.uk

Thank you for your participation in this research.

Signature  Date 27/05/15

If you have questions about your rights as a participant in this research, or if you feel that you have been placed at risk, you may contact the Chair of the Ethics Committee, Psychology, University of Southampton, Southampton, SO17 1BJ. Phone: +44 (0)23 8059 3856, email fshs-rso@soton.ac.uk

Resources:

Steps 2 Wellbeing Free counselling

Call 0800 612 7000 (self referral) or 02380 272000

Office hours: 8:30-17:30

Monday - Friday

sstw@dhuft.nhs.uk

Southampton office is located at:

Third Floor, Grenville House

Nelson Gate

Southampton

SO15 1GX

Helplines:

- **Samaritans**: 08457 90 90 90 jo@samaritans.org
- **Alcoholics Anonymous**: 0845 769 7555
- **Shelter's helpline**: 0808 800 4444 freephone

Telephone advice and information for people with a housing problem or who are homeless. Issues dealt with include housing rights, harassment, illegal eviction, rent and mortgage arrears, disrepair, housing benefit, domestic violence, hostel placements and finding accommodation. Helpline open 8am-8pm Monday-Friday and 8am-5pm at weekends.

Appendix F Realist Review Search Terms

PubMED 1946-2016

Adolescent OR Adult OR Aged OR Aged, 80 and over OR human OR young adult OR male OR female OR vulnerable populations

= 18,406,069

homeless OR homelessness

= 9,855

peer support OR peer specialist OR peer-led OR peer-provided services OR group intervention OR support intervention OR peers OR consumer-providers OR peer-assisted case management OR consumer survivor OR ex-patient movement OR peer support guidelines OR practice guidelines development OR consumer-delivered services OR peer intervention OR peer providers OR peer group OR counselors OR counsellors OR Alcoholics Anonymous OR AA OR sponsorship OR sponsor OR sponsee OR mentorship OR advocate OR sponsor characteristics OR sobriety OR drug abuse prevention OR rehabilitation OR trimorbidity OR social support OR community tenure OR supportive behaviors OR recovery orientation OR face-to-face support OR community treatment programs OR support OR self help groups OR citizenship OR self-disclosure OR lived experiences OR personal histories OR helper therapy OR experiential knowledge

= 9,136,097

change mechanisms OR critical ingredients OR process OR components OR Theory OR theoretical OR model OR framework OR conceptualisation

= 32,51,919

AND = 979

PsychINFO 1632-2016

1 = 1,596,400

2 = 9,118

3 = 788,685

4 = 1,753,585

AND = 778

LIMIT: English = 770

Appendix F

PsychARTICLES 1894-2016

1 = 99,858

2 = 39,977

3 = 440

4 = 77,823

AND = 30

MedLine 1977-2016

1 = 12,469,510

2 = 9,827

3 = 1,582,909

4 = 3,229,695

AND = 499

LIMIT: English

= 479

CINAHL 1937-2016

1 = 2,281,970

2 = 7,391

3 = 1,351

4 = 574,973

AND = 2

Web of Science 1950-2016

1 = 54,960,137

2 = 35,333

3 = 13,602,618

4 = 51,803,638

AND = 1,502

LIMITS: English = 1,434

DATABASE SEARCH AND SIFT

TOTAL = 3,772

With duplicates removed = 2,531 (eliminated 1,241 from the original 3,772 found)

Title Sift = 251 (exclude 2280)

Title sift—keeping any that need further exploration i.e. if there is ambiguity regarding its relevance, also some inclusion criteria may be developing around the research question—does this article have an aspect that might explain peer-support? E.g. the peer relationship, mentoring, theories, etc.

Keeping titles that may help to answer how and why peer support works, models, and assessing it as an intervention.

Abstract sift = 107 (Excluded 144—not related or did not inform how and why peers are effective)

Full text = 18 (80 excluded)

KNOWN SET SIFT

Total of 51 reports in the 'known set':

- 29 intervention studies on peer-support and homelessness/mental health/addiction/health
- 6 literature reviews on peer-support and mental illness
- 16 perspectives on peer-support and homelessness/mental health/addiction/health

Appendix G Realist Review Data Extraction Table

Extraction Table of Commentaries/Reports/Training/Grey Literature

Author	Context	Identified Mechanisms	Outcomes	Demi-Regularities	Theory cited	Values prioritised	How/Why of IUPS	Training	Population
Freddolino, P. P., & Moxley, D. P. (1992)	Outreach	Self-determination-leads to empowerment	Client satisfaction	Engagement-building trust enhances the relationship and improves outcomes	Based on Client Support and Representation Model (CSR)	Client-driven, empowerment, self-determination	Self-determination	Policies, Advocacy interventions: mediation, negotiation	Homeless & mentally ill
Cadell, S., Karabanow, J., & Sanchez, M. (2001)	Community	sense of belonging, shared experiences, common history	Empowerment and resilience	Community belonging leads to empowerment and resilience	Community->Empowerment->Resilience->Community	Shared experiences, wellness, empowerment, and resilience	Relational communities increase empowerment and resilience	NA	NA
Sumerlin, J. R. (1996)	Counselling	Empathy	Identity transformation	Recognising strengths and building upon those can improve outcomes	NA	Positive psychology, Existentialism, Humanistic perspectives	NA	NA	Homeless clients

Author	Context	Identified Mechanisms	Outcomes	Demi-Regularities	Theory cited	Values prioritised	How/Why of IUPS	Training	Population
National Lived Experience Advisory Council. (2016)	Homeless organisation	Value lived experience, Inclusion, value time, equality, , Work together, and authentic relationships	Ending homelessness	NA	NA	Lived experience, time, expertise, authentic relationships	Authentic relationships, being equal	Advocate training	Homeless
Ahmed, et al., (2012)	Peer-led interventions	Shared Experience, working alliance, mentorship, equality, self-determination, respect, empathy, self-disclosure and shared responsibility	Behaviour-based coping and problem solving skills	Advocating, training, and the relationship leads to positive outcomes	NA	Client-driven, self-determination, respect	Through the relationship and training, peers build trust, empathy, provide support, and acceptance	Advocacy &support skills	Those with Schizophrenia
Adame, A. L., & Leitner, L. M. (2008)	Mental Health	Relationships, shared sense of community, equality, social support, experiential knowledge,	Clients/peers develop new sense of self, meaning, and purpose	Peers reduce isolation, increase community and social networks	NA	peer-driven, empowerment, individual definitions of recovery	shared experience, built upon a strong therapeutic relationship	None	Mentally ill

Author	Context	Identified Mechanisms	Outcomes	Demi-Regularities	Theory cited	Values prioritised	How/Why of IUPS	Training	Population
Borkman, T. (1976)	Self-help groups	Experiential expertise (when one uses their experience to solve problems), here and now action, self-determination,	NA	Role models, holistic, increase trust	Experiential knowledge	Lived Experience	Lived experience as a mechanism to used as expertise and help others	NA	Self-help groups
Bradstreet, S. (2006)	Mental Health	Empathy, engagement, wellness, relationship	Enhanced recovery as defined by the client	That peers and clients benefit from PS	Individualised definitions of recovery	Defining recovery, mutuality, relationship, respect	Use lived experience to promote recovery	Should be--uses examples from USA	Mentally ill
Campbell, J. (2008)	Accessible, safe, informal setting for mental illness clients	Shared experiences, voluntary, recovery (personally defined),	Psychological wellbeing, empowerment, hope, recovery	Mentoring helps oneself,	NA	Mutual sharing, respect, responsibility, non-judgmental, welcoming, and safe	Mutual support, community-building, advocacy, tell ones story, mentoring, self-management, problem solving	Crisis prevention	Mentally ill

Author	Context	Identified Mechanisms	Outcomes	Demi-Regularities	Theory cited	Values prioritised	How/Why of IUPS	Training	Population
Crawford, S., & Bath, N. (2013)	Community and service controlled models of PS	Self-transformation, modelling, advocacy, relationships between clients/peers, peers as agents of change--to service and client outcomes	Reduction in drug use	Peers change services and the client outcomes, but also may feel isolated if no integral to the service	NA	Inclusion, safety	Peers model recovery and work in services to help inspire changes in clients	Safety, in drug and diseases	Health promotion
Mead, S., Hilton, D., & Curtis, L. (2001)	Mental Health	Shared experiences, relationships, advocacy, self-defined recovery, and flexible boundaries		Develop new sense of self through re-telling story--new ways to interpret past	NA	equality, mutual respect, responsibility,	Through shared experience, building unique relationships, and mutual benefit	Supervision, self-reflection	NA

Author	Context	Identified Mechanisms	Outcomes	Demi-Regularities	Theory cited	Values prioritised	How/Why of IUPS	Training	Population
Solomon, P. (2004)	Mental Health	Experiential expertise, mutual benefit, social support, role-modelling, empowerment	empowerment, drug/alcohol use, symptoms, QOL, self-esteem, social support	Peers develop mutually beneficial relationships that foster personal definitions of recovery	Social learning, social comparison, helper therapy, experiential expertise, and social support	Voluntary nature, peer-driven	Providing multiple types of social support to bring about change in personal or social wellbeing	stable, in recovery, not using, has experience	NA
Dennis, C.-L. (2003)	Nursing and Health	Emotional, Informational, and appraisal support: caring, encouragement, active listening, reassurance, advice, feedback, optimism	Feeling cared for, respected, empathised, valued, problem solving	Peers can have influence through 3 effect models: direct, buffering, and indirect.	Self-efficacy, social comparison, cognitive re-structuring	Empathy, shared experience, differing from informal peers and paraprofessional	PS works through three potential models	Informational, listening, advocacy	NA

Author	Context	Identified Mechanisms	Outcomes	Demi-Regularities	Theory cited	Values prioritised	How/Why of IUPS	Training	Population
Salzer, M. S. (2002)	Mental Health	Shared experiences	Symptom reduction, better coping	Sharing experiences enables empowerment and increased coping	Social learning, social comparison, helper therapy, experiential expertise, and social support	Peer-driven, empowerment	PS works through the shared experience and communicating that experience to novice members	Supervision, confidentiality, training in issues, provision of support, listening skills, organisational issues, how to provide emotional, informational, and appraisal support	NA
Faulkner, A., & Basset, T. (2012)	Mental Health	Shared experiences, identity development--telling our stories, empathy, advice, problem solving,	Reduced isolation, validation, empowerment, increased wellbeing,	Payment will change the nature of PS, Peer/client relationship drives need for boundaries, training, supervision, support.	Experiential knowledge	Independence, equality (that might not be possible in peer/client relationships),	Shared experience and maintenance of values can keep PS effective	In 1:1 peer/client relationships--yes	NA

Author	Context	Identified Mechanisms	Outcomes	Demi-Regularities	Theory cited	Values prioritised	How/Why of IUPS	Training	Population
Creamer, M. C., Varker, T., Bisson, J., Darte, K., Greenberg, N., Lau, W., . . . Forbes, D. (2012)	High risk organisations: where personnel are exposed to trauma (A&E, military etc.)	Shared experience, empathy, bridge to professionals	client feedback	NA	NA	Respect confidentiality, No consensus on peers being paid	NA	Basic skills--psyc first aid, information about other services. Supervision needed	NA
Faulkner, et al., (2015)	Mental Health and social care	NA	Self-esteem, satisfaction, QOL,	NA	NA	Effective and meaningful involvement of peer through: respecting principles, presence, process, and purpose	NA	Administrative, supervision, emotional support, training for professionals too	NA

Author	Context	Identified Mechanisms	Outcomes	Demi-Regularities	Theory cited	Values prioritised	How/Why of IUPS	Training	Population
Bowgett, K. (2015)	Homelessness organisations	Tangible and informational support	Increased access to healthcare	NA	NA	Equality, diversity, knowledge, stress management	NA	Advocacy, empowerment, safeguarding, risk, boundaries, role, evaluation, confidentiality, diversity, equality, challenging behaviour, stress, drug & alcohol, first aid, MI, basic mental health,	NA

Author	Context	Identified Mechanisms	Outcomes	Demi-Regularities	Theory cited	Values prioritised	How/Why of IUPS	Training	Population
Reissman, F. (1965)	Teaching others; examples are from schools	Peer is placed into a role where they are the 'upper class'--more is expected of them, and they demand more from themselves, leadership roles, improved self-image, self persuasion through persuading others, Cognitive beliefs	Enhanced learning of material/topic	Peers benefit a considerable amount, perhaps even more so than clients in the peer/client relationship	Helper therapy principle	Should not be involved in intensive treatment, unless considerable experience and awareness of the issue is attained	The benefits for the helper/peer are great and bolster PS as means to help both client and peer	Supervision is key	NA

Author	Context	Identified Mechanisms	Outcomes	Demi-Regularities	Theory cited	Values prioritised	How/Why of IUPS	Training	Population
Simoni, J. M., Franks, J. C., Lehavot, K., & Yard, S. S. (2011)	Health services	SS model, altered threat appraisal, lower physiological activity, less harmful behaviour, preventative behaviour, and increased coping. Self-efficacy model: mastery experiences, vicarious learning, social persuasion. Advocacy model: empowerment	Improved health outcomes	Peers can help increase self-efficacy through social persuasion and vicarious learning	Experiential knowledge, self-efficacy, social comparison	Theoretical foundation for PS programmes	NA	Selected for their social skills, trained to enhance effectiveness	NA
Bandura, A., & McClelland, D. C. (1977)	Social Sciences	Attention, retention, reproduction, motivation, self-efficacy through modelling (if	Self-efficacy, changed behaviour	People learn by observing behaviour and can replicate behaviour through the acquisition of	Social learning theory	Observational learning, self-efficacy	NA	NA	NA

Author	Context	Identified Mechanisms	Outcomes	Demi-Regularities	Theory cited	Values prioritised	How/Why of IUPS	Training	Population
		they can do it, so can I)		the belief that they can influence their own lives					

Author	Context	Identified Mechanisms	Outcomes	Demi-Regularities	Theory cited	Values prioritised	How/Why of IUPS	Training	Population
Festinger, L. (1954)	Social Sciences	Self-evaluations based on social comparisons	Level of self-esteem	People use others as a source of comparison to evaluate their own self. People will also have larger changes in evaluations of themselves if the similar model is slightly different, but not too different. Upward comparisons for those with low self-esteem usually results in negative self-evaluations, this may be mediated through the group status.	Social comparison theory	NA	NA	NA	NA

Extraction Table of Literature Reviews

Author	Context	Identified Mechani-sms	Outcomes	Demi-Regularities	Theory cited	Values prioritised	How/Why of IUPS	Training	Population-on	Intervent-ion method	Methods	Results	Limitation
Repper, J., & Carter, T. (2011)	Mental Health	Mutuality, cognitive restructu-re, normalise, relations-hips, role modelling, identity develop-ment, acceptan-ce, empathy, attitude change, hope	Empower-ment, hospitalis-ations, coping skills, communi-ty integrati-on, social support, social function-ing, and social skills, problem solving	Peers benefit more than clients--through their own personal growth. Boundari-es should be flexible, role confusion	Experient-ial knowledge	Staff valuing their contribu-tion, safety, taking care of themselv-es	Progressi-on for all involved--peers benefit and can move into employ-ment. Built upon the shared experien-ces.	Safety, knowledge of issues being treated, role clarificat-ion,	NA	NA	NA	NA	NA

Lloyd-Evans, et al., (2014)	Mental Health	none	Hospitali-sations, employ-ment, symptoms QOL, recovery, hope, empow-erment, satisfact-ion	There is little/no evidence for PS with severe MI	NA	NA	No evidence to suggest it isn't effective but also no evidence to suggest that it is.	NA	Severe mental illness	Commun-ity/intent-ional PS	NA	Little to no evidence of PS with severe MI	Strict--small number of studies, RCT's only

Extraction Table of Empirical Studies (in addition to those included in the systematic review in Chapter 3)

Author	Context	Identified Mechani-sms	Outcomes	Demi-Regulariti-es	Study Type	Theory cited	Values prioritised	How/Why of IUPS	Training	Population-on	Intervent-ion method	Methods	Results	Limitation
Whelan, et al., (2009)	AA sponsors, AA, addiction	Regular contact, sober, mentorsh-ip, social support	SAD-Q (severity of alcohol depende-nce)	NA	Cross sectional	AA context	AA values	Through sharing experie-nce, strength, and hope.	None	AA sponsors	AA, 28 sponsors	Sponsors-hip	16 roles of Sponsors, top 3 are guidance through 12-Steps, Sharing experien-ce, and advice giving.	Non-random, Measure used retrospe-ctively and might not be an accurate picture of alcoholism

Author	Context	Identified Mechani-sms	Outcomes	Demi-Regulariti-es	Study Type	Theory cited	Values prioritised	How/Why of IUPS	Training	Population -on	Intervent-ion method	Methods	Results	Limitation
Tulsky, et al., (2000)	TB TX for Homeless	Qualities of peers: reliable, shared experien-ce, caring, responsib-le, and able to retain info about TX	Improved adherence to TB TX	NA	RCT	NA	NA	Peer arm was not as successful as monetary arm, but did help to increase initial adherence	Hired on basis of certain qualities	Homeless TB	3 TX arms: Monetary incentive, PS, and TAU	Over 6 months, assessed the impact of each TX arm on adherence	Monetary arm was most successful, but PS arm lacked training and supervi-sion which may have helped	Had to change protocol to add $5 incentive as it was so successful.

Author	Context	Identified Mechani-sms	Outcomes	Demi-Regulariti-es	Study Type	Theory cited	Values prioritised	How/Why of IUPS	Training	Population-on	Intervent-ion method	Methods	Results	Limitation
Rowe, et al., (2007)	PS and Severe MI/DOA	Peers set goals & priorities, story-telling/self disclosure, informat-ional support, advocates, in conjunct-ion with TX	Increased civic participa-tion, social networks. Reduced ASI score, and criminal charges	NA	RCT	Citizenship framew-ork: citizenship as a measure of the strength of people's connect-ion to the rights, responsib-ilities, roles, and resources available through public and social institution	NA	Peers developed their own, unique role, sitting between case-managers and friends; providing role modelling, support, and self-disclosure	Confide-ntiality, client engage-ment, cultural compet-ence, roles of mental health and criminal justice system personnel.	Mental health and addicted	114 participa-nts: 41 in control (TAU). 73 in PS (TAU+PS)	Intervie-wing, reviewing public records	both groups reduced alcohol use and criminality peers had more impact in increasing commun-ity integrat-ion	peers were not isolated, participa-nts from same pool, small sample

Author	Context	Identified Mechani-sms	Outcomes	Demi-Regulariti-es	Study Type	Theory cited	Values prioritised	How/Why of IUPS	Training	Population-on	Intervent-ion method	Methods	Results	Limitation
Pilote, L., et al., (1996)	PS and TB TX for homeless	Establish contact, informat-ional support	increased TX adherence	NA	RCT	NA	NA	Peers are useful at enabling initial TX adherence	None	Homeless TB	3 TX arms for 244 participants: 82 in $5, 83 in PS, and 79 in TAU	Randomised participants to 3 TX arms to assess initial TX adherence	Monetary incentive was best, PS was also successful.	Participa-nts demons-trated interest in TX
Chinman, et al., (2014)	PS for Chronic illness for Homeless vets	Company-ionship and informat-ional support	reduced isolation	NA	Mixed methods: Surveys and interviews	Nolan's 4 step model to improve models	NA	Peers can help to bridge a digital divide between clients and computer software designed to help monitor health	NA	Homeless vets with chronic illnesses	optional PS for help with an at-home device to monitor health	optional PS: 10 (out of 14)	Participa-nts felt that PS did help, but was more successful in reducing isolation and helped to provide company-ionship support	Privacy laws limited participant pool to see how much impact peers could have on hard-to-reach, small sample

Author	Context	Identified Mechani-sms	Outcomes	Demi-Regulariti-es	Study Type	Theory cited	Values prioritised	How/Why of IUPS	Training	Population -on	Intervent-ion method	Methods	Results	Limitation
Fogarty, et al., (2001)	PS for HIV + and at-risk homeless women	Emotional and informati-onal support	increased self-efficacy	Possible that participant in shelters became dependent on peers and when support was gone, they regressed. Implies need for continued support	RCT for HIV+ study and Non-random for at-risk study	Transthe-oretical model	NA	used previous research to justify peers	On condom use with main male partner, condom use partner, contrace-ptive use. Rapport-building, stage of change—targeted	HIV+ and at-risk homeless women	Two studies: HIV+: TAU vs TX + PS, At-Risk: TAU vs TX +PS: Peers ran group sessions on informatio n and support; role play, discuss issues	Over 6 months, assessed the impact of PS+TX for two groups. Seeking to find out if PS has an impact.	PS was more effective in the HIV+ group than the at-risk--long term condom use, reduced relapse into risky behaviour than TAU	Participan-ts male partners changed over the study duration, thus changing variables. Attrition. Small sample in some groups
Deering, K. et al., (2009)	PS and HIV TX for homeless female sex-workers	Compan-ionship support and peer-client relations-hip	increased/ maintain-ned program-me adherence	PS intervene-tions are to harness positive aspects of social relation-ships to increase	Cross sectional	Social support and monetary incentive can help increase adherence	NA	Chose PS because of past research but also because social support can have a positive	On becoming a health advocate	HIV TX for homeless women	Group sessions aspects related to health and HIV, including safe disclosure. Managing	Assess-ment of a program-me over 12 weeks through various surveys and health records	Peers were successful in maintain-ing and increasing TX adherence	Not sure if it was peers or the financial incentive that impacted TX adherence

Author	Context	Identified Mechani-sms	Outcomes	Demi-Regulariti-es	Study Type	Theory cited	Values prioritised	How/Why of IUPS	Training	Population -on	Intervent-ion method	Methods	Results	Limitation
				healthy behaviour				impact on health			side effects, depression nutrition, and positive living. Peers helped to set goals		(viral load tests)	small sample size, no compariso n group
Blondell, et al., (2001)	PS and Alcoholism , AA, in Trauma centre	Emotional, company-onship, and informat-ional support	reduced alcohol use/abst-inence, and TX initiation for alcohol use	Peers can help to change the direction of someone's path after trauma	Longitud-inal	Bottoming out hypothesis	NA	The more similar the experien-ces, the more likely change will happen	AA	Alcoholics who have suffered a trauma	AA with a patient following a brief meeting with dr VS TAU VS brief meeting with doctor	phone-call follow up at 6 months	More success from PS+TX, then Brief TX, then TAU. Abstinent, TX in follow up	Specific setting, not generali-zable.

Author	Context	Identified Mechani-sms	Outcomes	Demi-Regulariti-es	Study Type	Theory cited	Values prioritised	How/Why of IUPS	Training	Population -on	Intervent-ion method	Methods	Results	Limitation
Eisen, et al.,(2015)	Peer specialists vs peer vocational rehab-- Two types of PS for veteran populati-ons compared	Compan-ionship, informat-ional, support, role modelling, self-disclosure	work related QOL, mental health, self-efficacy, helping related QOL	Helper therapy-- that peers benefit, this study shows that it is not necessary-ily the self-disclosure aspect of PS that is *most* beneficial	Cross sectional	Helper therapy	Principles of PS: social support, and self disclosure	Self-disclosure is important and can help peers to have higher QOL, but is not necessary-ily the most beneficial aspect	PS: social skills, role modelling, informa-tional support, sharing personal recovery stories. VR: Employm-ent skills, training, search strategies, NO personal sharing	Homeless veterans	Compared two types of PS: PS vs VR, where PS share their personal recovery story and VR's do not. Assessing if the two groups differ on work-related and helper QOL, mental health, and self-efficacy	Online surveys: WLQ, JSI, MBI, Basis-24, Stigmatiza tion scale, QOLI, Housing stability and satisfactio n. $20 incentive, N=374	No sig. difference between two peer groups Highlights that peer work can be beneficial without sharing personal recovery stories	No info about non-respond-ents, small female sample, might not be generali-zable to other peer groups

Author	Context	Identified Mechani-sms	Outcomes	Demi-Regulariti-es	Study Type	Theory cited	Values prioritised	How/Why of IUPS	Training	Population -on	Intervent-ion method	Methods	Results	Limitation
Goering, et al., (1997)	Assertive case manage-ment for homeless clients with severe MI *NOT PS, BUT MODEL IS VERY SIMILAR*	Working alliance, trust, develop-ing the relations-hip, holistic, tangible support, social support, being flexible, empow-erment, mutuality	Stronger working alliance earlier linked to better and quicker improve-ements. Overall, better social function-ing, reduced symptoms , and high client satisfa-ction	Working alliance/ strong relations-hip developed early can have very positive and quick impacts	Longitud-inal	Working alliance	Strong working alliance is VIP	The relations-hip is the key to helping	PROFS DELIVER-ED THIS	Homeless adults	Professi-onals did assertive case-manag-ement with homeless clients, very similar to PS, took time to develop the relation-ship, informal meetings, flexible, collabor-ative goal setting, advocating	Assessed through surveys: demogr-aphics/clin ical history using Uniform Client Data Instrum-ent, Specific Level of function-ing, Brief Psychiatric Rating Scale (BPRS), Housing, service use,	The working alliance was key to participant improve-ments; stronger bonds made earlier contrib-uted to quicker positive progress-ions, with higher social function-ing, reduced MH	Lack of a control group, within-group compare-sons.

Author	Context	Identified Mechani-sms	Outcomes	Demi-Regularities	Study Type	Theory cited	Values prioritised	How/Why of IUPS	Training	Population-on	Intervent-ion method	Methods	Results	Limitation
Finlayson, et al., (2016)	Homeless and PS and Health	Peer-client relations-hip, trust, shared experie-nces, empower ment, self-disclosure, social support	increased confide-nce, knowledge motivation and reduction in missed appoint-ments	Peer support can become an avenue to escape homeless by taking small steps	Mixed methods: surveys, interviews, and quant data	Advocacy	Lived experie-nce is a qualifica-tion and should be heard and utilised	PS works because peers come alongside and connect before requiring	Extensive: advocacy, empower ment, drug/alc-ohol, challen-ging behaviour, health and services	Homeless adults with ill health	Peers do "in-reach" and go out and reach out to hard-to-reach individuals	Interviews and surveys of peers, clients, and staff.	PS is found to benefit peers and clients: increased confide-nce knowledge motivation and <cost	Small sample sizes, impact of research on data.
Croft, et al., (2013)	Benefits of PS for peers in TB TX	Peer voice, making sense of the past, renewed self/ identity develop-ment, project context/ buy in from staff	becoming indepen-dent, synthesis of past selves, empathy, self-disclosure, sharing personal stories, identity develop-	Peers benefit from PS in a number of ways—progres-sing personally, through identity develop-ments, becoming a better helper,	Qual	Helper therapy--not cited but implied	NA	NA	Relevant training on TB to complete peer work	Homeless adults with TB and TB TX	PS in London has been going on since 2005 and researcher had not examined the impact the work has on the peers	Qual interviews of 6 peers currently working as peers. Investiga-ting their motivation and personal impact of being a peer.	Peers benefit personally from the work: identity transform ations, increased empathy, and becoming more indepen-dent.	Small sample, could be positive bias, as there was not disconfirm ing cases to use, researcher character-ristics could have

Author	Context	Identified Mechani-sms	Outcomes	Demi-Regulariti-es	Study Type	Theory cited	Values prioritised	How/Why of IUPS	Training	Population -on	Intervent-ion method	Methods	Results	Limitation
			ment, motivation	and motivate clients.										impacted data

Author	Context	Identified Mechani-sms	Outcomes	Demi-Regulariti-es	Study Type	Theory cited	Values prioritised	How/Why of IUPS	Training	Population -on	Intervent-ion method	Methods	Results	Limitation
Connor, et al., (1999)	PS to educate clients on health, developed by nurses, and try to break down barriers between nurses/ services and homeless clients	Role modelling, empathy, experien-tial knowledge active listening, and peers given meaning-ful roles within organisa-tion	Increased empower ment, commu-nity integra-tion, identity develop-ment, client engagem-ent	Empowe-ring clients through choices and reducing barriers helps clients gain access	Qual	Paulo Freire-- Focus on using the knowledge and experienc es of those who have endured it as experts. Empower ment is also key	Lived experie-nce, empower ment, and increasing self-efficacy	Those who are empow-ered can enact change in their lives.	Peers from first group were not reliable. So nurses used a local café recruited peers from there.	homeless clients with ill health	Peers acted as mentors and met with clients regularly, education al, drop-in Peers directed activities and coping methods	Written and oral evaluation by peers	Peers experie-nced increased confidenc e, esteem, and empower ment. identity transfor-mations. Peers had over 45 /month,	Small sample, assessm-ent of outcomes could be formalised

Author	Context	Identified Mechani-sms	Outcomes	Demi-Regulariti-es	Study Type	Theory cited	Values prioritised	How/Why of IUPS	Training	Population -on	Intervent-ion method	Methods	Results	Limitation
Anderson, C. (1993)	Addiction, identity developm ent of alcoholism	Re-structure personal narrative, story telling, 12-step ideology	Synthesis of past selves, identity transform ation	Being in a context the encourage one to share their personal life narrative meant to inspire, can contribute to identity transfor-mations and a new sense of self.	Qual	AA framewo-rk	AA values	AA	AA	Recover-ing alcoholics	AA--as an identity transform ation organisa-tion	Qual interviews with 30 recovering alcoholics on their alcohol use and their identity develop-ment during and after alcohol use.	Being in AA fostered identity develop-ments/ Transfor-mations Helping the to feel more positive identity conversion when moving from using to sober and alterations when using.	Limited sample

Appendix H MMAT

Souto et al. (2015)

Types of mixed methods study components or primary studies	Methodological quality criteria (see tutorial for definitions and examples)	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	• Are there clear qualitative and quantitative research questions (or objectives*), or a clear mixed methods question (or objective*)?				
	• Do the collected data allow address the research question (objective)? E.g., consider whether the follow-up period is long enough for the outcome to occur (for longitudinal studies or study components).				
	Further appraisal may be not feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.				
1. Qualitative	1.1. Are the sources of qualitative data (archives, documents, informants, observations) relevant to address the research question (objective)?				
	1.2. Is the process for analyzing qualitative data relevant to address the research question (objective)?				
	1.3. Is appropriate consideration given to how findings relate to the context, e.g., the setting, in which the data were collected?				
	1.4. Is appropriate consideration given to how findings relate to researchers' influence, e.g., through their interactions with participants?				
2. Quantitative randomized controlled (trials)	2.1. Is there a clear description of the randomization (or an appropriate sequence generation)?				
	2.2. Is there a clear description of the allocation concealment (or blinding when applicable)?				
	2.3. Are there complete outcome data (80% or above)?				
	2.4. Is there low withdrawal/drop-out (below 20%)?				
3. Quantitative non-randomized	3.1. Are participants (organizations) recruited in a way that minimizes selection bias?				
	3.2. Are measurements appropriate (clear origin, or validity known, or standard instrument; and absence of contamination between groups when appropriate) regarding the exposure/intervention and outcomes?				
	3.3. In the groups being compared (exposed vs. non-exposed; with intervention vs. without; cases vs. controls), are the participants comparable, or do researchers take into account (control for) the difference between these groups?				
	3.4. Are there complete outcome data (80% or above), and, when applicable, an acceptable response rate (60% or above), or an acceptable follow-up rate for cohort studies (depending on the duration of follow-up)?				
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the quantitative research question (quantitative aspect of the mixed methods question)?				
	4.2. Is the sample representative of the population understudy?				
	4.3. Are measurements appropriate (clear origin, or validity known, or standard instrument)?				
	4.4. Is there an acceptable response rate (60% or above)?				
5. Mixed methods	5.1. Is the mixed methods research design relevant to address the qualitative and quantitative research questions (or objectives), or the qualitative and quantitative aspects of the mixed methods question (or objective)?				
	5.2. Is the integration of qualitative and quantitative data (or results*) relevant to address the research question (objective)?				
	5.3. Is appropriate consideration given to the limitations associated with this integration, e.g., the divergence of qualitative and quantitative data (or results*) in a triangulation design?				
	Criteria for the qualitative component (1.1 to 1.4), and appropriate criteria for the quantitative component (2.1 to 2.4, or 3.1 to 3.4, or 4.1 to 4.4), must be also applied.				

*These two items are not considered as double-barreled items since in mixed methods research, (1) there may be research questions (quantitative research) or research objectives (qualitative research), and (2) data may be integrated, and/or qualitative findings and quantitative results can be integrated.

Appendix I AMSTAR

From Shea et al. (2007, p. 5)

1. Was an 'a priori' design provided? The research question and inclusion criteria should be established before the conduct of the review.	☐ Yes ☐ No ☐ Can't answer ☐ Not applicable
2. Was there duplicate study selection and data extraction? There should be at least two independent data extractors and a consensus procedure for disagreements should be in place.	☐ Yes ☐ No ☐ Can't answer ☐ Not applicable
3. Was a comprehensive literature search performed? At least two electronic sources should be searched. The report must include years and databases used (e.g. Central, EMBASE, and MEDLINE). Key words and/or MESH terms must be stated and where feasible the search strategy should be provided. All searches should be supplemented by consulting current contents, reviews, textbooks, specialized registers, or experts in the particular field of study, and by reviewing the references in the studies found.	☐ Yes ☐ No ☐ Can't answer ☐ Not applicable
4. Was the status of publication (i.e. grey literature) used as an inclusion criterion? The authors should state that they searched for reports regardless of their publication type. The authors should state whether or not they excluded any reports (from the systematic review), based on their publication status, language etc.	☐ Yes ☐ No ☐ Can't answer ☐ Not applicable
5. Was a list of studies (included and excluded) provided? A list of included and excluded studies should be provided.	☐ Yes ☐ No ☐ Can't answer ☐ Not applicable
6. Were the characteristics of the included studies provided? In an aggregated form such as a table, data from the original studies should be provided on the participants, interventions and outcomes. The ranges of characteristics in all the studies analyzed e.g. age, race, sex, relevant socioeconomic data, disease status, duration, severity, or other diseases should be reported.	☐ Yes ☐ No ☐ Can't answer ☐ Not applicable
7. Was the scientific quality of the included studies assessed and documented? 'A priori' methods of assessment should be provided (e.g., for effectiveness studies if the author(s) chose to include only randomized, double-blind, placebo controlled studies, or allocation concealment as inclusion criteria); for other types of studies alternative items will be relevant.	☐ Yes ☐ No ☐ Can't answer ☐ Not applicable
8. Was the scientific quality of the included studies used appropriately in formulating conclusions? The results of the methodological rigor and scientific quality should be considered in the analysis and the conclusions of the review, and explicitly stated in formulating recommendations.	☐ Yes ☐ No ☐ Can't answer ☐ Not applicable
9. Were the methods used to combine the findings of studies appropriate? For the pooled results, a test should be done to ensure the studies were combinable, to assess their homogeneity (i.e. Chi-squared test for homogeneity, I^2). If heterogeneity exists a random effects model should be used and/or the clinical appropriateness of combining should be taken into consideration (i.e. is it sensible to combine?).	☐ Yes ☐ No ☐ Can't answer ☐ Not applicable
10. Was the likelihood of publication bias assessed? An assessment of publication bias should include a combination of graphical aids (e.g., funnel plot, other available tests) and/or statistical tests (e.g., Egger regression test).	☐ Yes ☐ No ☐ Can't answer ☐ Not applicable
11. Was the conflict of interest stated? Potential sources of support should be clearly acknowledged in both the systematic review and the included studies.	☐ Yes ☐ No ☐ Can't answer ☐ Not applicable

Appendix J Q Sort Protocol

Introduction

Experts by experience represent individuals or groups who share a common experience of a phenomenon, such as homelessness. These peers provide various types of support for someone who is 'new' to the experience or the recovery from it . Alcoholics Anonymous (AA) characterises the most well-known of these peer groups that provide support for others, where more experienced members sponsor newcomers in the early stages of recovery. Indeed, this practice is also found in the mental health care systems; peers have been providing mutual support since the 1800's (Basset, Faulkner, Repper, & Stamou, 2010). Peers are a positive source for fostering change and reconnecting the individual with the community (Repper & Carter, 2011). Intentional peer-support is defined as a purposive relationship—where the supporter has personal experience of living and coping with a particular phenomenon and is using that experience to help another person in a similar situation (Mead et al., 2001).

This common practice is displayed by peer-support programs presence in numerous organisations and treatments nationally—in 2003, Wallcraft and colleagues identified over 716 programs that involve peers/consumers in England (Wallcraft et al., 2003). The literature examining peer-support use with a homeless population is sparse, and lacks consensus on the vital aspects of successful peer-support. A previous systematic review (Stephanie. L. Barker & Maguire, 2017), found that peers have a positive impact on clients experiencing homelessness. This review identified potential components of peer support and this was further explored in a qualitative study where these aspects were further defined by peers' experiences of supporting. For example, as shown in chapter 2 and 3, peer-support appears to be comprised of building trust, being versatile, emotional regulation, connecting as equals in the relationship, being unique from staff and informal peers, experiential knowledge, clear motivation for helping, role modelling, working with boundaries, providing individualised treatment, and providing social support (organised under four themes: 1) never giving up, 2) experience-based relationships, 3) motivation, and 4) how peers help).

To build on these results and further understand the vital aspects of peer-support, a consensus building study is proposed. A consensus building study gather opinions from experts on a specific topic area through asking them to rank-order statements on that particular topic. That is, the proposed study will seek out the views and opinions of those who provide and facilitate peer-support on these various identified aspects to discern which are viewed as the most valuable to successful peer-support with a homeless population. This will allow for the researcher to focus on

the meanings behind the construct of peer-support and results will show how components are related to one another. Indeed, a consensus approach allows for an exploration of the concepts from the point of view of those directly involved in the service and will help to further understand the process of peer-support. Q-Methodology, which involves rank-ordering concepts (usually developed from qualitative interviews), is the chosen method to develop consensus with local peers and professionals regarding the vital aspects of peer-support (S. R. Brown, 1996). Q-Methodology is a unique mixed-methods approach to understanding participants' opinions on a topic that they are familiar with. As data is gathered from the participants' viewpoint, certain biases, such as social desirability, are reduced (Watts & Stenner, 2005).

Research Question & Aims

The aim of this study is to assess what professionals and peer-supporters believe are the vital factors in successful peer-support. The concepts and themes developed from the qualitative study and the systematic review will serve as a foundation for this study, although more weight is given to findings from the qualitative report, as it encompassed results from the systematic review. Specifically, this study will ask professionals and peer-supporters to build consensus regarding statements on the various aspects of peer support. Thus, the research question is: what are the most and least important aspects of peer support according to peer-supporters and professionals? The chosen methodology permits the researcher to make comparisons and draw conclusions about the relationships between those constructs, based on how participants distribute the constructs, as a group.

Methods

This study will include the development of various statements that summarise the various components of peer-support and ask the participants to rank them into the most and least important, in their opinion. A Q-Sort design allows consensus to be built regarding a specific topic. This method also allows the participants to provide additional comments and contribute to any potential concepts that were not found in the systematic review or the qualitative study.

Statement Development

This Q-sort will be a quasi-naturalistic sample, where the statements are developed from primary and secondary sources, such as the qualitative interviews and previous literature, and where the participants from the interviews may not necessarily be participants in the proposed study (Du Plessis, 2005). Stephenson stipulates that a whole discourse is impossible to analyse, so a broadly representative sample of statements with psychological meaning are developed for this study (Brown, 1996; Watts & Stenner, 2005).

Statements were developed from an extensive review of the literature on peer-support and homelessness, which identified constructs that are thought to be involved in this type of support. Further, interviews have been conducted with 28 peer-supporters, exploring the constructs identified in the review. These interviews resulted in four themes that are hypothesised to be the critical elements of peer-support (i.e. never giving up, experience-based relationships, motivation, and how peers help, see chapter 3). Thus, the statements have been developed using these results as a guide. In addition to these primary sources, the researcher identified relevant literature that was not included in the review, which also informed statement development.

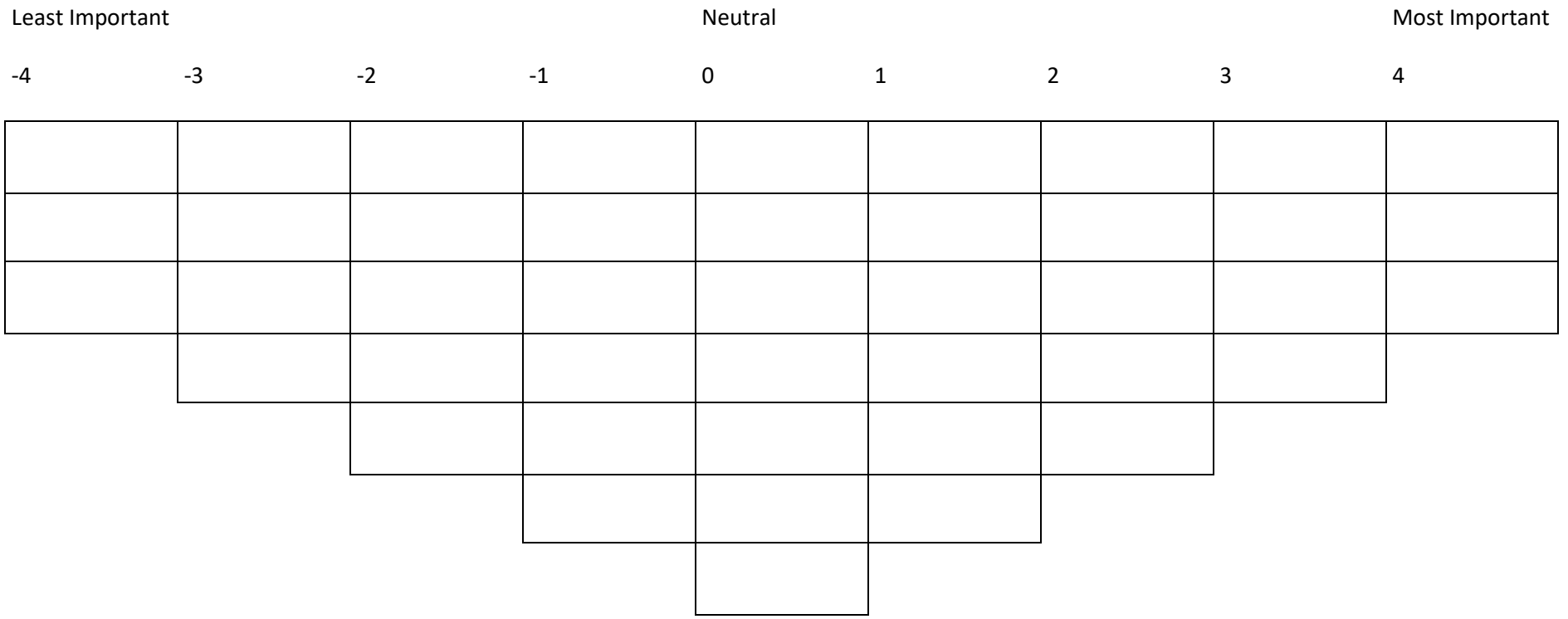
Participants & Procedure

As in qualitative methods, participants are selected through purposive sampling, recruiting those that have vital experiences in providing and delivering peer-support. Indeed, this study will include experts in peer-support with a homeless population as participants (Du Plessis, 2005; Trochim, 2006). This will include professional adults who work with the homeless population and have worked with peer-supporters. These professionals will be from various homeless charities and organisations that have been working with the homeless for longer than 6 months. The study will also recruit adult peer-supporters—those who have experienced homelessness and are currently working with an organisation to provide support to homeless persons at various stages of recovery from homelessness. It would be ideal to have a balanced number of both professionals and peers.

Large numbers of participants are rendered unnecessary as the method focuses on how a group of experts view the statements and the relationships between the constructs. S. R. Brown (1993) theorises that while enough participants are required to establish a factor, which are qualitative classes of thoughts, additional participants are unnecessary. However, the sample should have as much diversity as possible regarding gender and age, for example. Regarding ethics, the researcher completed an online checklist from the National Research Ethics Service from the NHS, to ascertain the degree of ethics required for this project (NRES, n.d.). This resulted in the researcher understanding that ethics attained from the University of Southampton's Ethical Review Board would be sufficient, as this project involves a non-vulnerable sample of professionals and peer-supporters. Employing an extensive person-sample approach, participants will sort the statements under one condition: how much they agree or disagree with the individual statement being important to peer-support with the homeless. This method typically needs about 40-60 participants (S. Brown, 1980). This will be done in a forced-choice condition, participants will be required to place all the statements onto a grid (see Table) where they will

need to choose the statements that they feel are the most important and least important in peer-support with a homeless population.

Q-Sort Forced Choice Distribution Grid



Statements will be delivered in an unstructured fashion; allowing participants to organise the various statements into a pre-determined grid, also known as a 'forced distribution'. This forces the participants to choose the top and bottom three statements that they feel are the most and least important to describing peer-support, in their opinion. Using this method creates a sorting that are more stable and discriminating than a free-distribution where participants can place any number of statements as the most or least important. Using forced-distribution elicits a sorting that is more stable because the participant has to read over the statements carefully and make a judgment about which statements represent aspects that are the most and least important to them, however this method may cause participants to feel overwhelmed if there are an excessive number of statements (Du Plessis, 2005). Thus, the researcher has 43 statements to reduce participant burden.

Participants will be recruited through various organisations. The study would be advertised through emails, posting flyers, online advertisements, and reaching out to various contacts through email and social media. As the study would be completed online, the potential participants that shows interest would be assessed for eligibility and then sent a hyperlink where they can complete the study.

Design

Q-Methodology uses factor analysis, a statistical method used to understand the latent structures of a set of variables (Du Plessis, 2005; Kline, 1994). Indeed, correlations between individuals' Q-Sorts are factored, determining which sets of people cluster together (Kline, 1994). Results display eigenvalues which account for the variance in the data; higher eigenvalues account for more variance and thus eigenvalues over 1.00 are extracted (Brown, 1980). Q-Methodology uses centroid factor analysis/simple summation method, creating correlation coefficient matrices, and the factor loadings represent each sort's relationship with the factors (Plessis, 2005).

Results

Results will be entered into the Q-Sort software package PQMethod Version 2.35 (Schmolck & Atkinson, 2012). This is the most recent software and it "computes intercorrelations among Q-Sorts, which are then factor-analysed with either the Centroid or Principal Component method" (Schmolck & Atkinson, 2012, para. 1). The factors are then rotated through an iterative process, known as Varimax rotation; this analysis involves including as many sorts as possible to maximise saturation and uncorrelated factors (Du Plessis, 2005).

This software package also allows for the researcher to use judgmental rotation, whereby the research includes certain sorts to answer a specific question or to account for the highest number of sorts with the lowest number of factors (Schmolck & Atkinson, 2012). Criticism of this method is around the subjective opinion of the researcher impacting which sorts are analysed. However,

by making use of a coherent theoretical understanding and informed judgement, Brown (1980) states that this criticism is unfounded.

Interpretations of the data will involve scrutiny of the factor scores provided by PQMethod software once the factors are deemed to be 'pure' (that is, they do not significantly relate to another factor) and reliable (where at least five participants defining the factor to generate reliability of .95; Brown, 1996). Lastly, a factor array, a diagram that represents an overall gestalt of the data, will be developed, involving consensus and distinguishing statements, from which the researcher will make assertions from (S. R. Brown, 1996)

Discussion

Data from this study will allow for the researcher to look for patterns in the grids, ranking the elements of peer-support, but also be able to examine the relationships between the constructs. For example, if experiential knowledge is noted by a majority of participants to be an important aspect of per-support, then the researcher can have more confidence in the model developed by the theoretical review, which posits that experiential knowledge is the overarching factor to intentional peer-support. Similarly, if a construct is consistently ranked as the least important, then the researcher will be able to examine the model without that construct or further explore how it is/isn't related to peer-support.

This further refinement of included constructs and their importance to peer-support will allow the researcher to understand how peer-support works and edit the assumptions made, so far. These results will serve as a starting point for which psychometric assessments will be useful in assessing the effectiveness of peer support in later studies.

Appendix K Q Sort Ethics Documents

K.1 Participant Information Sheet

Study Title: Peer-Supporters and Professionals' view of the critical elements of Peer-Support use with a homeless population

Researcher: Stephanie L Barker **Ethics number**: **19942**

Please read this information carefully before deciding to take part in this research. If you are happy to participate you will be asked to sign a consent form.

What is the research about?

This project, part of the researchers PhD thesis, is exploring the critical elements of peer-support/peer-advocacy/mentorship with a homeless population. I am interesting in finding out what professionals and peer-supporters think are the most and least important aspects of peer-support are. The information in this study have been developed from previous work, such as a systematic review, theoretical review, and a qualitative study exploring the process of peer-support.

Why have I been chosen?

You have been chosen as you are a professional or peer-supporter who has experience in providing or organising peer-support. That is, you have either been directly involved in supporting those who are homeless or you have seen this process take place and have helped to support the peers and the program.

What will happen to me if I take part?

If you chose to take part in this study, you will be asked to sort a number of statements that represent the various aspects of peer-support (e.g. shared experience of homelessness). You will need to read all the statements and then decide which ones you feel are the most, least, and not important to peer-support with a homeless population.

Are there any benefits in my taking part?

While there are no incentives for this research, you will be contributing to current knowledge on this topic and providing much needed evidence to understand the process of peer-support and how it can be best utilised to help those experiencing homelessness.

Are there any risks involved?

You might become tired while completing this task and are welcome to take breaks.

Will my participation be confidential?

All data collected will comply with the Data Protection Act and University policy and all the information will be stored and remain confidential. It will be kept on a password protected computer and identifying information will be removed.

What happens if I change my mind?

This study is completely voluntary and you have the right to stop, at any time, without consequence.

What happens if something goes wrong?

In case of concern or complaint, you can contact the Research Governance Manager +44 (0)23 8059 5058, rgoinfo@soton.ac.uk or the Chair of the Ethics Committee: Phone: +44 (0)23 8059 3856, email fshs-rso@soton.ac.uk

Where can I get more information?

If you have any questions, comments, or would like a copy of the final report, please feel free to email Stephanie Barker at S.L.Barker@soton.ac.uk, if you would like to speak with my supervisor, Dr Nick Maguire, you can contact him at nm10@soton.ac.uk

K.2 Consent Form

(Version 1 29/03/2016**)**

Study title: Peer-Supporters and Professionals' view of the critical elements of Peer-Support use with a homeless population

Researcher name: Stephanie L Barker **Ethics reference**: **19942**

Please initial the box(es) if you agree with the statement(s):

I have read and understood the information sheet (Version 1, 29/03/16) and have had the opportunity to ask questions about	☐
I agree to take part in this research project and agree for my data to be used for the purpose of this study	☐
I understand my participation is voluntary and I may withdraw at any time without my legal rights being affected	☐
I am happy to be contacted regarding other unspecified research projects. I therefore consent to the University retaining my personal details on a database, kept separately from the research data detailed above. The 'validity' of my consent is conditional upon the University complying with the Data Protection Act and I	☐

Data Protection

I understand that information collected about me during my participation in this study will be stored on a password protected computer and that this information will only be used for the purpose of this study. All files containing any personal data will be made anonymous.

Name of participant (print name)……

Signature of participant……..

Date……

K.3 Debriefing Statement

(Version 1, 29/03/16)

The aim of this research was to find out your opinions on critical elements of peer support and homelessness. Your data will help our understanding of how peer-support works and help to develop an evidence base for this common practice. Once again results of this study will not include your name or any other identifying characteristics. The experiment/research did not use deception. You may have a copy of this summary if you wish and you may have a copy of the research project once it is completed. If you have any further questions please contact me, Stephanie, at 02380594719 or S.L.Barker@soton.ac.uk

Thank you for your participation in this research.

Signature _____ Date ____29/03/16_____

If you have questions about your rights as a participant in this research, or if you feel that you have been placed at risk, you may contact the Chair of the Ethics Committee, Psychology, University of Southampton, Southampton, SO17 1BJ. Phone: +44 (0)23 8059 3856, email fshs-rso@soton.ac.uk

Resources:

Steps 2 Wellbeing Free counselling

Call 0800 612 7000 (self referral) or 02380 272000
Office hours: 8:30-17:30
Monday - Friday
sstw@dhuft.nhs.uk
Southampton office is located at:
Third Floor, Grenville House
Nelson Gate
Southampton
SO15 1GX

Helplines:

- **Samaritans**: 08457 90 90 90 jo@samaritans.org
- **Alcoholics Anonymous**: 0845 769 7555
- **Shelter's helpline**: 0808 800 4444 freephone

Telephone advice and information for people with a housing problem or who are homeless. Issues dealt with include housing rights, harassment, illegal eviction, rent and mortgage arrears, disrepair, housing benefit, domestic violence, hostel placements and finding accommodation. Helpline open 8am-8pm Monday-Friday and 8am-5pm at weekends.

HOPE project for pet owners who are homeless or in housing crisis and FREEDOM project for pet owners fleeing situations of domestic violence.

Dogs Trust Hope Project
17 Wakley Street
London
EC1V 7RQ
T: 020 7837 0006 F: 020 7833 8798
E: hopeproject@dogstrust.org.uk
W: https://www.moretodogstrust.org.uk

Appendix L Q Sort Detailed First Order Analysis Results

L.1 Principle Component Analysis Results: Peers

After rotating the factors, four factors were identified and extracted, which account for 52% of the study variance. The four factors are comprised of 16 Q sorts (four each) and the remaining four Q sorts were confounding. Each factor produced a unique factor array; however, Factor 4 had a rank-tie for the +2 column (Schmolck, 2017). That is, all the peer participants who load significantly onto this factor placed six statements at +2, when there is only space for 5, leaving one extra space at the +3 column. In order to conduct the interpretation and next level of analysis, the statements need to be placed into a single factor array.

Consequently, an examination of the participant with the highest factor loading helped to determine statement placements. Shane loads onto this factor at .69 and his Q sort is the most consistent with the overall factor array and therefore this factors viewpoint. Shane had rated statement #30 higher than the other Q sorts from column +2, it was decided to place #30 in the spare +3 position.

Statements that did not differentiate between factors are termed consensus statements, shown in Table 1 (Watts & Stenner, 2005). Participants value these statements in similar ways. Across all peer participants, statement 18 was ranked quite low, 15 out of 20 peers place this statement at -4. It is apparent that peers disagree with this statement; peers having negative motivations for embarking in peer-work does not contribute to effective peer-support. Conversely, peers generally agreed that confidentiality is an important aspect to effective peer-support. Peers having training in psychological skills were consistently ranked in the middle, highlighting that peers felt that training is important, but not vital to effective peer-support. Table 2 shows the factor arrays for each of the four factors in the peer analysis.

Table 1. Consensus Statements for Peer Analysis

Statement	Agreed Position
18 Peers are paying back for the wrong they did	-4
38 Peers have training in psychological skills, such as listening skills	0
41* Peers respect confidentiality	+3

All statements are nonsignificant at p <.01; * Nonsignificant at p < .05

Appendix L

Table 2 Factor Arrays for Peer Analysis

		Factor Array			
Q Set	Statement	F1	F2	F3	F4
1	Peers being persistent and clients help, taking time to develop trust.	+1	+3*	-1	-2
2	Building trust based on experience of homelessness	-3*	+4*	0*	+2*
3	Developing trust with clients	+4	+4	+2	+1
4	Peers being adaptable to clients' needs	+3	0	+2	-1
5	Peers being adaptable to clients' personalities and behaviours	+3	+3	-3*	-1*
6	Peers know their own triggers	-1	-3*	0	-1
7	Peers controlling their emotions around clients and professionals	0	+3*	-2*	0
8	Peers using support from organisations to cope with struggles	-1	0	+1	+2
9	Peers maintaining their recovery	-3*	+1	+1	0
10	Peers' unique ability to understand where the client is coming from because they have been homeless too	+1	+4*	-2*	0
11	Peers connecting to clients as equals	+2	+3	+1	-4*
12	Peers being different from professionals	-1*	+2	+2	-3*
13	Peers being different from other people experiencing homelessness through their training and connection to supportive organisations	-3	+1	+2	-3
14	Peers' positive attitude toward their experience of homelessness	-2	+2*	-1	-2
15	Peers knowing specific people or services that help	+2*	-1	-2	-3
16	Peers being committed to their clients	0	+2	0	+3*
17	Peers' motivations for helping are genuine, rather than for money	0	-1	+3*	+1
18	Peers are paying back for the wrong they did	-4	-4	-4	-4
19	Peers repaying for the kindness that was shown to them	-2	-1	-3*	-1
20	Peers learn skills help them escape from homelessness	-2	+1*	-2	-2
21	Peers are actively living a lifestyle that clients can look up to	-3	0	0	-2*
22	Peers model recovery by representing someone who has gone through a similar experience and thrived	-1	0	-1	-4

23	Peers respect boundaries	+3	0*	+3	+3
24	Peers bend boundaries to fit the needs of their client in a particular situation	-1*	-3	-3	-3
25	Peers go the extra mile for their client	+2	-1	0	-1
26	Peers being available outside of normal professional hours	-2	-2	-1	+1*
27	Peers understand, and can help to adapt treatment for their clients' needs	+1	-3	0	-2
28	Peers advocate for their clients and help them learn how to self-advocate	0	-1	+2	+3
29	Peers provide important information	+1	-2*	+1	+4*
30	Peers provide emotional support	+1	0	-4*	+2
31	Peers are a source of friendship for the client	+1	-4*	-4*	+2
32	Peers give advice to help	+4	-3	-2	+4
33	Clients can compare themselves to peers	-4	-4	-3	+1*
34	Peers provide an empathic, listening ear	+3	0	+3	+2
35	Peers identify clients who might be at risk to themselves or others	0	-1	-1	+1*
36	Peers facilitate connections to other services and help	+2	-2	-1	0
37	Peers help to increase psychological, health, and overall wellbeing of their clients	-2	+1	+4*	+1*
38	Peers have training in psychological skills, such as listening skills	0	-2	+1	0
39	Peers are a bridge between clients and professional help	+2*	-2*	+1	0
40	Peers have support from supervision and other peer-supporters	0*	+2	+3	+4
41	Peers respect confidentiality	+4	+2*	+4	+2
42	Peers reduce stigma around homelessness, mental illness, and addiction	-1	+1	+4*	-1
43	Peer-Support works because peers have been homeless too	-4*	-2	0	0

*Note. * Denotes distinguishing statements for that factor*

Appendix L

Factor 1: Treatment Relationship over the Peer-Client Relationship

This factor account for 12% of the study variance, with four peers loading significantly onto this factor. Three peers are male and the average age is 47.25 (range = 37-60). All peers reported experiencing homelessness and three reported addiction. In terms of peer-supporter experience, two peers have worked with this population for up to 1 year, one peer has up to 2 years' experience, and the final peer has up to 3 years' experience. This group represents viewpoints from two different organisations.

Exemplars in this factor value the practical aspects of the peer-support role over underlying elements specific to peers. For example, while participants felt that developing trust with clients is important (3: +4), they did not feel that building trust based on shared experiences of homelessness is vital to effective peer-support (*2: -3). This viewpoint is reinforced by participants' low ranking of other statements on lived experience (43: -4). Participants in this group do not feel that the shared experience of homelessness is an integral aspect to effective peer-support, as Murray describes:

"It helps to understand, but not all the time"

Further, peers need to respect confidentiality (41: +4), which helps to build trust and make peer-support effective: *"If someone knows that trust is there, they will open up for their needs"* (Murray). Exemplars felt that social support provision is integral to effective peer-support. For example, they felt that peers should give advice to clients (32: +4), provide an empathetic listening ear (34: +3), provide information (29: +1), emotional support (30: +1), and be a source of friendship for the client (31: +1). Mohammed commented on social support: *"if you don't want to help, why be a peer?"* Practical activities that positively affect clients are important to peer-support for this group. In addition to social support, this group valued statements on respecting boundaries (23: +3) and devalued statements that describe peers bending boundaries (24: -1) or peers working outside business hours (26: -2). Exemplars also felt that main functions of peer-support, such as facilitating connections to other services (36: +2) and bridging clients to professionals (*39: +2), are priorities of effective peer-support.

The above aspects are valued over potential underlying elements such as role modelling. Participants' felt that clients comparing themselves to peers (33: -4), clients looking up to peers (21: -3), and peers modelling recovery (22: -1) are not integral elements of effective peer-support. It is also apparent that peers' recovery status is not as important to practical support in effective peer-support (*9: -3; 8: -1), from this groups viewpoint.

In sum, this viewpoint minimises the importance of 'peer' aspects, such as role modelling, peer recovery, and experiential knowledge by prioritising the provision of practical activities of peer-support. Three of the four peers are from one organisation; therefore, this viewpoint may be a reflection of the training and directives that are communicated by professionals within this organisation.

Factor 2: Trusting the Lived Experience

Four peers load significantly onto this factor, accounting for 12% of the study variance. Two females and two males, with an average age of 51.35 (range = 47-55) from four different organisations contribute to this factors' unique viewpoint. All peers have homelessness experience and one peer reported experience with addiction. Three peers have worked with this population for up to 3 years and the fourth peer reported up to 5 years' experience.

Exemplars felt that a vital aspect of peer-support includes a strong experience-based trusting relationship. This factor posits that peer-support works because of trust that develops based on shared experiences of homelessness (*2: +4), and that developing trust with clients is key (3: +4).

"Trust is the ultimate necessity!" (Glenn)

Further, participants felt that peers have a unique ability to understand where the client is coming from because of their experiential knowledge of homelessness (*10: +4).

"The peer knows exactly what the other person is going through as they have been through a similar experience" (Libby)

Participants felt that the experience-based relationship develops upon a foundation of trust, peers connecting with clients as equals (11: +3), and peers being persistent with clients (*1: +3). Exemplars note the uniqueness of peers—being different from both professionals (12: +2) and other people experiencing homelessness (13: +1). Further, this factor notes the benefits that peers receive from helping; peers gain support from their respective organisations and other peers (*40: +2), and peers learn skills that help them escape homelessness (*20: +2). In addition, participants felt that peers who have a positive attitude towards their homeless experiences (*14: +2) and work to control their emotions around clients and professionals (*7:+3) enhances peer-supports' effectiveness. Easton describes an important factor in developing helping relationships:

"Be yourself in peer-supporting, [clients] recognise fakes easily"

This group devalues aspects that could be harmful to clients or peers, such as clients comparing themselves to peers (33: -4) or peers breaking boundaries by being the clients' friend (*31: -4). Exemplars felt that maintaining boundaries is vital to effective peer-support (24: -3).

Peers should be at a stable level of recovery (9: +1) to provide effective support, however, this group devalued the statement that peers should know their own triggers (*6: -3). This unexpected diversion may be explained by participant demographic information: only one of the peers reports experience with addiction and the term 'triggers' may be unfamiliar. Given that this group prioritised other elements on peer recovery and health (e.g. *7: +3; 8: 0; 9: +1), this is interpreted as a potential limitation in the study, where the statement used a potentially unfamiliar term.

Factor 3: Reaching Overall Goals

This factor accounts for the highest amount of study variance, 16% for the peer analysis. Four peers load significantly onto this factor, three females and one male (average age = 36.25, range = 30-42). Two peers reported experience with addiction. Three peers reported experience with homelessness, the one peer that reported no homeless experience has been working with this population using her lived experience of addiction for three years. This factor is comprised of peers from three different organisations, two have up to 2 years' experience, one peer reported 5+ years' experience working with this population.

Exemplars felt that peers help to increase the overall wellbeing of their clients (37: +4) by building trusting and confidential relationships (41: +4; 3: +2), which then help peers to reach an overall goal of overcoming barriers to services by reducing stigma around homelessness, mental illness, and addiction (42: +4). Peers increase trust through confidentiality:

"Building confidentiality with clients will build trust of clients with peers" (Sophie)

Further, participants felt that these goals are met by peers because they are different from professionals (12: +2) and other people experiencing homelessness (13: +2). Peers are unique and can provide a different level of support than professionals or informal counterparts. Peers that have honest motivations (*17: +3), support from their respective organisations (40: +3; 8: +1), and are maintaining their recovery (9: +1) are adept at helping clients increase their wellbeing. Exemplars felt that effective peer-support has firm boundaries that peers respect (23: +3). Bending boundaries (24: -3) or developing friendships with clients (31: -4) were ranked low by this group, strengthening the viewpoint that boundaries must be respected.

This factor posits that peers experiential knowledge of homelessness (*10: -3; *2: 0) are not vital elements of effective peer-support. Peers need to focus on building trusting, confidential relationships with clients. This group felt that the peers' lived experience has minimal impact on an effective PCR. Further, exemplars ranked statements on emotional and companionship social support lower than other factors (*30: -4; 32: -2), explained by Judith:

"It is not about giving advice, but it is about showing that there is always a way in life"

While participant's value peers' uniqueness, their placement of statements on social support suggest that they value a relationship that is more formal than a friendship (*31: -4).

In sum, this group felt that peer-support is most effective when peers are working towards overall goals of increasing their clients' wellbeing and helping to reduce stigma associated with homelessness, mental illness, and addictions—goals that are achieved through trusting and confidential relationships between peers and clients.

Factor 4: Informal Support, Provided by Supported Peers

This factor accounts for 12% of the total study variance with four people from three different organisations that load significantly onto it. All four peers are male with an average age of 36 (range = 25-47). Peers all report homelessness experience with two also reporting issues with addiction. Two peers reported up to 1 year experience working with this population and one reported up to 2 years' experience. The last peer has 15 years+, stating, "*As a service user, I acted as a peer*" however this does not clearly define when this peer had begun providing formal peer-support, clearly a limitation of the way this question was framed.

Exemplars valued statements on social support, identifying the provision of social support as key in effective peer-support. Exemplars ranked informational support (*29: +4) and appraisal support (32: +4) the highest, followed by emotional support (30: +3), and companionship support (31: +2). In addition, this factor holds a viewpoint that prioritises support for peers; support from supervision and other peer-supporters (40: +4), and that they utilise this support when coping with personal struggles (8: +2).

Peer-support is viewed as effective when conducted in an informal manner; peers giving advice (32: +4), being a source of friendship to clients (31: +2) and being available outside of normal business hours (*26: +1). Alec explains the value of informal peer-support:

"People no longer trust experts and would much rather engage with someone more on their level as they view it"

Exemplars felt that clients would engage with someone who is committed (*16: +3) and builds trust based on shared experiences (*2: +2). Although this group values an informal type of peer-support, they did not rank statements on peers' uniqueness highly (*12: -3; 13: -3).

Peers are *"not different…we're together in the struggle and we understand what [clients] are going through but…we can fight this together" (Shane)*

This factor describes a conflicting viewpoint, while participants value the informality of peer-support by being a source of friendship to the client; they do not value peers connecting to clients

as equals (*11: -4). Further, statements on role modelling were also devalued (*22: -4; 21: -2). This viewpoint echoes the interviews done in the development of the Q Sort statements, where peers felt that they are different but not better than their clients (Stephanie L. Barker et al., 2018). It is also possible that this conflicting viewpoint could be explained by the peers' organisational affiliations. The three organisations include training and supervision that distinguishes them from clients. Therefore, they acknowledge that there are power imbalances but that the actual provision of support operates within an informal relationship—potentially highlighting an element that is not represented within this research. Certainly, this factor and participant responses reinforce the lack of clarity around peer-support terms being clearly defined and understood. Alec described that he completed the Q Sort from his "*point of view as a client and how peer-support helped*" him. This points out a potential limitation with the survey questions—we did not ask about receiving peer-support, which could have aided in explaining the results in this study.

L.2 Principle Component Analysis Results: Professionals

Following the same procedure as the peer analysis, factors were rotated and extracted, accounting for 46% of the study variance. The analysis resulted in six factors with acceptable eigenvalues however four of these did not have enough significantly loading Q sorts (<3). Factors 1 and 3 both have eigenvalues > 1.00 and three or more significantly loading Q sorts, justifying extraction. An examination of the demographic data was conducted in order to ensure key viewpoints were included in the results.

This assessment resulted in the inclusion of one more factor. Factor 2 has an eigenvalue of 1.86 and only two Q sorts that load significantly onto it. This factor has been included in the analysis as it provides a unique perspective from two professionals who have also experienced homelessness. While other professionals reported homeless experience, Factor 2 presents an important viewpoint that reports the overall experience of experiencing homelessness and then becoming a professional within peer-support and homelessness. Therefore, the final professional analysis consists of three factors (See Table 4 for factor arrays).

The three factors are derived from perspectives of half of the professionals included in the study (*n* = 10). Three Q Sorts were confounding, two loaded onto a factor with a low eigenvalue, and five Q sorts generated three factors that did not pass extraction criteria.

Statements that professionals agreed upon are shown in Table 3. Professionals agreed that effective peer-support occurs when peers work to increase the psychological wellbeing of their clients, respect boundaries, have supervision, and support from professionals and other peers.

They also felt that peers are positive role models that provide emotional social support and bridge clients to professionals. Conversely, professionals felt that peers identifying clients who are at risk to themselves or others is not an integral activity for peers. Further, professionals did not feel that peers knowing specific services that help, having motivations not fuelled by money to engage in peer-work, or potentially overextending themselves enables peer-support to be successful. Professional felt that peers controlling their emotions, using support to cope with struggles, and facilitating connections to services were important, but not vital to effective peer-support.

Table 3. Consensus Statements for Professional Analysis

Statement		Agreed Position
19*	Peers repaying for the kindness that was shown to them	-2
35*	Peers identify clients who might be at risk to themselves or others	-2
15	Peers knowing specific people or services that help	-1
17*	Peers' motivations for helping are genuine, rather than for money	-1
25	Peers go the extra mile for their client	-1
7	Peers controlling their emotions around clients and professionals	0
8	Peers using support from organisations to cope with struggles	0
36	Peers facilitate connections to other services and help	0
22*	Peers model recovery by representing someone who has gone through a similar experience and thrived	+1
39	Peers are a bridge between clients and professional help	+1
30	Peers provide emotional support	+1
23	Peers respect boundaries	+2
40*	Peers have support from supervision and other peer-supporters	+2
37	Peers help to increase psychological, health, and overall wellbeing of their clients	+3

All statements are Nonsignificant at p <.01; *Nonsignificant at p < .05

Table 4. Factor Arrays for Professional Analysis

Q Set	Statement	Factor Array F1	F2	F3
1	Peers being persistent and clients help, taking time to develop trust.	0	-3	-2
2	Building trust based on experience of homelessness	+2	0*	+3
3	Developing trust with clients	+4	+4	+2*
4	Peers being adaptable to clients' needs	+2*	-1	-1
5	Peers being adaptable to clients' personalities and behaviours	0*	+2	+3
6	Peers know their own triggers	+4	+2	-2*
7	Peers controlling their emotions around clients and professionals	0	0	0
8	Peers using support from organisations to cope with struggles	-1	+1	0
9	Peers maintaining their recovery	-3	+4*	-2
10	Peers' unique ability to understand where the client is coming from because they have been homeless too	-2	-2	+4*
11	Peers connecting to clients as equals	0	-3*	+2
12	Peers being different from professionals	+3	-2*	+2
13	Peers being different from other people experiencing homelessness through their training and connection to supportive organisations	-2*	0*	-4*
14	Peers' positive attitude toward their experience of homelessness	-3	0*	-3
15	Peers knowing specific people or services that help	-1	-2	-1
16	Peers being committed to their clients	+1	+1	-2*
17	Peers' motivations for helping are genuine, rather than for money	-1	-1	+1
18	Peers are paying back for the wrong they did	-4	+3*	-4
19	Peers repaying for the kindness that was shown to them	-3	-3	-1
20	Peers learn skills help them escape from homelessness	0*	-4*	+3*
21	Peers are actively living a lifestyle that clients can look up to	-1*	+3*	+1*
22	Peers model recovery by representing someone who has gone through a similar experience and thrived	+1	-1*	+1

23	Peers respect boundaries	+2	+2	+1
24	Peers bend boundaries to fit the needs of their client in a particular situation	-1	0	-3*
25	Peers go the extra mile for their client	-2	-1	-3
26	Peers being available outside of normal professional hours	+2*	-4	-3
27	Peers understand, and can help to adapt treatment for their clients' needs	-4	-2	+1*
28	Peers advocate for their clients and help them learn how to self-advocate	+1	+3*	0
29	Peers provide important information	-1	+2	0
30	Peers provide emotional support	+1	+1	0
31	Peers are a source of friendship for the client	0*	-3	-4
32	Peers give advice to help	-4	-4	-1*
33	Clients can compare themselves to peers	-3*	-1*	+1*
34	Peers provide an empathic, listening ear	+3	+1	+3
35	Peers identify clients who might be at risk to themselves or others	-2	0	-2
36	Peers facilitate connections to other services and help	0	-2	0
37	Peers help to increase psychological, health, and overall wellbeing of their clients	+3	+3	+2
38	Peers have training in psychological skills, such as listening skills	+1	0	-1
39	Peers are a bridge between clients and professional help	+1	+1	0
40	Peers have support from supervision and other peer-supporters	+2	+1	+2
41	Peers respect confidentiality	+3	+2	-1*
42	Peers reduce stigma around homelessness, mental illness, and addiction	+4	-1*	+4
43	Peer-Support works because peers have been homeless too	-2*	+4	+4

*Note. * Denotes distinguishing statements for that factor*

Factor 1: The Peer Role

Three professionals load onto this factor, which accounts for 12% of the study variance. Two professionals are female and one is male (average age = 40.33, range = 23-64), from three different organisations. None of the professionals reported experience with homelessness or addictions. Regarding experience working with this population, one professional reported up to 1 year experience, one reported 5+ years, and the last reported 15+ years' experience.

Exemplars felt that peers are able to develop trust with clients (3: +4; 1: 0), based upon shared experiences of homelessness (2: +2). Further, peers are different from professionals (12: +3), which allows connections to develop that are less formal than professional relationships. Exemplars felt that peers must be active in their recovery; however, exemplars felt that knowing triggers (6: +4) is more important than maintaining recovery (9: -3). Peers need to be adaptable to their clients' needs (*4: +2), personalities and behaviours (*5: 0), need appropriate training (38: +1), and support from their organisations (40: +2) in order to cope with various situations. Professionals felt that peers need to be able to cope with various situations—peers need proficiency in coping with triggers and challenging situations to preserve client and peer safety.

Furthermore, peers help clients learn how to self-advocate (28: +1), provide emotional social support (34: +3; 30: +1), respect confidentiality (41: +3), and maintain boundaries (23: +2; 24: -1) in effective peer-support. Participants felt that peers help to reduce stigma around homelessness, mental illness, and addiction (42: +4) and increase their clients' overall wellbeing (37: +3) by breaking down these barriers to care.

This factor holds a viewpoint that peer-support is effective when peers are operating within a set of defined guidelines (e.g. training, goals, values). Exemplars felt that peers should not be providing treatment (27: -4), or giving advice (32: -4):

"Peers shouldn't be involved in treatment plans - it's not their role"—Sarah

"Peers are not in the business of providing treatment"—Max

"They aren't there to give advice, it's not their role. What works for one person won't work for another so advice is a dangerous ground"—Sarah

In sum, the peer role requires peers to receive training and supervision, build trust with clients, know their own triggers, provide clients with social support, respect confidentiality, be adaptive, and flexible—including working outside of normal professional hours (*26: +2). Peers provide a unique level of support, but need to operate within a defined role.

Factor 2: Healthy Peers, Healthy Clients

This factor represents a unique perspective from those who have experienced homelessness and use that experience as a professional. While only two professionals comprise this factor, their perspective is derived from distinct experiences; these two women have both experienced peer-support as clients, became peers, and have moved into a professional role. While our extraction criteria would recommend discarding this factor, S. Brown (1980) stipulates that a factor with two or more significantly loading sorts is acceptable. Therefore, it is included because it captures a unique viewpoint that would otherwise be discarded.

The small number of professionals loading onto this factor is reflected in the small amount of variance: 8%. Both professionals are demographically similar, about the same age (38 and 39), from the same organisation, and both have up to 3 years' experience working with this population. One professional reported experiencing addiction.

Exemplars value peer health concerning personal recovery; statements on recovery and peers being supported are ranked positively. Participants felt that peers need to maintain their recovery (*9: +4), know their own triggers (6: +2), use support from their respective organisations to cope with personal struggles (8: +1), and control their emotions around clients and professionals (7: 0). This factor holds the viewpoint that if peers are able to maintain their recovery, they will be more adept at living a lifestyle that clients can look up to (*21: +3).

"It is important for the peer to maintain their recovery because the clients see peer support as someone who is stable, they will usually model their life on [the peers]. Nobody will respect a peer who is in active addiction"—Julie

Participants value peers lived experiences, ranking the statement 'peer-support is effective because peers have been homeless too' at +4, but do not view experiential knowledge as vital to developing trust (*2: 0). Effective peer-support occurs when trust is developed between peers and clients (3: +4), but trust can be developed without a shared experience of homelessness (*10: -2; *1: -3).

Peers have valuable experience that contributes to peer-supports' effectiveness (43: +4) and are motivated by *"giving back to community"*—Molly (Professional), rather than being motivated by guilt to repay for the wrong done (*18: +3). Peers that are healthy and supported by their organisations (40: +1) are able to provide effective social support. For example, peers can provide important information (29: +2), be an empathetic, listening ear (34: +1), and provide emotional support without being overwhelmed, thus are able to manage challenging client behaviour (5: +2). Recovering peers can gain clients trust (3: +4; 2: 0) through the provision of support and being committed to the client (16: +1). Further, peers work to increase their clients overall wellbeing (*37: +3), and help them learn how to self-advocate (*28: +3).

This viewpoint ranked the statement describing peers' positive attitudes to their homeless experience higher than the other two factors in the professional analysis (*14: 0). Exemplars felt that while their homeless experience *"was not positive"* being able to overcome the challenges has made them a better professional (Julie).

Interestingly, this factor has ranked a statement on peer motivations significantly higher than the other factors (*18: +3). This is an important contribution to the overall analysis, exemplars identified with the language used in the statement, feeling that some peers are paying back for wrongdoings, suggesting that peer motivations are complex and important. Alternatively, this result highlights that the statement has potentially been misinterpreted by other participants and may have been ranked differently if it had been worded differently.

Regarding breaking boundaries, participants felt that peers being available out of normal working hours (26: -4) is "*not professional*" (Molly). Further, being a source of friendship (31: -3) and giving advice (32: -4) were devalued by this factor. Participants also felt that skills developed in peer-support (*20: -4) are not necessarily helpful for further career development:

"The skills you have may be different from the ones you need at work"—Molly

This group also devalues statements that acknowledge peers' uniqueness and equal level with clients (12: -2; 13: 0; 11: -3), explained by Julie:

"Being a professional that came from lived experience is also about your abilities and passion for your job, not just because you were homeless"

Consistent with this view, exemplars felt that peers should not be expected to perform tasks that are not expected of professionals. Interestingly, this group felt that skills developed from the peer role are not necessary for effective peer-support (20: -4). Obviously, exemplars placed skills around maintaining recovery as a priority for effective peer-support.

In sum, this factor provides a unique perspective of elements involved in effective peer-support from those with a breadth of experience. This group felt that effective peer-support starts with a healthy and supported peer; peers that are maintaining their recovery, seek help for personal struggles, and are positively motivated are good role models for clients.

Factor 3: Experience-Based Relationships

This factor accounts for 17% of the total study variance, representing the dominant professional perspective on effective peer-support. Five professionals (3 male and 2 female) from four different organisations comprise this factor (average age = 41, range = 35-44). Two professionals reported homelessness and addiction experience. One professional has up to 1 year experience working with this population, two professionals have up to 3 years' experience, one has up to 5 years' experience, and one has 15 years+ experience.

Exemplars value the shared life experiences that peers have with clients, peer-support works because peers have been homeless too (43: +4), and this shared experience allows for deep, genuine understanding of the clients perspective (*10: +4; *27: +1):

"The more a peer can empathise with a client due to their own experience, often leads to more connection"—Rick

This connection, an experience-based relationship, fosters the development of trust (2: +3; *3: +2). Participants identify peer-support as a unique level of support, where peers are different from professionals (12: +2):

"Homeless people have often used lots of different services and sometimes say professional only experience isn't relevant or is patronising, they are more trusting of those with lived experience"—Pippa

Exemplars also felt that the relationship is a conducive context for role modelling to occur, that peers live a lifestyle clients look up to (*21: +1), peers model recovery (22: +1), and that clients can compare themselves to peers (33: +1).

"Homeless people frequently make reference to 'successful peers' and model some of the behaviours"—Pippa

Participants also felt that peers help to reduce stigma, reducing barriers to services (42: +4) and help to increase client wellbeing (37: +2). Peers are a positive source of support—they respect boundaries (23: +1), have genuine motivations (17: +1), and benefit from providing support (*20: +3).

Exemplars felt that peer-support is less effective if peers are motivated by guilt (18: -4), if peers break boundaries by becoming friends with the clients (31: -4), overextend themselves (25: -3), or bend boundaries (24: -3). This group also devalued that statement differing peers from other people facing homelessness (13: -4), highlighting that this group feels that peers being unique in this respect is not a vital aspect to effective peer-support.

In sum, this dominant professional viewpoint posits that peers are effective because of their ability to develop unique experience-based relationships with clients and become positive role models for clients to model behaviours and lifestyles.

Appendix M Feasibility Study Protocol

Background and Rationale

Peer-support is commonly used with various populations to help people overcome particular difficulties, such as homelessness or mental illness. This kind of support can take multiple forms. For example, settings like group therapy allow members to benefit from each other's perspectives and inpatient services provide a context for friendships to develop that are often beneficial to clients (Yalom & Leszcz, 2005). This type of support is known as informal peer-support, where recipients are at the same level of recovery from a particular difficulty and the group, as a whole, is trying to work on a particular issue (Bradstreet, 2006). Another type of peer-support, formal peer-support, is similar to a mentoring approach, where peers are at a more advanced level of recovery and mentor clients through the early stages of recovery. The most widely recognised group of formal peer-support is AA—where those with more sobriety time mentor newcomers to work through the 12 Steps.

However, another derivative of formal peer-support is more often used in social services: multidirectional intentional peer-support (MIPS). MIPS applies the same principles as both informal and formal, but is termed 'intentional' because it is fostered and developed by professional organisations. MIPS can be either mentorship support or informal support (Faulkner et al., 2012). While this definition is helpful in developing our understanding of peer-support, it lacks clarity in specifying the interventions that clients are receiving, which limits the conclusions that can be drawn from effectiveness studies. Unsurprisingly, there is inconsistency in the literature regarding the effectiveness of peer-support. Repper and Carter (2011) found positive evidence for peer-support effectiveness within mental health services; in contrast, there was little evidence for this intervention in a systematic review for severe mental illness (Lloyd-Evans et al., 2014). However, a recent systematic review found evidence for the effectiveness of MIPS with a homeless sample (Stephanie. L. Barker & Maguire, 2017).

To differentiate and clarify peer-support that is currently being used in various services, we term it intentional, unidirectional peer-support (IUPS). IUPS is a formalised, mentorship type of peer-support where the peer is clearly more advanced and is mentoring the client in an organised fashion. IUPS is thought to work because of the unique relationship between peers and clients; peers are understanding, empathetic, and compassionate, which permits social learning and positive social comparisons to occur (Bandura & McClelland, 1977; Festinger, 1954; Salzer, 2002). Peers are role models for clients and provide an array of social support through their bond with the client. Emotional regulation is also thought to underpin IUPS, where clients increasingly are able to manage their emotions and navigate social relationships effectively.

By nature, IUPS requires the peer to be adequately trained to deal with various issues that clients experience. Further, peers must have support; they need strong professional and peer-group support networks to be effective in their role. IUPS occurs in organisations that value lived experiences; and help to build confidence and resilience in their clients through mentorship programmes.

As stated above, IUPS is used with various populations; the literature shows that peers are used to increase healthy behaviours (Dennis, 2003), reduce alcohol and drug use (Blondell et al., 2001; Galanter et al., 1998), increase mental health recovery (Campbell, 2008; Salzer, 2002), and reduce impacts of homelessness (Finlayson et al., 2016).

Regarding homelessness, there are a multitude of services in England that are using peers. Peers are used to engage entrenched rough sleepers, reduce barriers to accessing health systems, help clients cope with housing transitions, and generally, provide clients with a living example of someone who has survived and is thriving after experiencing a similar difficulty. Peer-support schemes are becoming quite common in homelessness services, with new programmes gaining funding (e.g. Ashford Place and Riverside in London, UK). Yet to be reflected in published literature, peer-support is a popular topic at prominent conferences (e.g. Street Medicine Institute Symposium 2016, The Faculty of Homelessness and Inclusion Health Symposium 2016 & 2017). Further, international organisations have developed standards and guidelines for involving those with lived experience into homelessness services (i.e. National Lived Experience Advisory Council, 2016).

Research on the effectiveness of MIPS on increasing health for homeless persons has found that peers are able to increase client engagement with health treatments (Connor et al., 1999; Deering et al., 2009; Fogarty et al., 2001; Pilote et al., 1996; Tulsky et al., 2004; Tulsky et al., 2000), and reduce barriers in accessing health services (Finlayson et al., 2016). Further, studies examining MIPS on mental health outcomes found that peers are able to improve clients' ability to cope with transitions from the hospital to independent housing (Weissman et al., 2005), increases in social networks (Stewart et al., 2009), and contribute to better overall outcomes for clients in services that incorporate peers (Bean et al., 2013; Galanter et al., 1998; van Vugt et al., 2012).

These results are encouraging; however, these studies have been conducted with varying types of MIPS, those with and without unidirectional support that is found in IUPS. Therefore, we cannot draw conclusions about which aspects of MIPS or IUPS are actually influencing client outcomes. Thus, there is a need to understand the elements that positively impact client outcomes. Further, given its common use within homelessness services, there is a need to identify specifically how IUPS impacts those experiencing homelessness. Client outcomes are thought to be mediated by two processes within peer support models: emotional regulation and the strength of the peer-

client relationship. Strong peer-client relationships should promote positive client outcomes (Stephanie. L. Barker & Maguire, 2017) and given that emotional dysregulation is associated with causing and/or maintaining homelessness (Maguire et al., 2012, manuscript in prep), it is hypothesised that client levels of emotional regulation will improve while receiving IUPS. Previous literature has highlighted certain client outcomes that IUPS may affect: drug and/or alcohol use, mental health, self-efficacy, and resilience.

Given the diversity of peer-support interventions used, the complex social systems involved in homelessness services, and the embryonic nature of the topic, the available research designs are limited. The participant pool of various organisations implementing peer-support are not using the same type of peer-support; furthermore, the populations served are also quite diverse. For example, a number of homeless charities with peer schemes in London serve the homeless, but their aims vary: Groundswell seeks to reduce health inequalities affecting the homeless, Riverside connects entrenched rough sleepers to services, Ashford Place takes referred clients and helps them deal with crises, and St. Mungos is primarily a housing and support organisation. There is overlap between these organisations, but by no means do they provide the same services and they certainly do not use peers in the same manner.

Due to the complex nature of evaluating peer-support, the Medical Research Council's guidance on complex interventions has been used to aid the development of this programme of research, organising the research in the first two phases (development and feasibility/piloting) as stipulated by Craig et al. (2008). This chapter focuses on the second phase, and proposes a feasibility study using a controlled cohort design to assess the effectiveness of peer-support with a homeless population through comparison of treatment and control groups. By assessing current programmes and utilising a feasibility approach, we can assess for contextual factors, participant opinions, the acceptability of randomisation, and the possibility of comparable control groups. Assessing the feasibility of conducting a controlled cohort study has high ecological validity but limits conclusions that can be drawn about outcomes.

In attempting to further the development of the research programme, it is essential to understand the process of undertaking a controlled cohort study with the target population. This feasibility study addresses the following research question: what is the feasibility of conducting a controlled cohort study assessing the impact of IUPS on those experiencing homelessness?

The objectives of the study are to:

- Explore professionals', peers', and clients' experiences of taking part in a controlled cohort study;
- Assess recruitment and retention rates;
- Assess the comparability of control and experimental groups;

- Evaluate the measurement tools, their appropriateness, and usability within a larger study;
- Identify the different components of the intervention, including frequency and type of interactions in peer-client interactions;
- Identify any barriers and facilitators to IUPS.

Methods

Design

Feasibility studies are pieces of research that precede a main study, and are primarily used to estimate parameters of the main study (Arain et al., 2010). Generally, the focus is not on the outcomes measured, but on the process of implementing the main design. A feasibility design is appropriate for this topic, because it allows the exploration and understanding of practical issues such as recruitment, acceptability of randomisation, suitability of an outcome measure, and development of an outcome measure (Arain et al., 2010).

This study is a feasibility of a controlled cohort study, which involves evaluating a sample before and after receiving an intervention (Mann, 2003). This involves a defined group of people (those experiencing homelessness), followed over time to examine associations between different interventions received (treatment as usual vs IUPS) and subsequent outcomes. This is a prospective study—recruitment occurs before intervention and participants are followed over time (Higgins & Green, 2008).

Sample Selection and Recruitment

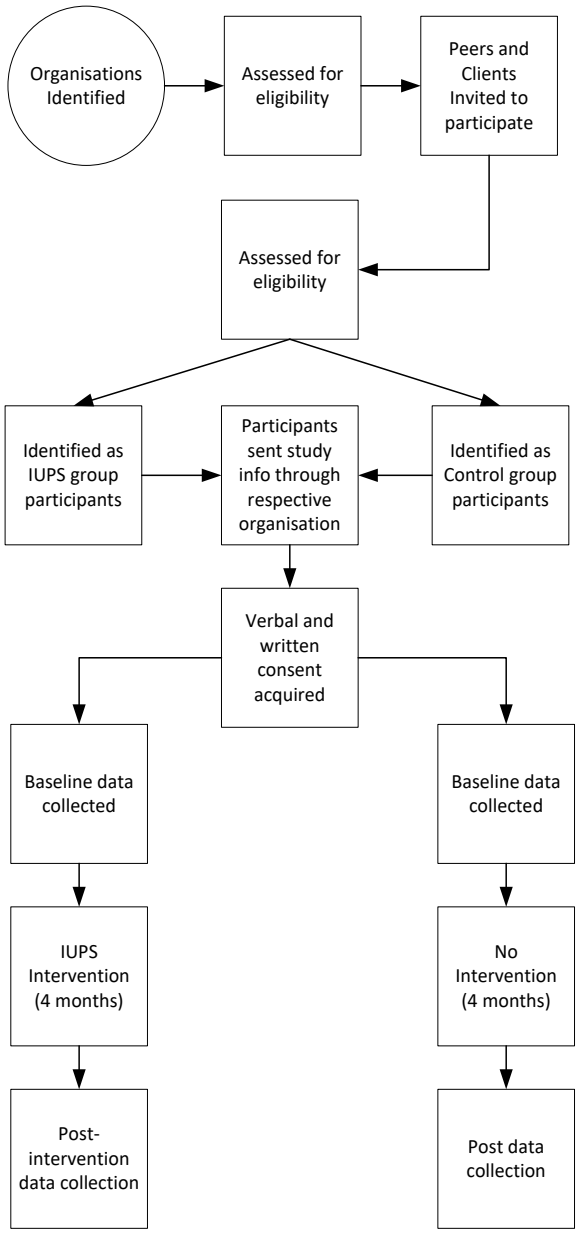


Figure 1. Controlled Cohort study outline

Participants will be recruited through three levels: organisations, peers, and clients. Organisations will be identified and assessed for eligibility (level 3). Within each organisation, we then recruit a number of peer-supporters (level 2). Then, each peer supporter will recruit a number of clients (level 1). Analysis will occur at level 1 where client outcomes are assessed. Within this study, we will assess the number of eligible participants and the feasibility of recruiting them into a research study.

Sample Size

Relevant literature evaluating peer interventions with homeless populations longitudinally is sparse, therefore, we draw upon existing literature to estimate sample size. For example, Fors and Jarvis (1995) included three arms in their longitudinal evaluation of peers with marginalised populations: 142 participants in the peer arm, 21 in the non-peer arm, and 14 in the control

group. Similarly, Resnick and Rosenheck (2008) had 78 participants in treatment groups and 218 in the control within their assessment of peer interventions for a veteran population compared to treatment as usual.

However, there are two known trials examining peers effectiveness in increasing homeless participants' treatment adherence in tuberculosis (TB) services (Pilote et al., 1996; Tulsky et al., 2000). These trials had similar numbers in each of their groups: an average of 81 and 39, respectively (Pilote et al., 1996; Tulsky et al., 2000).

Billingham et al. (2013) assessed pilot and feasibility studies on health interventions in England and found that the average number of participants in 2-armed studies was 30 per arm. Given that a full trial on a similar topic was conducted with 39 participants per arm, this feasibility study aims to recruit 20 participants in each group (N = 40).

The feasibility of recruiting more participants for a larger study will be assessed through an evaluation of how many possible participants there are within eligible organisations against how many are willing and lost to follow-up.

Treatment Group:

Eligible participants for the treatment group are those who have experienced homelessness and IUPS. In order to identify possible participants, the researcher will use the outline depicted in Figure 1, by firstly assessing peer programmes delivered by local homeless charities to identify which meet the following criteria:

- Provide services to a homeless population
- Include those with lived experience in their services
- Those with lived experience are trained in supporting clients
- Peers actively work one-to-one with clients to increase general wellbeing (e.g. health, mental health, assistance with benefits, accompanying clients to appointments, etc.)
- Peers are supported by professionals and/or group supervision

Once eligible organisations are identified, the researcher will approach them to ask for their participation in this feasibility study through emails, face-to-face meetings, and online advertising. Peers will recruit clients from eligible organisations on the following criteria:

Peers:

- Aged 18 and over
- Have personal experience of homelessness;
- Speak and read English fluently;
- Are engaged with IUPS provision;
- Have been providing IUPS for at least one month;
- If applicable, identify as being in recovery from drugs and/or alcohol;
- If applicable, identify as being in recovery from mental and/or physical illness

Clients:

- Aged 18 and over
- Are currently coping with homelessness;
- Mentored/working with a peer within a IUPS framework;
- Speak and read English fluently, or with assistance from their peer

Criteria are identified as being integral to participating in the feasibility study and future cohort studies. The requirement for peers to speak and read English fluently is derived from the included measurement tools, which may or may not have been translated in to other languages and subsequently tested for their validity and reliability. Further, peers should have at least one month of experience providing support. This criterion is selected because the IUPS framework identifies peers as being much more stable and further along in their recovery than their clients, thus they must have had time to attend training and become familiarised with providing peer-support.

Peers and clients will be invited to participate via emails, face-to-face meetings, and through organisation managers using a short description of the study and what would be asked of them, using a study advert (Appendix B). Once some participants have begun to engage with the researcher, a snowball sampling approach will be used, where participants will be asked if they know of others who would be interested in participating. Peers will be recruited until there are 20 clients in the treatment group. Therefore, the maximum number of peers that could be recruited into this study is 20.

Control group:

The control group participants will be recruited using a similar process; where homeless organisations that *do not* have peer-support programmes will be identified and then approached for their participation. Organisations to be identified will have similar services that are provided by the peer-support organisations to enhance the comparability of groups. For example, Groundswell provides IUPS, whereby clients are identified through referrals and peers support and aim to improve their clients' health. A comparable organisation would provide similar services but with professionals instead of peers, such as Southampton's Homeless Healthcare Team.

Recruiting for the control group will happen simultaneously to treatment group recruitment; organisations that provide IUPS will be approached first, then an equivalent service without IUPS will be contacted. Control group clients will be coping with homelessness and able to speak and read English fluently or with assistance from their professional worker.

Vouchers

Non-waged participants will be informed of a £5 voucher for each session (i.e. each survey session and each interview) that they participate in. These are high street vouchers that have been used

as compensation for the non-waged participants' time. Voucher amounts and guidelines are outlined in Table 1. In accordance with guidelines from the NHS Health Research Authority (HRA), voucher amounts do not place any undue inducements; £5 vouchers as payment for participants time while involved in the study is not an excessively attractive offer that would lead them to participate when they otherwise would not (Health Research Authority, 2014). The HRA recommends that payments are calculated from a rate of £100 per 24 hours. This study asks for participants to complete tasks that will take about 45 minutes per data collection point. Furthermore, recruitment documents will not unnecessarily highlight the payment (Health Research Authority, 2014).

Table 1. Voucher amounts and distribution

	Control		**Treatment**	
Data Collection Point	Clients	Professionals	Clients	Peers
Baseline	£5	Not eligible as they are paid	£5	£5
Post-treatment data	£5		£5	£5
Qualitative data collection	£5		£5	£5
Total	£15	£0	£15	£15

Measurement Tools

The intervention includes an evaluation of the IUPS services that participants are receiving and this will be tested through a battery of surveys. The surveys have been chosen to assess process and outcomes. As stated above, the peer-client relationship and the levels of emotional regulation are thought to be an integral elements to effective IUPS. Further, outcomes commonly associated with peer interventions include drug and alcohol use, mental health, resiliency, and self-efficacy (Blondell et al., 2001; Campbell, 2008; Galanter et al., 1998).

As feasibility studies are not oriented to evaluating outcomes, this study will assess if the treatment and control groups are similar enough that conclusions can be drawn from comparison of the two groups and the acceptability of measurement tools. Thus, the clients in each group will be asked to complete surveys over a similar timeframe, with two data collection time points: at baseline (within one month of starting with IUPS/services) and 3 months later.

Demographics Form

Clients will be asked to fill out a demographic form to ascertain their age, gender, ethnicity, mental health diagnosis, and mental health support. This information is required to assess the representation of the participant population to the rest of the homeless population and conduct comparisons between the treatment and control group. This information will be kept separate from any other data collected in order to ensure participant confidentiality.

Alcohol Use Disorders Identification Test (AUDIT)

To assess clients' alcohol use, the AUDIT will be utilised (Babor & Caetano, 2006; Saunders et al., 1993). This measure has been validated internationally through the World Health organisation (WHO), with various populations, including primary health care patients in six different countries (Saunders et al., 1993). The tool has good internal consistency (*r* = .86) and a high correlation coefficient (.78; Babor & Caetano, 2006). This measure has 10 items in total, eight are scored on a 5-point scale assessing the amount of alcohol use in a week, in one sitting, and over the past six months. The remaining two questions are scored on a 3-point scale assessing the impact of drinking on an individual's life, alcohol-related injuries, and other people being worried about the individuals' drinking.

Drug Use Disorders Identification Test (DUDIT)

To evaluate drug use, the DUDIT will be used (Berman et al., 2003). This 11-item measure was developed to accompany the AUDIT, in assessing drug use impact on an individual's life (Berman et al., 2003). Nine questions on the DUDIT are scored on a 5-point scale exploring the incidence of drug use and ability to stop once started. Questions 10 and 11 are scored on a 3-point scale, which examine drug-related injuries and if other people in the individual's life are concerned about their drug use. The tool has high convergent validity (*r* = .86) and a Cronbach's Alpha of .94 (Berman et al., 2003). The AUDIT and DUDIT are commonly used in conjunction with each other (Babor & Caetano, 2006).

Warwick-Edinburgh Mental Well-Being Scale (WEMWBS)

The WEMWBS assesses subjective mental wellbeing and psychological functioning through 14 items. The scale is scored on a 5-point likert scale and has been validated for use with UK populations, including the general population. Validation studies with the general population have shown the WEMWBS has a Cronbach's Alpha of .91 (Stewart-Brown, 2013; Stewart-Brown & Janmohamed, 2008).

General Self-Efficacy Scale (GSE)

The GSE examines participants levels of perceived self-efficacy, identifying coping and adaptation after experiencing stressors (Schwarzer & Jerusalem, 2010). This 10-item scale has a Cronbach's alphas that ranges from .76 to .90, in samples from 23 nations, with the majority in the high .80s (Schwarzer & Jerusalem, 2010). The tool is scored using a 4-point scale.

Connor-Davidson Resilience Scale (CD-RISC 2)

The CD-RISC 2 is a two item scale assessing resilience and the ability to "bounce back" after a stressful event (Vaishnavi et al., 2007). The scale includes two items, which were originally part of a larger scale assessing resilience. Vaishnavi et al. (2007) validated this two-item scale on various

populations and found that it is a valid tool for the general population, psychiatric populations, those with health issues, and healthy populations (J. Davidson & Connor, 2016).

Difficulty in Emotions Regulation Scale (DERS)

The DERS is a 36-item survey which assesses emotional dysregulation (Gratz & Roemer, 2004). The tool has six scales which all have a high Cronbach alpha (range .84-.89). The scales assess acceptance and awareness of emotions, impulse control, goal directed behaviour, strategies to cope with emotion, and levels of emotional clarity (Gratz & Roemer, 2004). The tool was developed with the general population and further tested with female participants diagnosed with borderline personality disorder.

Working Alliance Inventory (WAI-SR)

The WAI is used to assess the strength and impact of peer-client relationships. This tool is traditionally used to assess relationships between clients and helpers (usually therapists). However, it broadly defines the working alliance as a collaboration characterised by mutual trust, commitment, and compassion (Horvath & Greenberg, 1989; Kokotovic & Tracey, 1990). With author permission, the tool has been modified to reflect the language of peer-support (i.e. replacing “therapist” with “peer”).

This 12-item tool assess client’s perceptions of the working alliance they have with peers/professionals on a 4-point scale (Hatcher & Gillaspy, 2006). The WAI-SR has three subscales assessing the goals, tasks, and bond (Hatcher & Gillaspy, 2006). These subscales all have high correlation coefficients (ranging from .85-.90). For peers/professionals, the WAI-SR has 10 items scored on a 5-point scale and is administered to helpers only (Hatcher & Gillaspy, 2006).

Data collection

Quantitative Data

Participants will be asked to complete the eight surveys on two occasions: baseline and post intervention (3-4 months later). This feasibility study will assess three methods of survey data collection, outlined in Table 1. In all three methods, the researcher must be present, as the surveys require administration from an appropriately trained researcher. Furthermore, data that is collected in the field will require more than one researcher present, in order to comply with health and safety regulations outlined by the University. Completion of surveys is expected to take no longer than 45 minutes, but this timeframe can vary, depending on the participant’s literacy level.

Table 2. Survey data collection methods

Pairs	Groups	In the Field
• Pairs of peers and clients, or • Pairs of professionals and clients • Invited to respective organisations • Participants complete surveys with researcher	• Groups of participants • Invited to respective organisations • Complete surveys with researcher present	• Researcher collaborates with peer or professional • Organises a meeting spot (e.g. participant home, café, community centre) • Participants complete survey with researcher

The method chosen will depend on the participants' preferences. When recruiting participants into the study, the researcher will outline the options for data collection and allow the participants to decide. Each method will be assessed for participant preference but also the practicality of collecting data from a large number of participants and the required resources for each method.

Cohort designs are susceptible to confounding effects, which can be mitigated by blinding participants and/or researchers to group membership (Mann, 2003). Within this feasibility study, blinding participants is impossible, however an attempt will be made to blind researchers who are scoring the measurement tools. This will be achieved by anonymising the data before it is scored by the researchers. Each survey pack will be assigned a random participant number prior to data collection and identifying information will be separated out before it is scored. The procedure for this is as follows:

1. Survey packs are assigned participant numbers to every sheet within the pack
2. Data collection occurs
3. Consent and demographic forms are removed from the pack
4. Researchers score the surveys before inputting demographic data into digital format

Furthermore, the primary researcher will enlist voluntary research assistants (VRA) to assist with data collection and entry, including checking accuracy of data entry where double data entry will occur on 10% of participant data. This process will be evaluated for contamination and result in recommendations for the possibility of blinding researchers for a larger study.

Qualitative Data

Qualitative interviews allow a deeper understanding to the process of this feasibility study, thus all participants, including peers and professionals, will be invited to contribute to the study through qualitative interviews (Braun & Clarke, 2013). Peers, clients, and professionals will be informed of opportunities to provide feedback through interviews during quantitative data

collection and their interest will be documented. Participants will be contacted to participate in interviews and/or focus groups within 30 days of the second data point.

Primarily, qualitative data will be collected through one-to-one, semi-structured interviews, where participants can voice their experience of the study through informal discussions (Wilkinson et al., 2004). Interviews will be guided with a topic guide for each type of participant (see appendix A). Interviews will focus on the experience of the study, their opinions on the measurement tools (length, language, etc.), the presence of peers/professionals, and possibility of randomisation. Participants will also be asked their opinions on the processes and outcomes of IUPS, exploring what they feel are the driving factors and main outcomes that they have experienced as a result of this support. This will allow for the researcher to examine other potential measures that may need to be included in a larger study to accurately assess IUPS. Each interview will be audio-recorded with permission from participants.

Data Analysis

Interviews will be transcribed verbatim, input into the data managing software NVivo, and analysed using thematic analysis (QSR, 2012). Thematic analysis is a useful, flexible method for handling qualitative data (Braun & Clarke, 2006). Further, thematic analysis is the best method of analysis to achieve identified research aims. The analysis seeks to understand participant experiences of the cohort design and identify any barriers to carrying out a full-scale cohort study. The analysis will code inductively, following guidance developed by Braun and Clarke (2006), using participant words to identify issues with the research design and suggested changes.

Quantitative data will be entered into the software programme SPSS (IBM, 2016). Descriptive statistics and frequencies will be run on the data to summarise demographic data. This will allow for comparability of the treatment and control groups to be assessed. Further, the frequency of missing data will be assessed. Researchers will note the number of potential participants at each organisation and the number that did participate, allowing for the calculation of recruitment rates. In addition, quantitative data results will inform some questions in the qualitative interviews. However, rather than asking about changes in specific scores, researchers will review client scores prior to interviews and tailor questions to ask about any changes they experienced resulting from IUPS to supplement outcomes and examine if other measures need to be included to capture those changes within a larger study.

Ethics

Recruitment

Participants will be recruited through their respective organisations and will be informed that their participation is voluntary and has no impact on the services that they receive. They will be

informed of the details of the study through their line manager at their organisation, then again through the participant information sheet provided by the researcher(s).

Each non-waged participant will receive a £5 voucher for their time while participating in the study. The decision to use a non-cash compensation is derived from a standard practice of conducting research with this population. By not using cash, we are reducing the potential for harm from this feasibility study—participants cannot return the voucher for cash or use it to buy illegal substances.

Data protection

Participants' information will be kept strictly confidential. Participant evaluation packs will be allocated random participant numbers, where a number is written on the paper copies of the evaluation pack prior to meeting with the participant. Completed evaluation packs will be kept in a portable lock box until the researcher inputs the data onto three separate, password protected files: one file to link participant numbers to contact information, a second file where demographic data is kept, linked by participant number, and the third file will contain the survey data, again linked only by participant number. The paper copies of the evaluation pack will be separated into three locked filing cabinets, following the same organisation as the digital storage of data.

Regarding qualitative data, researchers will transcribe the audio recordings and allocate their participant numbers to the digital file. Audio recordings will be transferred from the portable device to a university-issued, password protected laptop as soon as possible. Once they have been transcribed and labelled, the audio recordings will be deleted. Transcribed interviews will not contain identifying information, such as organisation or locations. However, to manage data and maintain organisation, the researcher(s) will allocate identifying codes to organisation names. For example, the first organisation to be recruited will receive the code "ORG001". A digital file will be kept separate from transcribed interviews that identifies the names of each organisation.

The researcher(s) keeps the digital files on the University issued, password protected laptop computer and filing cabinets are kept at the University of Southampton in a locked office. Further, employees/volunteers of each organisation will not have access to raw data. Data will be kept for 10 years and then it will be destroyed. All data use is strictly within the terms of the Data Protection Act (DPA, 1998) and the data protection policy of the University of Southampton.

Risks to Participants

The survey items have the possibility of inducing negative emotional reactions in the participants. While this is unlikely, given that clients would talk about topics like drug and alcohol use with their peer/professional, precautions will be taken. Researchers will mitigate this through emphasising that the participant should only fill out what they are comfortable with sharing, taking breaks,

referring participants to talk with their peer/professional, and the resources outlined on the debriefing form. Further, clients will have their main source of support there with them while they are filling out the surveys.

For the qualitative interviews, it is less likely that participants will experience negative emotions, given that we will be discussing the study process rather than their specific life experiences. Nonetheless, it is still possible that the discussion will move towards their experiences of the intervention thus the same procedures as above will be utilised.

Risks to Researcher(s)

The main risks to the researchers result from the data collection methods. Data collected at respective organisations is the least likely to pose harm, however, the researcher(s) will take care to ensure their safety. For all data collection methods, researchers will let an external person know when they begin a session, including location information, the expected time of finishing, and will call/text when they are finished with a participant pair/group.

For data collected in the field, the researchers will follow the same protocol as outlined above and will collect data in pairs. This will ensure that the researcher is not alone and potentially vulnerable with participants.

Regarding VRA's, the principle researcher (SB) will provide them with training and support. VRAs will be recruited for data entry, which will occur during business hours at the University. VRAs will also be recruited for data collection. Training for data collection will include:

- An overview of the study protocol, including aims and design
- Detailed instructions on procedures for data collection methods
    - How/where data will be collected
    - Overview of the included measurement tools
    - Limits of confidentiality
- Detailed instructions on risk assessment procedures
    - Procedures in contacting someone when data collection starts and finishes
    - Overview of what can be expected from participants, such as limited literacy, potential intoxication, and emotional responses to measurement tools
    - SB will go over methods for coping with any emotional reactions from participants, such as taking a break or stopping, getting a drink of water, sitting closest to the door, having their mobile on hand to call SB and/or security.
        - Importantly, VRAs will know when to be concerned for the participants safety, such as if they threaten to harm themselves or others. SB will ensure that the VRA communicates this to the present researcher.

SB will also ensure that VRAs do not collect data alone; they will always be traveling with another researcher and collecting data within the same organisation/location with another researcher. VRA's will be recruited to help with data collection methods that occur in the field, so the primary researcher has a second person with them. This allows the VRA to participate in data collection but never be alone with participants outside of a controlled environment (such as a hostel or homeless organisation). SB will provide support to VRAs by preparing them for a data collection session with an overview of the schedule and what is to be expected. SB will conclude the data collection session with a discussion with the VRA on how they felt about it, if they were concerned or worried at any point, if they have any questions, and if they would like to continue. This discussion will be especially important if we experience any difficulties (e.g. an intoxicated or suicidal participant) thus, will occur directly after the event rather than at the end of the data collection day.

Appendix N Feasibility Measurement Tools

N.1 Demographic Data

Are you: Male ☐ Female ☐

How old are you? _____

How would you describe your ethnicity?

White Other	Mixed	Asian	Black	
☐ Irish	☐ White & Asian	☐ Bangladeshi	☐ Black African	☐ Chinese
☐ British	☐ White & Black African	☐ Pakistani	☐ Black Caribbean	☐
☐ Other White	☐ White & Black Caribbean	☐ Indian	☐ Other Black	
	☐ Other Mixed	☐ Other Asian		

Do you have a mental health need or condition which has been diagnosed by a doctor or other health professional?

Yes ☐ No ☐

If so, what is your diagnosis?

_____

Do you get support with your mental health e.g., community mental health team?

Yes ☐ No ☐

Please provide further details

_____

_____

_____

_____

_____

When did you start receiving peer-support/Case Management?

_____

Appendix N

Client Evaluation Pack

Please indicate your current housing situation:

Hostel	☐	Sleeping on somebody's sofa/floor	☐
Sleeping rough	☐	Squatting	☐
Own tenancy	☐	Supported accommodation	☐
Other, please specify:			

Please indicate the frequency of the following:

Nights spent sleeping rough in the past 6 months	☐
Tenancies held within the last 2 years	☐
Length of last tenancy (in months)	☐
Number of evictions within the last 2 years	☐

Please indicate how frequently you have engaged in the following behaviours in the past 4 weeks:

Violent incidents against people	☐
Violent incidents against property	☐
Incidents of threat against staff	☐
Incidents of threat against other service users	☐
Incidents of theft	☐

Please indicate the frequency of the following, in the past 6 months:

Nights spent in a police cell	☐
Number of arrests	☐
Nights spent in a psychiatric hospital	☐
Number of hospital nights	☐
Number of A&E admissions	☐

Are you registered with a General Practitioner (GP)?

Yes ☐ No ☐

If yes, how long have you been registered with a GP?

_____

If yes, how many times have you been to your GP?

In the last 6 ☐ months

In the last month ☐

N.2 AUDIT

1. How often do you have a drink containing alcohol?

0	1	2	3	4
Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

0	1	2	3	4
1 or 2	3 or 4	5 or 6	7, 8, or 9	10 or more

3. How often do you have six or more drinks on one occasion?

0	1	2	3	4
Never	Less than monthly	Monthly	Weekly	Daily or almost daily

4. How often during the last year have you found that you were not able to stop drinking once you had started?

0	1	2	3	4
Never	Less than monthly	Monthly	Weekly	Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

0	1	2	3	4
Never	Less than monthly	Monthly	Weekly	Daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

0	1	2	3	4
Never	Less than monthly	Monthly	Weekly	Daily or almost daily

7. How often during the last year have you had the feeling of guilt or remorse after drinking?

0	1	2	3	4
Never	Less than monthly	Monthly	Weekly	Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because you have been drinking?

0	1	2	3	4
Never	Less than monthly	Monthly	Weekly	Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?

0	2	4
No	Yes, but not in the last year	Yes, during the last year

10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?

0	2	4
No	Yes, but not in the last year	Yes, during the last year

N.3 DUDIT

1. How often do you use drugs other than alcohol?

0	1	2	3	4
Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week

2. Do you use more than one type of drug on the same occasion?

0	1	2	3	4
Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week

3. How many times do you take drugs on a typical day when you use drugs?

0	1	2	3	4
0	1 to 2	3 to 4	5 to 6	7 or more

4. How often are you influenced heavily by drugs?

0	1	2	3	4
Never	Less than monthly	Monthly	Weekly	Daily or almost daily

5. Over the past year, have you felt that our longing for drugs was so strong that you couldn't resist it?

0	1	2	3	4
Never	Less than monthly	Monthly	Weekly	Daily or almost daily

6. Has it happened, over the past year, that you have not been able to stop taking drugs once you started?

0	1	2	3	4
Never	Less than monthly	Monthly	Weekly	Daily or almost daily

7. How often over the past year have you taken drugs and then neglected to do something you should have done?

0	1	2	3	4
Never	Less than monthly	Monthly	Weekly	Daily or almost daily

8. How often over the past year have you needed to take a drug the morning after heavy drug use the day before?

0	1	2	3	4
Never	Less than monthly	Monthly	Weekly	Daily or almost daily

9. How often over the past year have you had guilt feelings or a bad conscience because you used drugs?

0	1	2	3	4
Never	Less than monthly	Monthly	Weekly	Daily or almost daily

10. Have you or anyone else been hurt (mentally or physically) because you used drugs?

0	2	4
No	Yes, but not in the last year	Yes, during the last year

11. Has a relative or a friend, or a doctor or a nurse, or anyone been worried about your drug use or said to you that you should stop using drugs?

0	2	4
No	Yes, but not in the last year	Yes, during the last year

N.4 WEMWBS

Below are some statements about feelings and thoughts.

Please indicate what best describes your experience over the last 2 weeks for each statement by writing the appropriate number from the scale below

1	2	3	4	5
None of the time	Rarely	Some of the time	Often	All of the time

1. _____ I've been feeling optimistic about the future
2. _____ I've been feeling useful
3. _____ I've been feeling relaxed
4. _____ I've been feeling interested in other people
5. _____ I've had energy to spare
6. _____ I've been dealing with problems well
7. _____ I've been thinking clearly
8. _____ I've been feeling good about myself
9. _____ I've been feeling close to other people
10. _____ I've been feeling confident
11. _____ I've been able to make up my own mind about things
12. _____ I've been feeling loved
13. _____ I've been interested in new things
14. _____ I've been feeling cheerful

N.5 GSE

1. I can always manage to solve difficult problems if I try hard enough.

1	2	3	4
Not at all true	Hardly true	Moderately true	Exactly true

2. If someone opposes me, I can find the means and ways to get what I want.

1	2	3	4
Not at all true	Hardly true	Moderately true	Exactly true

3. It is easy for me to stick to my aims and accomplish my goals.

1	2	3	4
Not at all true	Hardly true	Moderately true	Exactly true

4. I am confident that I could deal efficiently with unexpected events.

1	2	3	4
Not at all true	Hardly true	Moderately true	Exactly true

5. Thanks to my resourcefulness, I know how to handle unforeseen situations.

1	2	3	4
Not at all true	Hardly true	Moderately true	Exactly true

6. I can solve most problems if I invest the necessary effort.

1	2	3	4
Not at all true	Hardly true	Moderately true	Exactly true

7. I can remain calm when facing difficulties because I can rely on my coping abilities.

1	2	3	4
Not at all true	Hardly true	Moderately true	Exactly true

8. When I am confronted with a problem, I can usually find several solutions.

1	2	3	4
Not at all true	Hardly true	Moderately true	Exactly true

9. If I am in trouble, I can usually think of a solution.

1	2	3	4
Not at all true	Hardly true	Moderately true	Exactly true

10. I can usually handle whatever comes my way.

1	2	3	4
Not at all true	Hardly true	Moderately true	Exactly true

N.6 CD-RISC 2

As per request of authors (J. Davidson & Connor, 2016), one sample item is reported.

Sample item

	not true at all (0)	rarely true (1)	sometimes true (2)	often true (3)	true nearly all the time (4)
I am able to adapt when changes occur.	☐	☐	☐	☐	☐

N.7 WAI-RS

Below is a list of statements and questions about experiences people might have with their peer-supporter. Some items refer directly to your peer with an underlined space -- as you read the sentences, mentally insert the name of your peer in place of _____ in the text. Think about your experience in peer-support, and decide which category best describes your own experience.

IMPORTANT!!! Please take your time to consider each question carefully.

1. As a result of these meetings I am clearer as to how I might be able to change.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

2. What I am doing with peer-support gives me new ways of looking at my problem.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

3. I believe___likes me.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

4. ___and I collaborate on setting goals for my support.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

5. ___and I respect each other.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

6. ___and I are working towards mutually agreed upon goals.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

7. I feel that___appreciates me.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

8. _____ and I agree on what is important for me to work on.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

9. I feel _____ cares about me even when I do things that he/she does not approve of.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

10. I feel that the things I do in peer-support will help me to accomplish the changes that I want.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

11. _____ and I have established a good understanding of the kind of changes that would be good for me.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

12. I believe the way we are working with my problem is correct.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

Difficulties in Emotion Regulation Scale (DERS)

Please indicate how often the following statements apply to you by writing the appropriate number from the scale below on the line beside each item.

1----------2----------3----------4----------5

almost never (0-10%)	sometimes (11-35%)	about half the time (36-65%)	most of the time (66-90%)	almost always (91-100%)

_____ 1) I am clear about my feelings.
_____ 2) I pay attention to how I feel.
_____ 3) I experience my emotions as overwhelming and out of control.
_____ 4) I have no idea how I am feeling.
_____ 5) I have difficulty making sense out of my feelings.
_____ 6) I am attentive to my feelings.
_____ 7) I know exactly how I am feeling.
_____ 8) I care about what I am feeling.
_____ 9) I am confused about how I feel.
_____ 10) When I'm upset, I acknowledge my emotions.
_____ 11) When I'm upset, I become angry with myself for feeling that way.
_____ 12) When I'm upset, I become embarrassed for feeling that way.
_____ 13) When I'm upset, I have difficulty getting work done.
_____ 14) When I'm upset, I become out of control.
_____ 15) When I'm upset, I believe that I will remain that way for a long time.
_____ 16) When I'm upset, I believe that I will end up feeling very depressed.
_____ 17) When I'm upset, I believe that my feelings are valid and important.
_____ 18) When I'm upset, I have difficulty focusing on other things.
_____ 19) When I'm upset, I feel out of control.
_____ 20) When I'm upset, I can still get things done.
_____ 21) When I'm upset, I feel ashamed at myself for feeling that way.
_____ 22) When I'm upset, I know that I can find a way to eventually feel better.
_____ 23) When I'm upset, I feel like I am weak.
_____ 24) When I'm upset, I feel like I can remain in control of my behaviors.
_____ 25) When I'm upset, I feel guilty for feeling that way.
_____ 26) When I'm upset, I have difficulty concentrating.
_____ 27) When I'm upset, I have difficulty controlling my behaviors.
_____ 28) When I'm upset, I believe there is nothing I can do to make myself feel better.
_____ 29) When I'm upset, I become irritated at myself for feeling that way.
_____ 30) When I'm upset, I start to feel very bad about myself.
_____ 31) When I'm upset, I believe that wallowing in it is all I can do.
_____ 32) When I'm upset, I lose control over my behavior.
_____ 33) When I'm upset, I have difficulty thinking about anything else.
_____ 34) When I'm upset I take time to figure out what I'm really feeling.
_____ 35) When I'm upset, it takes me a long time to feel better.
_____ 36) When I'm upset, my emotions feel overwhelming.

Appendix O Feasibility Topic Guide

O.1 Questions for Peers/Professionals:

- Can you tell me what it was like for you, being involved in the study?
- What, if any, aspects of the study were positive for you?
- What, if any, aspects of the study were negative for you?
- Were you worried about your client at any point as a result of the surveys/study?
    - If so, do you have recommendations for us to avoid this in the future?
    - Is there anything you would suggest we do differently?
- What did you think about how we collected data (group/pairs/in the field)?
    - Which one did they use/prefer?
- What did you think about the time frame of completing surveys?
    - What about 3-4 months later? What do you think about that time frame?
- Is there anything about the study that you would change?
    - What would you like to see different about this study?
    - Is there anything that you would have liked to be included?
- In future studies, we would like to look at the effect of peer support where a computer would randomly allocate clients to one of two possible methods of treatment—to receive peer support or professional case workers.
    - What are your thoughts about this process?
    - Is this process similar to how you get new clients now? How do you get new clients?
    - How would you, as a peer/professional, feel if you had a client assigned to your caseload?
    - What, if any, impact do you think this may have?
    - How do you feel about having clients assigned to you?

Peer Questions:

- What are your thoughts about peers collecting this survey data?
- How would you feel if you were collecting survey data?
- Would you attend a peer training to do research?
    - Why, or why not?

O.2 Questions for Clients

Assess how they felt about the process

- Can you tell me how you felt about being involved in the study?
- What, if any, aspects of the study were positive for you?
- What, if any, aspects of the study were negative for you?
- What did you think about how we collected data (group/pairs/in the field)?
    - Which one did they use/prefer?
    - How did you feel about having your peer/professional with you?
        - If you were to do this again, would you like it to be different? How?
- Is there anything you would like to change about the study? Such as:
    - How we contacted you?
    - The setting where you completed the surveys?
    - Any of the questions in the surveys?

Opinions about the measures—language used, difficulties, peer/professional presence

- What did you think about the surveys? (review a blank one to refresh their memory)
    - What do you think about the language used in the surveys?
    - Did you find any part of it difficult?
    - Was it too long/short?
- Were there any questions that you did not want to answer?
- These measures look at the peer-client relationship, emotional regulation, drugs/alcohol, mental health, resilience and self-efficacy, is there anything else you feel is important in peer-support that should be included?

What makes peer-support work?

- Do you feel like you had a chance to express that in these surveys?

Compensation amount: Is a £5 voucher enough for the amount of work you put in?

In future studies, we would like to look at the effect of peer support where a computer would randomly allocate clients to one of two possible methods of treatment—to receive peer support or professional case workers.

- What are your thoughts about this process?
- How did you get your peer/professional?
- How would you, as a client, feel if you were assigned to a peer/professional?
- What, if any, impact do you think this may have?
- How do you feel about being assigned to a peer/professional?

Appendix P Feasibility Ethics Documents

P.1 Pre Study Interviews

P.1.1 Pre Study Interview: Participant Information Sheet

You are being asked if you would agree to take part in a pre-study interview to assess your opinions of a feasibility study evaluating client outcomes in peer-support and homelessness

What is the research about?

Peer Support services are aimed at helping service users to achieve goals. We want to find out what your opinions are of the barriers to conducting the feasibility study are with your client base.

Why have I been chosen?

We are approaching you to take part in this research because you/your organisation provides peer-support to those experiencing homelessness.

What will happen to me if I take part?

You are invited to complete an audio-recorded interview with the researcher to find out your views on conducting the feasibility study with your client base. This should take no more than 90 minutes. Your input helps us to adapt our approach and make sure we are sensitive to you and/or your clients' needs. Participation in the study will not affect any other aspect of your rights.

Are there any benefits in my taking part?

Yes, by taking part in this study, you will be adding to research on peer-support and how to conduct research with those experiencing homelessness.

Are there any risks involved?

It is very unlikely that you will find the interview upsetting; we will ask questions on what your thoughts are about how to conduct research with your client base.

Will my participation be confidential?

All information that is collected about you will be kept strictly confidential and separate from the services you provide and/or receive. The audio-recording will be put onto a password-protected computer and transcribed. Any identifying information will be anonymised so that you cannot be recognised from it. The audio recording will then be deleted.

We will, instead, identify you using a randomly generated number. It might be important to look at the data in years to come, so we will keep it for 10 years and then it will be destroyed. All data use is strictly within the terms of the Data Protection Act (DPA, 1998).

What happens if I change my mind?

You have the right to withdraw your data without your legal rights, or routine care being affected. However, we cannot withdraw data from a published report that may result from this study.

What happens if something goes wrong?

If you have questions about your rights as a participant in this research, or if you feel that you have been placed at risk, you may contact the Chair of the Ethics Committee, Psychology, University of Southampton, Southampton, SO171BJ. Phone: +44 (02380 593856, email fshs-rso@soton.ac.uk).

Where can I get more information?

If you would like more information about the study please contact Stephanie Barker at

Tel: 023 8059 4719 Email: S.L.Barker@soton.ac.uk

P.1.2 Pre Study Interview: Consent Form

CONSENT FORM: Pre- study Interview (Version 1, 23/04/2017, ERGO number: 25223)

Study title: The Feasibility of Conducting Research on the Effectiveness of Peer-Support with a Homeless Population

Researcher name: Stephanie Barker

*Please **initial** the box(es) if you agree with the statement(s):*

I have read and understood the information sheet (version 1, 23/04/2017) and have had the opportunity to ask questions about the study	☐
I agree to take part in this pre-study interview and agree for my data to be used for the purpose of evaluating the research process	☐
I understand my participation is voluntary and I may withdraw at any time without my legal rights being affected	☐
I understand and agree that this interview will be audio-recorded	☐
I understand that anonymised quotes will be used in the reporting	☐

Name of participant (print name) ……..

Signature of participant…….

Date……..

P.1.3 Pre Study Interviews: Topic Guide

The Feasibility of Conducting Research on the Effectiveness of Peer-Support with a Homeless Population (ERGO ID: 25223)

Pre-Study Interviews with Peers and/or Professionals:

Topc Guide (Version 1: 23/04/2017)

1. Introductions:
    a. Names
    b. Brief description of role
2. Have you had a chance to review the study materials? (i.e. the protocol, PIS)
    a. Give participants time to review the survey pack (because it cannot be sent out prior due to copyright)
3. What are your initial thoughts about conducting this study with your client base?
4. Do you see any specific problems?
    a. With the timeline? (pre/post surveys and post interviews over 3-4 months)
    b. With the survey questions?
    c. With data collection methods?
5. How can we address these barriers?
6. Do you have suggestions for how we can best assess client outcomes in peer-support?

P.1.4 Pre Study Interviews: Debrief Form

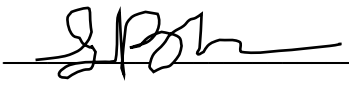
The Feasibility of Conducting Research on the Effectiveness of Peer-Support with a Homeless Population: Pre- Study Interview

Debriefing Statement (Version 1, 23/04/2017, ERGO number: 25223)

The interview aimed to find out your thoughts about conducting a feasibility study with your client base. We were interested in finding out what barriers you identify and any recommendations you have for how we can modify the study to maximise participation and maintain client and peer safety.

Once again results of this study will not include your name or any other identifying characteristics.
You may have a copy of this summary if you wish and you may have a copy of the research project once it is completed.
If you have any further questions and/or would like a copy of the report please contact me, Stephanie, at 02380594719 or S.L.Barker@soton.ac.uk

Thank you for your participation in this research.

Signature  Date _____23/04/2017_____

If you have questions about your rights as a participant in this research, or if you feel that you have been placed at risk, you may contact the Chair of the Ethics Committee, Psychology, University of Southampton, Southampton, SO17 1BJ. Phone: +44 (0)23 8059 3856, email fshs-rso@soton.ac.uk

P.2 Surveys: Treatment and Control Groups

P.2.1 Treatment Group Participant Information Sheet

You are being asked if you would agree to take part in a study that is separate from the support you are currently receiving. Before you decide if you wish to participate, please take time to read the following information carefully and ask us if there is anything that is not clear or if you would like more information.

What is the research about?

Peer Support services are aimed at helping service users to achieve goals. We want to find out how effective Peer Support Schemes are, so we are comparing peer services to case work services. We also want to know what your experiences are being in a research study.

Why have I been chosen?

We are asking you to take part in this research because you have been identified as a service user of Peer Support.

What will happen to me if I take part?

You will be asked to complete a set of surveys (taking about 35-45 minutes) on two occasions. The first will be soon after starting with peer support and the second will be after you have been involved in peer-support for 3-4 months. On each occasion, you will receive a voucher worth £5 for your time. Participation in the study will not affect any other aspect of your treatment or rights within the services you are receiving.

After the second time completing the surveys, you are invited to complete an interview with the researcher to find out how you felt about the whole study. This should take no more than 45 minutes.

Are there any benefits in my taking part?

Yes, research has shown that peer support can reduce substance misuse and enable positive connections with the local community. By taking part in this study, you will be adding to research on Peer Support and help us understand how to conduct research with those experiencing homelessness.

Are there any risks involved?

It's possible that you might find the surveys a little upsetting, as it will ask you questions about your personal recovery journey, including questions about your past and current drug/alcohol use, and your past/current accommodation situation.

Will my participation be confidential?

All information that is collected about you during the course of the study will be kept strictly confidential and separate from the services you receive. Any information about you will have your name and address removed so that you cannot be recognised from it.

We will, instead, identify you using a randomly generated participant number. There will be an encrypted file stored on a password-protected computer that will link your name and address to your participant number. We need to do this because we will asking you complete the surveys twice, so we'll need to be able to contact you. No one apart from those directly involved in the project will be able to access this information. It might be important to look at the data in years to come, so we will keep it for 10 years and then it will be destroyed. All data use is strictly within the terms of the Data Protection Act (DPA, 1998).

There are limits to confidentiality, if you tell us about something illegal or other banned activity, then we have a duty to report it. We are required to report if someone discloses that they have or are going to commit a crime.

What happens if I change my mind?

You have the right to withdraw your data from this time point and any previous time points without your legal rights, or routine care being affected. However, we cannot withdraw data from a published report that may result from this study. If you decide to stop during a session, you will still receive the £5 voucher.

What happens if something goes wrong?

If you have questions about your rights as a participant in this research, or if you feel that you have been placed at risk, you may contact the Chair of the Ethics Committee, Psychology, University of Southampton, Southampton, SO171BJ. Phone: +44 (02380 593856, email fshs-rso@soton.ac.uk).

Where can I get more information? If you would like more information, please contact Stephanie Barker at

Tel: 023 8059 4719 Email: S.L.Barker@soton.ac.uk

P.2.2 Control Group Participant Information Sheet

You are being asked if you would agree to take part in a study that is separate from the support you are currently receiving. Before you decide if you wish to participate, please take time to read the following information carefully and ask us if there is anything that is not clear or if you would like more information.

What is the research about?

Peer Support services are aimed at helping service users to achieve goals. We want to find out how effective Peer Support Schemes are, so we are comparing peer services to case work services. We also want to know what your experiences are being in a research study.

Why have I been chosen?

We are asking you to take part in this research because you have been identified as a service user who does not receive peer support.

What will happen to me if I take part?

You will be asked to complete a set of surveys (taking about 35-45 minutes) on two occasions. The first will be soon after starting with peer support and the second will be after you have been involved in case work for 3-4 months. On each occasion, you will receive a voucher worth £5 for your time. Participation in the study will not affect any other aspect of your treatment or rights within the services you are receiving.

After the second time completing the surveys, you are invited to complete an interview with the researcher to find out how you felt about the whole study. This should take no more than 45 minutes.

Are there any benefits in my taking part?

By taking part in this study, you will be adding to research on Peer Support and help us understand how to conduct research with those experiencing homelessness.

Are there any risks involved?

It's possible that you might find the surveys a little upsetting, as it will ask you questions about your personal recovery journey, including questions about your past and current drug/alcohol use, and your past/current accommodation situation.

Will my participation be confidential?

All information that is collected about you during the course of the study will be kept strictly confidential and separate from the services you receive. Any information about you will have your name and address removed so that you cannot be recognised from it.

We will, instead, identify you using a randomly generated participant number. There will be an encrypted file stored on a password-protected computer that will link your name and address to

your participant number. We need to do this because we will asking you complete the surveys twice, so we'll need to be able to contact you. No one apart from those directly involved in the project will be able to access this information. It might be important to look at the data in years to come, so we will keep it for 10 years and then it will be destroyed. All data use is strictly within the terms of the Data Protection Act (DPA, 1998).

There are limits to confidentiality, if you tell us about something illegal or other banned activity, then we have a duty to report it. We are required to report if someone discloses that they have or are going to commit a crime.

What happens if I change my mind?

You have the right to withdraw your data from this time point and any previous time points without your legal rights, or routine care being affected. However, we cannot withdraw data from a published report that may result from this study. If you decide to stop during a session, you will still receive the £5 voucher.

What happens if something goes wrong?

If you have questions about your rights as a participant in this research, or if you feel that you have been placed at risk, you may contact the Chair of the Ethics Committee, Psychology, University of Southampton, Southampton, SO171BJ. Phone: +44 (02380 593856, email fshs-rso@soton.ac.uk).

Where can I get more information? If you would like more information about the study please contact Stephanie Barker at Tel: 023 8059 4719 Email: S.L.Barker@soton.ac.uk

P.2.3 Treatment and Control Group Consent Form

CONSENT FORM: Surveys (Version 1, 26/01/2017, ERGO number 25223)

Study title: The Feasibility of Conducting Research on the Effectiveness of Peer-Support with a Homeless Population

Researcher name: Stephanie Barker

*Please **initial** the box(es) if you agree with the statement(s):*

I have read and understood the information sheet (version 1, 26/012017) and have had the opportunity to ask questions about the study	☐
I agree to take part in this research project and agree for my data to be used for the purpose of evaluating the research process and effectiveness of peer support	☐
I understand my participation is voluntary and I may withdraw at any time without my legal rights being affected	☐
I agree to be contacted for the follow up of this study	☐

Name of participant (print name) ……..

Signature of participant…….

Date……..

P.2.4 Treatment and Control Group Debrief Form

The Feasibility of Conducting Research on the Effectiveness of Peer-Support with a Homeless Population

Debriefing Statement (Version 1, 26/01/2017, ERGO number: 25223)

This study was investigating the effect and process of conducting research on homelessness services. We compared peer support to case work to evaluate the impact of these services. We were also interested in how you felt about the process of being involved in a long-term study and what recommendations you have to help improve the process, so we can conduct a larger study. This study did not use deception.

Once again results of this study will not include your name or any other identifying characteristics.
You may have a copy of this summary if you wish and you may have a copy of the research project once it is completed.
If you have any further questions and/or would like a copy of the report please contact me, Stephanie, at 02380594719 or S.L.Barker@soton.ac.uk

Thank you for your participation in this research.

Signature  Date 26/01/2017

If you have questions about your rights as a participant in this research, or if you feel that you have been placed at risk, you may contact the Chair of the Ethics Committee, Psychology, University of Southampton, Southampton, SO17 1BJ. Phone: +44 (0)23 8059 3856, email fshs-rso@soton.ac.uk

Resources:

EACH Brent
(Free support for drug and alcohol concerns)
Wembley Centre for Health and Care
116 Chaplin Road, Wembley HA0 4UZ
Tel: 020 8795 6050
Fax: 020 8795 6688
Email: info@eachbrent.org.uk
Web: www.eachcounselling.org.uk
Monday – Friday 9.30 am to 5.00 pm
Late openings on Tuesdays and Thursdays until 7.30 pm.

mind | Brent
Design Works, Park Parade,
Harlesden NW10 4HT
020 7604 5177
info@brentmind.org.uk

Helplines:

- **Samaritans**: 116 123
  jo@samaritans.org
- **Alcoholics Anonymous**: 0845 769 7555
- **Shelter's helpline**: 0808 800 4444
  Telephone advice and information for people with a housing problem or who are homeless. Issues dealt with include housing rights, harassment, illegal eviction, rent and mortgage arrears, disrepair, housing benefit, domestic violence, hostel placements and finding accommodation.

Helpline open 8am-8pm Monday-Friday and 8am-5pm at weekends

P.3 Interviews: Clients, Peers, Professionals

P.3.1 Participant Information Sheet

You are being asked if you would agree to take part in an interview to assess your experience of the study. Before you decide if you wish to participate, please take time to read the following information carefully and ask us if there is anything that is not clear or if you would like more information.

What is the research about?

Peer Support services are aimed at helping service users to achieve goals. We want to find out how effective Peer Support Schemes are, so we are comparing peer services to case work services. We also want to know what your experiences are being in a research study.

Why have I been chosen?

We are approaching you to take part in this research because you or your client has participated in two surveys earlier in this study.

What will happen to me if I take part?

You are invited to complete an audio-recorded interview with the researcher to find out how you felt about the whole study. This should take no more than 45 minutes. Your input helps us to design future research and make sure we are sensitive to you and/or your clients' needs. Participation in the study will not affect any other aspect of your rights.

Are there any benefits in my taking part?

Yes, research has shown that peer mentor programmes can improve service user's outcomes. Also, by taking part in this study, you will be adding to research on Peer Support and how to conduct research with those experiencing homelessness. Non-waged participants will receive a £5 voucher for their time.

Are there any risks involved?

While unlikely, it is possible that you might find the interview upsetting, as we will ask about you and/or your client's experience and participation in this study.

Will my participation be confidential?

All information that is collected about you will be kept strictly confidential and separate from the services you provide and/or receive. The audio-recording will be put onto a password-protected computer and transcribed. Any identifying information will be anonymised so that you cannot be recognised from it. The audio recording will then be deleted.

We will, instead, identify you using a randomly generated number. There will be an encrypted file stored on a password-protected computer that will link your name to your identifying number. No one apart from those directly involved in the project will be able to access this information. It

might be important to look at the data in years to come, so we will keep it for 10 years and then it will be destroyed. All data use is strictly within the terms of the Data Protection Act (DPA, 1998).

There are limits to confidentiality, if you tell us about something illegal or other banned activity, then we have a duty to report it. We are required to report if someone discloses that they have or are going to commit a crime.

What happens if I change my mind?

You have the right to withdraw your data without your legal rights, or routine care being affected. However, we cannot withdraw data from a published report that may result from this study.

What happens if something goes wrong?

If you have questions about your rights as a participant in this research, or if you feel that you have been placed at risk, you may contact the Chair of the Ethics Committee, Psychology, University of Southampton, Southampton, SO171BJ. Phone: +44 (02380 593856, email fshs-rso@soton.ac.uk).

Where can I get more information?

If you would like more information about the study please contact Stephanie Barker at

Tel: 023 8059 4719 Email: S.L.Barker@soton.ac.uk

P.3.2 Consent Form

CONSENT FORM: Interviews (Version 1, 26/01/2017, ERGO number: 25223)

Study title: The Feasibility of Conducting Research on the Effectiveness of Peer-Support with a Homeless Population

Researcher name: Stephanie Barker

*Please **initial** the box(es) if you agree with the statement(s):*

I have read and understood the information sheet (version 1, 26/01/2017) and have had the opportunity to ask questions about the study	☐
I agree to take part in this research project and agree for my data to be used for the purpose of evaluating the research process and effectiveness of peer support	☐
I understand my participation is voluntary and I may withdraw at any time without my legal rights being affected	☐
I understand and agree that this interview will be audio-recorded	☐
I understand that anonymised quotes will be used in the reporting	☐

Name of participant (print name) ……..

Signature of participant…….

Date……..

P.3.3 Debrief Form

The Feasibility of Conducting Research on the Effectiveness of Peer-Support with a Homeless Population

Debriefing Statement (Version 1, 26/01/2017, ERGO number: 25223)

This study was investigating the effect and process of conducting research on homelessness services. We compared peer support to case work to evaluate the impact of these services. We were also interested in how you felt about the process of being involved in a long-term study and what recommendations you have to help improve the process, so we can conduct a larger study. This study did not use deception.

Once again results of this study will not include your name or any other identifying characteristics.
You may have a copy of this summary if you wish and you may have a copy of the research project once it is completed.
If you have any further questions and/or would like a copy of the report please contact me, Stephanie, at 02380594719 or S.L.Barker@soton.ac.uk

Thank you for your participation in this research.

Signature _____ Date _____

If you have questions about your rights as a participant in this research, or if you feel that you have been placed at risk, you may contact the Chair of the Ethics Committee, Psychology, University of Southampton, Southampton, SO17 1BJ. Phone: +44 (0)23 8059 3856, email fshs-rso@soton.ac.uk

Resources:

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Helpline open 8am-8pm Monday-Friday and 8am-5pm at weekends

Appendix Q Feasibility Study: Missing Data Table

Univariate Statistics

	N	Mean	Std. Deviation	Missing Count	Missing %	No. of Extremes[a] Low	No. of Extremes[a] High
GROUP	38	1.68	.471	1	2.6	0	0
Participant_Number	38	79.71	50.833	1	2.6	0	0
Gender	38	1.26	.446	1	2.6	0	0
Age	36	39.47	10.416	3	7.7	0	0
Ethinicity	38	2.42	1.734	1	2.6	.	.
Mental_health_need	38	1.26	.446	1	2.6	0	0
Diagnosis	25	3.88	2.088	14	35.9	0	0
Getting_support	38	1.55	.504	1	2.6	0	0
Start_PS_KW	25	28.00	57.717	14	35.9	0	4
Sleeping_situation	38	2.76	2.509	1	2.6	0	0
Nights_slept_rough	37	32.54	55.455	2	5.1	0	6
Tenancies_held	38	.92	1.383	1	2.6	0	3
Length_of_last_tenancy	37	12.26	27.697	2	5.1	0	5
Evictions	36	.56	.877	3	7.7	0	1
Violence_against_people	36	.08	.500	3	7.7	.	.
Violence_againts_property	37	.22	.886	2	5.1	.	.
Threats_to_staff	38	.11	.509	1	2.6	.	.
Threats_to_service_users	37	.19	.877	2	5.1	.	.
Theft	36	.78	2.576	3	7.7	.	.
Police_cell	38	1.03	2.162	1	2.6	0	6
Arrest	38	2.39	7.016	1	2.6	0	6
Psychiactric_hospital	38	1.42	5.602	1	2.6	.	.
Hospital_nights	38	2.92	10.119	1	2.6	0	2
AandE	38	2.26	4.372	1	2.6	0	5
Registered_GP	38	1.07	.289	1	2.6	.	.
How_long_GP	33	89.31	153.066	6	15.4	0	7
GP_in_last_six_months	37	5.30	6.992	2	5.1	0	8
GP_in_last_month	37	1.30	1.714	2	5.1	0	1
BASELINE_AUDIT_1	38	1.47	1.672	1	2.6	0	0
BASELINE_AUDIT_2	38	1.13	1.379	1	2.6	0	0
BASELINE_AUDIT_3	38	1.26	1.446	1	2.6	0	0
BASELINE_AUDIT_4	37	1.11	1.524	2	5.1	0	0
BASELINE_AUDIT_5	38	.95	1.355	1	2.6	0	0
BASELINE_AUDIT_6	38	.84	1.498	1	2.6	0	8
BASELINE_AUDIT_7	38	.97	1.423	1	2.6	0	0

Appendix Q

	N	Mean	Std. Deviation	Missing Count	Missing %	No. of Extremes[a] Low	No. of Extremes[a] High
BASELINE_AUDIT_8	37	1.14	1.456	2	5.1	0	0
BASELINE_AUDIT_9	37	1.03	1.607	2	5.1	0	0
BASELINE_AUDIT_10	37	1.03	1.675	2	5.1	0	0
BASELINE_AUDIT_SUM	38	10.82	11.268	1	2.6	0	0
BASELINE_DUDIT_1	38	2.18	1.658	1	2.6	0	0
BASELINE_DUDIT_2	38	1.61	1.685	1	2.6	0	0
BASELINE_DUDIT_3	38	1.87	1.545	1	2.6	0	0
BASELINE_DUDIT_4	38	2.05	1.723	1	2.6	0	0
BASELINE_DUDIT_5	38	2.13	1.727	1	2.6	0	0
BASELINE_DUDIT_6	38	2.29	1.814	1	2.6	0	0
BASELINE_DUDIT_7	38	2.26	1.655	1	2.6	0	0
BASELINE_DUDIT_8	38	1.97	1.867	1	2.6	0	0
BASELINE_DUDIT_9	38	2.18	1.753	1	2.6	0	0
BASELINE_DUDIT_10	38	1.63	1.731	1	2.6	0	0
BASELINE_DUDIT_11	38	2.68	1.757	1	2.6	0	0
BASELINE_DUDIT_SUM	38	22.87	15.357	1	2.6	0	0
BASELINE_WEMWBS_1	36	3.06	1.120	3	7.7	5	0
BASELINE_WEMWBS_2	38	2.74	1.201	1	2.6	0	0
BASELINE_WEMWBS_3	38	2.92	1.171	1	2.6	0	0
BASELINE_WEMWBS_4	38	3.00	1.252	1	2.6	0	0
BASELINE_WEMWBS_5	37	2.57	1.237	2	5.1	0	3
BASELINE_WEMWBS_6	38	2.68	1.188	1	2.6	0	2
BASELINE_WEMWBS_7	38	2.92	1.217	1	2.6	0	0
BASELINE_WEMWBS_8	38	2.71	1.334	1	2.6	0	0
BASELINE_WEMWBS_9	38	2.53	1.289	1	2.6	0	0
BASELINE_WEMWBS_10	37	2.57	1.144	2	5.1	0	2
BASELINE_WEMWBS_11	37	3.19	1.151	2	5.1	0	0
BASELINE_WEMWBS_12	37	2.41	1.189	2	5.1	0	0
BASELINE_WEMWBS_13	38	3.03	1.262	1	2.6	0	0
BASELINE_WEMWBS_14	38	2.87	1.070	1	2.6	0	0
BASELINE_WEMWBS_SUM	38	38.74	12.894	1	2.6	0	0
BASELINE_GSE_1	38	2.71	.984	1	2.6	0	0
BASELINE_GSE_2	37	2.65	.889	2	5.1	0	0
BASELINE_GSE_3	37	2.32	.884	2	5.1	0	0
BASELINE_GSE_4	37	2.46	.900	2	5.1	0	0
BASELINE_GSE_5	38	2.66	.938	1	2.6	0	0
BASELINE_GSE_6	38	2.79	.843	1	2.6	0	0
BASELINE_GSE_7	37	2.49	.901	2	5.1	0	0
BASELINE_GSE_8	38	2.68	.842	1	2.6	0	0
BASELINE_GSE_9	38	2.63	.786	1	2.6	0	0

	N	Mean	Std. Deviation	Missing Count	Missing %	No. of Extremes[a] Low	No. of Extremes[a] High
BASELINE_GSE_10	38	2.63	1.025	1	2.6	0	0
BASELINE_GSE_SUM	38	25.76	6.784	1	2.6	0	0
BASELINE_CD_RISC_1	38	2.03	1.078	1	2.6	4	0
BASELINE_CD_RISC_2	38	2.55	1.005	1	2.6	1	0
BASELINE_CD_RISC_SUM	38	4.58	1.718	1	2.6	6	5
BASELINE_WAIS_1	36	3.17	.910	3	7.7	0	0
BASELINE_WAIS_2	36	3.50	1.028	3	7.7	1	0
BASELINE_WAIS_3	35	3.63	1.165	4	10.3	0	0
BASELINE_WAIS_4	36	3.72	1.162	3	7.7	0	0
BASELINE_WAIS_5	36	4.22	1.017	3	7.7	3	0
BASELINE_WAIS_6	36	3.97	1.000	3	7.7	0	0
BASELINE_WAIS_7	36	3.69	1.191	3	7.7	0	0
BASELINE_WAIS_8	36	3.92	1.079	3	7.7	0	0
BASELINE_WAIS_9	35	3.83	1.098	4	10.3	0	0
BASELINE_WAIS_10	36	4.08	1.025	3	7.7	5	0
BASELINE_WAIS_11	36	4.03	1.082	3	7.7	0	0
BASELINE_WAIS_12	36	4.00	1.014	3	7.7	0	0
BASELINE_WASI_SUM	36	45.39	10.078	3	7.7	0	0
BASELINE_DERS_1	38	3.05	1.272	1	2.6	0	0
BASELINE_DERS_2	38	3.26	1.309	1	2.6	0	0
BASELINE_DERS_3	38	2.74	1.267	1	2.6	0	0
BASELINE_DERS_4	38	2.26	1.245	1	2.6	0	0
BASELINE_DERS_5	37	2.38	1.255	2	5.1	0	4
BASELINE_DERS_6	37	2.57	1.094	2	5.1	0	2
BASELINE_DERS_7	37	2.78	1.294	2	5.1	0	0
BASELINE_DERS_8	37	3.03	1.404	2	5.1	0	0
BASELINE_DERS_9	37	2.57	1.324	2	5.1	0	5
BASELINE_DERS_10	38	2.50	1.310	1	2.6	0	0
BASELINE_DERS_11	38	2.95	1.374	1	2.6	0	0
BASELINE_DERS_12	38	2.95	1.251	1	2.6	0	0
BASELINE_DERS_13	37	3.08	1.256	2	5.1	0	0
BASELINE_DERS_14	38	2.58	1.482	1	2.6	0	0
BASELINE_DERS_15	38	2.63	1.478	1	2.6	0	0
BASELINE_DERS_16	38	3.00	1.336	1	2.6	0	0
BASELINE_DERS_17	38	3.13	1.417	1	2.6	0	0
BASELINE_DERS_18	38	3.05	1.374	1	2.6	0	0
BASELINE_DERS_19	38	2.84	1.424	1	2.6	0	0
BASELINE_DERS_20	38	2.37	1.217	1	2.6	0	0

Appendix Q

	N	Mean	Std. Deviation	Missing Count	Missing %	No. of Extremes[a] Low	No. of Extremes[a] High
BASELINE_DERS_21	38	2.87	1.379	1	2.6	0	0
BASELINE_DERS_22	38	2.87	1.277	1	2.6	0	0
BASELINE_DERS_23	38	3.03	1.423	1	2.6	0	0
BASELINE_DERS_24	37	2.70	1.351	2	5.1	0	0
BASELINE_DERS_25	38	2.68	1.378	1	2.6	0	0
BASELINE_DERS_26	38	3.11	1.371	1	2.6	0	0
BASELINE_DERS_27	37	2.78	1.397	2	5.1	0	0
BASELINE_DERS_28	38	2.68	1.378	1	2.6	0	0
BASELINE_DERS_29	38	2.87	1.379	1	2.6	0	0
BASELINE_DERS_30	38	3.13	1.359	1	2.6	0	0
BASELINE_DERS_31	38	2.66	1.475	1	2.6	0	0
BASELINE_DERS_32	38	2.61	1.306	1	2.6	0	0
BASELINE_DERS_33	38	3.05	1.251	1	2.6	0	0
BASELINE_DERS_34	38	2.82	1.353	1	2.6	0	0
BASELINE_DERS_35	38	3.00	1.336	1	2.6	0	0
BASELINE_DERS_36	37	3.08	1.341	2	5.1	0	0
BASELINE_DERS_SUM	38	101.00	27.407	1	2.6	0	1

a. Number of cases outside the range (Q1 - 1.5*IQR, Q3 + 1.5*IQR).

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