Peer Support Critical Elements and Experiences in Supporting the Homeless: A Qualitative Study

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Abstract

Peer-supporters are individuals with lived experience and are an integral part of healthcare systems, providing support to those affected by various phenomena such as homelessness and addictions. However, little is known about the critical elements that underpin peer-support interventions. This qualitative study sought to understand the critical elements of intentional peer-support with a homeless population, voiced by those who provide and/or receive this support. Twenty-nine participants from four different homeless charities in England were interviewed about their experiences of providing/receiving peer- support and what they felt were critical factors to its success. Participants defined peer-support as an experience-based relationship, built upon mutual understanding, empathy, and support. Thematic analysis was utilised to in developing six themes. Results identified peers’ persistence in developing unique experience-based relationships, providing social support, role-modelling recovery, and peers’ motivations were perceived as important factors involved in peer-support. It was also found that peers described benefitting from helping, such as, undergoing transformative identity developments that helped them to escape homelessness. Through the re-telling of their stories, they create meaning and re-structure their autobiography, attributing experiences of homelessness as a catalyst for positive changes in their lives. Limitations and future research are discussed.

Peer-support refers to the system whereby individuals with lived experience of a particular difficulty provide support to others. The idea that peers can help others through specific struggles is used in the rehabilitation of offenders, homelessness services, addiction treatment, and mental and physical health services (Adair, 2005; Chinman et al., 2014; Davidson, Chinman, Sells, & Rowe, 2006). In the USA, 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”, who “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 is reflected in the various modalities of peer-support that are found across health services, ranging from self-help groups to peer employees. However, Bradstreet (2006) discusses 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, occurring frequently in mental health and addiction services (Wallcraft, Rose, Reid, & Sweeney, 2003). IPS can be delivered as mutual support (peers are at the same level of recovery) or mentorship (one peer is at a higher level of recovery and mentors the newcomer) (Barker & Maguire, 2017; Faulkner & Basset, 2012).

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). Additionally, 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 (Anderson, 1993; Campbell, 2008; Croft, Hayward, & Story, 2013; Eisen et al., 2015; Mead, Hilton, & Curtis, 2001). Further, the helper-therapy principle posits that non-professional helpers benefit from being in helping roles—experiencing increased sense of interpersonal competence, knowledge, and social approval (Reissman, 1965).

Although IPS is recognised to support recovery from multiple phenomena, little is known about critical elements underpinning IPS that effect cognitive, behavioural, or emotional changes in client and peer outcomes. There are no known reports exploring these elements of change and the experiences of those providing/receiving IPS. 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. The model provides a conceptualisation of IPS, citing emotional, appraisal, and informational social support as its defining attributes.

Whelan, Marshall, Ball, and Humphreys (2009) also found that sponsors in Alcoholics Anonymous (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, Behrens, Smith, Greene, & Servoss, 2008; 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. 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 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).

## IPS in Homelessness

Given the popularity and effectiveness of IPS in mental health and addiction services, unsurprisingly, homelessness services have increased uptake of this intervention. However, those who experience homelessness suffer additional problems to those experienced by clinical populations, often evidencing the most complex, multi-morbid conditions requiring significant resource to engage in health interventions (Barker & Maguire, 2017; Maguire, Johnson, Vostanis, & Keats, 2010). For example, street-homeless people are 11 times more likely to have mental illness compared to housed counterparts (Aldridge et al., 2017; Fitzpatrick, Kemp, & Klinker, 2000). Furthermore, the mortality rate is much higher than the general population—the average age of death for those who die on the street is just 47 (Aldridge et al., 2017; Crisis, 2011). Indeed, drugs, alcohol, violence, and communicable diseases are everyday threats for homeless people (Crisis, 2011; Fitzpatrick et al., 2000).

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 (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, Boleman, Young, & Kwan, 2016; Luchenski et al., 2017).

A recent systematic review highlighted the need for more rigorous studies to examine IPS and homelessness as there was a “a breadth of evidence examining IPS within other contexts that, by chance, had participants experiencing homelessness in their sample” (Barker & Maguire, 2017, p 600). Despite this, Barker and Maguire (2017) included 11 articles and found that IPS had a significant impact on homeless client’s overall quality of life by reducing alcohol/drug use, improving mental/physical health, and increasing social support. Additionally, as in mental health, addiction, and healthcare literature, it was found that shared experiences, role-modelling, and social support are important to IPS in homelessness (Barker & Maguire, 2017). Authors also identified that IPS helped to maintain client engagement. Similarly, 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 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). Authors showed that 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 peer support interventions, rather than the exploration of elements that contribute to effective peer support. 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 peer support in their sample.

## 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 mechanisms that might underpin successful IPS in homeless populations through an exploratory investigation of recipient and peer provider 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. For the purpose of this study, homelessness is defined as single adults being without suitable accommodation including sleeping rough, in transient housing, or other inappropriate accommodation. 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.

# Methods

## Design

We 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). Participants received a £10 voucher for their time. Ethical approval was gained by the University of Southampton.

## 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, volunteer 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. Peer-supporters are supported by the organisation to provide support through supervision and resources for personal issues.

Organisation 2 is a 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—volunteer peer-supporters get supervision and support, but the work is completely peer-led.

Organisation 3 provides emergency accommodation to single people experiencing crises. Peer-supporters are integrated into services, with volunteer 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 and mentorship 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.

## Participants and Recruitment

Participants were recruited if they were aged 18 and above, had experience with homelessness and provided and/or received IPS. 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). Participant characteristics and experiences are reported in Table 1.

**INSERT TABLE 1**

## Interviews

Interview questions were derived from previous literature on IPS in other areas (e.g. Campbell, 2008) to define IPS and explore participants’ experiences of this intervention. A topic guide 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?
* What is important in peer-support?

One researcher (SB) 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). 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). 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.

## 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 herself with the interviews reading the transcripts, SB 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, the researchers attempted to include quotes from every participant, choosing those that best exemplified each theme. To contextualise quotes, we include a description of participants IPS experience (i.e. provider only, recipient only, or recipient to provider). Participants’ names have been changed throughout and identifying details omitted.

# Results

Participants understood 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, six themes captured critical elements of successful IPS, contributing to ‘How peers help’ and describing specific aspects of the IPS process, which benefitted both recipients and providers (Figure 1). Results are described as they are presented in the thematic map.

**INSERT FIGURE 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 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)

## 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. Experiential knowledge comprises 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 being homeless, but it is the individual’s attitude towards their experience that determines whether this ‘knowledge’ is useful. 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 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)

## 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 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 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)

## 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 IPS models.

## 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 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 and help 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.

## 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)

## Summary of Results

The analysis resulted in six themes describing participants’ experiences and opinions of key elements in 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.

# Discussion

This study sought to understand the key elements of IPS provided by peer-supporters to those experiencing homelessness and the experiences of those providing/receiving support. Participants’ defined 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). Participants’ reports of the vital aspects of IPS were consistent with previous literature. They suggested that 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 (Barker & Maguire, 2017; Odierna & Schmidt, 2009; Tulsky et al., 2000).

## 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 IPS, as it allowed for unique understanding and empathy to develop. 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 IPS.

Boundaries were an interesting 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 (Barker & Maguire, 2017; Stevens & Jason, 2015; Whelan et al., 2009). Stevens and Jason (2015) state that their findings of 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 current results do not favour one type of social support over another.

## 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 be 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, 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 meaning-making as a mechanism of change (Barker & Maguire, 2017).

Some limitations of the present study must be acknowledged. The primary researcher 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 all contributing authors. Nonetheless, due to the nature of qualitative data, researcher bias may be present in the interpretation. Further, the primary researcher, as a female, viewed as a professional, 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 but 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 homeless experience, and what peer-supporters in homeless services see as the key elements of support. This study expands upon previous literature by focusing IPS use with a specific population and provides evidence for 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). 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).

## Practical Implications for Homelessness Services

Organisations that include IPS 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). Moreover, training of peer-supporters should highlight coping with difficult behaviour and foster skills in conflict resolution, while providing support for each peer, including supervision.

Given the mixed views on payment and valuing peer-supporters, each organisation should encourage discussion to assess any potential negative outcomes, specifically those affecting the peer-client relationship. Regarding boundaries, organisations should provide guidance to manage specific situations, but endeavour to remain flexible.

# Conclusion

This study contributes to scarce evidence on 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 IPS, not an exhaustive list, but theoretically consistent with previous literature.

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

# References

Adair, D. (2005). Peer Support Programs Within Prisons: University of Tasmania.

Ahmed, A. O., Doane, N. J., Mabe, P. A., Buckley, P. F., Birgenheir, D., & Goodrum, N. M. (2012). Peers and peer-led interventions for people with schizophrenia. *Psychiatry Clinic North America, 35*(3), 699-715. doi:10.1016/j.psc.2012.06.009

Aldridge, R. W., Story, A., Hwang, S. W., Nordentoft, M., Luchenski, S. A., Hartwell, G., . . . Hayward, A. C. (2017). Morbidity and mortality in homeless individuals, prisoners, sex workers, and individuals with substance use disorders in high-income countries: a systematic review and meta-analysis. *The lancet*. doi:<https://doi.org/10.1016/S0140-6736(17)31869-X>

Anderson, C. (1993). Types of Identity development in addicts and recovery. *Sociological Focus, 26*(2), 133-145.

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

Bassot, B. (2015). *The reflective practice guide: An interdisciplinary approach to critical reflection*: Routledge.

Blondell, R. D., Behrens, T., Smith, S. J., Greene, B. J., & Servoss, T. J. (2008). Peer support during inpatient detoxification and aftercare outcomes. *Addictive Disorders & Their Treatment, 7*(2), 77-86.

Blondell, R. D., Looney, S. W., Northington, A. P., Lasch, M. E., Rhodes, S. B., & McDaniels, R. L. (2001). Can recovering alcoholics help hospitalized patients with alcohol problems? *Journal of Family Practice, 50*(5), 447.

Borkman, T. J. (1976). Experiential knowledge--New concept of analysis for self-help groups. *Social Service Review, 50*(3), 445-456.

Bradstreet, S. (2006). Harnessing the 'lived experience': Formalising peer support approaches to promote recovery. *Mental Health Review Journal, 11*(2), 33-37.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. doi:10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*: Sage.

Campbell, J. (2008). *Key ingredients of peer programs identified.* Paper presented at the Alternatives 2008 Conference, Buffalo, New York. Retrieved March 2015.

Campos, F. A. L., Sousa, A. R. P. d., Rodrigues, V. P. d. C., Marques, A. J. P. d. S., Dores, A. A. M. d. R., & Queirós, C. M. L. (2014). Practical guidelines for peer support programmes for mental health problems. *Revista De Psiquiatria Clinica, 41*(2), 49-55. doi:10.1590/0101-60830000000009

Chinman, M., George, P., Dougherty, R. H., Daniels, A. S., Ghose, S. S., Swift, A., & Delphin-Rittmon, M. E. (2014). Peer support services for individuals with serious mental illnesses: assessing the evidence. *Psychiatric Services, 65*(4), 429-441. doi:10.1176/appi.ps.201300244

Creamer, M. C., Varker, T., Bisson, J., Darte, K., Greenberg, N., Lau, W., . . . Forbes, D. (2012). Guidelines for peer support in high-risk organizations: an international consensus study using the Delphi method. *J Trauma Stress, 25*(2), 134-141. doi:10.1002/jts.21685

Crisis. (2011). *Homelessness: A silent killer*. Retrieved from London, UK:

Croft, L. A., Hayward, A. C., & Story, A. (2013). Tuberculosis peer educators: personal experiences of working with socially excluded communities in London. *International Journal of Tuberculosis and Lung Disease, 17*(10 Suppl 1), 36-40. doi:10.5588/ijtld.13.0309

Davidson, L., Chinman, M., Sells, D., & Rowe, M. (2006). Peer support among adults with serious mental illness: a report from the field. *Schizophrenia Bulletin, 32*(3), 443-450. doi:10.1093/schbul/sbj043

Deering, K. N., Shannon, K., Sinclair, H., Parsad, D., Gilbert, E., & Tyndall, M. W. (2009). Piloting a peer-driven intervention model to increase access and adherence to antiretroviral therapy and HIV care among street-entrenched HIV-positive women in Vancouver. *AIDS Patient Care STDS, 23*(8), 603-609. doi:10.1089/apc.2009.0022

Denzin, N. K., & Lincoln, Y. S. (2005). *The Sage handbook of qualitative research*: Sage.

Eisen, S. V., Mueller, L. N., Chang, B. H., Resnick, S. G., Schultz, M. R., & Clark, J. A. (2015). Mental health and quality of life among veterans employed as peer and vocational rehabilitation specialists. *Psychiatr Serv, 66*(4), 381-388. doi:10.1176/appi.ps.201400105

Emerging Horizons. (2017). *Birmingham changing futures together: Lead worker and peer mentor fieldwork evaluation* Retrieved from <http://changingfuturesbham.co.uk/wp-content/uploads/2017/07/BVSC-MARCH-EVALUATION-REPORT-V2-TMcK-002.pdf:>

Faulkner, A., & Basset, T. (2012). A helping hand: taking peer support into the 21st century. *Mental Health and Social Inclusion, 16*(1), 41-47.

Faulkner, A., Basset, T., & Ryan, P. (2012). A long and honourable history. *The Journal of Mental Health Training, Education and Practice, 7*(2), 53-59. doi:doi:10.1108/17556221211236448

Faulkner, A., Yiannoullou, S., Kalathil, J., Crepaz-Keay, D., Singer, F., James, M., . . . Kallevik, J. (2015). 4pi: National Involvement Standards. *Report: National Survivors Network*.

Felton, C. J., Stastny, P., Shern, D. L., Blanch, A., Donahue, S. A., Knight, E., & Brown, C. (1995). Consumers as peer specialists on intensive case management teams: impact on client outcomes. *Psychiatric Services, 46*(10), 1037-1044. doi:10.1176/ps.46.10.1037

Finlayson, S., Boleman, V., Young, R., & Kwan, A. (2016). *HHPA: Saving Lives, Saving Money*. Groundswell Homeless Healthcare Reports. Retrieved from <http://groundswell.org.uk/wp-content/uploads/2016/03/Saving-Lives-Saving-Money-Full-Report-Web.pdf>

Fitzpatrick, S., Kemp, P., & Klinker, S. (2000). Single homelessness: an overview of research in Britain.

Ham, C. C., LeMasson, K. D. S., & Hayes, J. A. (2013). The Use of Self-Disclosure: Lived Experiences of Recovering Substance Abuse Counselors. *Alcoholism Treatment Quarterly, 31*(3), 348-374. doi:10.1080/07347324.2013.800399

Luchenski, S., Maguire, N., Aldridge, R. W., Hayward, A., Story, A., Perri, P., . . . Hewett, N. (2017). What works in inclusion health: overview of effective interventions for marginalised and excluded populations. *The lancet*. doi:10.1016/S0140-6736(17)31959-1

Maguire, N., Johnson, R., Vostanis, P., & Keats, H. (2010). *Meeting the psychological and emotional needs of homeless people*. London.

Mead, S., Hilton, D., & Curtis, L. (2001). Peer support: a theoretical perspective. *Psychiatric Rehabilitation Journal, 25*(2), 134-141.

Odierna, D. H. D. M. S., & Schmidt, L. A. P. M. S. W. M. P. H. (2009). The Effects of Failing to Include Hard-to-Reach Respondents in Longitudinal Surveys. *American Journal of Public Health, 99*(8), 1515-1521.

Phillippi, J., & Lauderdale, J. (2017). A Guide to Field Notes for Qualitative Research: Context and Conversation. *Qualitative Health Research, 0*(0), 1049732317697102. doi:10.1177/1049732317697102

QSR. (2012). NVivo qualitative data analysis Software; QSR International Pty Ltd. Version 10, 2012.

Rayburn, R. L., & Wright, D. J. (2009). Homeless Men in Alcoholics Anonymous: Barriers to Achieving and Maintaining Sobriety. *Journal of Applied Social Science, 3*(1), 55-70.

Reissman, F. (1965). The 'helper' therapy principle. *Social work, 10*(2), 27-32.

Resnick, S. G., & Rosenheck, R. A. (2008). Integrating peer-provided services: a quasi-experimental study of recovery orientation, confidence, and empowerment. *Psychiatric Services, 59*(11), 1307-1314. doi:10.1176/appi.ps.59.11.1307

Sadler, G. R., Lee, H. C., Lim, R. S., & Fullerton, J. (2010). Recruitment of hard-to-reach population subgroups via adaptations of the snowball sampling strategy. *Nursing and Health Sciences, 12*(3), 369-374. doi:10.1111/j.1442-2018.2010.00541.x

Salzer, M. S. (2002). Consumer-delivered services as a best practice in mental health care delivery and the development of practice guidelines. *Psychiatric Rehabilitation Skills, 6*(3), 355-382. doi:10.1080/10973430208408443

SAMHSA. (2015). Peer Support and Social Inclusion. Retrieved from <http://www.samhsa.gov/recovery/peer-support-social-inclusion>

Solomon, P. (2004). Peer support/peer provided services underlying processes, benefits, and critical ingredients. *Psychiatric Rehabilitation Journal, 27*(4), 392-401.

Stevens, E. B., & Jason, L. A. (2015). An Exploratory Investigation of Important Qualities and Characteristics of Alcoholics Anonymous Sponsors. *Alcoholism Treatment Quarterly, 33*(4), 367-384. doi:10.1080/07347324.2015.1077632

Tracy, K., Burton, M., Miescher, A., Galanter, M., Babuscio, T., Frankforter, T., . . . Rounsaville, B. (2012). Mentorship for Alcohol Problems (MAP): a peer to peer modular intervention for outpatients. *Alcohol and alcoholism, 47*(1), 42-47. doi:10.1093/alcalc/agr136

Tracy, K., Guzman, D., & Burton, M. (2014). Treatment Process and Participant Characteristic Predictors of Substance Use Outcome in Mentorship for Addiction Problems (MAP). *Journal of Alcohol & Drug Dependence, 2*(171), 2.

Tulsky, J. P., Pilote, L., Hahn, J. A., Zolopa, A. J., Burke, M., Chesney, M., & Moss, A. R. (2000). Adherence to isoniazid prophylaxis in the homeless: a randomized controlled trial. *Archives of Internal Medicine, 160*(5), 697-702.

Varker, T., & Creamer, M. C. (2011). Development of guidelines on peer support using the Delphi methodology. *Australian Centre for Posttraumatic Mental Health: Unpublished report: ACPMH (*[*www.acpmh.unimelb.edu.au*](http://www.acpmh.unimelb.edu.au)*).*

Wallcraft, J., Rose, D., Reid, J., & Sweeney, A. (2003). *On our own terms: Users and survivors of mental health services working together for support and change*: Sainsbury Centre for Mental Health.

Whelan, P. J., Marshall, E. J., Ball, D. M., & Humphreys, K. (2009). The role of AA sponsors: a pilot study. *Alcohol & Alcoholism, 44*(4), 416-422. doi:10.1093/alcalc/agp014