Developing a Model of Change Mechanisms within Intentional Unidirectional Peer Support (IUPS)

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Abstract_ *Peers are those with lived experiences of adversity and are commonly utilised in services. However, little is known about change mechanisms, resulting in undefined concepts and weak assertions on peer supports' effectiveness. Further, peer interventions are becoming increasingly common in homelessness services, without the theoretical understanding to support it. This review systematically explores literature to close this gap. Iterative searches from PsychINFO, PsychARTICLES, PubMED, MEDLINE, CINAHL, Web of Science, and grey literature resulted in 71 included sources. Through realist synthesis, a model of client and peer pathways through peer support was developed. Through inclusion of literature from multiple health contexts (i.e. homelessness, mental health, addiction, and criminal justice), the review identified mechanisms of working alliances, role modelling, experience-based social support, and processes of becoming a peer-supporter. The model asserts that 1) the working alliance quality influences client/peer outcomes, 2) clients learn behaviours modelled by peers, 3) peer outcomes are mediated by being a role model, 4) peers provide social support, impacting client/peer outcomes, and 5) training, supervision, and support are directly linked to peer-supporters' effectiveness.*

Keywords_ *Realist synthesis; peer mentors; peer support; homelessness; working alliance*

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Introduction

Peer support refers to the system whereby individuals with lived experience of a particular difficulty provide support to others. Peer support is prevalent; in England alone there are over 700 programmes that involve peers/consumers (Wallcraft *et al*., 2003). It also features in international guidelines, recommended for use within high-risk environments in Finland, Australia, and homelessness services in Canada (Tainio and Fredriksson, 2009; Creamer *et al.*, 2012; National Lived Experience Advisory Council, 2016). The idea that peers can help others through specific struggles is used in homelessness services, rehabilitation of offenders, addiction treatment, and mental and physical health services (Adair, 2005; Chinman *et al*., 2006; Chinman *et al.*, 2014). In the USA, the Substance Abuse and Mental Health Services Administration (SAMHSA) broadly defines peer support as "services [that] are delivered by individuals who have common life experiences with the people they are serving" (SAMHSA, 2015, para. 1). However, in practice and reflected in the literature, there are many different terms for peer interventions, such as 'peer support worker'; 'peer advocate'; 'wounded healer'; 'consumer survivor'; or 'peer to peer' (Bowgett, 2015; Finlayson *et al*., 2016; Heidemann *et al*., 2016). Each term may invoke different interpretations by the reader (about the type of lived experience or what the role entails, for example), which adds to the lack of clarity in this field. Certainly, research to define what is actually meant by "peer" and what constitutes common lived experiences is required. For the purposes of this paper, we will use the neutral/general term 'peer mentors' or 'peers' with the aim of being inclusive/encompassing all current variants/interpretations of peer interventions. Further, common life experience refers to peers' experiences and assumes that the peer has similar life experience to the client.

Bradstreet (2006) discusses three types of peer support: informal (naturally occurring), participation in peer-led services, and intentional peer support (IPS). IPS is fostered and developed by organisations, occurring frequently in mental health and addiction services (Wallcraft *et al.*, 2003). Proponents of peer support in mental health define peer support as:

> "Involving one 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" (Davidson *et al.*, 2006, p.444).

Despite being clear, there has been limited uptake of this definition. Peer interventions are still commonly referred to as 'peer support' or 'IPS' referring to both mutual and mentorship support, leading to mixed and uncertain conclusions about effectiveness (e.g. Repper and Carter, 2010; Lloyd-Evans *et al.*, 2014). This was

indicated in a study where peers and clients were recruited if they were providing/receiving IPS and 93% of participants described being involved in a mentorship-type of IPS (Barker *et al*., 2018). The Barker *et al.* (2018) results describe one facet of IPS—unidirectional IPS, evidencing the need for further clarification in defining IPS interventions. To differentiate and clarify IPS that is currently being used in various services, it is necessary to functionally divide IPS into two types: intentional, unidirectional peer-support (IUPS) and intentional, bidirectional peer support (IBPS). Whereas IBPS reflects the reciprocal and mutual type of peer intervention, 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 Davidson *et al.* (2006). This definition and new abbreviation are proposed with the aim of enabling clarity in future research and the development of peer interventions.

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, multimorbid conditions requiring significant resource to engage in health interventions (Maguire, Johnson, Vostanis, & Keats, 2010; Barker and Maguire, 2017). For example, street homeless people are 11 times more likely to have mental illness compared with housed counterparts (Fitzpatrick, Kemp, & Klinker, 2000; Aldridge *et al*., 2018). 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 (Thomas, 2011; Aldridge *et al*., 2018). Indeed, drugs, alcohol, violence, and communicable diseases are everyday threats for homeless people (Fitzpatrick *et al*., 2000; Thomas, 2011).

Although we have interest in understanding IUPS interventions for use with homeless people, this review considers literature across multiple health areas to identify change mechanisms that transcend contexts and can be applied to a homeless population (Wong *et al*., 2013). That is, literature examining IUPS in the context of homelessness is sparse and therefore understanding of underlying mechanisms is even more limited, so we look to existing literature within mental health, addiction, physical health, and criminal justice to identify possible mechanisms that underlie multiple contexts. Additionally, the review has a psychological lens, whereby there is a focus on formulating the interplay between behaviours, emotions, and cognitions that are present in IUPS interactions.

This is not to suggest that context is unimportant, however, there are some prerequisites for IUPS to be effective—services should foster a person-centred work environment, be flexible and supportive for peers without judgement 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.

The primary objective of this work is to identify and clarify concepts by examining change mechanisms that underlie IUPS that are potentially transferable across health areas and therefore useful to peer interventions with a homeless population. Secondly, the review aims to provide testable concepts to assess the utility of the developed model, in line with realist methods. The aim of developing a model is that once developed, it can then be tested and potentially modified/elaborated in different contexts to further our understanding of IUPS interventions.

Method

We used realist synthesis/review methods to build a model that identifies and examines the mechanisms of change within IUPS and the relationships between the mechanisms of change. Realist methods allow for inclusion of articles with varying designs, permitting researchers to draw interpretations from related literature and theoretical sources (Wong *et al*., 2013).

Inclusion and Exclusion Criteria

This review utilised broad inclusion criteria, given our aim and the lack of literature on IUPS and homelessness. Articles were included if they discussed elements of how or why IUPS works. Further, we did not exclude based on the papers' chosen term for 'peer', to capture the varying uses of the terms and to include a wide set of literature on peer interventions. We also included papers that described paid and unpaid peer interventions, again to capture broad descriptions/evaluations of peer interventions. Theoretical papers, commentaries, perspective papers, and literature reviews that potentially explain processes and common elements in IUPS, and empirical articles that identify or test common elements in IUPS were included. Articles were excluded if they lacked focus on IUPS, reported on a topic irrelevant to the research aims, and/or were not in English.

Search Strategy

The search process was conducted in four phases. To begin with, in line with realist methods (Pawson *et al*., 2005; Wong *et al*., 2013), a known set of literature on IUPS was compiled from the researchers' familiarity with the topic, similar to methods used in McMahon and Ward, (2012; e.g. Mead *et al*., 2001; Dennis, 2003; Davidson *et al*., 2006 etc.).

Secondly, we searched academic databases including PsychINFO, PsychARTICLES, PubMED, MEDLINE, CINAHL, and Web of Science using a combination of the keywords 'peer support', 'homelessness', 'adult/young adult', 'change mechanisms', and their synonyms. IUPS was not included in the search terms, as it is yet to be reflected in published literature.

The known set of articles and those identified through database searching were then sifted, to find papers relevant for inclusion. The included studies were then subjected to a citation search using Web of Science, PsychINFO, and Google Scholar to identify any missing literature.

Finally, once the initial model had been developed, the iterative search process concluded with a final citation search, which identified relevant literature to support and/or contradict the overall model of IUPS. Data extracted from all included studies can be found in supplementary materials.

Quality Assessment

Pertinent data was extracted from each article and quality assessed using the Mixed Method Appraisal Tool (MMAT) and A Measurement Tool to Assess Systematic Reviews (AMSTAR) (Shea *et al.*, 2007; Crowe and Sheppard, 2011; Souto *et al.*, 2015). The MMAT and AMSTAR provided justification on how much to weigh articles when considering the impact on the developing model. For non-empirical articles, we used guiding principles of relevance to the research aims and rigour as noted by Wong *et al*., (2013).

Model Development

The realist review process requires analysis of the source documents in detail (Pawson and Bellamy, 2006). Thus, once data was extracted and quality assessed, we developed models for each of the included studies. Again, using similar methods to McMahon and Ward (2012), we then sorted articles into two groups – those with a primarily theoretical focus, and those with a primarily empirical focus.

Firstly, theoretical articles were examined to seek explanations of how IUPS works. The theoretical literature was divided into specific contexts (i.e. mental health, physical health, addiction, criminal justice, and homelessness), where formulations of the IUPS process were developed. Models of IUPS were then combined into one overall model. This process resulted in data from 28 articles being developed into a preliminary theoretical model of IUPS (available in supplementary material).

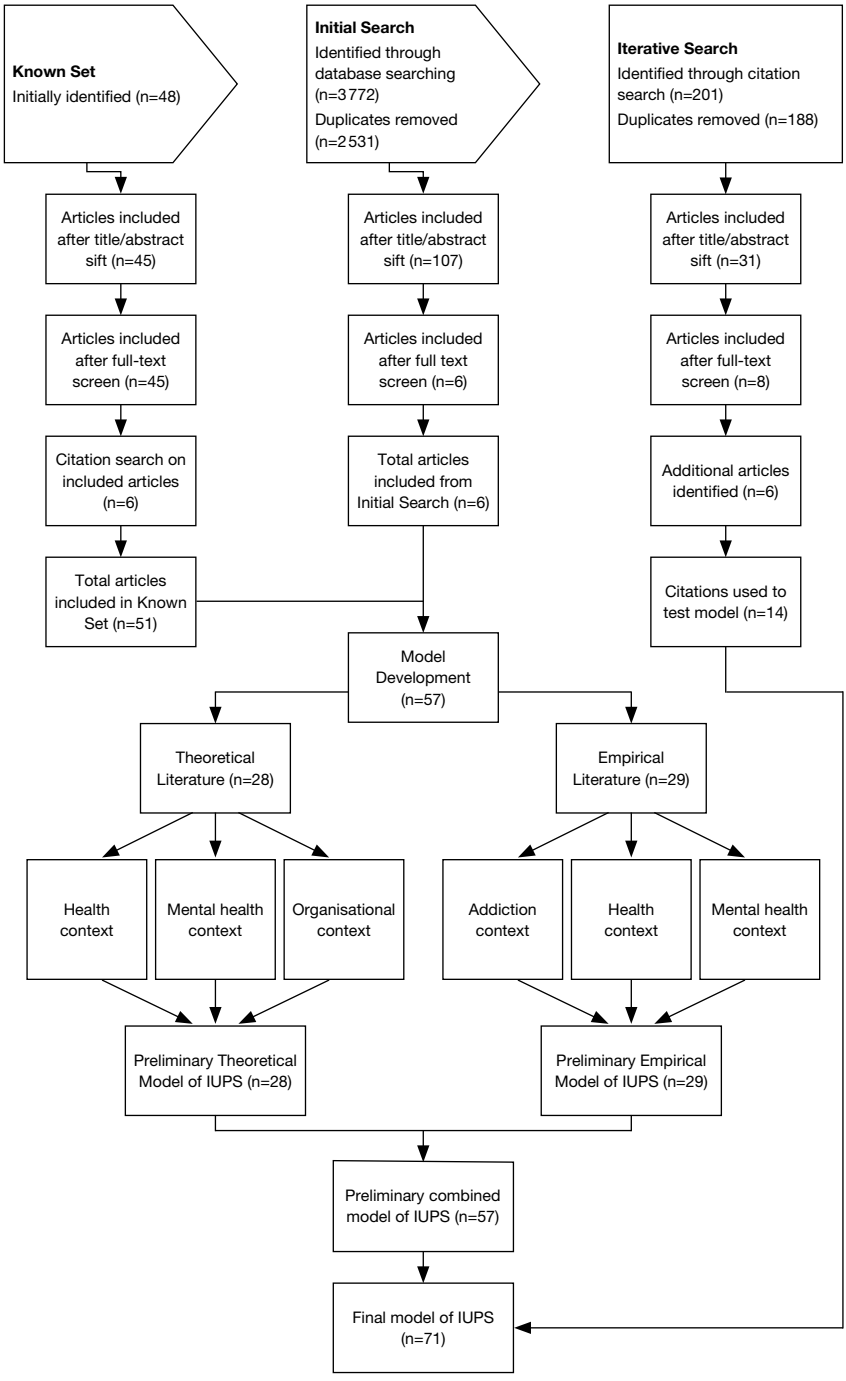
Secondly, empirical articles were assessed to seek explanations of how IUPS works but with a focus on explaining outcomes and evidencing pathways identified in the theoretical model. Again, articles were grouped into multiple contexts, formulating models for each, resulting in a model for IUPS within addictions, mental

health, and physical health. Again, these models were combined into one overall preliminary empirical model of IUPS with data from 29 articles (available in supplementary material).

Once both preliminary models were developed, they were combined to create an overall model of IUPS. As realist methods are predominantly theory driven, we prioritised the theoretical literature, using the empirical articles to ascertain the strength of each pathway and edit the preliminary models. Finally, in line with iterative methods, we refined the model using literature from the citation search. This process of model development is displayed in Figure 1.

It became clear during this synthesis that there are common elements for peers and their clients within IUPS. However, peers and clients experience these elements differently and the final model aims to reflect this.

Figure 1. Flow chart of search strategy and model development.



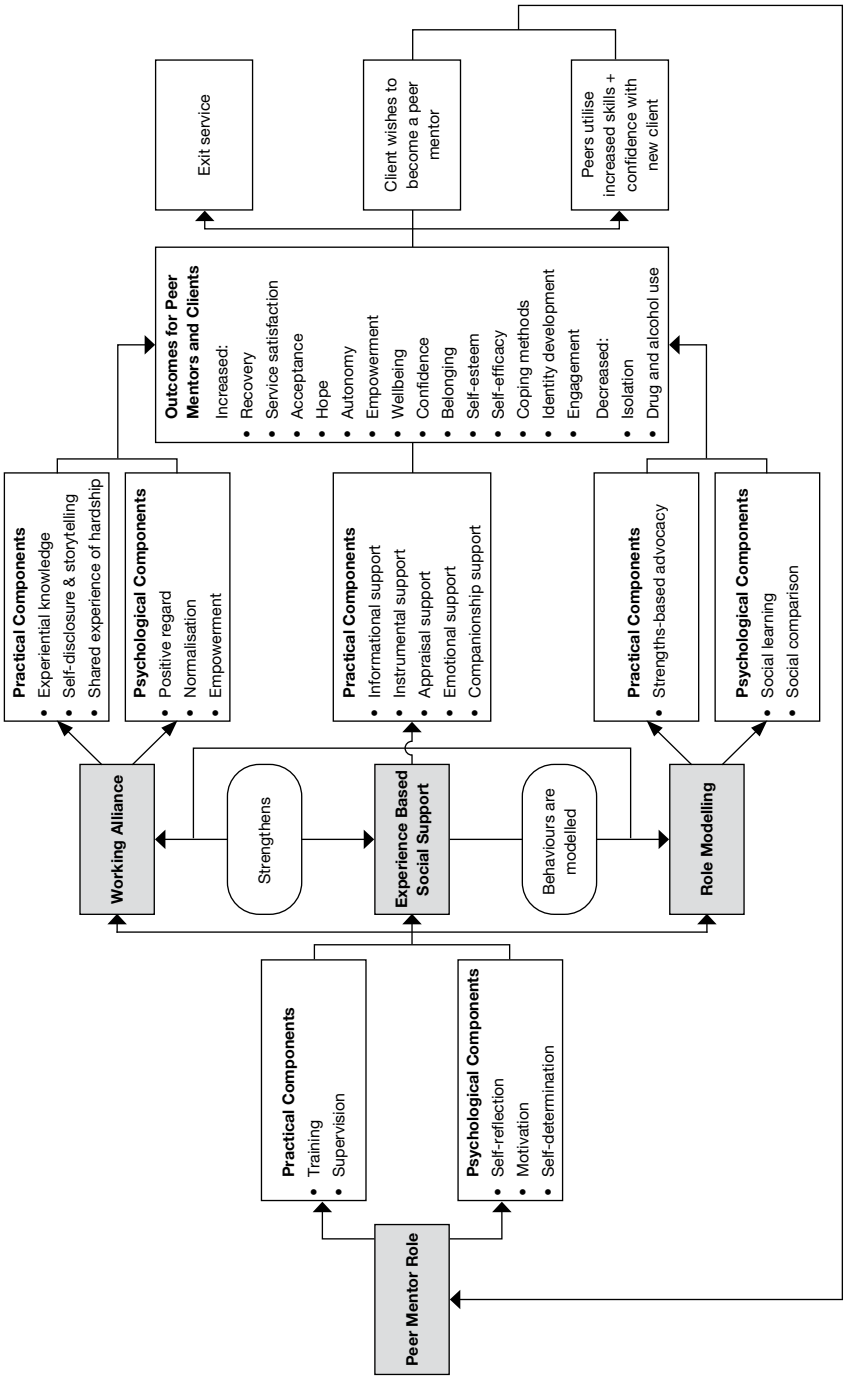
Results

The following results are discussed as they are read within the model (see Figure 2). Reading from left to right, the first mechanism of the model is the peer mentoring role. This is deliberate as the peer mentors themselves – and their skills, knowledge, experience and personal qualities are central to the quality of support their clients receive – and essentially are *the* intervention. This is also the beginning of the process for peer mentors in IUPS and influences the other mechanisms in the model.

Next, the three main mechanisms of change – working alliance, experience-based support, and role modelling are depicted at the same level of the model. This is because temporally, these processes can occur simultaneously. The mechanisms are also multiply interlinked, with processes in one mechanism affecting the other. For instance, the experience-based social support component of the model is related to the working alliance component, as experience-based social support strengthens the working alliance between peers and their clients. Conversely, having a strong working alliance also increases feelings of social support. The experience-based social support mechanism is also related to the role modelling mechanism, as clients can model the behaviours of peers that they observe when receiving various types of social support. Peers may also be viewed as positive role models within the working alliance, and having a strong working alliance may offset any potential negative effects of upward social comparisons that occur during the role modelling mechanism.

The model describes practical and psychological components of each mechanism, and the outcomes they have for the peer mentors, their clients, and the working alliance between the two. We conceptualised practical components as tangible elements of the intervention that the peer mentors do, and psychological components as the underlying psychological processes that occur within each mechanism. It is important to note that while this model is presented as linear, in reality it is much more complex—clients and peers may enter or exit into any part of the model, and may engage with some processes in the model and not others. Thus, the model outlines the typical pathway that clients and peers can take. Each component of the model and the processes within it are discussed below.

Figure 2. Combined model of change mechanisms within IUPS.



The Peer Mentoring Role

The literature covers various elements and considerations of the peer mentoring role in IUPS, including practical considerations such as training and supervision of peers and psychological elements such as self-reflection, self-determination, motivation and personal growth.

Training and supervision

The development of this practical element of the mechanism came from 19 articles that discussed the importance of training and supervising peers. The literature stated that professionals involved in the IUPS service must train peers in the context of the intervention and ensure that they are sufficiently supported in their role. For example, with the provision of supervision from clinical professionals and opportunities for group supervision (Pilote *et al.*, 1996; Mead *et al.*, 2001; Faulkner *et al*., 2012; Crawford and Bath, 2013; Bowgett, 2015; Faulkner *et al.*, 2015). From an organisational standpoint, 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). Additionally, as the recovery process is not linear, training and supervision can enable the peer mentors to manage their own emotional reactions when there are relapses or breakdowns in the working alliance.

Training and supervision also confer numerous benefits for both peers and their clients and is key to successful IUPS. Adequate training not only serves to screen 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). For example, peers may receive training in basic psychological skills, enabling them to effectively communicate empathy and acceptance and equipping them with the skills to navigate working alliances (Weissman *et al*., 2005; Creamer *et al.*, 2012). While peers undoubtedly have a range of problem solving strategies, training may help with the real-time handling of problem solving and coping, enabling the provision of comprehensive and effective support to clients (Tulsky *et al.*, 2000).

Further, engaging with the organisation during training allows the peer to develop pro-social relationships with other peers and professionals (Moran *et al.*, 2012). This supportive environment fosters personal growth, and encourages peers to be self-reflective and self-determined (Moran *et al.*, 2012).

Self-reflection and motivation

This psychological element of the mechanism was included as articles reported that peers should be reflective in their work and strive for personal growth (Mead *et al.*, 2001; Campbell, 2008; Ahmed *et al.*, 2012; Simoni *et al*., 2011). 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; Bassot, 2015). Having the opportunity and encouragement to be reflective in their work helps peers to develop their sense of self as a helper / role model and improves how they help others (Bassot, 2015). Peers themselves also benefit from being in a supportive role and can experience an increased sense of interpersonal competence, increased knowledge, and social approval from their work (Reissman, 1965). 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).

Self-reflection and motivation are linked, as reflecting on reasons for engaging in peer work, understanding the motivations that drive moving into a helping role deepens self-understanding. This introspection enables the peer to avoid making judgements or behave in a potentially discriminating manner.

Indeed, Moran *et al*., (2014) found that while peers entered into IUPS for instrumental needs (employment), they mainly cited internal motivations including 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). According to self-determination theory, the satisfaction of these three needs allows for optimal functioning and personal growth (Deci and Ryan, 2008). The literature echoes this – peers who experience personal growth are more likely to be autonomous and function better (Mead *et al.*, 2001; Moran *et al.*, 2012; Croft *et al*., 2013). Further, successful working alliances between peers and clients are built upon self-determination, respect, and shared responsibility (Simoni *et al.*, 2011; Ahmed *et al.*, 2012). Thus, peers' motivations are important to successful IUPS, as they affect the working alliance and are integral to the quality of the support clients receive.

Working Alliance

The next step in the model is the working alliance between peer mentors and their clients. This relational mechanism was described in 33 of the 71 included articles as the main mechanism for successful IUPS. Thus, it is argued that the quality and strength of the working alliance will be directly related to client outcomes (Goering *et al*., 1997; Solomon *et al*., 1995; Hurley *et al*., 2016). The impact of the working alliance on outcomes for peer mentors was also described by 11 included studies.

Gelso (2014, p.120) states that the "real relationship" (part of all human relationships) is the foundation of the working alliance that can develop in IUPS. Horvath and Greenberg (1989) describe a sense of bonding, agreement on goals, and a collaborative approach as components of an effective working alliance. Research

has shown that an increased sense of working alliance can result in increased feelings of recovery, and increased service satisfaction and recovery outcomes in peer interventions. (Moran *et al.*, 2014; Thomas and Salzer, 2017).

The included literature states that a successful working alliance in IUPS involves practical elements such as self-disclosure, storytelling, and a shared experience of hardship – and psychological elements including positive regard, normalisation, and empowerment.

Experiential knowledge

The practical components of the working alliance are based around the idea of experiential knowledge. Thirty-six of the included 71 articles discussed some aspect of experiential knowledge, including shared experiences, self-disclosure, or storytelling.

Authors cited the importance of the relationship being built upon shared experiences and how peers share their "experience, strength, and hope" with clients (Whelan *et al.*, 2009, p.7). Peers and their clients will typically have a shared experience of hardship, which fosters a bond, building the working alliance. Specifically, Salzer (2002) and Solomon (2004) suggest that the element of shared experiences in peer support increases acceptance, normalises the client's experiences, reduces isolation, and increases clients' social networks.

A particularly important process in IUPS involves the dialogue between clients and peers (Ahmed *et al.*, 2012). Self-disclosures are thought to enhance the working alliance between peers and clients by creating a bond. The use of storytelling and self-disclosure by peers facilitates cognitive restructuring—giving clients a new perspective and opportunities to change their thought patterns based on peers as models (Adame and Leitner, 2008).

Peers also benefit from sharing their personal story, finding new ways to re-interpret their past and further developing their identity to integrate a new sense of purpose and meaning (Anderson, 1993; Moran *et al.*, 2012). Additionally, 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). However, it is important to ensure self-disclosure is practiced safely – where the peer is trained to only share what they are comfortable with and perhaps trained to identify which parts of their own history would be especially useful for their clients (Moran *et al.*, 2012).

Positive regard

This psychological component of the model arose from 13 articles that described the importance of an approach incorporating attitudes and expressions of acceptance, care and respect. Strengthened through experiential knowledge, peers are understanding of client situations and provide empathy – which builds and fosters the working alliance. Peers' endeavour to be genuine, accepting, and understanding

in their work is consistent with client-centred approaches (Raskin and Rogers, 1989; Salzer, 2002; Campbell, 2008). The articles asserted that a peer-client working alliance characterised by high levels of empathy, understanding, active listening, and acceptance, leads to client outcomes such as higher levels of hope, autonomy, insights, and feeling understood (Connor *et al.*, 1999; Davidson *et al.*, 2006; Repper and Carter, 2011; Chinman *et al.*, 2014; Gillard *et al.*, 2015).

One way in which peers engage with clients is through active listening, which develops the working alliance and builds trust. Active listening creates a constructive 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 and Bath, 2013; Croft *et al.*, 2013). It encourages the listener to become more engaged with the meaning of the story and the impact on the client—enhancing peers' helping skills.

Normalisation

The included studies identified the psychological process of normalisation as an integral aspect of IUPS. Normalisation was described as peers developing strong working alliances with clients, helping to normalise clients' experience of hardship, including associated emotions and cognitions (Davidson *et al.*, 2006; Davidson *et al.*, 2012; Repper and Carter, 2011). Normalisation may serve as both a mechanism and an outcome in IUPS. Empirical literature identified normalisation as a mechanism in IUPS as it leads to an increased sense of wellbeing, self-care, and feelings of empowerment (Repper and Carter, 2011). Normalisation through the working alliance enables the client to feel more accepted and that they belong, perhaps increasing feelings of social support (e.g. emotional and companionship support). However, theoretical articles identified normalisation as an outcome of IUPS, that is, the shared experience of hardship with a peer mentor fosters feelings of normalisation for the client.

Empowerment

The included studies also identified the psychological process of empowerment as an integral aspect of IUPS. Adame and Leitner (2008) define empowerment as the degree to which a client has the agency and ability to make choices about what is best for them within the service/system that they are receiving treatment from. Through IUPS, clients experience personal empowerment and take active roles in their recovery (Campbell, 2008). Empowerment is described as a mechanism of IUPS as it allows the client more freedom, control, and choices in their recovery from hardship. (Cadell *et al.*, 2001; Davidson *et al.*, 2006; Adame and Leitner, 2008; Whelan *et al.*, 2009; Repper and Carter, 2011).

In IUPS, power differentials are lower than in typical 'helper-client' relationships (but are still present given the *unidirectional* nature of the mentoring process), allowing peers to connect with clients on a different level, which may also be empowering. Further, engaging with peers and their affiliated organisations can provide avenues to engage with social justice work and getting lived experience voices heard, helping to reduce social inequities and stigma, which may increase social empowerment.

As reflected in current IUPS services, empowerment and advocating for excluded populations is a key element of IUPS (Moran *et al.*, 2012; Bowgett, 2015). Peer-supporters 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).

Experience-Based Social Support

Eighteen of the 71 articles discussed types of social support. These types include informational, companionship, emotional, instrumental and appraisal social support. Social support, as a general concept, was discussed by seven of the included articles, as a key process, as an outcome, or both. We conceptualised the whole mechanism of experience-based social support as a practical component of the model, as providing support to someone else is a tangible process of 'doing'. This is not to suggest that psychological processes do not occur alongside the practical elements, indeed, attachment may play a role within receiving emotional and/or companionship support, however, none of the included articles discussed this.

Social support is defined as "an exchange of resources between two individuals… intended to enhance the well-being of the recipient" (Shumaker and Brownell, 1984, p.11). Shumaker and Brownell (1984) assert that an important aspect of social support involves self-disclosure. In the context of IUPS these self-disclosures are generally based upon shared experiences and this may help to facilitate development of the working alliance. Peers and clients must have similar goals, similar modes of helping/receiving help, and interpersonal skills to accept support (Shumaker and Brownell, 1984).

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). Fourteen studies highlighting informational support suggest that the provision of information regarding specific illnesses, treatments, or methods of coping lead to increased treatment

adherence, knowledge, and problem solving skills (Fogarty *et al.*, 2001; Deering *et al.*, 2009; Repper and Carter, 2011; Finlayson *et al.*, 2016), and stronger working alliances between peers and clients (Goering *et al.*, 1997).

Further, providing informational support to clients confers benefits for peers. When engaging in the process of informational support, peers consolidate and find the limits of their knowledge, which may prompt them to seek out more information and increase their knowledge base (Borkman, 1976).

Companionship social support

Companionship support includes linking clients to a social network and could be conceptualised as 'belonging' support, (Lakey, 2000; Salzer, 2002). While the term 'companionship' may imply an informal, even friendly type of relationship, here it is described as a process that provides the client with a sense of belonging. Peers introduce clients to pro-social peers (e.g. Alcoholics Anonymous (AA)) increasing their social networks and enabling clients to feel supported. Seven studies cited that companionship support, provided by peers, helps clients to experience increased self-esteem, confidence, efficacy, belonging, social functioning, and increased social networks (Blondell *et al.*, 2001; Weissman *et al.*, 2005; Rowe *et al.*, 2007; Whelan *et al.*, 2009; Gabrielian *et al.*, 2013; Chinman *et al.*, 2014; Finlayson *et al.*, 2016). Companionship support can also lead to a stronger working alliance and thus better outcomes for clients.

Emotional social support

Emotional support is the third most common type of social support reported by six 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. 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, and leads to increases in perceived levels of social support. Emotional support is found to be critical for positive outcomes early on in the working alliance between peers and clients (Whelan *et al.*, 2009) and leads to a stronger relationship (Goering *et al.*, 1997; Finlayson *et al.*, 2016). Thus, emotional social support helps to build the working alliance, fostering trust and an emotional bond.

Peers also benefit from providing emotional and companionship support, as they further develop their skills in effectively communicating empathy and compassion (Mead *et al.*, 2001; Creamer *et al.*, 2012) and become better helpers (Borkman, 1976).

Instrumental social support

The fourth most common type of social support, discussed by three articles, involves the provision of tangible support, such as buying coffee, meals, supplying transportation, assistance completing paperwork, and locating services (Pilote *et al.*, 1996; Finlayson *et al.*, 2016) 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 working alliance, and increase perceived levels of social support (Pilote *et al.*, 1996; Goering *et al.*, 1997; Finlayson *et al.*, 2016).

Peers may also benefit from this process. 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 mentor (Barker *et al.*, 2018).

Appraisal social support

The final type of social support, appraisal support, is that information is useful for self-evaluation and encourages one to take actions and get feedback to resolve a problem (Lakey, 2000), which was discussed by three articles. Peers encourage clients to take action to change their situation, for example, to go to the GP or sleep in a hostel, and then provide positive communication / feedback to assess the outcome of these actions. This results in clients engaging in restructuring beliefs about themselves and their situation (Dennis, 2003; Whelan *et al.*, 2009; Finlayson *et al.*, 2016).

Role Modelling

Many of the included studies discussed the importance of role modelling in IUPS. Key theoretical articles suggest the role of social learning and social comparison in IUPS models (Salzer, 2002; Solomon, 2004). Social learning and social comparison theories are thought to underpin the role modelling mechanism in IUPS and form the psychological component of this mechanism of change in the model. Additionally, empirical literature often described that IUPS uses a strengths-based approach in advocating for clients and is added as a practical component in the model. Further, included studies discuss the impact of the role modelling mechanism on the peer.

Social learning

Social learning is an active cognitive process that occurs within social contexts, where we learn from observing the behaviour of others, particularly when we perceive the model as similar to ourselves (Bandura, 1977; Bandura, 2010).

Twenty articles discussed role modelling or mentoring, suggesting that IUPS involves a stable and more advanced peer to mentor the client through a *unidirectional* relationship, in phases of treatment. Mentoring involves peers using their experience to model specific behaviours and practices through various types of social support – a critical element of IUPS (Solomon, 2004; Bradstreet, 2006; Campbell, 2008; Ahmed *et al.*, 2012; Crawford and Bath, 2013; Gillard *et al.*, 2015). As peer mentors and their clients have a shared experience of hardship, in this case the model may be perceived as more similar to the client than in other 'helping' relationships, making it more likely that the client reproduces the modelled behaviour. Thus, social learning through role modelling/mentoring is identified as a key mechanism of change within the model.

Indeed, Solomon (2004, p.5) suggests, "enhanced self-efficacy occurs as a result of interactions with peers", and role modelling/mentoring engenders numerous positive outcomes for clients including: increased self-esteem (Fors and Jarvis, 1995; Stewart *et al.*, 2009), hope (Davidson *et al.*, 2006; Davidson *et al.*, 2012; Resnick and Rosenheck, 2008; Whelan *et al.*, 2009; Repper and Carter, 2011), improved coping methods (Galanter *et al.*, 1998; Resnick and Rosenheck, 2008; van Vugt *et al.*, 2012), and reduced drug and/or alcohol use (Stewart *et al.*, 2009; Whelan *et al.*, 2009; Tracy *et al.*, 2012; Bean *et al.*, 2013; Tracy *et al.*, 2014).

The modelling process also benefits peers; Barker *et al.* (2018, p.11) found that being able to 'inspire' clients led peers to feel that their work is beneficial. Peers experience increased self-esteem, confidence, independence, higher levels of quality of life, and become better helpers from role modelling (Moran *et al.*, 2012; Croft *et al.*, 2013; Eisen *et al.*, 2015).

Social comparison

Six included articles discussed how clients compare themselves to peers, viewing them as positive role models within the working alliance and citing social comparison as an important theoretical construct in explaining how clients benefit from IUPS (Salzer, 2002; Solomon, 2004; Bradstreet, 2006; Campbell, 2008; Ahmed *et al.*, 2012; Crawford and Bath, 2013).

Social comparison theory (Festinger, 1954) centres on the belief that there is a drive within individuals to self-evaluate, comparing themselves to others in order to reduce uncertainty and learn how to define the self. While upward comparisons for those with low self-esteem usually results in negative self-evaluations (Wills, 1981; Buunk *et al.*, 1990), in IUPS, clients' desire to have a valued social position and be associated with the peers can convert these upward comparisons into positive ones (Tracy *et al.*, 2012; Tracy *et al.*, 2014). Additionally, peers can help circumvent negative effects of upward comparisons by developing a strong working alliance with the client, increasing the clients' self-efficacy and self-

esteem. Further, IUPS contributes to client identity development to a recovery narrative in defining the self through peers' modelled experiences (Mead *et al.*, 2001; Salzer, 2002; Campbell, 2008).

Further, peers can conduct positive self-evaluations of themselves, bolstering their self-esteem by comparing themselves to clients, serving as a reminder of their own journey. Additionally, Tracey *et al.*, (2012; 2014) suggest that the peer role is a valued social position, and peers report living with meaning and purpose while in a supportive role (Moran *et al.*, 2012; Barker *et al.*, 2018).

Strengths-based advocacy

As described by Moran *et al.* (2012), the contextual factors that contribute to effective peer interventions include acceptance and valuing of lived experience. That is, the service (including personnel at all levels) prioritises and recognises the skills, insights, and abilities which are fostered through lived experience. There is also a focus on advocacy, where peers identify and break down barriers that clients often face in accessing services, developing and setting goals, reaching milestones, and generally, helping clients to learn how to self-advocate (Fogarty *et al.*, 2001; Rowe *et al.*, 2007; Finlayson *et al.*, 2016). Thus the final component of role modelling describes IUPS as a strengths-based advocacy approach.

The empirical literature states that IUPS uses a strengths-based approach to advocating for clients and is a mechanism in reducing stigma (Freddolino and Moxley, 1992; Rowe *et al.*, 2007; van Vugt *et al.*, 2012; Gillard *et al.*, 2015; Finlayson *et al.*, 2016). Strengths-based advocacy has been shown to lead to better outcomes for the clients including, higher engagement with services (Finlayson *et al.*, 2016), fewer hospital admissions and days (Repper and Carter, 2011; Davidson *et al.*, 2012), increased autonomy (Davidson *et al.*, 2006), and higher levels of hope (Solomon, 2004; Bradstreet, 2006; Campbell, 2008; Lloyd-Evans *et al.*, 2014). Further, a strengths-based approach enables clients to challenge internalised stigma, increasing hope (Gillard *et al.*, 2015).

Refining the Model

The final iterative search yielded papers that provided further considerations and additions to the IUPS model. The literature supported the overall model, and also highlighted that clients and peers may exit the IUPS process through any of the mechanisms.

For example, although the peer mentoring role confers benefits for peer mentors, it is possible for peers to have negative experiences while being a peer. For instance, peers may develop inappropriate relationships with clients, which leads to relapses or romantic relationships that interfere with their work (Barker *et al.*, 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. Peers must have support to navigate boundaries with clients (Mead, 2001; Mead *et al.*, 2003) and ensure that they do not engage in maladaptive behaviours that negatively impact their own or the client's recovery (Finlayson *et al.*, 2016). However, peers can also exit the service in a positive manner i.e. new job opportunities.

In terms of working alliance, further literature searches supported the mechanisms described as being vital to successful IUPS relationships. However, it is possible that working alliances between peers and clients may be unsuccessful. For example, a negative working alliance lacking trust has the potential to leave clients feeling that their peer was withholding support, engaging in detrimental behaviours such as gossiping, being controlling, and abusing their power. This may be prevented by peers taking time to develop trust, being available, sharing power and control, and listening (Coatsworth-Puspoky *et al.*, 2006).

Through IUPS, peer mentors provide multiple types of experience-based social support. However, clients may also desire different support and drop out of the service as they feel their needs are not being met (e.g. clients may require psychological therapies).

Finally, through the role modelling mechanism, clients can learn positive behaviours and skills (e.g. coping strategies) directly or indirectly from their peer-supporters. 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).

Discussion

This realist review sought to identify the mechanisms that underpin effective IUPS 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. The model shows that both clients and peers experience mechanisms of the working alliance, role modelling, and experience-based social support. However, clients and peers experience each of these mechanisms differently.

Summary of IUPS Process

Peer mentors enter the process of IUPS when they take on a peer mentoring role. In an organisational context, they are provided with training and supervision and opportunities for self-reflection, self-determination, and personal growth. The peers themselves are *the* intervention and provide support to their clients through three main mechanisms: the working alliance, experience-based social support, and role modelling.

The working alliance between peers and their clients functions through experiential knowledge, positive regard, normalisation, and empowerment. As part of the intervention, peers may provide a variety of experience-based social support to clients (e.g. instrumental, emotional), strengthening the working alliance. The behaviours peers carry out when providing experience-based social support may then be modelled by their clients. The role modelling mechanism functions through social comparison, social learning, and strengths-based advocacy.

Clients voluntarily enter into IUPS and experience benefits though these mechanisms. Peers progress through the same mechanisms as clients, however, they experience different outcomes. Once clients have progressed to a point of stability and recovery, they can exit the services or they can continue in the IUPS pathway and begin the process of becoming a peer mentor, through training, self-reflection, and self-determination.

While these mechanisms potentially transcend contexts they are still a simplistic representation of the actual process of IUPS and the human relationships that develop. Clients can, and do, exit IUPS services at any point of this model—through the breakdown of a working alliance, negative social comparisons, and mismatched support needs, for example.

Outcomes for clients

Peers and clients bond upon their shared experience of hardship, fostering a strong working alliance and improving outcomes for clients (Gidugu *et al.*, 2015; Solomon *et al.*, 1995). Strong working alliances, 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 (Felton *et al.*, 1995; Connor *et al.*, 1999; Cadell *et al.*, 2001; Weissman *et al.*, 2005; Whelan *et al.*, 2009; Repper and Carter, 2011; Creamer *et al.*, 2012; Finlayson *et al.*, 2016).

Clients benefit from experience-based social support that peers provide to them directly and indirectly. For example, 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 working alliance and as an opportunity for the peer to share

some of their own story, model recovery, and develop their position as a role model. Peers model recovery through social interactions and sharing their personal stories with clients, which enables clients to feel as though they are able to achieve a similar lifestyle. This process leads to enhanced self-esteem, self-efficacy, motivation, hope, coping methods, and positive self-evaluations (Freddolino and Moxley, 1992; Solomon, 2004; Rowe *et al.*, 2007; van Vugt *et al.*, 2012; Finlayson *et al.*, 2016;).

Outcomes for peers

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 (Mead *et al.*, 2001; Moran *et al.*, 2012; Croft *et al.*, 2013). By developing strong working alliances, 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 (Borkman, 1976).

Implications for practice

It is important to note that this review highlights key aspects for service providers to consider when implementing or modifying IUPS interventions. These elements have been identified as integral to successful IUPS. Therefore, services may consider creating or amending policy around the peer role with consideration to the training and supervision of peers, namely processes that enable self-reflection, self-determination, motivation, and personal growth. However, flexibility is required given that reality is much more complex and organic than this paper could convey. The identified mechanisms could be considered when developing training materials for peers, and breakdowns in the working alliance could be used as sources of reflection for the peers.

Strengths and Limitations

The key limitation of this review is that it involved a significant amount of interpretation and arguably, could have been interpreted differently. To manage this, we attempted to be as explicit as possible in describing the methods and encourage readers to access our additional materials by contacting the first author to assess the progression of the synthesis. 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 randomised controlled trials, 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 one researcher, although the research team was consulted throughout the search and synthesis process. This review did not delineate between genders of client groups, and although we attempted to be as broad as possible in our literature search/inclusion, there was no explicit discussion of the requirements for female service users. Arguably, service providers could match peers with clients who have similar life experiences (and this could include matching by gender), but should consider specific circumstances for their female service users. Lastly, this review is limited to peer support models that use IUPS. Thus, it cannot be generalised to interventions involving IBPS or peer-led interventions.

This review is strengthened by the diversity and number of included studies that enabled the development of the IUPS pathway. This enabled mechanisms to be identified 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 and Bellamy, 2006; Wong *et al.*, 2013), strengthens this review. Further, the search was iterative, across multiple databases, and information was used from multiple sources (i.e. interviews, organisational reports, and grey literature). 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. Previous reviews have focused on the effectiveness of peer support and collectively, they have mixed or weak evidence for peer support (e.g. Repper and Carter, 2011; Lloyd-Evans *et al.*, 2014; Barker and Maguire, 2017). 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 research to research the underlying mechanisms of different types of peer support.

Future Research

Included literature did not discuss the role of power and power differentials that can exist in IUPS models. Literature on IBPS often discusses how peer interventions reduce power differentials (e.g. Mead *et al.*, 2001). Arguably, power differentials are lowered in IUPS but they are still present and future research should explore how these do or do not affect the working alliance. Specifically, research should examine if/how power differentials are related to the provision of companionship and emotional support. Additionally, included literature lacked explanations for the psychological processes for peers in experience-based social support. Future research should evaluate and identify these process beyond the inferences made

in this paper. While we did find some literature that explains the process for peers, there is still a lack of understanding of how peers experience each of these mechanisms and future research should explore the assertions in this paper.

Future research could explore the nature of breakdowns in the relationships between peers and services and/or clients, identifying where in the mechanism this occurred. Further, future research should address the issues around terms and definitions identified in the introduction. Specifically, clarity is needed around what the term 'peer' actually describes and further understanding around common life experience.

With the development of this model identifying potential mechanisms that underpin IUPS's effectiveness, the following assertions can then be tested and potentially modified/elaborated on in different contexts: 1) the quality and strength of the working alliance 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, and 5) training, supervision, support, and opportunities to be self-reflective are directly linked to peer-supporters' effectiveness.

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. The 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.

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