SERVICE EVALUATION REPORT

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EXECUTIVE SUMMARY

- An evaluation of Ashord Place's peer support network was commissioned by Ashord Place, to be conducted by the University of Southampton.
- A theoretical approach to design and methods was used, based on newly acquired information around unidirectional peer support
- Qualitative information was gathered from service users, peers and staff around the experiences of peer mentorship
- Quantitative information was gathered around wellbeing, self esteem and working alliance (relationships), general self-efficacy, job-search self-efficacy, resilience and drug and alcohol use.
- Data was gathered at baseline (entry into the project) and then at 6 months and 1 year.
- Total number of data sets completed was 450. From this, complete sets of data were gathered from 229 people at time 1 droppng to 74 at time 3. This represents one of the largest recent data sets of this nature in the country.
- Behavioural data were also gathered that had asocial consequences. An economic anaylsis was performed.
- Results indicated that around £200 per person was saved in antisocial behaviour costs, attributable to the intervention.
- Quantitative results for drug and alcohol use were mixed, but all other measures showed trends towards improvement
- Qualitative data indicated evidence of growth for the peers, learning by staff, and usefulness of training, as important themes among others.
- Conclusions can be drawn about the need to attend to training and staff turnover, diversity of peers and the value of their knowledge. Service recommendations are made.

INTRODUCTION

HOMELESSNESS IN BRENT

The project is delivered in the London borough of Brent, with high numbers of rough sleepers (increasing by 671% since 2011), high levels of low pay, temporary accommodation, and Housing Benefit claims (London Poverty Profile, 2013). Problems faced by the people and communities supported include:

- Homelessness and risk of homelessness
- Lack of decent, affordable accommodation
- Financial crisis and poverty
- Mental ill health and substance misuse
- Crime and anti-social behaviour
- Social exclusion, including language and cultural barriers

ASHFORD PLACE: PEER SUPPORT IN PRACTICE

The combination of drop-in models and peer-support is a novel idea within homelessness. Independent Lifestyles (IL), led by Ashford Place, is one initiative on the forefront. Ashford Place has a comprehensive peer support programme for those with complex needs and an integrated evaluation process. Ashford Place targets marginalised people experiencing crisis and struggling to access services. A strengths-based 'whole person' model combines lived experience with organisational expertise and resources to meet immediate needs, resolve problems, provide a platform of stability and support, and enable people to take control of their lives.

Through combined drop-in services and peer-support, IL aims to take people off the street into high quality 24/7 emergency accommodation, prevent evictions, meet basic needs, address substance misuse, improve mental health, build resilience and skills, reconnect clients with support networks including family, peer support, and community groups, and help people to get their voices heard.

Ashford Place supports the outcomes identified in IL by utilising their resources and services already provided. Further, the project delivers weekly drop-in crisis intervention support (both on site and in other areas in the community), where those in need can come a get information and referrals to housing supports, legal assistance, GP care, job matching, and benefits support, from both peer supporters and staff.

WHAT IS PEER SUPPORT & HOW DOES IT WORK?

Initially utilised in mental health and addictions, peer support is where individuals with lived experience of a particular difficulty provide formal support to others who are in early recovery (Mead, Hilton, & Curtis, 2001). Intentional peer support (IPS) is fostered and developed by organisations creating specific roles for those with lived experience of the phenomena (Bradstreet, 2006). Peer support 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).

When peer support programmes are developed adjunct to regular treatment, client outcomes improve. For example, clients have better outcomes in overall quality of life, increased social support, higher employment, and a reduction in mental and physical health issues (Felton et al., 1995; Barker & Maguire, 2017). Peer support use is an effective method for helping those with complex needs, such as homelessness.

A model developed, shown in Figure 1, outlines the process of peer support for clients and peers. The model shows that both clients and peers experience elements of peer-client relationships, role modelling, and experience-based

social support. However, clients and peers experience each element differently. Peers experience training and supervision when entering the peer role, shown in the 'peer mentor role' mechanism.

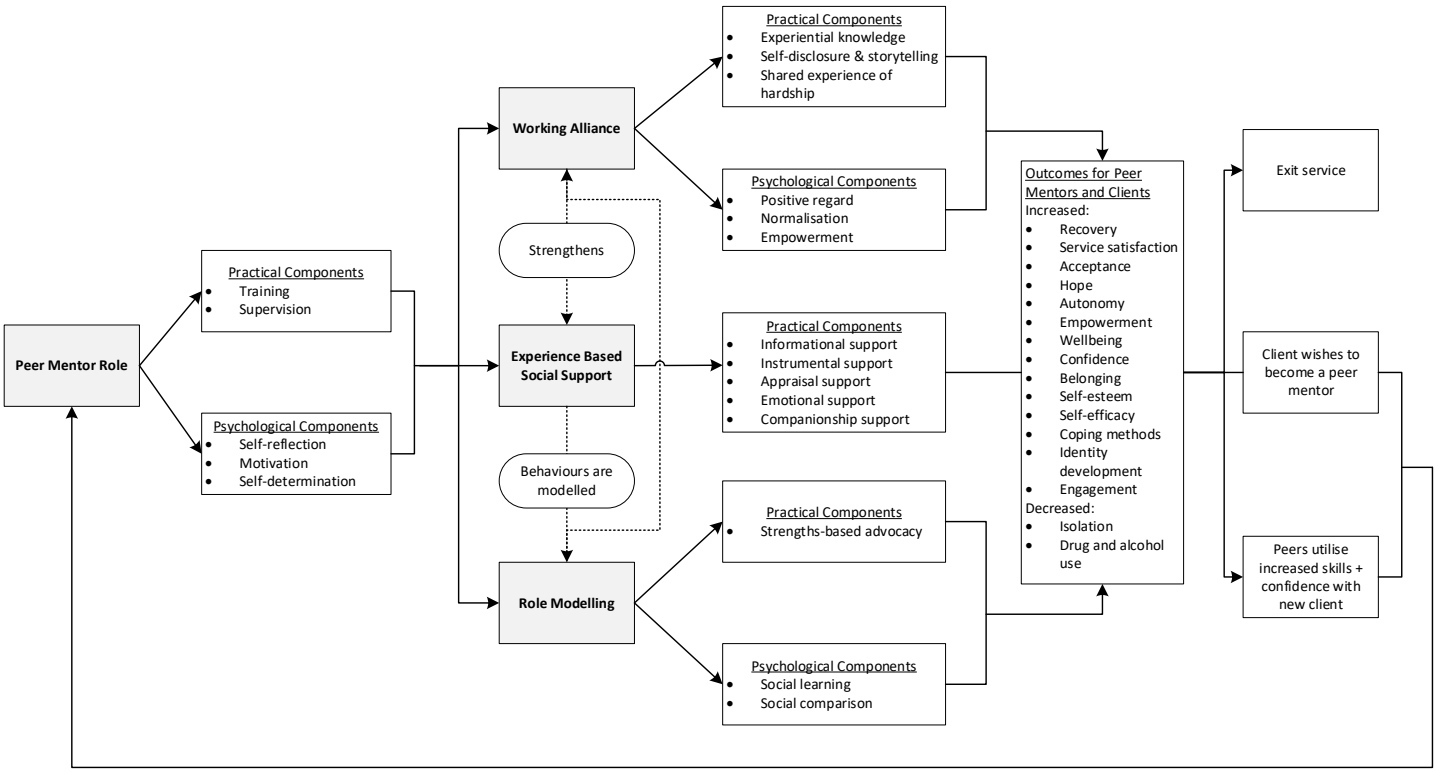


Figure 1. **Peer support model of potential change mechanisms and elements (Barker, Bishop, Stopa, Bodley Scott & Maguire (2020))**

EVALUATION AIMS

This programme evaluation aims to understand if the peer support scheme combined with drop-in services is effective for homeless clients. Specifically, we are interested in the impact on mental health symptoms, drug and/or alcohol use, overall wellbeing, self-efficacy, resilience, and the incidence of various behaviours (e.g. arrests, hospital nights, A&E admissions, and nights spent in a police cell). Additionally, we are interested in the impact this programme has on the peer-supporters. Research shows that peers can benefit from being in the helping role and this evaluation provides opportunity to further explore the reach of these benefits (see Eisen et al., 2015; Reissman, 1965).

Thus, our evaluation aims to:

- Understand the impact of Ashford Places' Independent Lifestyles Programme on client outcomes in mental wellbeing and addiction.
- Assess if the programme is effective at building clients' self-efficacy and ability to cope with crises over time.
- Measure the impact on peer-supporters who are in a helping role—enabling them to access educational, training, and employment goals.
- Help to evaluate and improve the peer training module that Ashford Place implements.
- Understand the economic impact of this programme on the community.
- Provide an evidence base for improving the impact of peer volunteer services in helping to reduce and prevent homelessness.

The evaluation involves collecting data from the same participants over a period of time to evaluate the initial and long-term impact of an intervention. A battery of surveys over a 12-month period for each participant is collected. Specifically, participants are invited to complete surveys when they first engage with Ashford Place's services and again at two six-month intervals. Further, qualitative interviews with a sample of clients and peers are used, to contextualise quantitative results and ascertain client, peer, and staff experiences.

STUDY DESIGN AND METHOD

In order to evaluate the effectiveness of the programme, we used a combination of quantitative and qualitative methods.

QUANTITATIVE METHOD

The quantitative part of the evaluation involved using a battery of questionnaires, which we administered to clients when they joined the project and then roughly every six months.

In this report, the first set of data gathered when clients joined the project will be referred to as *baseline* or *Time 1* data, the second set, collected roughly six months later will be called *Time 2* data, the third set, collected at 12 months post-baseline will be called *Time 3* data.

QUESTIONNAIRE MEASURES

The questionnaire pack included bespoke measures to gather data on the following key areas: demographics, mental health diagnoses and support, GP use, and behavioural outcomes – such as the number of nights spent in a police cell and the number of trips to A&E; outcomes which could be used to assess the economic impact of the intervention.

We also used seven validated psychometric scales to measure wellbeing, drug use, alcohol use, self-efficacy, resilience, job search self-efficacy, and the working alliance between peer supporters and clients.

The measures used are listed below, and were selected according to what was thought may change as a result of the intervention (based on the previous literature cited). Further information on each of the measures is provided in the corresponding sections of the report.

- Alcohol Use Disorders Identification Test (AUDIT) – a measure of alcohol use. (Page 12)
- Drug Use Disorders Identification Test (DUDIT; Berman et al., 2005) – a measure of drug use. (Page 14)
- Warwick-Edinburgh Mental Wellbeing Scale (WEBWEMS) – a scale of mental wellbeing. (Page 16)
- General Self-efficacy Scale (GSES) – a measure of self-efficacy, i.e. how effective one perceives oneself to be. (Page 17).
- Conner-Davidson Resilience Scale (CD-RISC-2) – a measure assessing resilience and the ability to "bounce back" after a stressful event. (Page 19).
- Working Alliance Inventory – Short Revised (WAI-SR) – used to assess the strength and impact of the peer-client relationships. (Page 20).
- Job Search Self-Efficacy (JSSE) – this tool captures employment outcomes in the evaluation and predicts job search intentions and behaviours. (Page 22).

QUESTIONNAIRE SCORING AND INTERPRETATION

The scores for each item on the questionnaire measures are summed to create a *total score* for the questionnaires. Each individual in the group will have their own total score for each questionnaire. To see what is happening at a group level as opposed to an individual level, we can combine the individual total scores together. The individual total scores are summed and then divided by the number of individuals that completed the questionnaire. This creates a *mean total score* or *average* for the group.

Sometimes, there will be variation in what people score, some individuals will score much lower than the mean total score for the group, and some will score more highly. This variation is denoted by the *standard deviation (SD)* of the scores. A high standard deviation signals that the scores are spread out from the mean, while a low standard deviation signals scores are close to the mean.

QUALITATIVE METHOD

We carried out interviews with staff, peers, and clients to help contextualise the quantitative data. A total of 10 interviews have been conducted, with four clients, three peers, and three staff members. The surveys also asked clients a series of open-ended questions about their experience of Ashford Place.

DATA GATHERING

The time schedule of data gathering went in accordance to plan.

- Time 2 data was collected, on average, 168 days (roughly 5.5 months) after Time 1.
- Time 3 data was collected, on average, 178 days (roughly 6 months) after Time 2 data.
- The time from Time 1 to Time 3 was 344 days on average (roughly 11.5 months).

We administered a total of 450 evaluation packs to 229 individual clients over the two year data gathering period of the evaluation (Jan 2017 to Jan 2019).

We collected Time 1 data from 229 clients, Time 2 data from 147 clients, and Time 3 data from 74 clients.

FINDINGS (CLIENTS)

PARTICIPANT BACKGROUND INFORMATION

DEMOGRAPHICS

At baseline, 68.4% of participants reported their gender as male, 30.7% reported their gender as female, and 0.9% of participants left the question blank.

Participants' ages range from 18 to 69 years old, with an average age of 38.5 (*SD*=14.07)

Figure 2. shows the ethnic backgrounds of participants sampled at baseline.

Eighty percent of participants were current residents of Ashford Place's emergency accommodation.

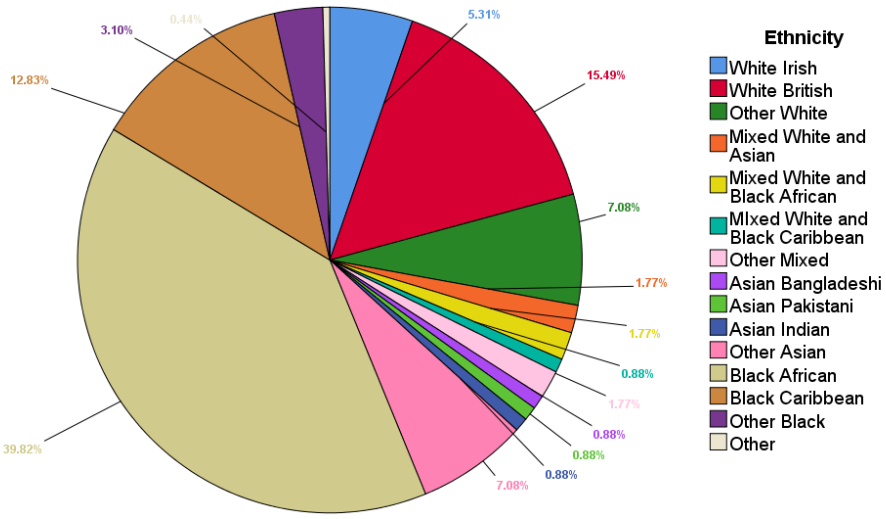


Figure 2. **Breakdown of ethnicities at baseline**

HOUSING

At baseline, when asked their current housing situation, 65.9% of clients were staying in a hostel, 12.8% were in supported accommodation, 8.4% had their own tenancy, 7.5% were rough sleeping, 3.5% were sofa surfing, 0.9% were squatting and 0.9% had 'other' housing arrangements.

The majority of participants (67%) had not held a tenancy in the previous two years, 24.5% had held one tenancy, 6.1% had held two, and 2.4% reported having between three and 15 tenancies.

For those participants who had held a tenancy, the length of the previous tenancy ranged from one month to 42 years, with the median length of 15 months.

In terms of evictions, 78.8% of participants had not been evicted in the previous two years, 18.9% had been evicted once, and 2.3% had been evicted two or three times.

MENTAL HEALTH

At baseline, 25.2% of participants reported having a diagnosed mental health need.

Of the 25.2% – depression is the most common mental health need, with 80.4% of people having this diagnosis. 5.9% have a diagnosis of depression and anxiety, 5.9% have a diagnosis of PTSD, 3.9% have a personality disorder and 2% experience cognitive issues such as memory loss.

SUPPORT, SERVICE PROVISION AND SERVICE USE

MENTAL HEALTH SUPPORT

Of the 25.2% of participants who reported having a diagnosed mental health need, 41.4% reported receiving support for their mental health, from sources including their GP, mental health nurse, counselling, care coordinator, recovery navigator, and psychologist.

SUPPORT AT ASHFORD PLACE

To understand how participants initially felt about coming to Ashford Place and getting their problem dealt with, we asked them to report how many times they had come for support and how efficiently their problem had been dealt with.

- The majority of people (59%) had come once, 27.9% had come two to five times, 7.2% had been between five and 10 times, and 5.9% of clients had visited 10+ times.
- Sixty-two percent of clients reported that their issue was resolved within the first meeting.

PRIMARY CARE

Primary Care is the first point of contact for most people with a health problem, but many people who are homeless struggle to access a GP. Without an address, it is often hard to register with services (Pathway, 2020).

This perpetuates health inequalities and indeed, homeless people are many times more likely than those who are housed to suffer from numerous physical health conditions including tuberculosis, Hepatitis C, epilepsy, heart disease and asthma (Pathway, 2020). Street-homeless people are 11 times more likely to have mental illness compared to their housed counterparts (Aldridge et al., 2017; Fitzpatrick, Kemp, & Klinker, 2000) and the average age of death for those who die on the street is just 47 (Aldridge et al., 2017; Crisis, 2011).

Research by the charity Pathway found that homeless patients attend A&E six times as often as housed people. They are admitted to hospital four times as often and stay twice as long. This is because they are two to three times sicker when they arrive. Homeless people go to A&E because their health has deteriorated to the point of emergency, and they have no other options.

Good health services have a vital part to play in helping people with their health, but they can also help patients address the problems that led them to the street. As a homelessness service, helping clients to access a GP service is an important part of care provision. Thus, as part of the evaluation, we tracked whether clients were registered with a GP and their use of primary care.

We can see in Table 1. below, that from Time 1 to Time 3, the percentage of clients registered with a GP has increased from 74.8% to 84.5%. This is a positive finding and suggests that engaging with services at Ashford Place is improving access to primary care for clients. However, there is room for improvement, as at Time 3 – a year after first becoming a client of Ashford Place, 15.5% of participants are still not registered with a GP.

Table 1. Primary Care Use

		Time 1	Time 2	Time 3
Are you registered with a GP?	**Yes**	166 (74.8%)	110 (82.1%)	60 (84.5%)
	No	56 (25.2%)	24 (17.9%)	11 (15.5%)
Visits in the past six months		4.7 (*SD*=15.6)	2.3 (*SD*=3.2)	2.0 (*SD*=2.7)
Visits in the past month		1.1 (*SD*=1.7)	1.0 (*SD*=1.6)	1.2 (*SD*=1.8)

ECONOMIC IMPACT OF SERVICE USE

As mentioned above, homeless people use services such as A&E and hospital more often than housed people do. This type of emergency service use has an economic cost. Similarly, homeless people are more likely to have been involved with the criminal justice system, which also has costs. We asked participants to report the incidences of their service use in order to ascertain whether engaging with services at Ashford Place would affect participants' use of public services and have an economic impact. Table 2. shows the frequencies at which participants used public services in the six months prior to being surveyed at each time point and the economic impact of such use.

Table 2. Frequency of Service Use at Each Time Point and the Associated Costs

	Cost per incidence[a]	Time 1 (N = 216)			Time 2 (N = 125)			Time 3 (N = 73)		
		Freq.	**Cost**	**Cost pp**	**Freq.**	**Cost**	**Cost pp**	**Freq.**	**Cost**	**Cost pp**
Night spent in police cell	£104.22	21	£2,189	£10.13	10	£1,042	£8.34	5	£521	£7.14
Arrests	£248	22	£5,456	£25.26	11	£2,728	£21.82	16	£3,968	£54.36
Nights in psychiatric hospital	£451	94	£42,394	£196.27	38	£17,138	£137.10	4	£1,804	£24.71
Nights spent in hospital	£400	232	£92,800	£429.63	40	£16,000	£128.00	60	£24,000	£328.77
A&E admissions	£148	112	£16,576	£76.74	14	£2,072	£16.58	11	£1,628	£22.30
Total			£159,415			£38,980			£31,921	
Average cost pp			£738.03			£311.84			£437.28	

([a]See Appendix A for more information on where this information was sourced. Freq = frequency of incidence; pp = per person)

As fewer people have been sampled at Time 2 and Time 3, we cannot directly compare the costs across time points as fewer people means fewer costs. Therefore, we calculated the average cost of service use per person for each time point across all services (shown in red) and for each service (shown in blue). As you can see, from Time 1 to Time 3, there has been a £300.75 saving in average cost per person.

However, it's possible that the that clients with fewer needs/less chaotic service use may have been more likely to have been retained in the evaluation, while those who dropped out of the evaluation may have more costly needs, which could be contributing to this shown effect. (i.e. the participants sampled at Time 3 are a different population to those that dropped out).

Therefore, to test this, we carried out the cost analysis with only the participants who stayed in the evaluation for all three time points. A similar pattern appeared – see Table 3. below.

Table 3. Cost Analysis for Clients Retained in the Evaluation from Time 1 to Time 3.

	Time 1	Time 2	Time 3
Total cost	£46,177.88	£24,923.00	£ 31,921.10
Average cost per person	£624.03	£336.80	£431.37

Here, there is an average saving of £192.66 per person over the year from Time 1 to Time 3. If we apply this saving to all 229 participants we sampled, this amounts to a saving of £44,119.14 for the tax payer.

Whilst it appears that engaging with services at Ashford Place is reducing costly public service use, it's important to note that although the economic cost per person decreased between Time 1 and Time 2, it increased again between Time 2 and Time 3 (while still remaining lower than at Time 1). This may be due to random fluctuation, however it could be that clients are in need of some more follow up support.

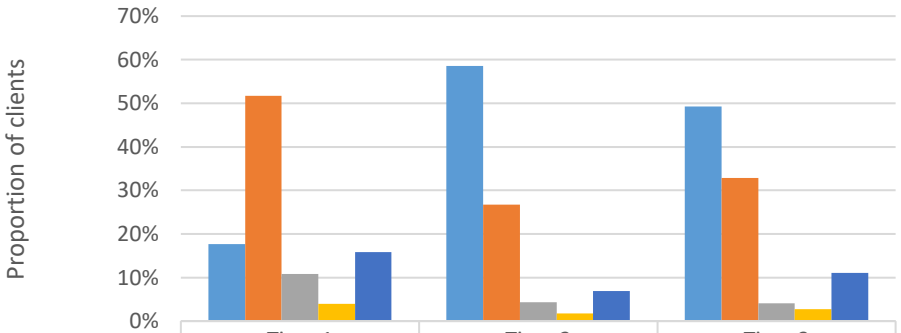
At Time 1, 22 people account for £145,585.08 of the total cost. These clients may fall into a group of people referred to as "High Needs High Cost" (HNHC) clients. These clients often suffer from multiple co-morbidities and face gaps in care and care coordination. Targeted interventions for these clients may improve their care and reduce costs.

ROUGH SLEEPING

We asked clients how many nights they had spent rough sleeping months in the six months prior to being surveyed at each time point.

Figure 3. below shows the duration of time participants have spent rough sleeping in the six months leading up to each time point.

- At Time 1, in the six months before being a client of Ashford Place, 82.3% of clients had spent at least one night sleeping rough. Almost 20% had spent over two months sleeping out.
- At Time 2, the proportion of participants who had spent at least one night sleeping rough had decreased to 41.4% and those sleeping rough for over two months reduced to 8.6%.
- At Time 3, this percentage of clients who spent at least one night sleeping out increased again to 50.7% and similarly, the percentage of clients sleeping rough for over two months increased again to 13.7%.



	Time 1	Time 2	Time 3
0 nights	17.70%	58.60%	49.30%
1 – 30 nights	51.70%	26.70%	32.90%
31 – 60 nights	10.80%	4.30%	4.10%
61 – 90 nights	3.90%	1.70%	2.70%
91+ nights	15.80%	6.90%	11.00%

Figure 3. Distribution of rough sleeping durations per time point

The total number of nights in the past six months slept rough by all participants decreased from 8276 at Time 1 to 2166 at Time 2 and 1734 at Time 3. However, the number of participants sampled also decreased. To allow for comparison between time points, total nights have been divided by the sample size to show the average number of nights spent rough sleeping per person. This is displayed graphically in Figure 4.

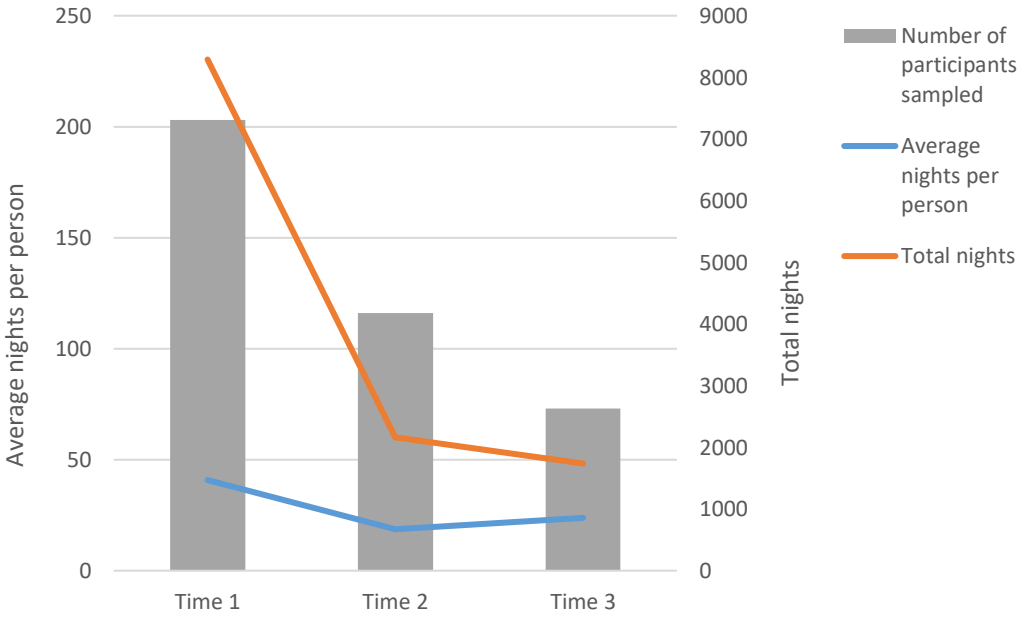


Figure 4. Average and total nights spent sleeping rough

The large reduction in rough sleeping from Time 1 to Time 2 and the smaller increase from Time 2 to Time 3 follows a similar pattern to the results of the economic analysis.

This may be due to the fact that fewer clients have completed questionnaires at Time 3. Alternatively, it may be that a year after initial contact at Ashford Place, some clients may have struggled to maintain a tenancy. Overall, this suggests that participants have a reduced number of nights sleeping rough after experiencing services, but it is not necessarily a long-lasting change for everyone. Some clients may benefit from more follow-up care.

PSYCHOMETRIC MEASURES - OVERVIEW

Table 4 shows clients' scores for each of the questionnaire measures across the three time points. The mean scores, the standard deviation of scores, and the number of clients who completed each measure are included in the table. The data in Table 4 is interpreted and discussed in the text on Pages 12–X.

Table 4. Descriptive Statistics for Client Scores at Time 1, Time 2 and Time 3.

Measure[a]	Total Possible Score	Ashford Place Time 1			Ashford Place Time 2			Ashford Place Time 3		
		N	M	SD	N	M	SD	N	M	SD
AUDIT	36	229	3.96	7.95	137	4.60	7.05	75	2.72	4.92
DUDIT	36	227	2.08	6.15	136	2.47	5.59	75	1.41	5.81
WEMWEBS	70	228	45.87	14.06	137	47.34	14.44	75	50.71	11.64
GSE	40	227	30.22	7.71	137	32.52	7.40	75	34.95	5.84
CD-RISC-2	8	223	5.79	2.09	134	6.22	2.15	75	6.72	1.57
JSSE[b]	100	105	62.90	25.56	68	70.44	30.05	50	75.98	23.80
WAI-SR	60	194	37.88	19.38	134	48.48	14.14	75	54.49	9.67

(M = Mean, SD = Standard Deviation, N = Sample Size)

[a] Please see page 6 for a full list of abbreviations.

[b] The sample size is smaller for the JSSE as this measure was only introduced in February 2018.

ALCOHOL USE

To evaluate alcohol use in clients, we used the Alcohol Use Disorders Identification Test (AUDIT). The AUDIT is a screening tool developed by the World Health Organization (WHO), used to assess alcohol consumption, drinking behaviours, and alcohol-related problems. Scores range from 0 – 40. A lower score indicates a positive outcome.

At Time 1, clients scored an average of 3.96 (*SD*=7.95), at Time 2 they scored an average of 4.60 (*SD*=7.05) and at Time 3 they scored an average of 2.72 (*SD*=4.92). This is displayed graphically in Figure 5. As you can see, there is a downward trend in alcohol use, with scores decreasing by 31.25% from Time 1 to Time 3.

We used a repeated measures ANOVA to test if the differences in scores between time points were significant. The test showed that there were no statistically significant differences.

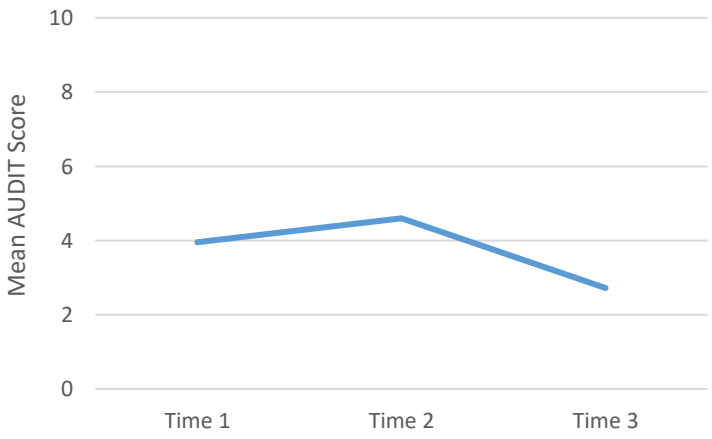


Figure 5. Alcohol use over time

WHAT DO THE SCORES INDICATE?

Threshold (or cut-off) values allow for interpretation of questionnaire scores. These are displayed in Table 5 below. As you can see, clients' average score falls into the 'normal' category of alcohol use at all time points.

Table 5. Threshold Values for AUDIT

Score	Interpretation	WHO Recommendation
0 – 7	Normal	
8 – 15	Medium level of problems	Should receive advice on reducing hazardous drinking
16 – 19	High level of problems	Counselling and continued monitoring recommended
20+	Probable alcohol dependence	Warrants further diagnostic evaluation for alcohol dependence

At all time points, participants from Ashford Place have considerably lower scores for alcohol use than we would normally find in homeless samples. For instance, in previous research, we found the mean score for clients across homeless hostels in Hampshire to be 9.25 (*SD*=9.98) and 17.50 (*SD*=12.88) across hostels in Lambeth, London.

This could be explained by the fact that Ashford Place does not permit clients to drink and/or use drugs on the premises and 80% of the participants sampled in the evaluation had been a resident at Ashford Place during the evaluation. The evaluation made efforts to be inclusive and attain data from the multiple pop-up services (i.e. from clients who are not current residents), so that we could test whether there were differences in substance use between residents and non-residents.

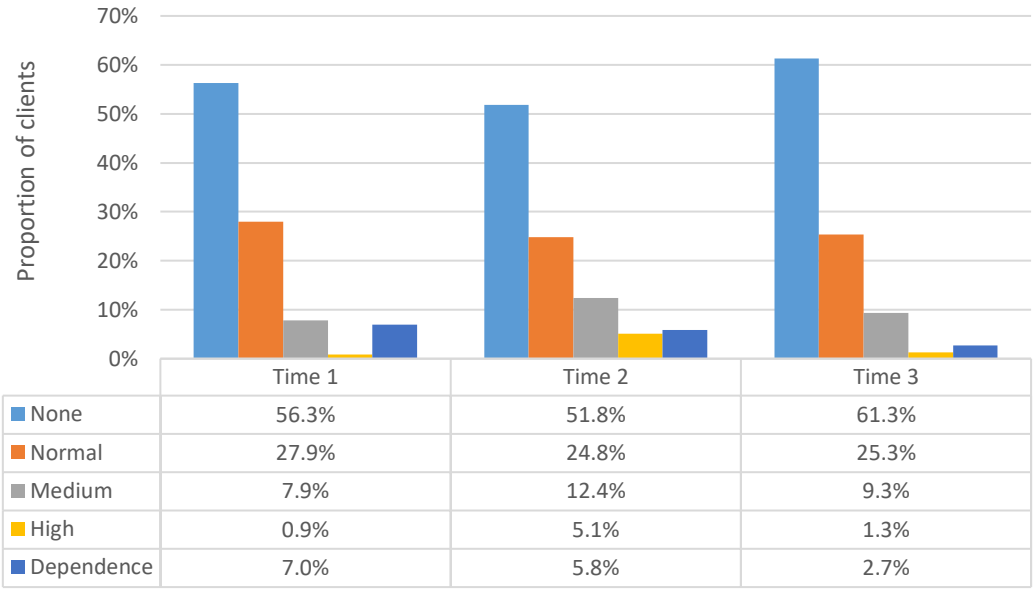
There were significant differences in alcohol use between the two groups ($t(44.90) = 3.551$, $p=.001$). Non-residents consumed significantly more alcohol than current residents: 9.63 (*SD*=12.10) vs 2.73 (*SD*=5.87), respectively.

Also, it is important to note that these are average scores. The variation in scores means that a small minority of participants scored more highly on the AUDIT. For example, at Time 1:

- 56.3% of participants sampled do not drink alcohol
- 27.9% of participants drink in the normal range
- 7.9% have a medium level of alcohol-related problems
- 0.9% have a high level of alcohol-related problems
- 7% are likely to be alcohol dependent

This dispersion of scores across the usage categories is displayed in Figure 6 below for the three time points. The graph shows that from Time 1 to Time 3:

- The proportion of clients who have stopped drinking alcohol altogether has increased by 5%
- Fewer clients are dependent on alcohol – the proportion of those dependent has decreased by 4.3%



	Time 1	Time 2	Time 3
None	56.3%	51.8%	61.3%
Normal	27.9%	24.8%	25.3%
Medium	7.9%	12.4%	9.3%
High	0.9%	5.1%	1.3%
Dependence	7.0%	5.8%	2.7%

Figure 6. Dispersion of scores across AUDIT categories

Ultimately, the large variances in scores suggest that individuals have diverse needs.

DRUG USE

To evaluate drug use in clients, we used the Drug Use Disorders Identification Test (DUDIT). This tool was developed as a parallel instrument to the AUDIT for identification of individuals with drug-related problems. Scores range from 0 – 44. Lower scores indicate a positive outcome.

At Time 1, clients scored an average of 2.08 (*SD*=6.15), at Time 2, clients cored an average of 2.47 (*SD*=5.59), and at Time 3, clients cored an average of 1.41 (*SD*=5.81). This is displayed graphically in Figure 7. As you can see, there is a downward trend in alcohol use, with scores decreasing by 32.03% from Time 1 to Time 3.

We used a repeated measures ANOVA to test for significant differences in scores between time points. There were no statistically significant differences.

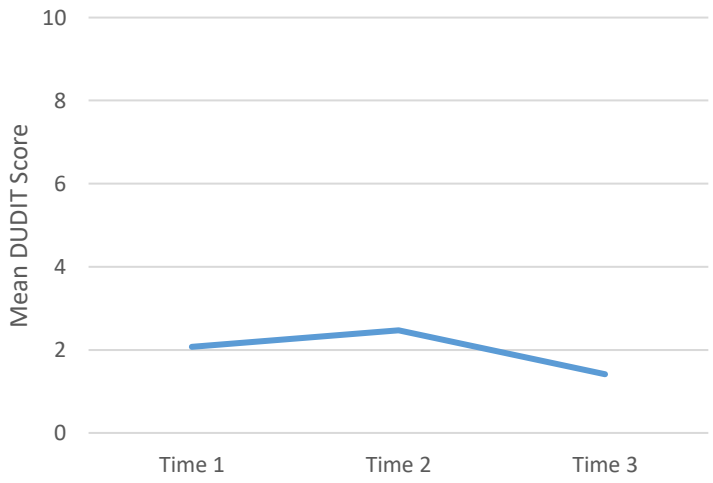


Figure 7. **Drug use over time**

WHAT DO THE SCORES INDICATE?

The threshold values for interpretation of scores are displayed in Table 6. On average, clients are not using drugs at a level that indicates drug abuse.

Table 6. Cut-off values for DUDIT scores

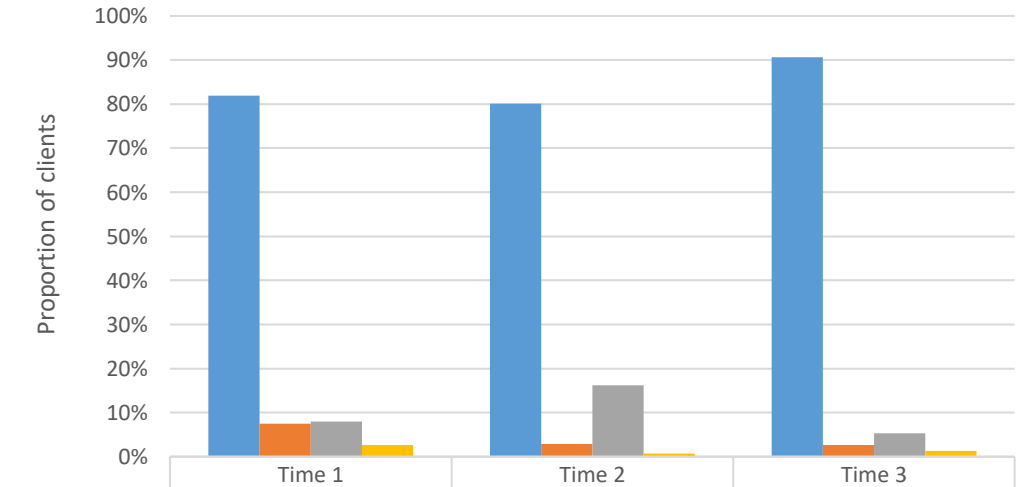
Score	Interpretation
0	Does not use drugs
1 – 7	Low level drug use
8 – 24	Indicates drug abuse
25+	Likely to be heavily dependent on drugs

Similarly to alcohol use, at all time points, participants from Ashford Place have considerably lower scores for drug use than we would normally find in homeless samples. For instance, in previous research, we found the mean score for clients across homeless hostels in Hampshire to be 13.06 (*SD*=14.20) and 18.96 (*SD*=14.95) across hostels in Lambeth, London. This is likely to be for the same reasons stated above.

Average drug use scores differed between current residents (1.74, *SD*=5.36) and non-residents (4.38, *SD*=9.50), however this difference was not significant ($t(45.35) = -1.69$, $p=.098$).

However, as with alcohol use, we must remember that these are average scores and the variation in scores means some clients will have scored more highly on the DUDIT. For example, at Time 1:

- 81.9% of clients do not use drugs
- 7.5% use drugs but not at levels which indicate abuse (<8)
- 7.9% abuse drugs
- 2.6% are likely to be heavily dependent on drugs



	Time 1	Time 2	Time 3
None	81.9%	80.1%	90.7%
Low level use	7.5%	2.9%	2.7%
Abuse	7.9%	16.2%	5.3%
Dependence	2.6%	0.7%	1.3%

Figure 8. Dispersion of scores across DUDIT categories

This dispersion of scores across the usage categories is displayed in Figure 8 for the three time points. The graph shows that from Time 1 to Time 3:

- The proportion of clients who do not use drugs has increased by around 9%.
- Low level drug use, drug abuse, and drug dependence have decreased.

WELLBEING

We used the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) to assess mental wellbeing. Items cover both the subjective feeling and psychological functioning aspects of mental wellbeing. Scores range from 14 – 70. Higher scores on the WEMWBS mean that clients are more likely to be confident, have good self-esteem, are able to cope with day-to-day life, and are generally feeling positive.

At Time 1, clients scored 45.87 (*SD*=14.06) on the WEMWBS, at Time 2, this increased to 47.34 (*SD*=14.44), and at Time 3, this increased to 50.71 (*SD*=11.64). From Time 1 to Time 3, this is an increase of 10.54%. This upward trend is displayed graphically below in Figure 9. However, to test whether this increase was significant, we used a repeated measures ANOVA and the results were non-significant.

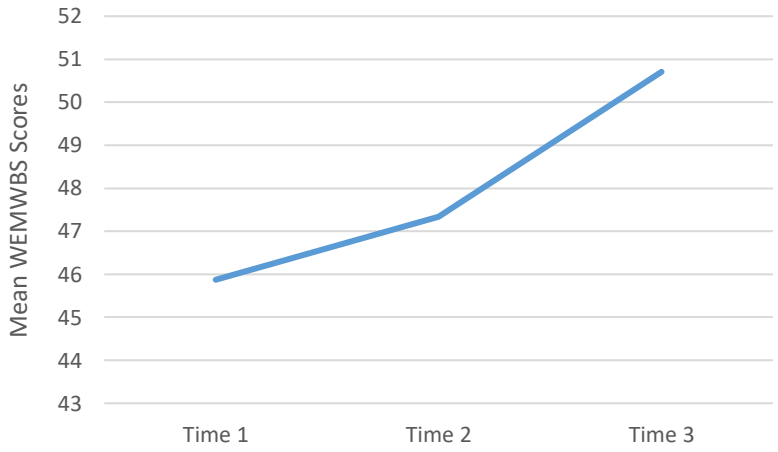


***Figure 9*. Wellbeing scores over time**

WHAT DO THE SCORES INDICATE?

In comparison to our samples from previous research, at Time 1, Ashford Place clients scored higher on wellbeing (45.87, *SD*=14.06) than those in Hampshire (40.06, *SD*=11.46) and in Lambeth (40.01, *SD*=13.37).

There are no threshold values to allow for interpretation of the WEMWBS scores, however, there is population data from the 2011 Health Survey for England (see Figure 10). This allows us to compare the wellbeing of our sample with the wellbeing of the general population in England. The 2011 Health Survey for England sampled a total of 7020 people, who averaged a score of 51.61 (*SD*=8.71).

Figure 10 shows the distribution of scores from the population survey. The orange line plotted onto the graph indicates the mean score obtained by clients at Time 1, the blue line indicates the mean score obtained by clients at Time 2, and the green line indicates the mean score obtained by clients at Time 3. By Time 3, client's average wellbeing scores are almost the same as the general population (50.71, *SD*=11.64 vs 51.61, *SD*=8.71).

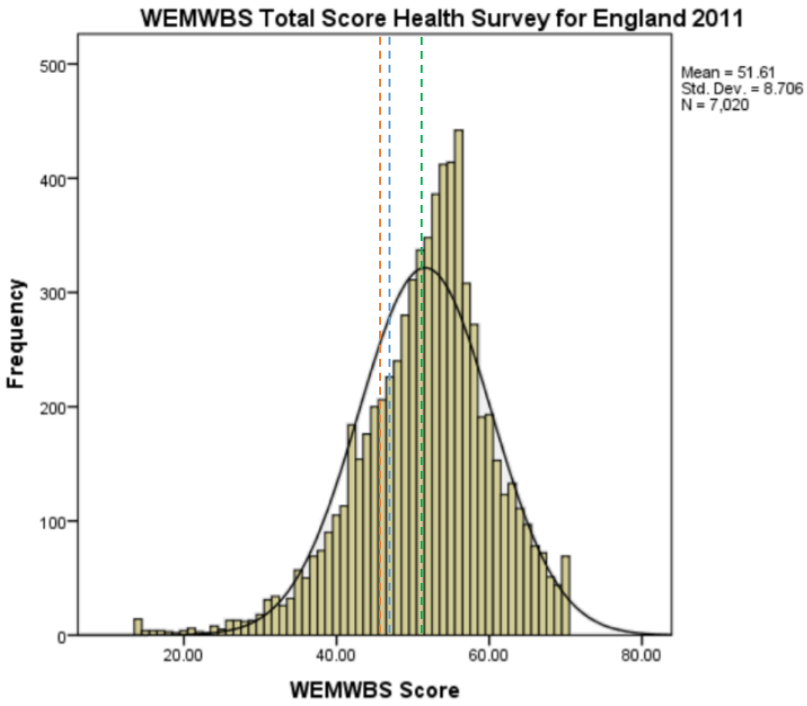


Figure 10. **Population and client wellbeing scores**

QUALITATIVE INTERVIEWS

In the interviews, clients spoke about how Ashford Place had helped them:

"Ashford Place help a lot during the time when I was very low and they provided me with accommodation and support, mentally and emotionally"—Client Participant

One client said that specifically, it was his good relationship and communication with staff had helped him:

"They were very helpful and caring, considerate, understanding, loving. Felt some love. […] I think communication is important and we had a good rapport. You know like, any kind of problems, I could discuss it with them. The team, we came to an understanding very quickly. Because there was communication." —Client Participant

One client spoke about his journey over the past year and felt that during his experience at Ashford Place gave him an opportunity to reflect on his life. He reports using the questions in the survey for self-reflection:

"I really love the questions about how you feel. It was um, good questions yeah. Um I think, I've never been those sort of questions in those sort of ways. So I had to think, quite deep. In terms of are you really happy? Are you really having enough time to find what you're doing like reading and stuff? Those questions really do like stir you back to focus"—Client Participant

Although the increase in wellbeing was non-significant, the work that staff and peers do with clients, such as providing individualised support, *"compassion and understanding",* and connecting clients to CBT therapy, seem to be having a positive impact.

SELF-EFFICACY

Self-efficacy is the belief that one can perform successfully in a variety of situations and cope with difficult tasks. Perceived self-efficacy facilitates goal-setting, effort investment, persistence in the face of barriers, and recovery from setbacks. Higher self-efficacy predicts coping with daily hassles and adaptation after experiencing all kinds of stressful life events (Schwarzer & Jerusalem, 2010). Self-efficacy is important because it can play a major role in how one approaches goals, tasks, and challenges.

To evaluate self-efficacy, we used the General Self-Efficacy Scale (GSES; Schwarzer & Jerusalem, 1995). Scores range from 10 – 40 and higher scores indicate a positive outcome. The General Self-Efficacy Scale is positively correlated to emotion, optimism, work satisfaction and negatively correlated to depression, stress, health complaints, burnout, and anxiety.

At Time 1, clients achieved an average score of 30.22 (*SD*=7.71), at Time 2, they scored an average of 32.52 (*SD*=7.40) and at Time 3 they scored an average of 34.95 (*SD*=5.84). From Time 1 to Time 3, this represents an increase of 15.64%. This increase over time can be seen in Figure 11 below.

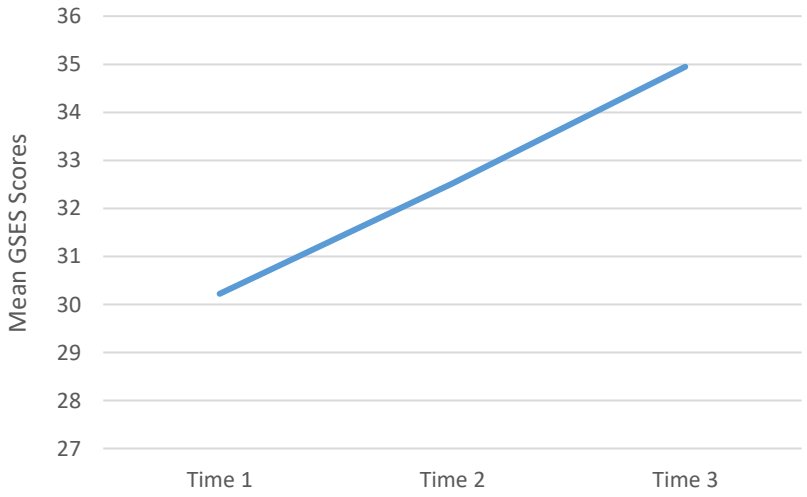


Figure 11. **Self-efficacy scores over time**

To test whether the differences between time points were statistically significant, we conducted a repeated measures ANOVA. The test was significant with a medium to large effect size ($F(1.8, 132) = 8.127$, $p=.001$, $\eta p^2=.110$). A post-hoc pairwise comparison using the Bonferroni correction showed a significant increase in self-efficacy from Time 1 to Time 2 ($p=.037$), however, from Time 2 to Time 3, the increase was non-significant ($p=.218$). This means that most of the gains in self-efficacy are achieved during the first six months of being a client at Ashford Place.

WHAT DO THE SCORES INDICATE?

The authors of the GSES state that in many samples, the average score is 29. Thus, at all time points, clients at Ashford Place score above average on self-efficacy.

QUALITATIVE INTERVIEWS

One client spoke about his experience at Ashford Place:

"When I came in here, I was like, quiet and you know, just keep myself to myself and stuff. But um, after a few months…got my confidence back, and I tried to help some of the other people in here, to give them confidence too"—Client Participant

Staff and peers discussed strategies to help clients to increase their ability to cope with situations:

"We work with the client, helping them through whatever the issue is, but not just doing it for them, taking them through the steps you've taken. So that if it happens again, they know what to do"—Staff Participant

These activities help the client to learn how to manage and cope with situations, and increases their abilities and beliefs that they can handle crises in the future. Clients have increased self-efficacy after being in the service, and are more equipped to cope with crisis and obstacles. This increased coping continues to improve over time.

RESILIENCY

To assess resiliency, we used the short version of the Connor-Davidson Resilience Scale (CD-RISC 2; Vaishnavi, Connor, & Davidson, 2007). The scale authors describe resilience as the ability to "thrive in the face of adversity". The scale measures adaptability and the ability to "bounce-back". Scores range from 0 – 8 and higher scores indicate a positive outcome.

At Time 1, clients scored an average of 5.79 (*SD*=2.09), at Time 2 they scored 6.22 (*SD*=2.15) and at Time 3 they scored an average of 6.72 (*SD*=1.57). From Time 1 to Time 3, this is a 15.99% increase. This upward trend is displayed graphically in Figure 12 below.

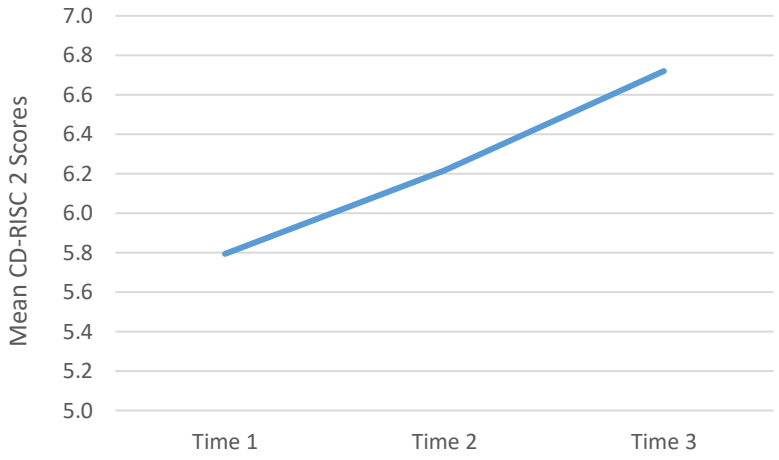


Figure 12. **Resilience scores over time**

To test whether the differences between time points were statistically significant, we conducted a repeated measures ANOVA. The test was significant ($F(2,128) = 3.145$, $p=.046$, $\eta p^2 = .047$) with a small to medium effect size. A post-hoc pairwise comparison using the Bonferroni correction showed a non-significant increase between Time 1 and Time 2 ($p = .866$), and a non-significant increase between Time 2 and Time 3 ($p = .407$).

WHAT DO THE SCORES INDICATE?

In a general population survey of US adults, mean CD-RISC 2 score was 6.91, while lower scores were observed in psychiatric groups with depression (5.12), generalised anxiety disorder (4.96) and post-traumatic stress disorder (4.70) (Vaishnavi et al, 2007). Therefore, by Time 3, clients appear to have an average level of resilience.

QUALITATIVE INTERVIEWS

Interviews showed that peers instil hope and use their lived experience to show clients how they have resiliency. That they can overcome anything because they have already been through a terrible experience:

"If you can survive homelessness, my goodness. You…fear will not exist in you anymore. You know what I mean? You have any fear, to be fearful of anything. If you can survive that, my goodness, your resiliency is going to go from here to here. It's going to boost up immediately. Because you survived it"—Peer Participant

Staff increase client resiliency by providing clients with individualised support, challenging negative beliefs, addressing underlying issues, and *"encourage the client to get involved in problem solving to help their own situations"—Peer participant.*

The strength of the peer-client relationship (or working alliance) is a critical component of effective peer support and services for clients with complex needs (Barker, Bishop, Stopa, Bodley Scott & Maguire, 2020).

The working alliance is a characteristic of the partnership that develops between the helper and the person being helped. The alliance refers to a collaborative relationship between helper and the client; meaning that there is a consensus and willingness from both parties to engage in and do the work that leads to improvement. There is a broad agreement that this collaborative engagement involves:

- Consensus over the goals of treatment.
- A sense of confidence and commitment to the kinds of activities that the helper and helpee engage in as part of the helping journey.
- The relationship or engagement is in a context of mutual trust, confidence and liking of one another.

Several meta-analyses on the links between the quality of the alliance and therapy outcome, in a broad variety of helping contexts, have consistently reported a positive relation between the quality of the alliance and the results of the helping process.

To assess the strength of peer-client relationships, we utilised the Working Alliance Inventory-Short Revised (WAI-SR). This tool is used to assess relationships between clients and helpers (usually therapists). With author permission, the tool has been modified to reflect the language of peer-support (i.e. replacing "therapist" with "peer"). There are three subscales which measure three key aspects of peer-client relationships: (a) agreement on tasks set (b) agreement on the goals of peer support (c) development of an affective bond. Scores range from 12 – 60, and higher scores indicate a stronger working alliance and a positive outcome.

At Time 1, clients scored an average of 37.88 (*SD*=19.38) on the WAI-SR, at Time 2 this increased to 48.48 (*SD*=14.14) and at Time 3, this increased again to 54.49 (*SD*=9.67). From Time 1 to Time 3, this represents a 43.85% increase and this upward trend can be seen in Figure 13 below.

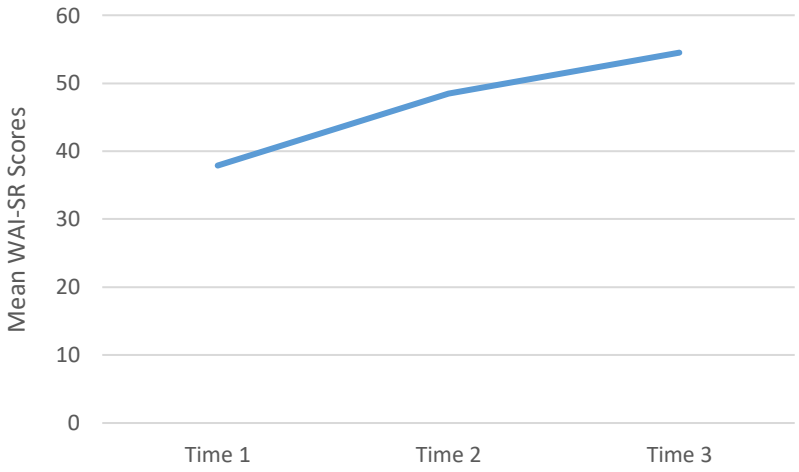


Figure 13. **Peer-client relationships over time**

To test whether the differences between time points were statistically significant, we conducted a repeated measures ANOVA. The test was significant with a large effect size ($F(2,114) = 12.392$, $p<.001$, $\eta p^2 = .179$). A post-hoc pairwise comparison using the Bonferroni correction showed a non-significant increase in the working alliance from Time 1 to Time 2 ($p=.078$), however, the increase in working alliance from Time 2 to Time 3 was significant (p=.008).

This shows that the working alliance takes time to develop, with the gains occurring within the six to 12 month time frame.

All three subscales of the WAI also showed increases over time (Figure 14).

- Goal: F(2,110) = 7.014, p =.001, ηp^2 = .113 (med-large), again T2 to T3 is when the significant increase occurs.
- Task: F(2,112) = 13.938, p <.001, ηp^2 = .199 (large), sig increases in T1 to T2 and T2 to T3
- Bond: F(1.8,96) = 9.871, p<.001, ηp^2 =.155 (large), sig increase between T2 and T3.

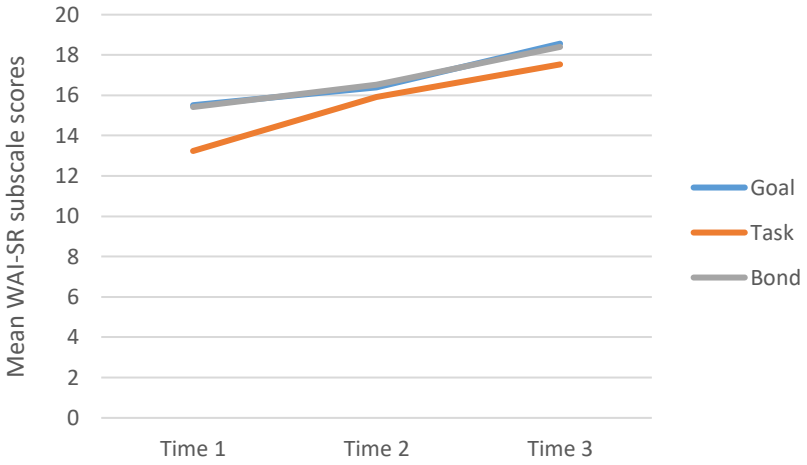


Figure 14. **Peer-client relationships (subscales) over time**

WHAT DO THE SCORES INDICATE?

This evaluation aims to examine the predicting role of peer-client relationships on client outcomes. At all three time points, working alliance scores are significantly correlated to general self-efficacy, resilience, and wellbeing.

Pearson correlations

	WAI			GSE			CD-RISC			WEMWBS		
	Time 1	**Time 2**	**Time 3**	**Time 1**	**Time 2**	**Time 3**	**Time 1**	**Time 2**	**Time 3**	**Time 1**	**Time 2**	**Time 3**
WAI Time 1	1											
WAI Time 2	0.08	1										
WAI Time 3	-0.12	0.20	1									
GSE Time 1	0.23**	0.33**	-0.01	1								
GSE Time 2	0.01	0.52**	0.22	0.43**	1							
GSE Time 3	-0.14	0.14	0.37**	0.06	0.34**	1						
CD-RISC Time 1	0.16*	0.30**	0.02	0.70**	0.37**	-0.05	1					
CD-RISC Time 2	-0.06	0.51**	0.03	0.39**	0.74**	0.08	0.34**	1				
CD-RISC Time 3	-0.03	0.10	0.29*	0.14	0.26*	0.73**	0.02	-0.05	1			
WEMWBS Time 1	0.27**	0.31**	-0.02	0.51**	0.34**	-0.03	0.50**	0.28**	-0.04	1		
WEMWBS Time 2	0.08	0.43**	0.26*	0.23**	0.58**	0.32**	0.24**	0.50**	0.17	0.24**	1	
WEMWBS Time 3	-0.14	0.17	0.27*	0.08	0.31*	0.67**	-0.002	0.22	0.55**	-0.05	0.30*	1

**. Correlation is significant at the 0.01 level (2-tailed).
*. Correlation is significant at the 0.05 level (2-tailed).

QUALITATIVE INTERVIEWS

Interviewed clients felt that they developed "strong bonds" with the peers and that could rely on them when they needed support:

"They help with any problems you are facing, internal or external"—Client Participant

EMPLOYMENT / JOB SEARCH SELF-EFFICACY

At Time 1, clients scored an average of 62.90 (*SD*=25.56), at Time 2 clients scored an average of 70.44 (*SD*=30.05), and at Time 3, clients scored an average of 75.98 (*SD*=23.80). From Time 1 to Time 3, this represents a 20.80% increase and this upward trend can be seen in Figure 15 below.

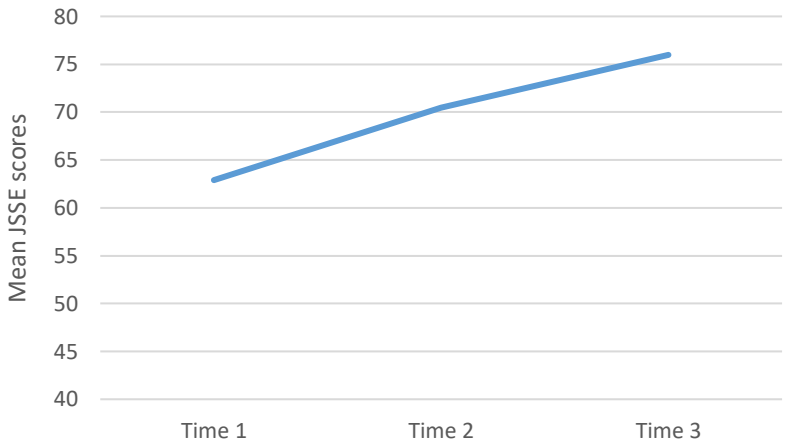


Figure 15. Job search self-efficacy over time

As the JSSE was added to the battery of questionnaires at a later date, we have a smaller sample size which means we need to use a different statistical test to test for differences in scores over time. A t-test for the differences between Time 1 and Time 2 was significant ($t(39) = -4.045$, $p<.001$), meaning there were significant improvements in job search self-efficacy over time.

By Time 3, 44% of clients had met their employment / educational goals.

QUALITATIVE INTERVIEWS

Interviewed participants suggest that clients get support for employment through practical support to find and apply for jobs, building up skills through training and volunteering, and one-to-one support.

Participant responses from the surveys indicate that clients want more opportunities for training, that Ashford Place play a larger role in helping the clients to access training and educational resources to help them develop skills:

"Help me with training"—Client Participant

"Train me, if possible"—Client Participant

One participant discussed his transition from client to key worker within Ashford Place:

"my overall experience at AP, it was very good because I had a specific goal in mind. In that I knew I was here because something that I didn't do, lead me here…Whilst I'm here let me try and better myself and try to develop areas that I was weak at. Uh so for example, when I was made redundant, I realised that the reason why was because I didn't find the job that I really loved. So whilst I was at AP, I said you know what? Let me at least try and do a few courses so I can try to find a job that I really love so that next time, I won't be made redundant because I didn't

have any passion…I ended up becoming a volunteer afterwards. And seeing that this is the job that I want to be doing for the next, however long. You know, however long it takes to end homelessness. Um so overall, I think it was quite good, because I ended up accomplishing my goal. To find a job that I really love"

This participant used his time at Ashford Place to change his life and get a job that he is committed and passionate about. They also had praise for the opportunities to do volunteering at Ashford Place:

"I don't think I would have been able to secure the employment had I not been at Ashford Place and also a volunteer […] I really loved it, at times I actually felt like I wasn't working. But it was because, you know, I have experienced it – so when I'm giving them advice, it's not work to me, it something I enjoy doing."

OTHER CLIENT EXPERIENCES FROM INTERVIEWS

The qualitative data suggests that participants are happy with the services that they have received:

"Everything I want, I find. Ashford Place help me very much"—Client Participant

Participants expressed feeling supported on getting immediate shelter, long-term housing, and move-in support. One interviewed participant explained their experience with Ashford Place:

"I find everyone there to be friendly and approachable and nothing is too much trouble. My brother came out of prison in November of last year, 2017 and I took him along to see Jack. My brother had nothing, he literally had nothing. He had the clothes he was standing up in. Didn't even have a birth certificate. Now he has one and a passport and a bank account and has just moved into his own studio flat and is quite happy and settled. Thanks to Jack. I find Ashford Place offers a fantastic support system for people who find themselves in life changing situations sometimes through no fault of their own"—Client Participant

However, one person stated that the services they needed (psychological) were not available to them. Other negative comments about their experience related to logistical issues, such as broken toilets, shower times, tea/coffee issues, and behaviour of other service users.

Another interviewed client provided the suggestion of having a "buddy system"—where clients support each other to familiarise the new clients with the building, the rules, and norms of the service.

"Buddy people up. People who have been here a bit longer, to say these are the rules mate. If you don't get them then you don't get that. Someone there, not as a mentor, but someone there to say here, this is what we do, how we do that, this has to be done…to give the experienced client a confidence boost and help them do more of what they need to"—Client Participant

This suggestion derived from the client's experience of arguments between clients in the centre, usually revolving around chores or the rules.

Another client who was interviewed believed there should be more follow up support once clients move on from Ashford Place:

"Once I went, moved out of here, it's like I didn't exist. And I've said it before, for the first three months minimum, I think there should be some sort of support. 'Cos a lot of people – I'm not as bad off as some of the people here, I understand that – but some people need a lot more support. And [they're] not getting it and I know they're not. Just someone to pop up see them once per week, 'have you checked on your housing benefit, have you etc etc.' and that doesn't come from here. It's like once you're out the door, you don't exist."

FINDINGS (PEER MENTORS)

BACKGROUND INFORMATION

Thirty peer mentors were sampled in the evaluation. Roughly three quarters of peers are male (76.7%) and roughly a quarter are female (23.3%). The peers have an average age of 33.68 (SD=11.02) and the majority of peers have a Black African background (see Table X). Only three peers report a mental health need and one reports getting support for this.

Table X. Ethnic Backgrounds of Peer Mentors at Ashford Place

Ethnicity	Percent (%)
British	13.3
Other White	13.3
Indian	3.3
Black African	50.0
Black Caribbean	13.3
Other Black	6.7

PSYCHOMETRIC MEASURES

Peers were asked to complete a set of surveys at two time points, including scales on mental wellbeing, self-efficacy, employment, and peer-client relationships. Table X. shows the scores the peers obtained on the questionnaires over the two time points.

Table X. Descriptive Statistics for Peer Scores at Time 1 and Time 2.

Measure[a]	Total possible score	Time 1			Time 2		
		N	M	SD	N	M	SD
WEMWBS	70	29	54.97	11.63	26	53.50	12.78
WAI-SR	60	26	43.58	8.26	25	56.52	22.63
GSE	40	28	32.64	7.75	25	35.48	5.41
JSSE[b]	100	4	78.00	18.17	10	45.20	4.13

(M = Mean, SD = Standard Deviation, N = Sample Size)

[a] Please see page 6 for a full list of abbreviations.

[b] The sample size is smaller for the JSSE as this measure was only introduced in February 2018.

WELLBEING

There were no significant differences between time points for wellbeing scores ($t(25) = 1.49$, $p=.150$). However, the wellbeing of peers is something organisations with peers should make a priority as "being a peer can be really hard"—Peer Participant.

Interviewed peers spoke about difficulties in the transition from being a client to becoming a peer, that they would have to navigate the relationships they had with other clients, but as a peer. That some clients would try to take advantage of their new role—asking to go out after hours for a cigarette, for example. One peer felt that a break between being a client and becoming a peer might help to reduce these issues. However, it was expressed that once there was a new cohort of clients, these issues were reduced and the peer was able to develop in their role as a result:

"It helped me to overcome and become a better peer"—Peer Participant

SELF-EFFICACY

There was an increase in self-efficacy over time, however this difference was not statistically significant ($t(22) = -1.47$, $p=.156$). It may be that the timescales of measurement of change may not have been long enough to have had an effect on a construct as fundamental as self-esteem.

PEER-CLIENT RELATIONSHIPS

There were, however, significant increases in scores on the working alliance inventory ($t(22) = -3.17$, $p=.004$), denoting that the strength of the peer-client relationship has increased over time.

This is a good outcome – as previously mentioned on Page 20, the strength of the peer-client relationship is a critical component of effective peer support and services for clients with complex needs (Barker, Maguire, Bishop, & Stopa, 2018), and the quality of the working alliance is related to outcomes for clients in a variety of contexts.

CLIENT EXPERIENCE OF PEERS

Many clients have reported finding peers useful for 'advice and support'.

At Time 3, 90% of clients cited peer support as the service they found to be the most helpful, compared to 56% for the drop-in, 46% cited the pop-up, and 20% cited online services as being the most helpful.

QUALITATIVE DATA

Participants felt that peers are a great element of the support at Ashford Place:

"The fact that nothing is too much trouble for them to help with and being non-judgemental and friendly"—Client Participant

"These people have been in a similar situation and have insight into the source of my issues"—Client Participant

Participants felt that peers provide emotional support and they can connect with them on a different level. This is consistent with current literature—peer-supporters who are committed, persistent, caring, and trustworthy can develop strong experience-based relationships with those experiencing homelessness and help them escape it (Barker et al., 2018). Participants have repeatedly informed us about how much they respect and like working with the peers.

"They help, you need information and guidance, support, and making you feel at home"—Client Participant

"We respect each other"—Client Participant

Participants were also asked to comment on things they thought the peers need improvement on. Mainly, clients felt that peers needed support to communicate and could provide more continued support:

"Sometimes lack of communication"—Client Participant

"A better support for the first month, maybe a volunteer could just pop round once per week just to see your paperwork etc. is up to date and your coping"—Client Participant

Client and peer comments suggest that peers need more training in managing relationships, dealing with difficult behaviour, and helping them to be reflective on their role.

EMPLOYMENT

Thirty percent of peers report that they have achieved their employment/educational goals, and 85% of peers stated that they are doing the things they want to weekly or daily. Qualitative data suggest that peers are *"feeling good"* about being in a helping role and that it is *"rewarding"*

Peers have had the opportunity to develop skills that they will be able to put on their CVs and increase their employability:

"I have developed my people skills, I have a better understanding of other cultures, religions, and experiences" – Peer Participant

"Learnt how to support and advise clients, helped them with job searches, property viewings, setting up emails, adding client email to mailing list. Improved my listening skills" – Peer Participant

To get a better idea of what it is like as a peer, we asked one peer to elaborate on his experience from client to peer to support worker:

"My experience at Ashford place has been one great uplifting experience from day one. Every day you meet different people from all walks of life with different problems…this requires you to know the right information to give, which gives you more confidence on carrying out every day daily activities at the centre"—Peer Participant

DISCUSSION AND RECOMMENDATIONS

- Improved follow up support – based on data on rough sleeping and service use data, and client interview
    - Quantitative evidence indicates improvement in working relationships. The qualitative data suggests that this may be down to practical and emotional support, and the experiential knowledge of the peers leading to increased quality of relationsips. The quality of support was mentioned as a significant factor. In order for these factors to be sustained, the wellbeing and workloads of the peers will need to be attended to. The lack of significant increase in wellbeing of the peers may be important here, indicating that more attention should be paid to factors that may worsen mental health issues.
    - Training programmes are essential in enabling peers to understand the pulls on their emotions that can result from peer mentor work. This will contribute to sustaining of peer wellbeing and the effectiveness of the work, and reduce peer turnover
- Diverse / varied needs – these need individualised tailored support
    - Such as the support provided by a comprehensive peer support programme. This will need to be sustained over time as peers turn over. The turnover will require a continuous programme of training to catch new peers.
    - Some peers are better than others in certain areas. Having an eye to the specific skills of peers and matching them to the diverse needs of individuals may be useful.
- Peer mentoring programme
    - It became apparent that this was less of a priority for the service towards the end of the evaluation period). This may be an issue in the long-term as peer traning is essential to address a number of factors, including peer wellbeing, boundaried care and burnout, listening skills, engagement in change and motivational interviewing skills etc. To lose the training may mean losing an effective peer service. If peers stop coming to training that is being provided, this should be addressed as a motivation issue

- Formalising peer-mentoring scheme again including training etc. Peer mentor schemes work best with they roll over, keeping momentum. Building up programmes takes time and skills are aquired over a long period. Having experts who have a good deal of experience to bring others along is essential.

- Developed peer training manual, which outlines the content of peer skills and attitudes. This has been carefully written to be understandable at all levels, to be used as an ongoing manual, and needs to be integrated into practice in addition to training.

- The high staff turnover is a challenge. Towards the latter third of the project a number of key staff were lost. This led to a deterioration in the effectiveness of the peer mentor programme and the evaluation, which was noted by some peers.

- Development of reflective practice groups for both peers and staff – and protected time and space for these. Reflective practice is an essential augmentation of training and enables a deeper consideration of skills acquisition and intrapersonal issues.

- A number of these issues are outlined in the Psychologically Informed Environment literature (particularly around training and reflective practice - https://eprints.soton.ac.uk/340022/1/Good%2520practice%2520guide%2520-%2520%2520Psychologically%2520informed%2520services%2520for%2520homeless%2520people%2520.pdf) and the peer mentorship literature. These may be useful resources to sustain an effective peer mentorship programme.

GLOSSARY

P-value:

Effect size:

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APPENDIX A

We calculated that a night spent in prison costs £104.22 using government data available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/653972/costs-per-place-per-prisoner-2016-2017-summary.pdf

However, this may be a conservative estimate as a freedom of information request to the metropolitan police revealed that the estimated cost of holding a detainee per incidence is £326. Information available at https://www.met.police.uk/SysSiteAssets/foi-media/metropolitan-police/disclosure_2017/december_2017/information-rights-unit---the-cost-of-housing-prisoners-in-police-cells

The median cost of a day in a psychiatric hospital is £451, according to the Health Service Journal, information available at https://www.hsj.co.uk/commissioning/how-to-get-better-value-for-money-from-psychiatric-care-units/5041168.article

The average cost of a night in hospital is £400 according to government data and the Bristish Medical Association, see https://www.bma.org.uk/-/media/files/pdfs/collective%20voice/influence/key%20negotiations/nhs%20funding/bma-position-on-health-spend-july-2017.pdf?la=en

An A&E admission costs the NHS £160, see https://improvement.nhs.uk/documents/1972/1_-_Reference_costs_201718.pdf

Peer Mentor Handbook 2018

Congratulations on becoming a peer mentor! This handbook contains most of the resources you will need for working as a mentor at Ashford Place.

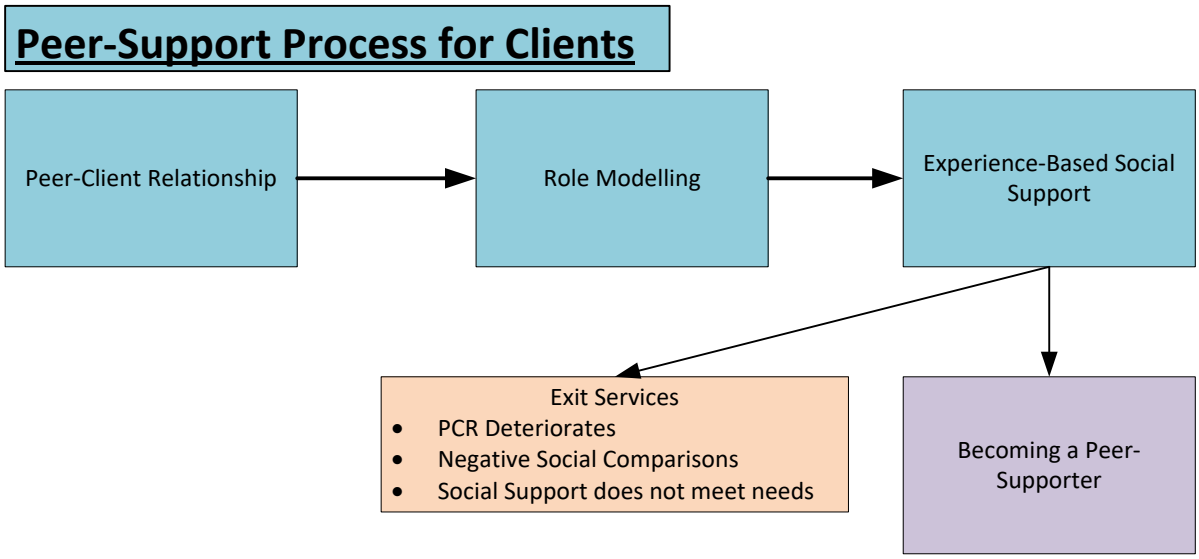
Contents:

What is a Peer Mentor?

A peer mentor is someone who has experience of homelessness and is now at a more stable stage in their life where they can support someone who is currently homeless (and in this case staying at Ashford Place).

The value of lived experience: The peer-client relationship is unique because it is based on a shared experience of hardship. Peer mentors become role models for clients as they are someone who has faced similar difficulties and succeeded in overcoming them. Peers have an understanding of what clients are going through because they have been through it themselves.

Peers provide empathy, acceptance, active listening, companionship and empowerment to their clients. The relationship is beneficial to both the client and the peer. Through volunteering as a mentor peers are improving their own confidence, developing skills and building relationships.



Structure of Mentoring at Ashford Place

Every peer-client relationship will be different. We have made a general structure as a guideline for you to follow:

- 6 meetings between peer and client, 1st meeting when the client moves in
- Peer is clients point of contact for Ashford Place
- Peer can accompany the client to any important appointments

- Peer actively listens and engages with the client
- Peer helps clients identify goals/areas of their life they want to improve
- Peer supports clients in reaching those goals
- After the sixth meeting review how things are going and decide on how many more meetings the client wants to have
- Agree when client moves out of Ashford Place on how you wish to follow up. Example: Peer agrees to phone client once a month for two months to see how they are getting on

Active Listening

Active listening is exactly what you might think: listening actively. Listening is the most important part of communication. Instead of just hearing what the other person is saying you make a conscious effort to listen to them and let them know you are paying attention. This helps the person to feel heard, at ease around you and builds trust. It requires patience and is a method of communication often used in counselling.

How to listen actively:

Pay attention:

- Look directly at the person talking
- Don't be distracted by your own thoughts or things going on around you
- Don't think about what you are going to say in reply while they are still talking

Show that you're listening:

- Have open body language, face towards the person talking without your arms crossed
- Make eye contact
- Nod and or say "yes" or "go on" to show you are listening

Provide Feedback

- Our own personal biases can sometimes influence what we hear
- Make sure you understand what the person is trying to say by reflecting and asking questions
- Summarise what they have said back to them to confirm you have understood it correctly – for example: Let me make sure I have this right…

Defer judgement

- Don't interrupt or be argumentative
- Let them finish their point before you start talking

Respond Appropriately

- Be open and honest when speaking
- Show compassion
- Even if you disagree with their views treat the other person with respect and dignity

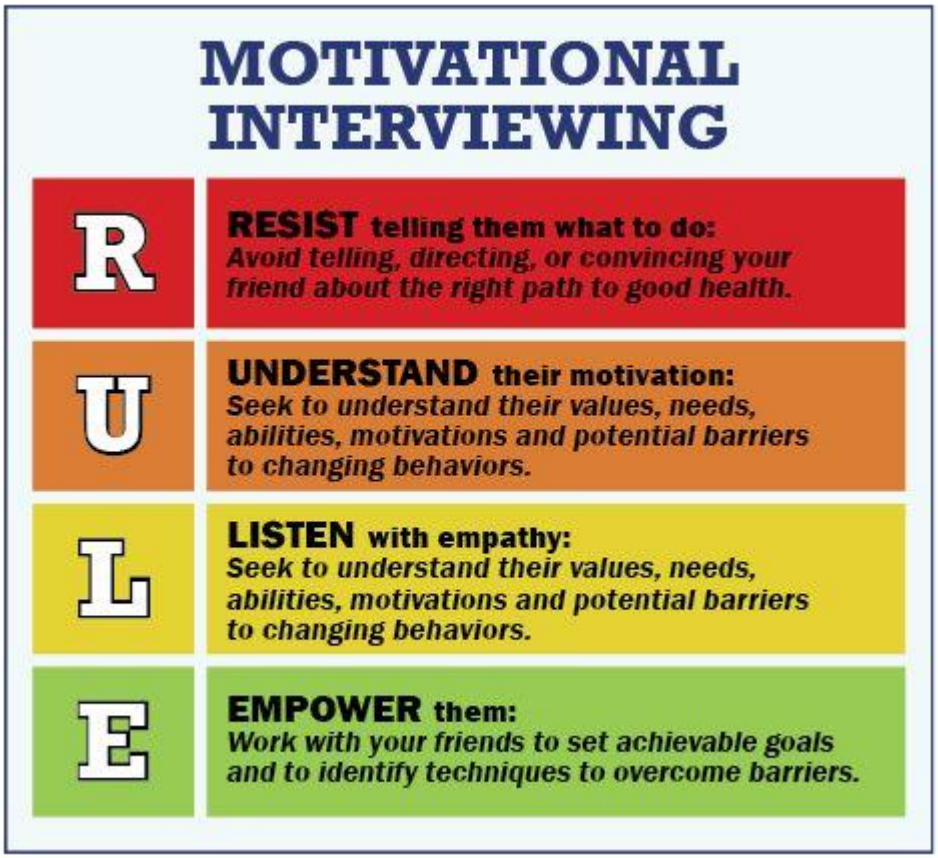
You can use this to help you effectively engage too:

Use OARS:

- Open-ended questions
- Affirm—Highlight their progress or any positives
- Reflect—on what they say, repeat it back for clarity
- Summarise—what you heard them say, so you know exactly what they mean

Examples of bad listening/What not to do!

1. Ordering, commanding them
2. Telling people what they should do—morality
3. Judging, criticising
4. Shaming, blaming
5. Agreeing with everything, approving negative things



Goal Setting

Part of your role as a peer mentor will be to motivate and support clients in achieving their goals. When you are in crisis it can be hard to look forward and plan for the future. Your encouragement can play a big part in helping someone see that real change in their lives is possible.

By understanding what the client values, hopes for, or wants, you can help them to set meaningful goals and help them achieve their goals.

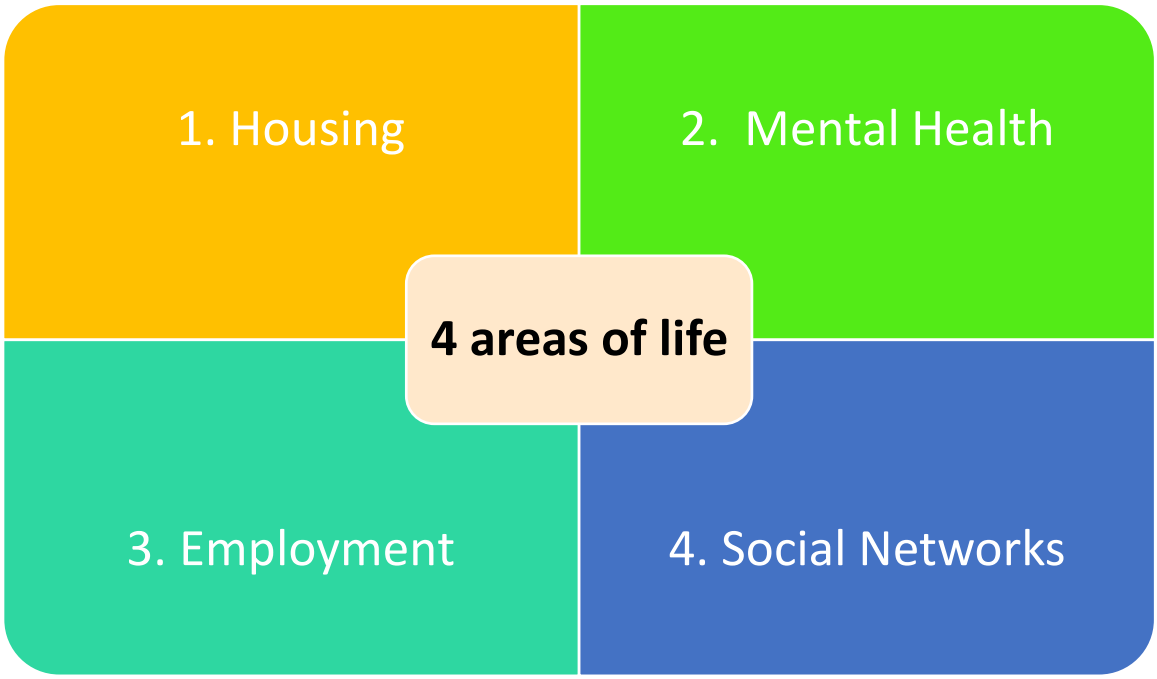
Understanding what someone values can be difficult. If you are feeling stuck, you can use the values sort activity in the peer/client workbook.

Ask your client to identify 4 areas of their life they want to improve. Try not to dictate this but allow the client to speak freely about what they want. Identify together what would make them happier with each area. Break each major goal down into short-term and long-term goals. Each session you will look at a different area together and work towards reaching those goals. It's important for the goals to be attainable, realistic and that you have set a timeframe for them.

Here are some examples of leading questions you can ask to get your client talking about their goals for the future:

What would you like to be doing this time next year?	What is important to you in life?	What do you feel your strengths are?	What do you think you can improve?
When are you happiest?	Is there a career/job you feel you would enjoy?	What do you want that you don't have?	What do you want that you already have?

Here are some examples of goal setting. Your client will have a template that you can fill in together at each session. Below is an example of a completed template:



1. Housing

Before our next session I will: Sign up to the mailing list for viewings, start searching online for properties and get together the documents I need (ID, bank statement, proof of work or benefit)

In one month's time I will: Be regularly attending viewings and searching online

In six month's time I will: Have my own place and focus on maintaining my tenancy

2. Mental Health

Before our next session I will: Call a counselling service or ask my caseworker to refer me for therapy

In one month's time I will: Be engaging with mental health services

In six month's time I will: Have improved my mental health and know where to go if I feel unwell

3. Employment

Before our next session I will: Ask about applying for my SIA licence and attend a jobs club for help writing my CV

In one month's time I will: Have my licence and CV, searching for jobs online

In six month's time I will: Be working part-time as a security guard

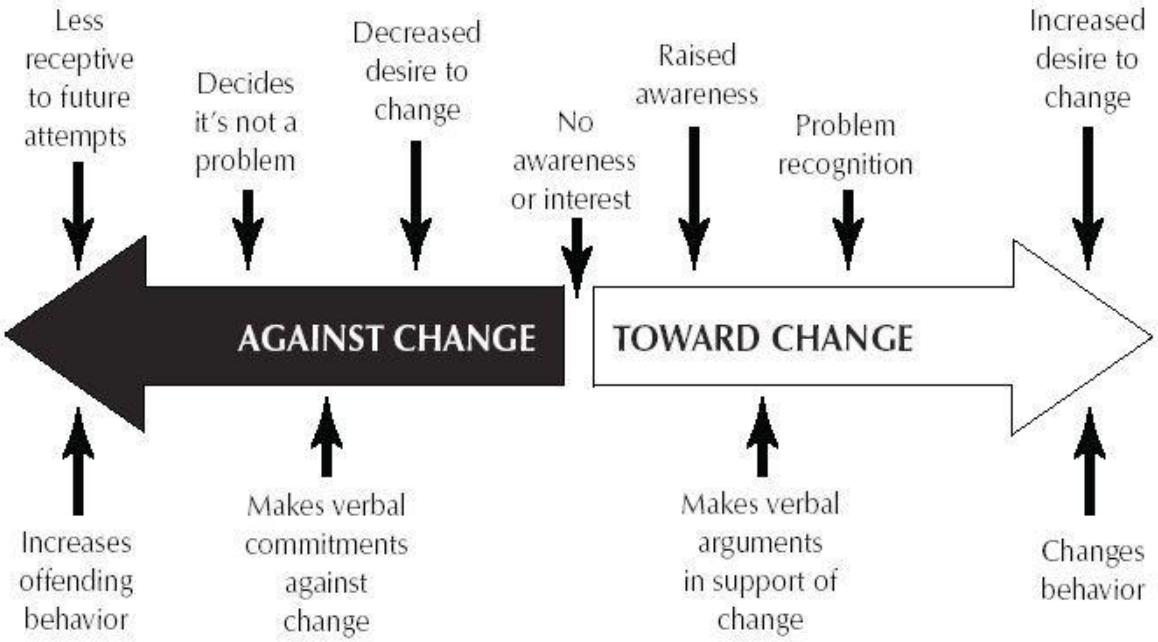
4. Social Networks

Before our next session I will: Sign up to an art class because I am interested in it and will give me the chance to meet new people

In one month's time I will: Be going regularly to art class and looking for other activities

In six month's time I will: Have built a social network and socialise with other people regularly

FIGURE 1.



Boundaries

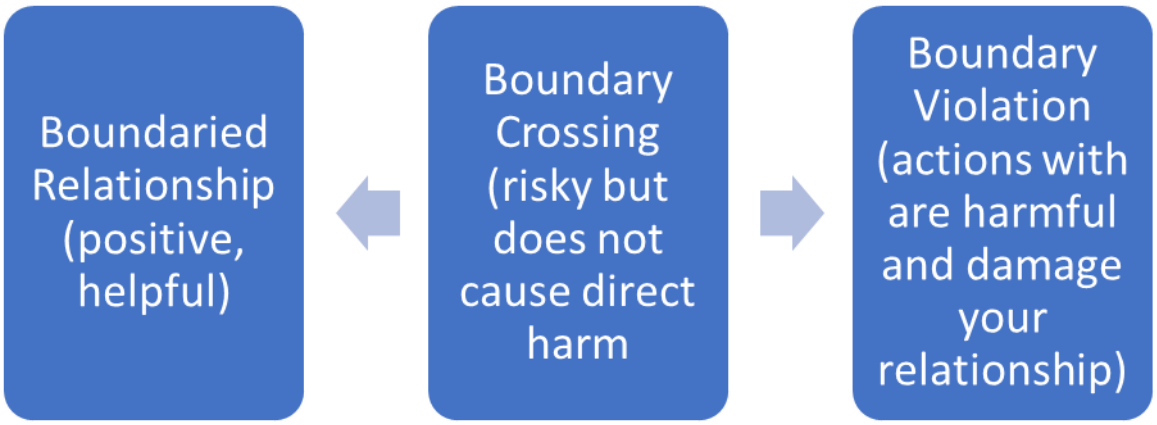
Your role as a peer support worker is centred around building relationships with your clients. It is important to understand the difference between a professional and personal relationship. Your relationship with your clients can be very strong, but as a peer mentor you have a duty to keep the relationship professional.

This doesn't mean that you can't share things about yourself and get along well with your clients; it just means you have to respect boundaries. This will help your client in the long run as you develop a therapeutic relationship with them.

Some boundary issues are straightforward but some can be trickier and might seem like a good idea at the time but in the long run are not the best move for you or your client. We need boundaries to establish a safe and supportive environment, avoid clients becoming overly dependent on you and preventing you from "burning out" or taking on too much responsibility.

Boundary crossing: Something that can lead to a boundary violation, for example spending more time with one particular client because you prefer them to your other clients

Example of boundary violations: Going for a drink with a client, inviting them over to your home, engaging in a romantic relationship together or lending each other money



Sharing about your own experiences

Sharing about your own experiences is a vital part of peer support. Self disclosure can be great if it is beneficial to your client and doesn't make you uncomfortable to share it with them. For example an experience you have had that you learned something from and you think it could be an example for them to follow and learn from. It is important to protect yourself and make sure you only share with your clients information you would be happy for others to know.

Confidentiality

Everything you will discuss in these sessions are confidential between yourself and your client. You can discuss their case with staff and at reflective practice sessions as they have consented to their information being shared with the team at Ashford Place. It is important not to share anything about one of your clients with other clients or people other than those invested in their support. The only time you break confidentiality is if you are worried about your client's safety or the safety of others. In this case you need to report your concerns to a member of staff immediately or in some circumstances emergency services.

e.g. someone threatens to hurt themselves or someone else.

Ashford Place Peer Mentoring Session 1 Template

This is a step by step guide for mentors on their first session with a client who has just moved into Ashford Place. Remember it is only a guide and a way of reminding you what things to cover in your meeting. You don't have to stick to the script exactly – you have your own unique perspective and way of connecting with people so if your meeting follows a slightly different structure do not worry.

1. Introduce yourselves – spend a few minutes chatting, this is a chance for you to tell them a bit about your experience and get to know each other.
2. Briefly explain how Ashford Place is run and what your client can expect from their time staying there. Give your client a chance to ask any questions they have about how things work at Ashford Place.
3. Explain the mentoring process and your role. You can explain that you have six meetings together and that this will be the first one. You can arrange for more meetings after this if you decide between the two of you that more support is needed.

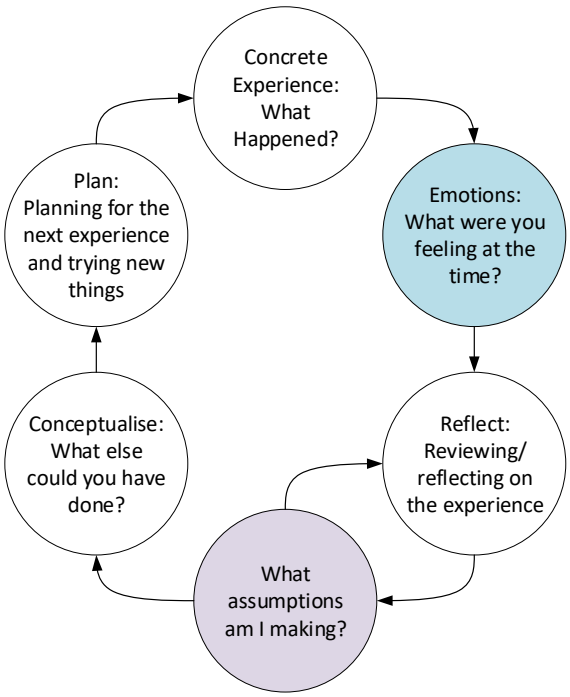
4. Have a chat with them about areas of their life they might like to work on and how you can help them in these areas. Please use the chart on their worksheet to establish 4 areas of their life they want to address. Examples of areas people might like to work on could be mental health, employment, housing, making friends/building support network, education, physical health etc.
5. Pick one of these four areas and discuss with your client what outcome they want. Break the area down into short-term and long-term goals.
    a. Example: Sarah wants to work on employment, she has been out of work for three years and is lacking confidence. A short-term goal could be for her to sign up to a computer class by your next meeting. A long-term goal would be that she has a job in six month's time.
    b. Example: Sarah is unhappy with her relationships with Friends and family. She has isolated herself over the last few years and doesn't feel she has many people around her she can call a friend. A short-term goal could be for Sarah to join a club or activity or calling up an old friend/family member she hasn't spoken to in a while. A long-term goal would be for Sarah to feel more supported and build up a network over the next year.
    c. If you are struggling to come up with short-term goals please see the Goals part of this manual for help with leading questions and the values sheet attached. If you are both still struggling to come up with goals you can always come back to it at your next meeting and ask staff or other mentors for advice in the mean-time.
6. Finish up the session by going back over what you have discussed, give the client a chance to ask any more questions they have. Pick a time and date for your next meeting.
7. After you have finished up take the time to go through the reflection sheet on the next page by yourself.

Reflective Practice Explained

Being reflective is important if we are to grow and become better helpers. Being a peer mentor can be hard, and reflecting on your meetings with clients will help you to avoid boundary violations and burnout.

Reflective practice is a structured way of thinking about how we help other people. After meeting with a client, it's best to take a few minutes to write down what happened and to think about why things went that way—if it was a positive or negative meeting. Reflecting on what went well can help you to refine your helping skills. Reflecting on things that went badly can help you to identify your own triggers, assumptions made about people, and areas for personal growth.

There are a few steps in being reflective, shown below. It's important to identify that you might already be doing these things, and this is just a way to help you develop skills.



Steps in Reflective Writing:

1. Reflecting
   a. Focus on event
   b. Write freely and try not to judge what you write
2. Analyse
   c. What has happened?
   d. What assumptions am I making (about myself or others)?
   e. What does this show about my beliefs?
   f. What are some other ways of looking at this?
3. Action
   g. What action could I take?
   h. What can I learn from this?
   i. How might I respond if it happens again?

Reflection sheet

- What happened at the meeting today?
- How did you feel during the meeting today?
- What did you feel was positive about the meeting?
- Were there any challenges?
- If there were challenges, why do you think these happened?
- If you could change anything about the meeting today what would it be?
- What things will you do differently next time?

Feedback

As this is a pilot of the peer mentoring project we would greatly appreciate any feedback on what you feel needs to be improved. Please use this page to jot down any notes or comments you have:

APPENDIX C PEER TRAINING SLIDE DECK

UNIVERSITY OF Southampton

Ashford Place

Peer Mentor Training

Stephanie L Barker
Cristin O'Leary

1

Outline

- Intro to Theory and Research
- Self-Reflection
  - Writing as a tool
- Self-Motivation
- Peer Mentoring Handbook

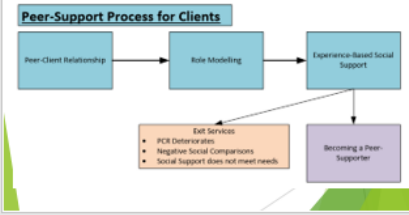
2

How does peer mentoring work?

- Reviewed research articles, peer programmes, interviews with peers, clients, and staff to come up with a model of how we think peer support works
  - Understand the specific things that make it work
- Model describes a specific type of peer support:
  - Intentional, Unidirectional Peer support
    - Intentional because its organised/supported by AP
    - Unidirectional because the peer is more stable, supported, and trained
    - Peer support because you have been there and know what it is like

3

Peer-Support Process for Clients



4

Mechanism	Components	Outcomes
Becoming a Peer-Supporter Once clients have progressed through the process as a client, they can begin the training to become a peer-supporter	**Self-Reflection & Self-Determination** • Peers are trained to support clients in a reflective manner, where they are striving for self-improvement and autonomously motivated to be a peer	Develop their identity Are more able to support autonomy in others Develop their sense of self

Now that you have some background on the research, lets focus on

- Self-Reflection
- Self-Determination

5

Self-Reflection: What is it?

- The ability to think about ourselves
- Be willing to learn how to improve
- Introspection
  - The examination of one's own conscious thoughts and feelings

6

Self-Reflection: Becoming Self-Aware

Those of us who do things for others without deepening our own self-understanding...will have nothing to offer—Thomas Merton, 1971

Drivers of Behaviour	
Be Perfect	Accurate eye for detail, neat and tidy, tendency to be harsh on themselves
Be Strong	Excellent in a crisis, reliable and dependable, makes people feel safe and secure, but does not tend to show feelings
Try Hard	Very strong work ethic, persistent, resilient, often not comfortable receiving praise
People Pleaser	Great team member, gets on with everyone, never want to upset anyone
Hurry Up	Enthusiastic, productive, can be prone to making mistakes

7

Self-Reflection: Experiential Learning

- Learning by doing
- Value your own experience
- Experiences need reflection to learn from them
- Where have you already done this?
  - Learned from important moments in your life?
- Use both positive and negatives events to learn from

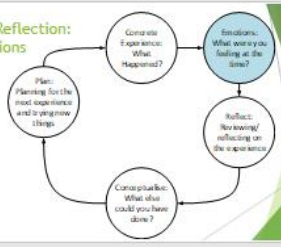
8

Self-Reflection: Emotions

- Emotions can create an overall guiding state—influencing our thoughts, behaviours, and bodily sensations
- Need to understand what we are feeling so that we can control our own **triggers**
  - Memories and feelings are often stored together
  - Do you know some of your triggers and why they may make you feel a certain way?
- Fight or Flight!
  - Our instinctive emotional response will happen first
  - Slow down and think!
  - Breathe deeply

9

Self-Reflection: Emotions



10

Self-Reflection: Questioning Assumptions

- Assumptions are ideas and thoughts that become ingrained into how we process the world around us
- If we fail to questions assumptions:
  - We may be discriminating
  - E.g. "they are not fixing their situation because they are lazy"
- Challenge your assumptions by asking:
  - Why might they be doing this?
  - Did I play any part in their behaviour?

11

Self-Reflection: Questioning Assumptions

12

Self-Reflection: Writing as Tool

- Aims of reflective writing:
  - Record experiences
  - Increase thinking skills
  - Form of self-expression
- Write in your Handbook about your experiences with clients
- Do it when it suits you
- 10-15 minutes of writing—not much!

13

Self-Reflection: Writing as Tool

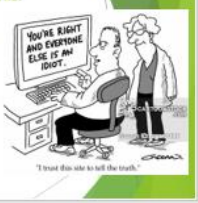
- Steps in Reflective Writing:

1. Reflecting
   - Focus on event
   - Write freely and try not to judge what you write
2. Analyse
   - What has happened?
   - What assumptions am I making (about myself or others)?
   - What does this show about my beliefs?
   - What are some other ways of looking at this?
3. Action
   - What action could I take?
   - What can I learn from this?
   - How might I respond if it happens again?

14

Why should we care about this?

- Asking yourself these questions can help you understand yourself
- Can also help you to see your own biases
- Helps to regulate emotions
- Something you can model to your clients
- Helps you to grow!



15

Reflective Group Meetings

- We will hold monthly reflective group meetings
  - To prevent:
    - Isolation
    - Burnout
    - Cope with stress
- Staff and peers are invited
- Chance to discuss client interactions that were challenging
  - Could also be interactions with anyone else
- There will be a confidentiality agreement, so what is said at the meeting, stays at the meeting

16

Self-Motivation

- What is your view on human nature?
  - Are people generally good/bad/in between?
- What do you think motivates people to change?
  - Money? Values?
- What barriers are there in making changes?
  - Fear? Government policy?
- Why do you want to be a peer mentor?
- What do you want to get out of the experience?

17

MASLOW'S HIERARCHY OF NEEDS

18

Self-Determination Theory

- Internal motivators:
  - Autonomy
    - Control/independence
  - Competence
    - Feeling confident and capable
  - Relatedness
    - Connected to others
- External motivators:
  - Seeking employment
- https://www.youtube.com/watch?v=3sRBBNkSXpY

19

What exactly does Peer Mentoring involve?

- 6 meetings
- Point of contact for client
- Actively listen and engage
- Provide emotional support and listening ear
- Accompany to important appointments
- Work on goals together
- Decide on support after moving on

20

Active Listening

Active listening is exactly what you might guess: listening actively!

Instead of just hearing what the other person is saying you make a conscious effort to listen to them and let them know you are paying attention.

Cristin and Steph are going to demonstrate two examples - see if you can guess who is actively listening!

21

MOTIVATIONAL INTERVIEWING

R	**RESIST** telling them what to do: Avoid telling, directing, or convincing your friend about the right path to good health.
U	**UNDERSTAND** their motivation: Seek to understand their values, needs, abilities, motivations and potential barriers to changing behaviors.
L	**LISTEN** with empathy: Seek to understand their values, needs, abilities, motivations and potential barriers to changing behaviors.
E	**EMPOWER** them: Work with your friends to set achievable goals and to identify techniques to overcome barriers.

22

Goal Setting

- By understanding what your client values, hopes for, or wants, you can help them to set meaningful goals and help them achieve their goals.
- Understanding what someone values can be difficult. If you are feeling stuck, you can use the values sort activity in the peer/client workbook.

23

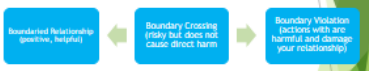
Setting Goals

1.
- ***Before our next session I will:***
- ***In one month's time I will:***
- ***In six month's time I will:***

24

Boundaries

What are boundaries and why do we need them?



Example of boundary violations: Going for a drink with a client, inviting them over to your home, engaging in a romantic relationship together or lending each other money

25

Confidentiality

- Everything discussed with your client is confidential
- You can share at reflective practice groups and with staff
- Do not discuss your client with anyone other than those involved in their support
- You can break confidentiality if your client or someone else is at risk

26

Self Disclosure as a peer

When/Why to self disclose

- Identifies you as a role model
- Shared experiences
- Teaching/learning experience

What to be mindful of

- Are you happy for others to know this information?
- Do you think what you are sharing is beneficial to your client in some way?

27

Structure of meetings

Let's take some time to look through the manual and review the guidelines for structuring your meetings

Any questions/comments welcome!

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