A Report on Peer Support Specialists: Identification and Stakeholder Engagement within Housing First

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Peter McVerry Trust Mission Statement

Vision

An Ireland that supports all those on the margins and upholds their rights to full inclusion in society.

Mission

Peter McVerry Trust is committed to reducing homelessness, the harm caused by substance misuse and social disadvantage. Peter McVerry Trust provides low-threshold entry services, primarily to younger people and vulnerable adults with complex needs and offers pathways out of homelessness based on the principles of the Housing First model.

Aims

To target those most marginalised in society and offer a safe, challenging and supportive environment through our service provision.

To treat participants with warmth and respect and actively encourage them to be involved in all aspects of their own support plan.

To offer a comprehensive prevention package of support in order to reduce the likelihood of homelessness to those leaving care, those leaving treatment, those leaving prison or other institutions and those whose accommodation is vulnerable.

To offer a comprehensive package of support that will provide the best opportunity possible for and assist them in planning a pathway out of homelessness or drug use, or if they continue to use drugs, to assist them towards some level of stabilisation in order to live a life of dignity, with respect and opportunity.

To assist each person to re-establish himself or herself in the community and move towards greater independence.

Acknowledgements

Peter McVerry Trust would like to express a sincere appreciation to all stakeholders who participated in the Peer Support Specialist consultations. The development of the current Report would not have been possible without their time commitment and sharing of their perspectives on peer support.

In particular, we would like to express gratitude to:

Peer Support Specialists employed by PMVT, for their assistance during the research design stage and participation in a consultation, where they selflessly dedicated their time, expert knowledge, and valuable insights from a perspective of a peer supporter.

PMVT HF participants who took part in the survey. The participants committed their time and allowed us to gain a grasp of their experiences of peer support and the impact it has had on them.

HSE and Housing Authority Representatives for committing their time to attend a consultation and providing us with their perspectives on the importance of the role of peer support specialists in the homeless sector.

All PMVT staff attending consultations, including ICMs, MDT members, Directors of Services, Head of Services, and Service Managers for their assistance in the survey distribution and contributions during consultations. Their commitment, professionalism, and insights are greatly appreciated.

Finally, we would like to thank the Housing First National Office for provision of the funding for the series of consultations on Peer Support Specialists carried out by the PMVT Research Department.

List of abbreviations

HF	Housing First
HSE	Health Service Executive Representative
LA	Local Authority Representative
PMVT	Peter McVerry Trust Organisation
PMVT DoS	Peter McVerry Trust Director of Services
PMVT HoS	Peter McVerry Trust Head of Services
PMVT ICM	Peter McVerry Trust Intensive Case Manager
PMVT MDT	Peter McVerry Trust Multidisciplinary Team
PMVT SM	Peter McVerry Trust Service Manager
PSS	Peer Support Specialist

Definitions

Housing First participant – An individual accommodated in Housing First property. Peter McVerry Trust chooses the term 'participant' when addressing all individuals who utilize the services provided. The participants are not merely seen through the economic lens of consumerism (as consumers or customers), but rather as active participants in decisions regarding their own lives and the services they access.

Peer Support Specialist – A person that 'collaborates with consumers to provide individualized and flexible support to engage and integrate them into the community, and helps to facilitate their access to resources and supports to maximize their independence and potential, and promote their recovery'[1]

Social Prescribing – A means of enabling healthcare professionals and other professionals to refer people to a range of local, non-clinical services, primarily provided by the voluntary and community sector[2].

Executive Summary

Background

Over the past decades, peer-support programmes have emerged as a common practice in health and community settings, with particular prominence in areas of addiction, mental and physical health, as well as rehabilitation of offenders[3,4,5]. The value of lived experience has been acknowledged as an integral component of the support provided to the most marginalised in society – the homeless population[6]. Therefore, an increasing number of homeless services are developing peer support programmes, intending to utilise peers to support individuals who have suffered from homelessness and/or co-occurring mental health problems, substance use, and traumatic stress disorder by supporting their re-integration into society[6,7].

Aims and Objectives

The PMVT Research Department has undertaken a series of consultations in order to produce a comprehensive report on the status of Peer Support Specialist (PSS) programme delivery and outcomes within Housing First to date. The main aims of the report are to gain an in-depth understanding of the PSS role and to assess the perceived effectiveness of implementing the PSS programme.

Methodology

The consultations involved a total of 35 individuals, this includes 8 HF participants and 27 stakeholders across the Health Service Executive (HSE), Local Authority (LA), and Peter McVerry Trust (PMVT) sectors. The consultations were carried out in late December 2022 and early January 2023 across four regions: Dublin, Northeast, Mideast, and Midlands. The HF participants' satisfaction with the PSS programme and the impact of PSSs on their lives was facilitated through a PMVT organisation-wide survey. The nature of the role, recruitment strategies, supervision and training, impact of the PSS role on the HF infrastructure, and challenges, were discussed in the survey and within–focus group consultations.

Key Findings

All HF participants agreed that their PSS helps them establish goals, motivates them to reach these goals and supports them in achieving them. Most HF participants said that the PSSs help them make healthier life choices, manage the stress in their daily lives, help their mental health and have supported them in reducing their risk-taking behaviours.

All stakeholders highlighted the importance and positive impact of PSSs on the lives of HF participants and HF services. PSSs were seen as pillars of support for HF participants, where the amalgamation of

emotional and practical supports enhanced HF participants empowerment, recovery and social integration. Equally, knowledge drawn from PSSs greatly benefited HF support teams and served to bridge identified gaps in HF service provision.

Nature of Role

The PSSs employed in the homeless sector represent individuals with lived experience in areas related to homelessness, including mental health, addiction, and recovery. The fundamental nature of the PSS role is to facilitate the development of strong connections with HF participants and to support their empowerment and reintegration into society. Engagement with HF participants in a continuous and consistent manner serves to corroborate HF participants' stability and recovery. The importance of maintaining self-awareness and self-regulation strategies ensures PSSs stay on a pathway to recovery and positive well-being.

Recruitment

Life expertise related to homelessness (substance abuse, mental health, trauma) is a prerequisite for the role, while education qualifications are desirable but not mandatory requirements. Recruitment through both internal and external pathways are desirable in order to identify the most appropriate candidates for the role. Previous graduates of HF programmes need to be taken into strong consideration.

Supervision and Training

Supervision for the PSS role needs to be structured, regular, and tailored to PSSs' needs. Both external and internal supervisors are recommended. The provision of training sessions needs to be well structured, and monitored, preferably in the areas of substance misuse, mental health, trauma-informed care, first aid training, and motivational interviewing. Training through employment based 'shadowing' of active PSSs and/or HF team members is to be considered.

Impact of PSS Role

Overall, empowerment of HF participants through companionship and practical support on a daily basis. The benefits of peer support are personal growth, mental and physical well-being, self-efficiency, initiative, and perseverance. Benefits to services are valuable contributions through expert insights and knowledge – which contribute to bridging the gap, and distribution the workload.

Key Challenges

The main challenges are identified in the following areas: establishment of professional boundaries, transportation, and geographical constraints which may lead to a lack of frequency and reduced time spent with HF participants.

Chapter 1: Introduction

Equipped with lived expertise in homelessness and/or co-relating issues, peer supporters hold a unique position to offer and provide support to others experiencing similar challenges[6,7,8]. Due to their personal experience, peer supporters have the expertise and real-world knowledge that professional training cannot replicate[7]. Peer support encompasses a range of activities and interactions, encouraging individuals to develop their own goals, create strategies for self-empowerment, and take concrete steps towards building fulfilling lives for themselves[9,10]. Hence, peer-provided support for vulnerable groups provides a platform of stability. This nurtures empowerment amongst individuals, enabling them to develop life skills, independence, and further take control of their lives.

The current development of peer-support programs across the homeless sector is reflected in the increased engagement with understanding the specific nature of the peer-support role and relevant interventions.

Peer Support Specialists within Peter McVerry Trust Housing First

Peter McVerry Trust is Ireland's largest provider of Housing First services. The Housing First (HF) model aims to provide a person sleeping rough, or someone who has been long-term homeless, with their own secure accommodation as well as access to intensive and specialised support services.

A Peer Support Specialist (PSS) holds an important place in HF support services. A unique lived experience allows for the PSS to serve as a role model for participants within a professional relationship. Integration of the PSS into the HF team provides space to develop a deeper understanding of the participants' experiences, their struggles and challenges; as well as to further support the HF team in implementing solutions to meet participants' needs.

Role of a PSS

PSSs are individuals who, at one point, overcame personal challenges in which they needed to obtain assistance and treatment in order to engage in personal recovery or to integrate into normative social roles.

PSSs are members of the HF Multidisciplinary Teams and provide pivotal support to the participant group who require intensive engagement as a result of:

- a history of homelessness;
- mental health challenges;
- problematic substance use;
- a history of prison custody;

- domestic violence;
- physical and/or sexual abuse; and/or
- other challenges.

Currently, within PMVT HF services, some of the main requirements for the PSS role are to:

- Have a minimum of 2 years in recovery and to be at a point where they have achieved stability in regards to mental health;
- Have lived experience of homelessness and/or, addiction/mental health issues;
- Hold a relevant QQI Level 5 qualification in a health, education, or related field suitable to the requirements of the role.

The duties of the PPS are assigned in accordance with their roles and responsibilities with a focus on ensuring the PSS are assigned caseloads for which their experience and skills can have the most impact, that such caseloads are in conjunction with Intensive Case Managers, and part of an agreed support planning and key working intervention.

Present Report

In order to gain an in-depth understanding of the PSS role, and to assess the perceived effectiveness of the PSS programme, this report compiled the perspectives and experiences of a wide range of stakeholders familiar with the PSS programme. Intending to contribute to future programme development and delivery, the report sets out to explore the various understandings of the role, benefits, and challenges emerging from the implementation and employment of PSSs.

This Consultancy Report aims to:

1. Provide insight into the understanding and nature of the PSS role
2. Identify the main pathways for the recruitment of individuals for the PSS role
3. Explore the type of support, supervision, and training necessary for the PSS role
4. Investigate the impact PSS has on the HF team dynamic and participants accommodated in HF
5. Identify challenges/barriers for the PSS role

The purpose of this report is to provide recommendations for the development of a PSS Toolkit. This includes highlighting effective organisational structures for supporting, embedding, and expanding the PSS programme within HF and the inter-agency landscape.

Layout of Report

This report is broken up into 10 chapters:

- **Chapter 2** highlights the methodologies used for this report. Both quantitative and qualitative approaches are used to captures the voices of HF participants and all other HF stakeholders.
- **Chapters 3 to 7** report the independent results for active HF participants and regional stakeholders. These include the HF participants (chapter 3), Dublin region (chapter 4), Northeast (chapter 5), Mideast (chapter 6), and Midlands (chapter 7)
- **Chapter 8** provides a combined summary of the findings in chapters 3 to 7. This summary focuses on the importance of the PSS role and the impact incorporating this role into the HF infrastructure would have on HF participants.
- **Chapter 9,** in line with the aims and objectives of this report, addresses various stakeholder recommendations on the recruitment, employment, and practical supports needed for the PSS role to function effectively.
- **Chapter 10** concludes this report with a short summary on the key aims and findings of the report.

Chapter 2: Methodology

In order to capture a robust understanding of the role and perceived effectiveness of services provided by PSSs in the homeless sector, the PMVT Research Department facilitated a series of consultations with a variety of stakeholders across Ireland. The consultations with stakeholders commenced in December 2022 and were conducted in stages, with the last consultation taking place in January 2023. The consultations with stakeholders incorporated a wide range of participants, including PSSs, HF Participants and professionals representing organizations including HSE, Local Housing Authorities, and PMVT. The consultations included two methods of data collection: a series of focus groups and a survey.

The survey questions and focus group guides were designed in collaboration with two PSSs employed by PMVT. PMVT PSSs in a research advisory role provided valuable perspectives into the area of peer support, and further ensured the adequacy of the research questions and topics of discussion. One PMVT PSS provided insightful guidance and feedback throughout the development of the current report.

A description of the study design is provided in further detail below.

Section 1: Survey

The purpose of the participant survey was to gain a better understanding on the relationship PMVT HF participants had with the PSSs and the nature of the supports provided. All PMVT participants who are engaged with a PSS were invited for consultation. In total, eight participants accommodated in PMVT HF participated in the survey. Information sheets were provided, and consent was sought at the onset of survey initiation and participants could not access the survey unless consent was granted.

The survey consisted of four sections including-

- Demographic Profile of Participants
- Participant Nature of Engagement with PSS
- Impact of the PSS Programme on Participants
- Participant Satisfaction and Future Directions

Demographic variables were collected on age, gender, employment status, prior length of stay in homelessness, length of engagement with HF, and level of engagement with a PSS.

The answering format for section 2 followed a Likert response, where participants were provided with a range of items on the types of supports provided and their relationship with their PSS. Participants

were asked to answer how strongly they agree or disagree with statements such as 'I feel the things I do with my peer support worker help me to accomplish the changes I want'.

Sections 3 and 4 were open-ended questions asking about the specific change's participants noticed, and whether and how they would like peer support to be delivered going forward.

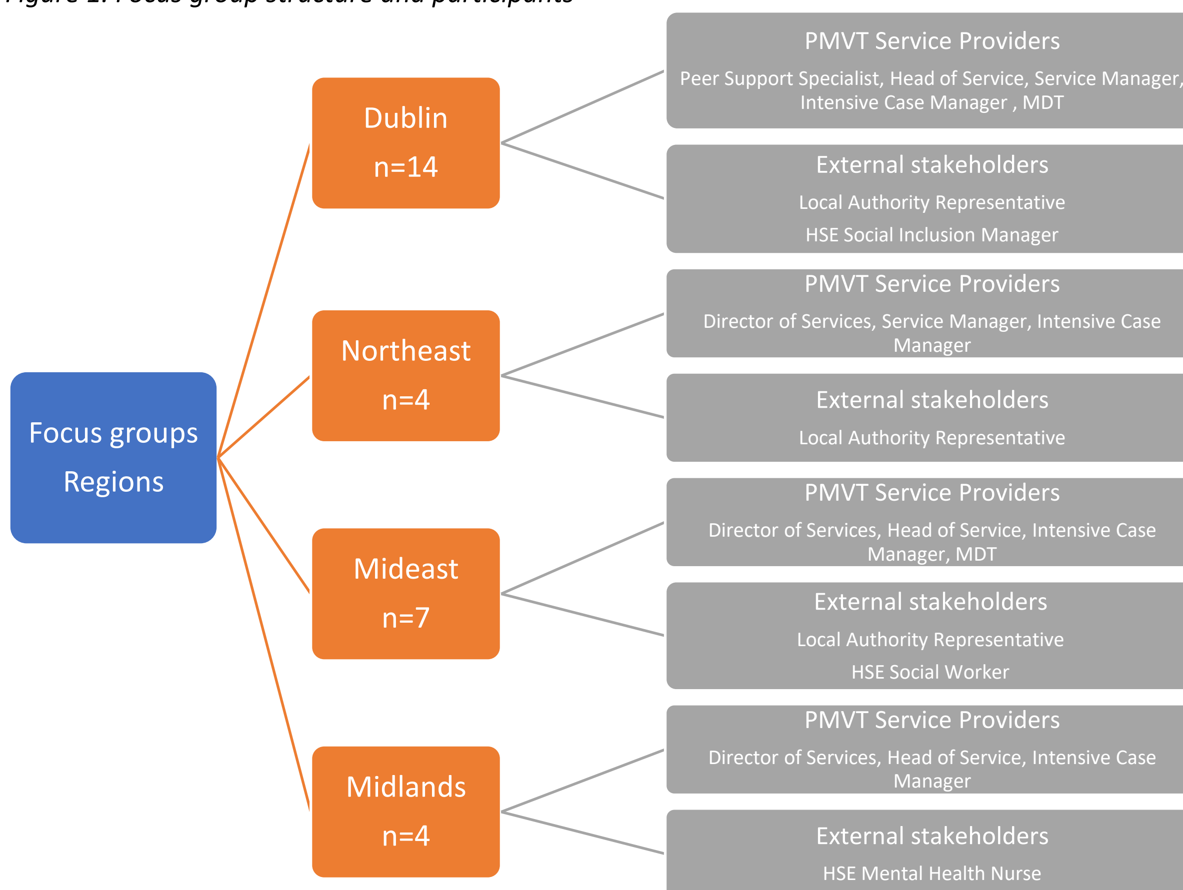
The survey questions and the information sheet can be viewed in Appendix I and Appendix IIa.

Section 2: Focus groups

The purpose of the focus groups was to create an open dialogic space where stakeholders would have an opportunity to interact and share their experiences and perspectives on PSS programmes.

In total, six focus groups were facilitated across four regions including Dublin (three focus groups), Northeast (one focus group), Mideast (one focus group), and Midlands (one focus group) (Figure 1) (Appendix III).

Figure 1. Focus group structure and participants



The focus groups consisted of a variety of individuals with a range of professional roles. These individuals had extensive knowledge of the PSS role, and/or experience working with a PSS. The

professionals consulted included Peer Support Specialists themselves (n=2), HSE Representatives (including mental health nurse, social inclusion manager, and social care worker; n=5), Local Authority Representatives (n=3), and PMVT Representatives (including Directors of Services, Heads of Services, Service Managers, ICMs, and MDTs; n=17). Currently within PMVT HF, PSSs are employed in the Dublin region, and therefore they only participated in the Dublin region focus group.

In total, 6 focus groups were facilitated through the Microsoft Teams or Zoom online platforms, and one focus group was facilitated in person, in a PMVT HF office. From the outset, the information sheet and consent forms were sent to all survey participants and stakeholders (Appendix IIb and Appendix IV) outlining the aims of the consultation and what their participation would entail. Prior to each focus group, the focus group moderator discussed the objectives of the PSS consultation and gathered participants' verbal permission to audio-record the consultation.

Each focus group discussion lasted for approximately 30 to 90 minutes. The semi-structured nature of the focus groups included the following areas of interest:

- The role of the PSS and pathways of recruitment
- Training and Supervision needs for the PSS role
- Effectiveness of PSSs on HF participants and services
- Challenges and barriers of the PSS role
- Recommendations on key areas to strengthen and integrate PSS within HF

For the focus group topic guide, see Appendix V.

Section 3: Data Management and Analysis

Data arising from the focus group discussion was analysed by applying a content analysis framework.

Firstly, all conversations were transcribed and prepared for analysis, with all potentially identifying information (locations, names of services, etc.) either anonymised or removed to protect all stakeholders who participated in the consultations. The transcripts were read and re-read, following the development of two separate coding frameworks devised inductively from the data. The frameworks were developed using the Microsoft Excel program, and verbatim responses extracted from the main transcripts were organised under pre-agreed categories and themes.

The surveys were completed using Qualtrics software and the collected responses were downloaded from the Qualtrics software in an Excel form where a descriptive analysis of the data was performed. The open-ended survey data was analysed in the Microsoft Excel programme and a quantitative content analysis was performed.

Section 4: Ethics

The PSS Consultation adhered to the PMVT Research Ethics Policy, and all necessary measures were taken to ensure the continued and ongoing safeguarding of all individuals participating in the focus groups and the survey. Consent, in written and/or verbal form, was sought from all participants prior to participation.

Section 5: Limitations

As in any project, it is important to highlight that limitations existed in actualising the report. First and foremost, the timeframe in which all elements of the project were to be completed, narrowed the potential resources to be directed towards certain elements of the consultancy. This included the identification and engagement with potential PSSs and the additional work created on the Midlands. As a response to this, the consultation on Midlands was a scaled back process in anticipation of the requirement for consultation in the region.

Time also acted as a significant barrier in the availability to access HF participants, PMVT staff, potential PSSs and external stakeholders. While every attempt was made to engage with candidates for the project, the holiday period centred in the primary data collection period, reduced the pool of available individuals for the consultancy.

Chapter 3: Housing First Participants

In order to capture a meaningful quantity of HF participants engaged with PSSs, a survey was distributed across all HF services where a PSS was in place. The survey results are provided below for the 4 sections. These include the demographic profile, nature of engagement with PSS, impact of PSS programme on participants and participant satisfaction/future directions.

Section 1: Demographic Profile

The participants involved in this survey were predominantly male (75%), with an age range between 35 to 64. Their main form of employment was disability allowance (50%) and prior to engaging with HF services, the majority of participants had been homeless for over 5 years (63%). Relevant participant demographics including age, gender, and employment status are provided below (see Table 1):

Table 1. Demographic profile of the participants

	N	%
Gender		
Male	6	75%
Female	2	25%
Age		
35 - 44	1	13%
45 - 54	4	50%
55 - 64	3	38%
Main Employment Status		
Disability Allowance	4	50%
Jobseeker	2	25%
Unemployed	2	25%
Length of Stay in Homelessness		
Less than 6 months	1	13%
2 to 5 Years	2	25%
Over 5 Years	5	63%

The majority of participants have subsequently been engaged with HF services for 1 to 2 years (75%) and all participants have been engaged with their PSS for less than 6 months (100%). The majority of participants said they engaged with their PSS once a week (62%), while others said 2 to 3 times a week (38%). The main form of contact between the participant and their PSS was reported to be in person (87%).

Section 2: Nature of Engagement with PSS

This section discusses the nature of engagement between the PSS and the participants. This includes the impact the programme has on the participants' perceived physical, social, and emotional health. For this section, participants were queried on the type of support provided by their PSSs, as well as the relationships established with their PSS. This was followed by whether or not their PSS contributed to improved wellbeing and, if they did, how specifically the PSS contributed.

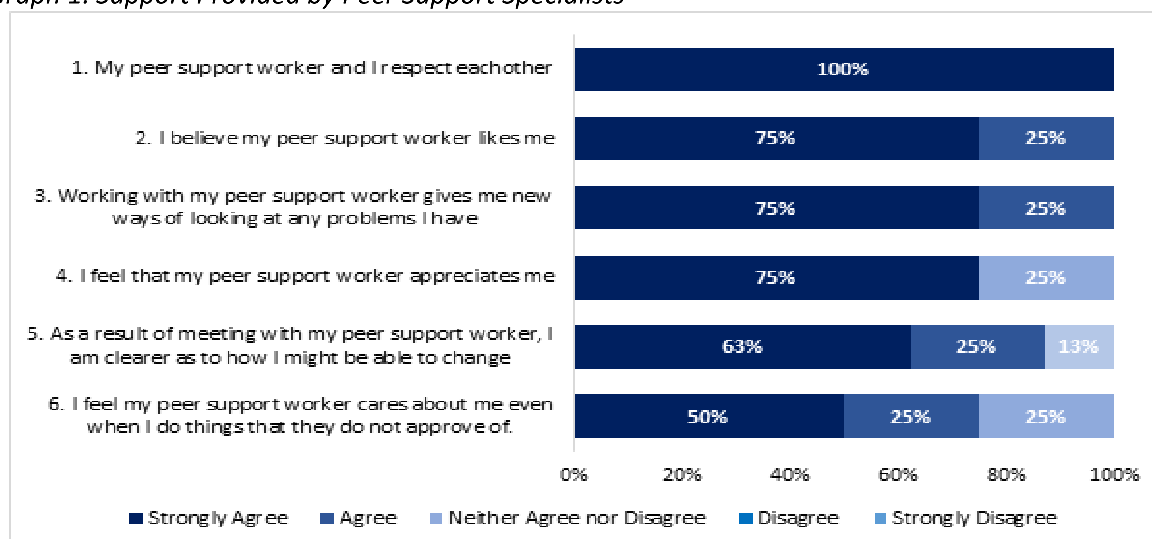
See Table 2 below for breakdown of participant engagement with HF and the PSS.

Table 2. Engagement with Housing First and Peer Support Specialists

	N	%
Length of Engagement with Housing First		
Less than 6 months	1	13%
1 to 2 Years	6	75%
2 to 5 Years	1	12%
Current Length of Engagement with PSS		
Less than 6 months	8	100%
Frequency of Engagement with PSS		
Once a week	5	62%
2 – 3 times a week	3	38%
Main form of Contact with PSS		
In person	7	87%
Phone Calls	1	13%

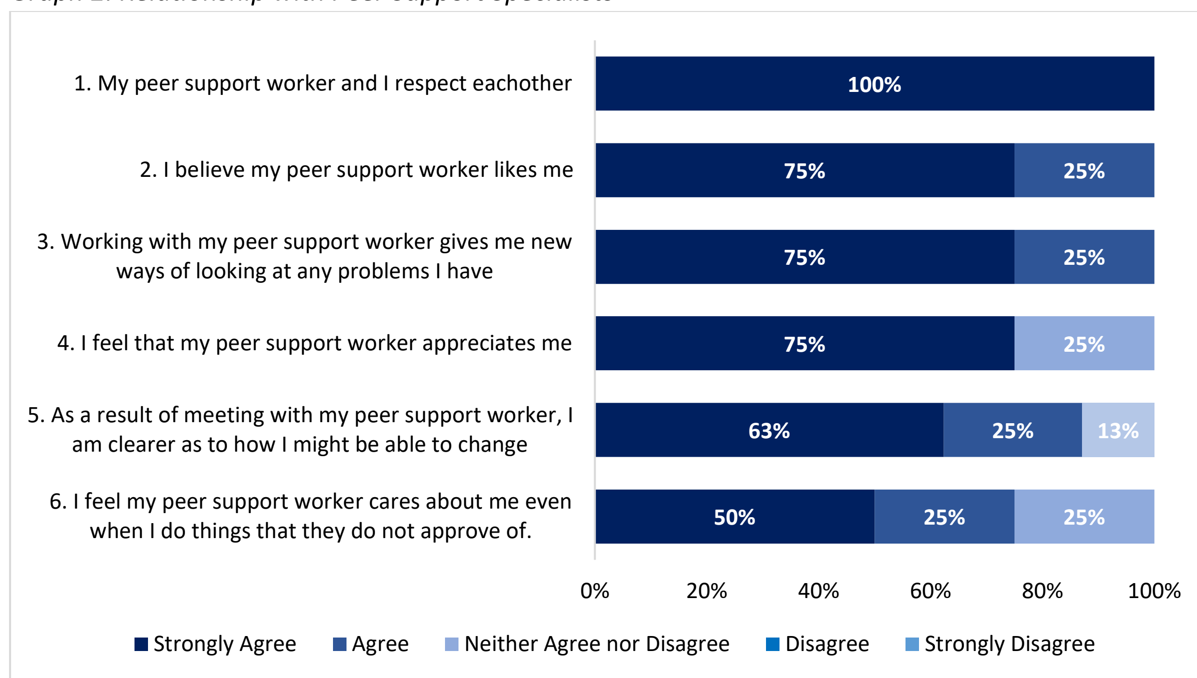
Participants were asked how strongly they agreed or disagreed with statements related to the type of support provided by their PSS (Graph 1). All participants strongly agreed or agreed on 5 out of 7 of the items. These items were related to how the PSS helps establish goals, motivates the participant to reach these goals, and supports them in achieving them.

Graph 1. Support Provided by Peer Support Specialists



Next, participants were asked about the nature of their relationships with their PSSs, and all participants either strongly agreed or agreed to 4 out of 6 of the items asked. These items focused on mutual respect, levels of acceptance, and accountability.

Graph 2. Relationship with Peer Support Specialists



Section 3: Impact of PSS Programme on Participants

'I now have someone to trust'

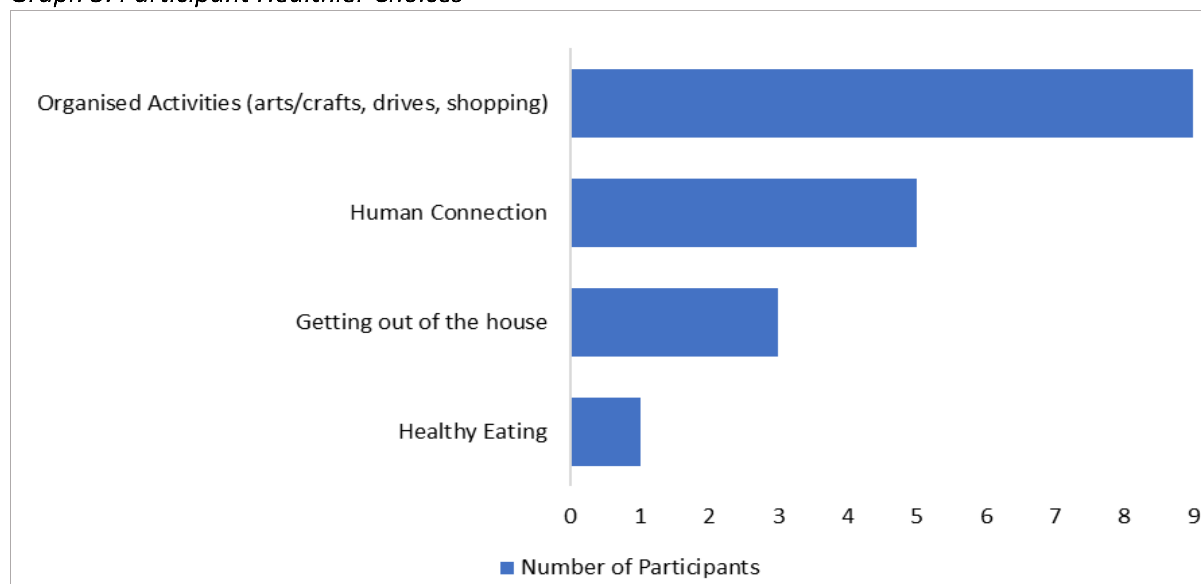
(HF participant)

Participants were asked 5 sets of questions in relation to the impact the PSS has on their HF experiences, to which they answered 'yes', 'no', or 'unsure'. The questions were as follows:

Question 1: Do you think you are doing more healthy things since you started engaging with your peer support worker?

Findings indicate that 100% of participants said that they have increased the number of healthier choices they make since first engaging with their PSS. Participants were then asked 2 open-ended questions. The first open-ended question asked to list the healthier choices they now make (Graph 3). In total 86% said they attended more structured and organised activities, 71% said their PSS helps them to get out of the house, and 57% said that their PSS helps them re-engage with society through human connection; with one participant in particular saying *'I now have something to look forward to'* (HF Participant).

Graph 3. Participant Healthier Choices



The second open-ended question asked participants to expand on the types of activities they attend with their PSS (Graph 4). Every participant went to coffee shops or went out for food with their PSS, participants also disclosed that they attended a wide variety of activities tailored to their interests.

Graph 4. Activities attended with Peer Support Specialists

Question 2: Does your peer support worker help you manage things in your life? (e.g. stress, money management)?

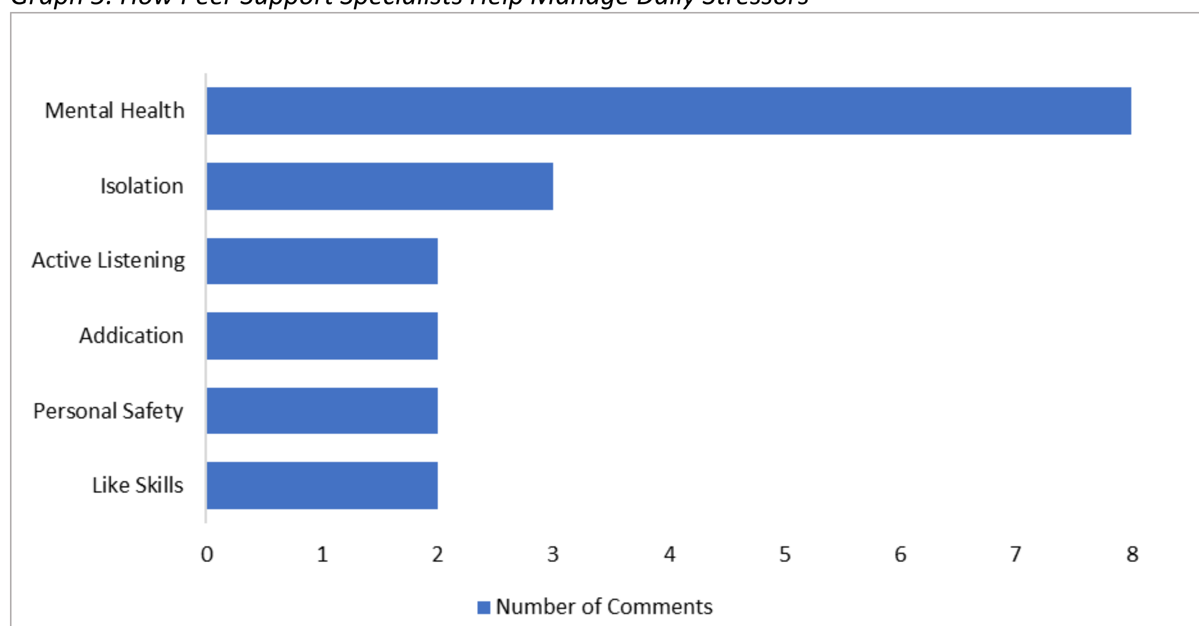
'He listens to me about my family problems. He is helping me get help for my addiction and is always there for me. He is a life saver, I am so much happier that he is there now.'

(HF participant)

Next, participants were asked whether their PSS helped them cope or manage ongoing stressors in their lives. 86% of participants said their PSS helps them in managing things in their lives, and 14% said they were unsure.

The participants who said their PSS did help them, were then asked to expand on the *ways* in which their PSS supports them (Graph 5). If the participants confirmed that the support provided by their PSS was helpful, they were offered an option to expand on their response. All the subsequent participants acknowledged that their PSS helps with their mental health (100%). For example, one participant stated, '[*PSS's name] helps with my mental health and is always talking to me about my safety*' (HF Participant). The participants also mentioned how they feel supported to manage their daily stressors from their PSS actively listening to them. Some participants also felt supported in their addiction recovery journeys, where one participant added, *'Mental Health, Life Support, No Judgement. It's not like a job; he makes me feel important and listened to'* (HF Participant).

Graph 5. How Peer Support Specialists Help Manage Daily Stressors



Question 3: Do you think having a peer support worker has helped your mental health?

'In every way, I can trust again and talk openly'

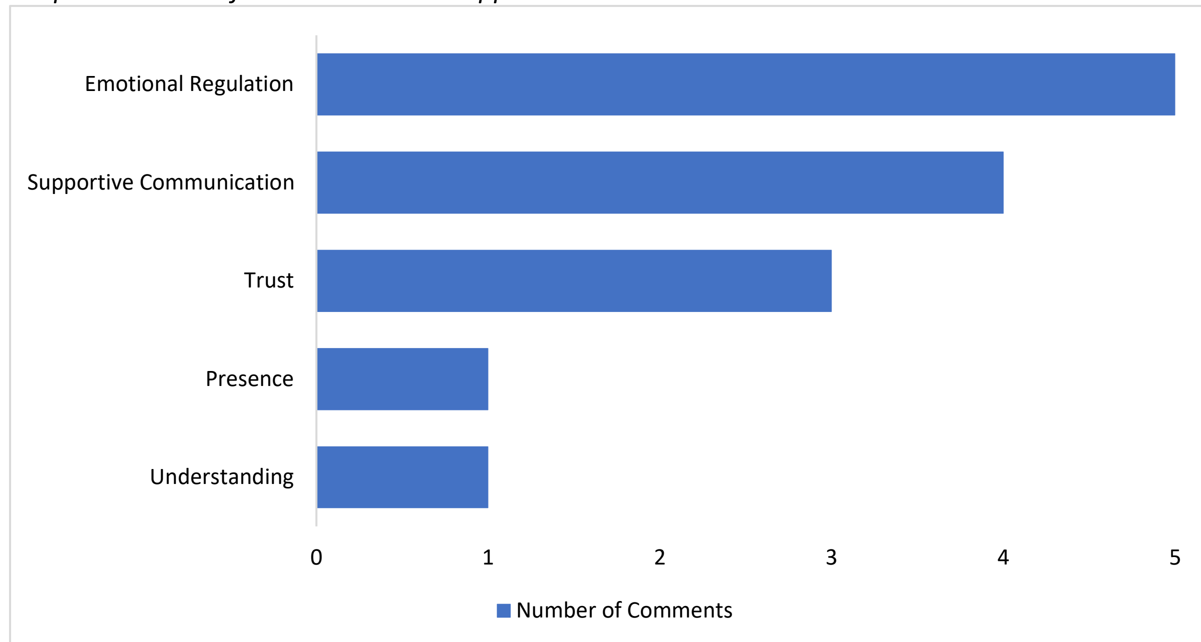
(HF participant)

Participants were asked directly whether engaging with a PSS helped with their mental health. Overall, 80% of participants said 'yes' (Graph 6).

The participants who responded 'yes' were then asked how their mental health is supported by their PSS (Graph 9). Participants suggested that the PSS's presence helps with their emotional regulation. One participant said, *'I can talk to him because [PSS] knows about life and things I went through. He helps with my mood and supports me always'* (HF Participant). Similarly, supportive communication helps, as another participant says, *'I can talk with him because he listens and makes me feel wanted*

and listened to' (HF Participant). Trust, presence, and the PSS's understanding as a result of similar lived experiences were also identified as ways participants feel supported with their mental health.

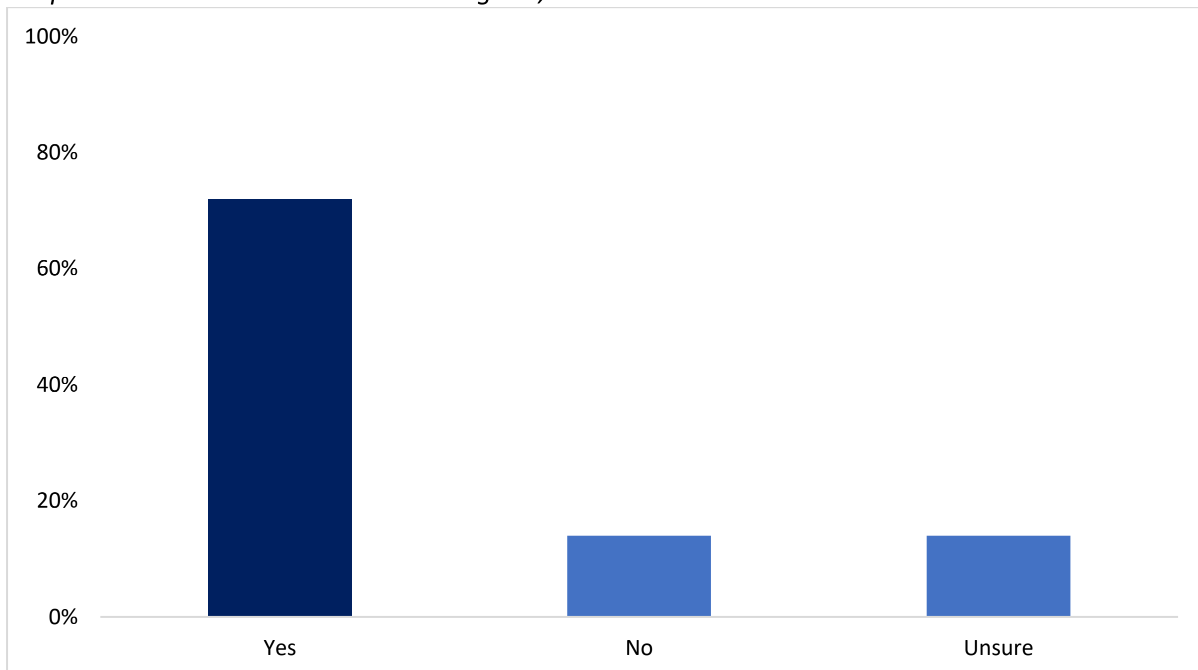
Graph 6. Methods for Mental Health Support



Question 4: Do you think you are less involved in drug use, crime and/or risk activities since you started engaging with your peer support worker?

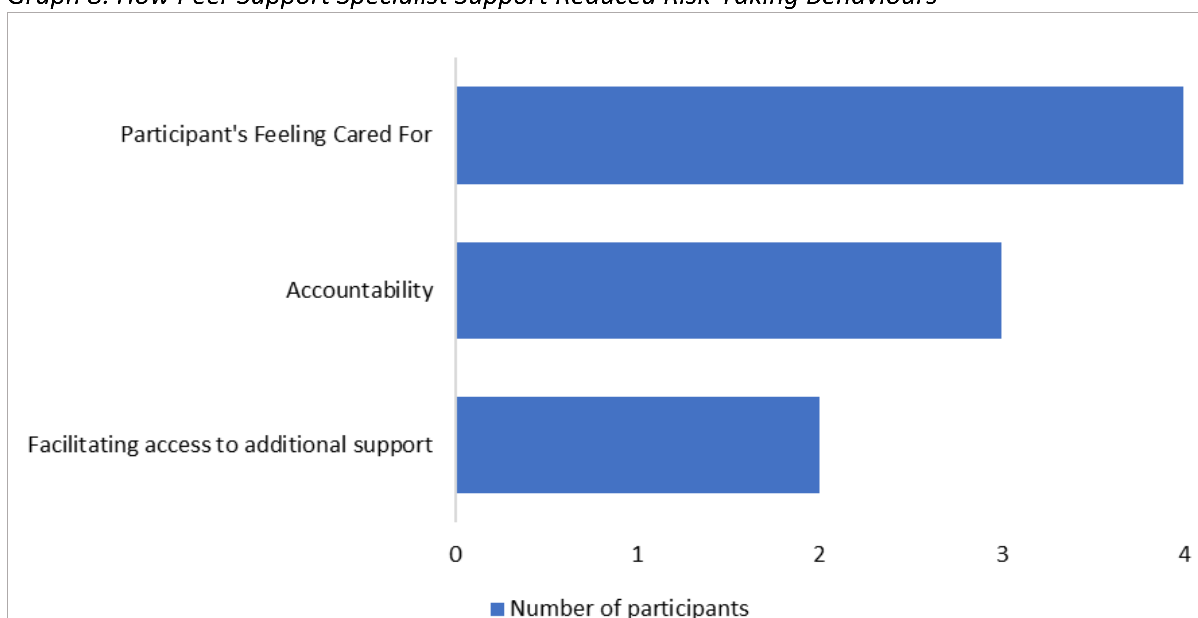
Next, participants were asked whether their involvement with drug use, crime and/or risk activities have reduced since they started engaging with a PSS (Graph 7). In total 71% of participants said 'yes', while 14% said 'unsure' and 'no'.

Graph 7. Reduced involvement with drug use, crime and risk activities



Of the participants who said that engagement with a PSS had reduced their risk behaviours, the majority said that feeling cared for by their PSS (80%) helped them reduce risk behaviours (Graph 8). One participant mentioned that their PSS *'talks about keeping me safe and out of trouble because I don't want to do anything bad now because I see things better'* (HF Participant). The PSS being easily contactable and bolstering engagement with additional support services were also other ways identified in which the PSS supports the reduction of risk-taking behaviours.

Graph 8. How Peer Support Specialist Support Reduced Risk-Taking Behaviours



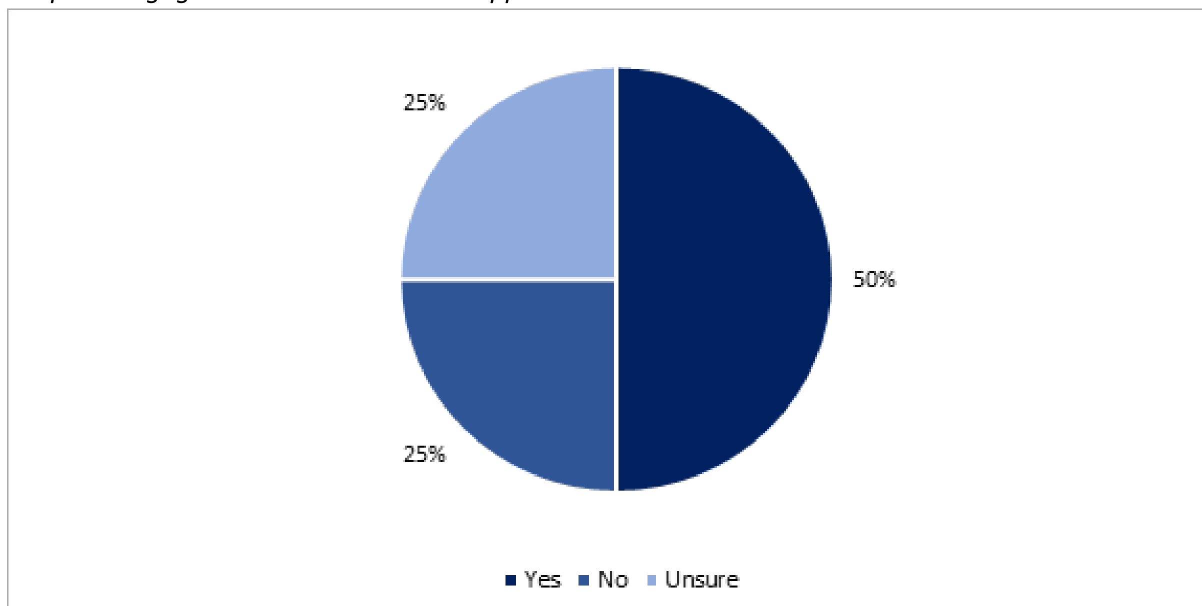
Question 5: Since you started engaging with your peer support worker, have you looked for any other support (e.g. programmes, agencies, people)?

'We will get there, as I'm very unsteady on my feet'

(HF participant speaking about PSS)

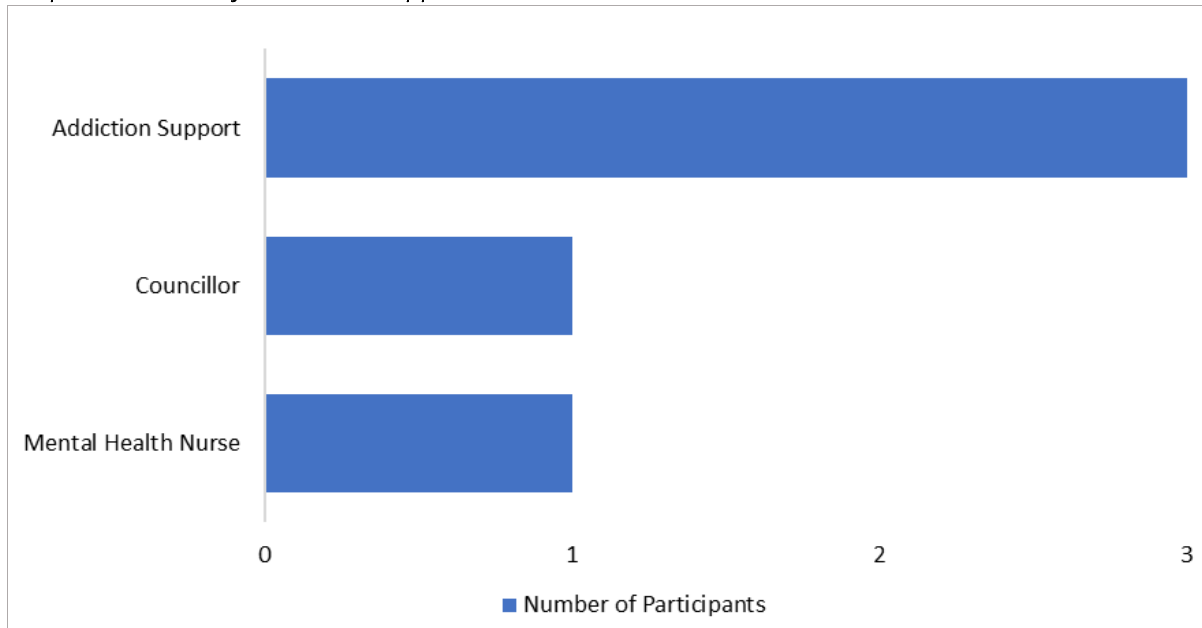
Following on, participants were asked whether having a PSS has motivated them in seeking additional avenues of support. As all participants have been engaged with their PSS less than 6 months (Table 2), remarkably 50% have already starting seeking additional support (Graph 9).

Graph 9. Engagement with Additional Supports



For participants who are seeking additional supports, they were subsequently asked what type of additional support they had started engaging with. The findings indicate that 75% of participants had started seeking additional addiction support, while 25% were seeking additional counselling or engagement with a mental health nurse (Graph 10).

Graph 10. Means of Additional Support

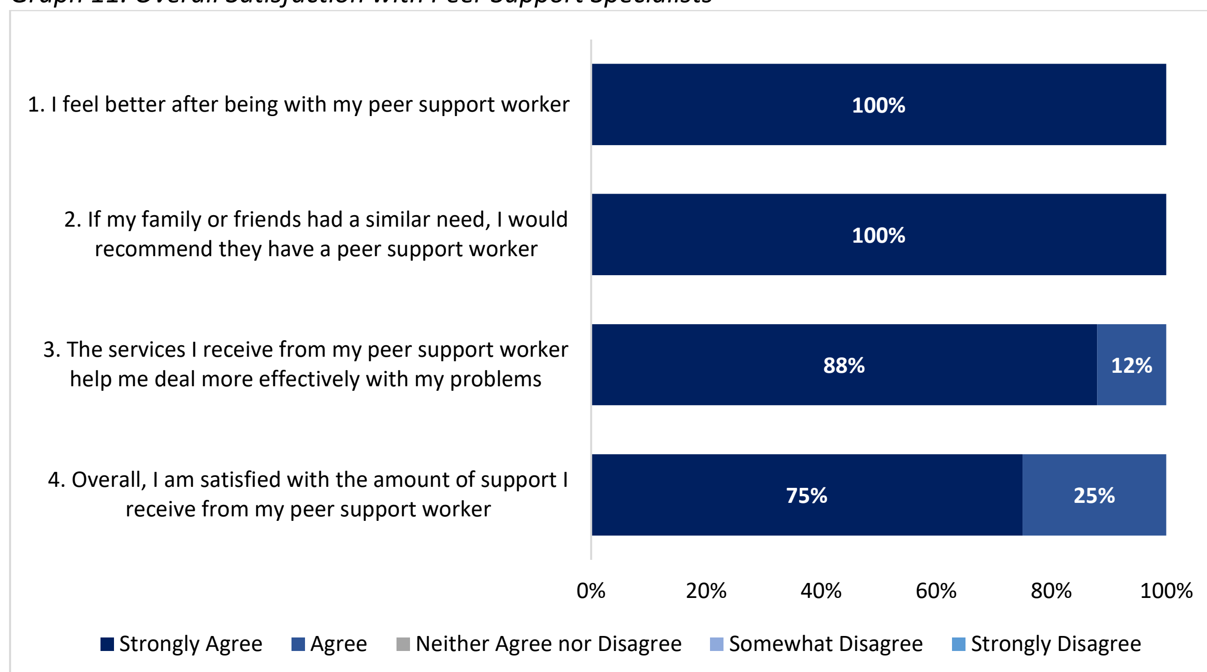


Section 4: Participant Satisfaction and Future Directions

Finally, participants were queried on their overall satisfaction with the PSS programme, and if and how they would like the programme to be developed.

Overall, every participant strongly agreed or agreed that the support they currently receive from PSS is beneficial to their recovery and re-integration into society. All participants said they feel better after being with their PSS, the services they receive help them deal with their current problems more effectively and that they would recommend friends or family to have a PSS if they needed one (Graph 11).

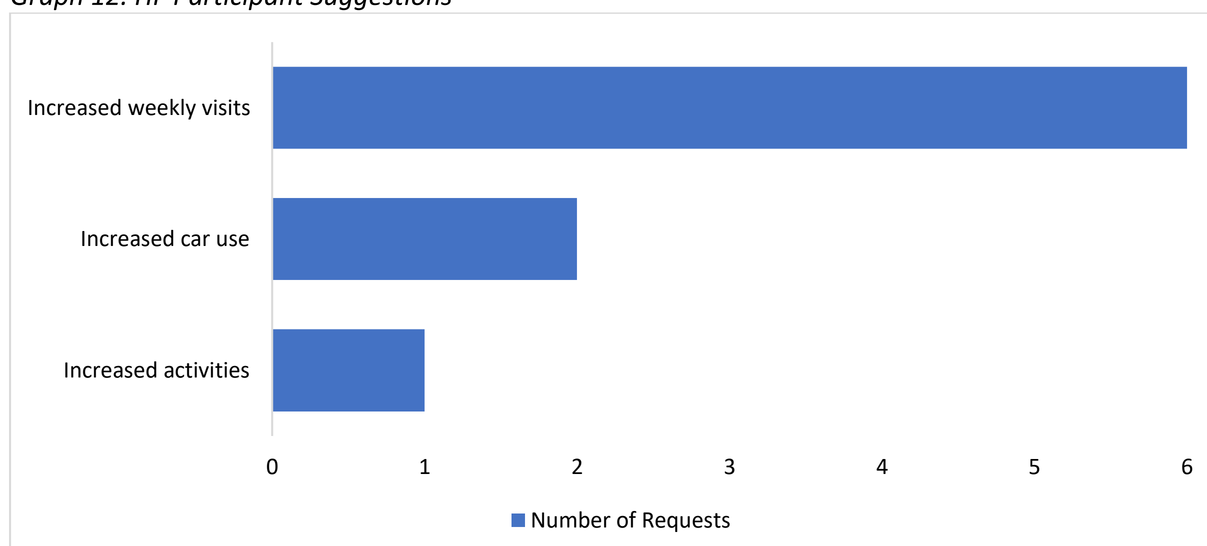
Graph 11. Overall Satisfaction with Peer Support Specialists



The next question focused on the continuation of the PSS programme and how participants would like the programme to be developed. Participants were firstly asked whether they would like additional peer support engagement. 88% of the participants said yes, while 13% of participants were unsure.

Those who indicated interest in receiving further supports, were subsequently provided with an open-text box to indicate *how* they would like additional supports to take place (see Graph 12). All participants emphasised that more frequent visits would be beneficial. Additionally, participants voiced interests in more structured activities with their PSS, which may be facilitated by reliable access to a vehicle.

Graph 12. HF Participant Suggestions



Section 5: Summary of Housing First Participants Survey

The key points from each section of the Housing First Participant Survey are provided in the table below (Table 3).

Table 3: Summary of Housing First Participant Survey

Theme	Key Points
1. **Demographic Profile**	• The participants were predominantly ***male*** (75%), between the ages of ***35 to 64.*** Their main form of employment was the ***disability allowance*** (50%) and the majority had been in ***homelessness for over 5 years*** prior to engaging with HF services (63%).
2. **Nature of Engagement with PSS**	• All participants were ***engaging with their PSS for less than 6 months*** with their main form of contact being ***in person*** (62%). • All participants agreed that their PSS helps them ***establish goals, motivates them*** to reach these goals and ***supports them*** in achieving them.
3. **Impact of PSS**	• Most participants said that the PSSs help them make ***healthier life choices, manage the stress in their daily lives,*** help their ***mental health*** and have supported them in ***reducing their risk-taking behaviours***.
4. **Overall Levels of Satisfaction**	• All participants expressed significantly ***high levels of satisfaction the PSS programme.***
5. **Participant Recommendations**	• A majority of participants ***recommended increase time and activities with PSSs.*** • Participants suggested that ***consistent access to HF transportation*** would enhance the quality and length of time that PSSs can provide.

Chapter 4: Housing First Dublin Region

The following chapter provides an in-depth examination of Dublin region key stakeholders' perspectives on the PSS role and effectiveness of the support provided. In total 14 professionals participated in discussions distributed across 3 focus groups. A breakdown of the participants is provided below (Table 4).

Table 4. Breakdown of the focus group participants

	Role	Pseudonyms	No. of participants
Focus Group 1 **PMVT Service Providers**	Peer Support Specialist (x2)	PSS 1 PSS 2	8
	Peter McVerry Trust Service Manager (x2)	PMVT SM 1 PMVT SM 2	
	Peter McVerry Trust Intensive Case Manager (x2)	PMVT ICM 1 PMVT ICM 2	
	Peter McVerry Trust Multidisciplinary Team (x2)	PMVT MDT 1 PMVT MDT 2	
Focus Group 2 **PMVT Service Providers**	Peter McVerry Trust Head of Services (x2)	PMVT HoS1 PMVT HoS2	2
Focus Group 3 **External Stakeholders**	Local Authority Representative	LA 1	4
	HSE Social Inclusion Manager (x3)	HSE 1 HSE 2 HSE 3	
	Total		**14**

The results from the focus group discussions with key stakeholders are illustrated within five already established themes in the areas of 'Nature of PSS Role', Recruitment', 'Supervision & Training', 'Impact of PSS' and 'Key Challenges'. Themes are partially illustrated by participant quotes (Table 5). A further display of the quotes can be found in the Supplementary Text (Appendix VIa).

Table 5. Categorisation of themes and subthemes

Themes	Subthemes
1. Nature of the PSS Role	Experts by experience Bridging the gap True value vs tokenism
2. Recruitment	Pre-Requisites Pathways of recruitment
3. Supervision and Training	Supervision • Types of supervision • Supervision methods Training • Importance of training resources • 'Mapping down' future directions
4. Impact of the PSS Role	Impact on participants • Empowerment through befriending • Mental wellbeing • Re-integration into society Impact on services • Provision of insider's perspective • 'Door opening' role • Distribution of workload
5. Key Challenges	Boundaries Public Perception Practicalities of Role

Section 1: Nature of the PSS Role

The stakeholders extensively discussed the nature of the PSS role and highlighted the importance of the PSS's personal experience, capacity to make a connection with HF participants, and bridging the gap with service providers.

Experts by experience

All of the stakeholders acknowledged the importance of the PSSs role. It was highlighted that PSS's lived expertise in the areas related to homelessness, including mental health, addiction, and recovery,

serves as a unique feature of the support provided to HF participants. It was agreed that a PSS is equipped with the skills that cannot be taught, and can only greatly benefit all participants; as pointed out by a Head of Service, '*[...]peer support specialists come from lived experience. They have specific skills, they have specific experiences, whether it be employment, education or otherwise. So, they will be bringing that with them [...]'* (PMVT HoS 1)

The sharing of PSSs' lived experiences is not merely seen as a work requirement and expectation of the PSS role, but as a key mechanism of establishing the connection between the HF participant and the PSS. Once the connection with HF participants is established, the PSS has an opportunity to further motivate and nurture the empowerment of participants, as both Peer Support Specialists disclosed:

'*I know how to motivate them; I know how to talk to them [...]*' (PSS 1)

'*We're able to kind of guide them […] we can kind of move down there, 'til they're more comfortable with it, so they get to use the support.*' (PSS 2)

Establishment of this connection is believed to create a foundation for trust and allow a space for further support from additional HF MDT members to be facilitated.

Bridging the gap

The characteristics of relationship-building through lived expertise creates a clear distinction between the role of the PSS and other professionals (including ICMs and MDTs), where '*the participants really feel peer supported, they're there for them, they're advocating for them'* (PMVT SM 1).

The development of the relationship between PSS and HF participants allows further promotion of participants' well-being, which might not necessarily take place when supported by other staff members. The stakeholders felt that staff members are often *'perceived as an authority figure and can be very intimidating'* (LA 1), whereas, with PSSs, an emphasis is placed on what is deemed to be a 'friendship zone' – where participants feel comfortable discussing the topics and disclosing issues unshared with others. As highlighted by a Peer Support Specialist '*there's certain things that they would tell me that they won't tell the ICM'* (PSS 1). The relationship is based on interpersonal trust and understanding.

Therefore, '*stepping into peer support, friendship versus ICM'* (PMVT ICM 1) role, creates a space for further engagement with participants and creates possibilities to bridge a gap within the support services provided. Being perceived as '*peacekeepers and the nice guys'* (PSS 2), allows the PSS to establish an additional level of support, and develop strong connections with the participant.

However, as outlined by one of the Health Service Executive Representatives, the development of personal relationships can create issues for PSSs. The participants may find it hard to differentiate between the role of a PSS and their companion. To prevent this issue from occurring, the stakeholders recognised that training in creating and maintaining boundaries is of significant importance.

True value vs tokenism

Some of the stakeholders highlighted that the PSS role must be appropriately acknowledged and valued in order to avoid tokenistic perspective and treatment. Health Service Executive Representatives emphasised that peer support has multiple benefits for the HF participants and HF team where ‘t*he participant is going to benefit and so is the service or organisation’* (HSE 3). Therefore, appropriate payment and recognition are essential.

Stakeholders agreed that the role of the PSS should not be on a voluntarily basis and that the payment should match the pay scale of other support staff employed by the organisation. A Health Service Executive Representative strongly expressed that ‘*Paid peer support because that's what we need, not only payment but to be on a scale that matches the other, their colleagues*’ (HSE 1).

Section 2: Recruitment

The recruitment of the PSSs was mainly reflected through discussions on PSS role requirements and current pathways for their recruitment.

Pre-requisites

Some of the stakeholders suggested that having a relevant educational background would be desirable in order to employ a PSS. However, the levels of education were not specified, as a Health Service Executive Representative described: *‘I don't know if you could put like a level on it, whether it's a QQI level 5 or a level 7’* (HSE 3). Although the importance of educational qualifications or training was welcomed, possessing life experience was outlined as a prerequisite for the role:

‘*They have an in education of life. Let's say with their lived experience you know*’ (HSE 1)

‘[…] people come from college. And they come with an education and a degree in relation to, I suppose, how to fix people. But the service user – our Peer Supporter – come from a very different experience, you know. We don’t always have to fix people’ (LA 1).

It was also suggested that even if initially a PSS does not have a relevant educational background, involvement in ongoing professional pieces of training and upskilling, combined with their lived expertise, will equip them with skills necessary for the role.

Pathways of Recruitment

The stakeholders expressed a variety of views regarding the recruitment pathways, highlighting that both internal and external hiring methods are equally beneficial and pose a variety of unique advantages.

A few stakeholders agreed that when the role of a PSS is publicly advertised, an equal opportunity is provided for the internal and external candidates. This would ensure that the recruitment and selection process is executed effectively and that the best candidate is selected for the role.

However, some stakeholders displayed a preference for internal recruitment, expressing that if a potential PSS is recruited through internal channels, they are more likely to possess direct knowledge and experience of HF as a previous graduate of the HF programme. The information on potential candidates and recommendations for the PSS role would often originate from the Intensive Case Manager who would have a strong familiarity with a prospective candidate:

'*We have a client and they're highly intelligent and they were offered a peer support role in the stabilisation or detox service they had been after they had finished, after a few months they were offered to come back in a peer support role in one of those centres as well*.' (PMVT ICM 1)

Internal recruitment was also seen as beneficial since the employment of previous HF participants would aid them to progress through the organisation and to progress from employment and volunteering into paid work.

Section 3: Supervision and Training

The importance of appropriate supervision and training has been recognised as an integral factor for successful peer support. Therefore, a great deal of discussion was centred on the supervision and training that should be provided and necessary for the PSS role.

Supervision

Types of supervision

Among the stakeholders, supervision was seen as a key component in addressing challenges experienced while providing peer support services. Within PMVT HF, supervision currently takes place through team meetings and 1-to-1 meetings.

As suggested by the HF Service Managers, the team meetings – also known as hub meetings – take place frequently with the PSSs being present: *'daily planning meetings, there's monthly planning meetings, there's also the peer support worker would participate in all of those pieces, particularly if*

you're seeing an individual' (PMVT SM 2). Other members of the HF team also attend the hub meetings, including members of the ICM team and MDT, as well as management. It was disclosed that during the hub meetings attendees have an opportunity to share the information relevant to a particular HF participant and '*the hub is kind of an opportunity to meet up and kind of offload'* (PMVT SM 1).

A PMVT Head of Service highlighted that '1-to-1 meetings' take place in a regular and ongoing manner, where the team leader or manager will *'sit down with them during those times and work through what's working well and support in terms of how to manage what may need improvement'* (PMVT HoS 1). At 1-to-1 meetings, a PSS has an opportunity to discuss and debrief any areas or situations of concern, including issues concerning boundaries which could potentially arise during peer support.

Supervising methods

As disclosed by PMVT Representatives, current supervising methods in PMVT HF were mainly adjusted to the PSS's needs. These were determined by the PSS's requirements for more or less frequent meetings and the types of barriers or struggles they encounter. Both Peer Support Specialists expressed that they felt supported, respected, and provided with *'incredible leeway without micromanagement, which I think is the key to this role'* (PSS 2). Additional external counselling services, as well as support regarding bereavement, were also offered within PMVT HF.

The Health Service Executive Representatives strongly suggested that the supervision provided for PSSs has to be structured, compulsory and organised on a regular basis, in order to assure high levels of continuous supervision are maintained for PSSs:

'*Then it's just about looking after them, making sure they're, you know, looked after really*.' (HSE 3)

Effective supervision and established support mechanisms were acknowledged as imperative to PSSs. As the Health Service Executive Representative outlined, *'I just think you need to be careful around making sure there's proper support available to the supervision support.'* (HSE 3)

It was suggested that the assignment of the external supervisor, such as an independent professional outside of the organisation the PSS is employed in, should be considered. An external supervisor could potentially address any issues or discomfort experienced by PSS, which essentially cannot be communicated to the internal supervisor *'[…] am I failing if I say this or how do I call out my supervisor if I feel I wasn't supported in that particular circumstances […] having an independent and maybe they're not actually getting the support required from the supervisor, and they feel that they can't*

actually say that, so I don't know whether an external person close to the project has an understanding of what the role should be' (LA 1).

The combination of meaningful external and internal supervision would ensure that adequate support mechanisms were placed to support PSSs' well-being and ensure a successful transition to their role.

Training

All stakeholders agreed that the provision of adequate training is necessary if the benefits of employing a PSS are to be garnered. Therefore, availability and accessibility of the wide range of training programmes prior to and/or upon commencement of employment are considered to be of high importance.

Importance of training resources

As indicated across focus groups, the training would allow further development of skills and knowledge required to guide PSS work and to maintain professional and personal boundaries. Stakeholders' accounts strongly suggested that training programmes would lead to upskilling which is understood as a key for self-improvement and provision of more comprehensive services provided by a PSS.

'*In general, we'll always look towards meeting those needs by way of training and upskilling the staff team, that's both for the peer support specialists, the ICMs and the likes.*' (PMVT HoS 2)

'*I think if you give them skills and tools and with their education for lived experience that they would flourish and the service they're employed for, the service would reap the rewards*.' (HSE 1)

The stakeholders outlined that all training programmes available to staff members should be available to PSSs. It was explained that, within PMVT HF, training programmes (such as Mental Health training, Trauma-informed care, Naloxone training, First Aid training and Motivational Interviewing) are provided to all staff members, including PSSs. However, as disclosed by a PMVT Service Manager, PSSs also have an opportunity to enrol in additional training programmes that could benefit HF participants they work with:

'[…] *it will all be dependent on the individual and what it is that they're bringing and what it is that would benefit our client group going forward*.' (PMVT SM 2)

It was suggested that identifying personal developmental needs would aid in assigning future training and educational programmes.

'Mapping down' future directions

Going forward, PMVT Representatives expressed that additional training modules in Mental Health, Addiction and Practical skills, including dual diagnosis and challenging behaviour, are planned to take place. The auxiliary pieces of training and upskilling were welcomed by PSSs who felt that they are *'open to doing different courses'*, and found these opportunities valuable.

The development of more standardised training programmes, specifically focusing on the needs of HF participants, was considered a critical driver for future steps. As agreed among HSE Representatives insightful planning is highlighted as necessary to be able to identify what type of training and education would be most beneficial in the provision of formalised peer support with practical assistance to HF participants. As one Health Service Executive Representative disclosed, '*It's not just to align themselves with the client and you know […] they need the education to back up and the systems and the thought processes that goes with the education side. So that they're able to do both.*' (HSE 2)

Although it was suggested that the development of a universal training manual would be difficult, HF managers indicated that the next steps should be taken in expanding training curricula tailored to the needs of PSSs. While expanding training curricula, it was suggested that addressing *'where the growth and development should come from'* (LA 1), and how it would serve for further empowerment and personal development of peer supporters, should be considered. Awarding accreditation of PSS training within QQI levels (5-7) would lead to '*Empower that person as a peer supporter to go on to further education to get their qualifications'* (LA 1).

Section 4: Impact of the PSS Role

The focus group discussions regarding the impact of the PSS were divided into two main areas: the impact of the PSS role on participants and on the organisation/services.

Impact on Participants

The discussions across the focus groups proposed that the possession of the wealth of personal experiences allowed PSSs to relate to HF participants, which in turn created an opportunity to establish meaningful relationships. As a result of the provision of companionship, and practical support with daily living activities, PSSs created positive impacts on HF participants. This included improvement of social functioning and mental well-being. These positive effects further contribute to the empowerment of HF participants with regards to their self-efficacy and self-management on a daily basis and lead to the enhancement of their overall quality of life.

Empowerment through befriending

The stakeholders across the focus groups viewed PSSs' experiential knowledge as a cornerstone in establishing relationships with HF participants. As the Local Authority Representative observed, the relationship foundation between PSS and HF participants needs to be based on *'non-judgmental, trusting and empowering'* (LA 1) pillars.

As outlined by most of the stakeholders, PSSs can empathise with frustrations experienced by HF participants due to their own experiences of similar issues and struggles. Therefore, PSSs were often seen as role models whose achievements serve as a positive example or reminder of how the current life circumstances of HF participants can be improved.

'*They actually see how it's tangible to them to kind of go: 'that's where I could be.*' (LA 1)

'[…] *they tend to gravitate towards that person because they know they've walked that path*.' (HSE 2)

Being able to connect with HF participants, either through experience, empathy, or as a potential role model, provides PSSs with an opportunity to build the relationship and create a strong foundation for companionship. Befriending greatly benefits HF participants and contributes to their overall well-being, self-esteem, and empowerment. As commented by the Local Authority Representative, '[…] *when you actually see a person that has come through a system and says I'm living proof that this can actually happen. So, I think that's very empowering*.' (LA 1)

Empowerment consequently leads to taking an initiative or re-gaining control over one's life in order to achieve self-efficacy. Empowering HF participants could be exemplified by the following account from a Service Manager:

'There's one client, that I know peer supporter 1 would work with who he goes to gym with quite regularly and like that client at one point was very chaotic within our services. Was very hard to manage. Very hard to work with, was just overall very difficult with where they were at. And Peer Supporter 1 would meet them quite regularly, go to the gym together. They're clean, now. They're in recovery. They do talks and stuff in their area to younger people. Like they're doing really, really well.' (PMVT SM 2)

The supportive nature of peer relationships allowed HF participants to create strategies for lifestyle modifications, and to lead the most fulfilling life they can achieve.

Mental wellbeing

As echoed by many stakeholders, HF participants often experienced multiple social challenges, including isolation and loneliness. Moving into a new property or new home created additional stressors, which commonly negatively impacted their well-being:

'[…] *our clients are very isolated and very lonely, and they wouldn't necessarily have a lot of family support or friends*.' (PMVT SM 2)

'*And in managing those feelings of loneliness or isolation that can sometimes come with accessing a property*.' (PMVT HoS 1)

In order to improve mental well-being, befriending was reported as a main source of emotional support:

'*This one client, they love me, they want me in their company, and, you know, they're not like that with everybody*.' (PSS 1)

'*He doesn't have anybody else, he has not got any contact with his family, he bought me a Christmas present, that he should not bought. He says that he doesn't care about anybody else as long as I'm with him... they need to know that you're there, a lot of them want to know you're there and they're happy*.' (PSS 2)

The stakeholders agreed that the friendship provided by PSSs aims to alleviate the negative effects of both loneliness and social isolation on mental well-being, foster independence and inspire confidence.

Re-integration into society

In order to combat loneliness and social isolation, PSSs were often focused on connecting people with activities that allow HF participants to become more interested and empowered.

Therefore '*walks, visits to gym'*, as well as *'exploring their interests and their hobbies and stuff'* (ICM 1) were some of the activities often utilised in order to encourage further integration into society.

These activities were not merely seen as 'getting them out of the house', they also encouraged HF participants to achieve goals and engage with society in a convenient manner and further served as a capacity-building exercise for engagement over time.

'*A lot of our clients like sitting in Costa or Starbucks, you know, they see people sitting in there in uniforms and dressed well. They find themselves thinking, am I actually sitting in here having a coffee,*

you know, going in and having a coffee is not really part of their lifestyle. That builds their kind of self-esteem and they feel better about themselves.' (PMVT SM 1)

PMVT service providers felt that, although some of these goals may seem to be on a small scale, they also represented essential steps on the path to re-engaging as active members of the community.

In addition, PMVT Representatives agreed that the provision of practical, day-to-day supports, such as attending scheduled appointments, shopping, paying bills, and setting up bank accounts by PSSs, created positive effects on the participants' confidence and further empowered their social integration. As a Service Manger explained '[...] *they feel very accomplished when they attend their appointments. That boosts their self-esteem, then, I've done this today and you feel very, I suppose, rewarded'* (PMVT SM 1).

Reintegration into society was seen as a critical aspect of mental wellness and recovery of HF participants, as well as a facilitator of further improvement of self-esteem, and social skill development.

Impact on HF services

Across focus group discussions, PSSs were considered to be a great asset to the HF teams, by providing valuable contributions to services, teamwork, and team-building practices. The contributions to HF services are mainly seen through bridging the gap between HF participants and HF support workers; providing an in-depth understanding of HF participants' needs; as well as by 'opening the door' for further engagements with the participants.

Provision of an insider's perspective

Stakeholders agreed that PSSs serve as a great source of information. Due to their lived experiences, PSSs were in a position to offer an in-depth understanding of the issues that HF participants experience, as well as deeper insights into participants' recovery journeys. For example, the Health Service Executive Representative highlighted:

'They can use their experience in some ways if they have been through housing first or if they have been in homeless accommodation to inform the staff. You know, maybe that's not working. Maybe this will'. (HSE 2)

By having access to this added perspective, and getting advice from a knowledgeable insider, the MDT is provided with a unique understanding of the participant's journey.

'Door opening' role

PSSs were perceived as a key figure in developing trusting relationships with HF participants. This crucially diminishes the distinction placed on staff by HF participants of the 'them and us' that often exists between service users and professional support workers. As PSSs were viewed as a representation of 'us' by HF participants, they are more likely to establish trust, greater levels of engagement, and cooperation with HF participants, paving the way for similar relationship to be made with

A PMVT Service Manager disclosed that '*they've probably been dealing with services and professionals most of their life, like one of the tenants comes out with 'you're a social worker'. It's like they make up their mind of who you are and what you're doing there and they're not letting that go and I suppose the more we go, but they kind of just make up their mind that you're putting me in this category so I'm not going to let my guard down but when you go in very informal and relaxed, you get more'* (PMVT SM 2).

The HF participants confide in their PSS. This creates an opening and capacity to build a greater liaison relationship with other support workers and encourages HF participants to communicate their needs and issues with other support team members. In return, this leads to improved trust and communication within the organisation itself, and allows for further supportive steps.

'[…] peer support is able to kind of get down and sit down and encourage them, build them up to the point that our organisations can start to actually engage with them.' (LA 1)

'If the service user knows that this person has walked the same path as them, they'll be a little bit more open to opening the door, you know, and engaging. And so, I think it does that quite well. It gets the staff, the others in the door.' (HSE 2)

Distribution of workload

Since PSSs and other members of the HF support team work closely in an integrated manner, they are also able to share the workload. This is highlighted as beneficial for the service, as well as for the service users. By being able to share the workload, this contributes to less burnout among staff, less stress, and better dedication to more demanding clients' needs.

As one Service Manager reflected:

*'They're (the ICMs) carrying a lot, and they're also working with very difficult clients like 90% of the time. And they don't get to do that kind of positive piece like they would like to with their clients. And I think when we have peer support in doing it, it's a little bit less of a stress for the ICMs.' (*PMVT SM 2)

Section 5: Key Challenges

The stakeholders identified three main categories of challenges that PSSs experience: establishing boundaries, challenges arising from public perceptions and practical challenges.

Boundaries

Two types of issues concerning boundaries were identified. Firstly, the peer support model assumes that informal relationships between PSSs and HF participants are helpful to the participant. These informal relationships may include social activities, conversations, and sharing of personal experiences that resemble connections between friends. Since an emphasis was placed on what was deemed to be friendship, rather than a professional role, this often creates ambiguous boundaries difficult to navigate. As one HF Service Manager observed:

'I think that sometimes where peer support specialists may struggle is in the fact that because they have that shared experience, there can be a [...] they may find it difficult to separate the sympathy with the empathy you know and where then they are overly involved.' (PMVT SM 2)

Secondly, maintaining friendship-like relationships with HF participants can blur the boundaries of professional support, which can lead to the development of strong attachments and intensified devotion among peers:

'You can have an opposite effect if the peer support becomes too high with the person, there needs to be a boundary in the middle' (HSE 1)

'They can't help but be overly invested in a particular case and look the wheels of all these systems, they move very slowly, so that we've seen it before where even with the Ukrainian response, people are really overly invested in the people they are looking after and saying why can't it just happen quicker, this person really needs XY and Z and I think the peer support in terms of homelessness and housing first. I think it would only be amplified in that because people have been there before and they've seen it and they know that look, this doesn't happen in the next X amount of time.' (HSE 3)

Public perceptions challenges

PSSs disclosed that the PMVT organisation is often associated with poverty, homelessness, and addiction, and therefore PSSs felt that HF participants they work with could be stereotyped and stigmatised by their community. A possibility that their neighbours would recognize the PMVT logo could potentially affect their levels of engagement with their PSS and re-integration into society.

'Even just driving the vans around, it's almost like they're watching you. Just because you're driving the van […] People associate it (Peter McVerry Trust) with addiction straight away. And that's what our clients are trying to step away from that and to integrate into society and the last thing what they want is their neighbours discuss them in a way.' (PMVT SM 2)

'I suppose you wouldn't want the neighbours to know that you're with PMVT' (PSS 1)

Practical challenges

A few practical challenges, such as getting transport to HF participants and a lack of time to dedicate to all HF participants equally, were raised by PSSs. Considering that PSSs were currently seeing multiple HF participants per week, having a company vehicle would allow them to get in touch with HF participants promptly and more efficiently:

'[…] something we found out in areas of the services that our clients would probably try to avail of aren't nearby. Everything's pretty spread out'. (PMVT ICM 1)

Section 6: Summary of Housing First Dublin Region

The table provided below provides a brief summary of the key point discussed within each theme for the Dublin region (Table 6).

Table 6: Summary of Housing First Dublin Region Results

Theme	Key Points
1. Nature of the Role	• PSS ***personal experience*** in the areas related to ***homelessness, including mental health, addiction,*** and ***recovery*** fundamental for the role. • Ability to ***develop a relationship*** with HF participant, based on ***interpersonal trust*** and ***understanding*** is outlined as one of the main requirements of the role. • Appropriate ***acknowledgment*** and ***value*** have to be added to the role.
2. Recruitment	• Educational qualifications or training was welcomed, and ***possessing life experience*** was outlined as a ***prerequisite for the role*** • ***Internal*** and ***external hiring methods*** are equally ***beneficial, previous HF graduates*** highly ***desired***
3. Supervision and Training	• Supervision is required to be ***structured, regular***, organised through ***1-1- sessions*** and ***team meetings***; and ***tailored to PSS needs.*** • Internal and external supervision methods are welcomed

	• Training sessions in the areas of ***Substance misuse Mental health, Trauma-informed care, First Aid training*** and ***Motivational Interviewing*** are suggested. • Importance of identifying ***additional training modules*** for further ***upskilling*** of PSSs.
4. Impact of the PSS Role	• The empowerment of HF participants is seen through the ***provision of companionship***, and ***practical support*** with daily living activities; where the participants take further steps towards ***reintegration into society***. • The contributions to HF services are mainly seen through ***bridging the gap*** between HF participants and HF support workers; providing an ***in-depth understanding*** of HF participants' ***needs***; as well as through the ***distribution of workload***.
5. Key Challenges	• ***Transportation*** challenges and ***a lack of time*** to dedicate to all HF participants equally are identified.

Chapter 5: Housing First Northeast Region

The following chapter provides an in-depth examination of the discussion among stakeholders located in the Northeast Region. The stakeholders' provided their perspectives and understanding of the PSS role, implementation and outreach benefits. In total, 4 professionals participated in the discussion and a breakdown of the participants is provided below (Table 7).

Table 7. Breakdown of the focus group participants

	Role	Pseudonyms
PMVT service providers	Director of Services	PMVT DoS 1
	Intensive Case Manager	PMVT ICM 3
	Service Manager	PMVT SM 3
External stakeholders	Local Authority Representative	LA 2

The results from the focus group discussion with key stakeholders are illustrated within five already established themes in the areas of 'Nature of Role', Recruitment', 'Supervision & Training', 'Impact of PSS' and 'Key Challenges'. Themes are partially illustrated by stakeholders' quotes (Table 8). A further display of the quotes can be found in the Supplementary Text (Appendix VIb).

Table 8. Categorisation of themes and subthemes

Themes	Subthemes
1. Nature of the PSS Role	Experts by experience Bridging a gap
2. Recruitment	Pathways of recruitment
3. Supervision and Training	Supervision structure Training structure
4. Impact of the PSS Role	Empowerment through role modelling Provision of insider's perspective
5. Key Challenges	Boundaries Risk of destabilisation Practicalities of role in Region

Section 1: Nature of the PSS Role

The theme 'Nature of the role' followed the same concept as the previous three regions, highlighting PSS's personal experiences, the significance of self-awareness while undertaking the PSS role, and the contribution to services by bridging the gap between HF service providers and HF participants.

Experts by experience

The Northeast stakeholders predominantly saw a PSS as an individual with extensive lived expertise which is greatly beneficial to HF participants. As the Local Authority Representative described: *'The peer support worker is someone that is an expert and has lived experience […] they have lived through it. They are and can be a great benefit and the role is of benefit' (LA 2).* The importance of holding a unique position of having had a history of addiction or homelessness with extensive knowledge and resources beneficial to HF participants was echoed by all stakeholders in the focus group.

Being able to maintain the transparency of the experience and share valuable thoughts and techniques around self-care and resilience was considered to be crucial: *'It's important to be transparent at any given time, and I suppose, from a peer point of view, that concept of practising what you preach is a very important piece'* (PMVT DoS 1). The PSS was seen as *'[…] someone that they* [HF participants] *can relate to'*, with shared experiences and life pathways, who overcame the obstacles and is in the position to promote a change through *'*role modelling aspect*'*. The recognition and nourishment of PSSs' self-care and self-regulation were highlighted as crucially important.

Considering that initially PSSs might not have in-depth knowledge of what peer support entails, regarding the workload and levels of HF participants' demands, PSSs were urged to maintain self-awareness. The preservation of self-awareness was considered to be essential to be able to identify and potentially cease negative triggers in their own recovery: '[…] *actively practising their recovery, and I suppose increased self-awareness is what I would say, so I suppose when we talk about self-awareness. We also link it with self-care, which is a critical piece'* (PMVT DoS 1). Self-regulation was mainly seen through the recognition and fostering of a wide spectrum of boundaries while providing peer support.

Bridging the gap

The stakeholders strongly believed that PSS aided the HF team by expanding the awareness and knowledge of particular needs, and types of support required by HF participants. As the Director of Services states *'I suppose when there is a peer support worker as part of the team, there's an understanding, and there's also the potential for the peer support to be able to share some lived*

experience with the team' (PMVT DoS 1). Peer Support Specialises provide the missing link to understanding the current experiences of HF participants.

The PSS's knowledge was also outlined as beneficial to the HF support team in identifying and assessing the current circumstances of HF participants, as *'someone might say I am clean and I am fine, but someone who has been through that process will know the story and be able to see that they are not ok'* (LA 2) and assisted in the provision of prompt adequate assistance.

In addition, the stakeholders felt that the presence of a PSS would contribute to more open communication and the establishment of stronger pillars of trust between HF support staff and HF participants. As the Local Authority representative observed, *'[…] a major role appears to be a trust enhancing in the service'* (LA 2), therefore, successfully bridging any possible divides between the HF participant and the HF service.

Section 2: Recruitment

The recruitment of potential PSSs was mostly discussed regarding appropriate pathways to recruit a person, where internal and external avenues were explored.

Only one stakeholder proposed that relevant qualifications should be in the area of social or community care *'in areas around the substance abuse, mental health issues should be mandatory qualifications in that in that particular area'* (LA 2).

Pathways of recruitment

The stakeholders felt that having a background in addiction services or being a previous graduate of the HF programme would be the most appropriate path for the recruitment of PSSs.

It was suggested that, if PSS was coming from the addiction area, the connection made with HF participants would be stronger and based on reciprocity and trust because '*the lads will respect that worker a lot more, so I think if they had a background'* (PMVT SM 3). A history in addiction combined with obtaining relevant qualifications was viewed as an ideal amalgamation of lived experience and educational background.

Taking into consideration previous HF participants as candidates for the PSS position was seen as an additional avenue of recruitment. The best practice to achieve this was to ensure that the connections with individuals who graduated from the HF programme were maintained over years. The

stakeholders assumed that this would generate natural engagement with previous graduates while offering a position of peer supporter.

However, it was also highlighted that only graduates who exited the HF programme in the last few years, should be considered. A significant period of abstinence would ensure that previous HF graduates were stable, and progressed with their own recovery path, as the Team Leader suggested, *'I wouldn't necessarily say I'd be ruling anyone out from the Housing First programme. Definitely not. No. I just think there would have to be like a period of abstinence from the programme from the staff. I think if they graduate, maybe in a two to three-year gap from the programme'* (PMVT SM 3).

Recruitment constraints in the Northeast region were also noted. The stakeholders felt that due to geographical location, the pool of applicants was very limited, and the main focus should be placed on PSSs located in a central location for the region, such as in County Cavan. Central locations would allow logistical benefits, such as easier access to sites with HF participants.

Section 3: Supervision and Training

Supervision and training were considered to be the main pillars of support necessary for the PSS role in the Northeast. The stakeholders felt that appropriate supervision and training would guide the evolving growth of PSSs as well as the HF team workforce.

Supervision structure

Supervision was considered an essential piece required to be established prior to employing PSSs. Discussing the expectations on supervision, the stakeholders proposed that the supervision has to be mandatory, structured, and undertaken on a regular basis, preferably once a week. Regularity of supervision was seen as a necessity in ensuring quality support following organisational principles. The internal supervision stream was proposed to be led by senior management.

'[…] there would be a direct streamline piece within the organisation and that would actually be held by a member of the senior management team under the MDT remit, and in addition to that, then would be the ongoing counselling supports.' (PMVT DoS 1)

The external supervision was suggested to take place through counselling sessions, organised by an employer and tailored towards a PSS's requirements. The amalgamation of both, internal and external supervision was seen as most beneficial.

The supervision meetings should also serve to address any issues with professional boundaries and to foster accountability. Oversharing was highlighted as a potential issue that could take place when

working with peers, as expressed by the Intensive Case Manager, '*I just think it's blurred and they'd have to be really boundaried and be mature and that's like – They're not oversharing, or it doesn't become inappropriate'* (PMVT ICM 3). Therefore, guidance on how to navigate the boundaries while maintaining the flexibility of disclosure was suggested to be taken into consideration.

Training structure

The stakeholders felt that the provision of adequate training, complimented by supervision, would equip PSS with sufficient knowledge and confidence to support HF participants.

It was indicated that PSS training should be mandatory, well-structured and monitored, provided prior to and during the PSS's employment contract. Once employed, the PSS should receive the same type of training as other HF support staff, as *'training by the service provider using the parameter of the staff training already been done by the existing peer support workers, it would be essential and not put someone in the deep end'* (LA 2).

Shadowing sessions were also suggested, either by shadowing an active PSS or a current HF support staff member. These sessions were highlighted as very beneficial in gaining practical knowledge of what the role entails, as the Intensive Case Manager expressed *'I think it's really imperative to shadow shifting and coming along with staff, that's the best way to learn a service, I suppose'* (PMVT ICM 6), followed by a Local Authority representative's view that *'[…] working with an existing peer support worker who has experience and observing them and see how they carry out the role'* (LA 2).

The training as supervision should also be centred around maintaining appropriate boundaries, with an emphasis on the importance of self-care practices – *'The training specific to boundaries also, and I suppose a recognition in and around the importance of you know, being able to mind one's own self-care'* (PMVT DoS 1).

Section 4: Impact of the PSS Role

Impact on participants

Empowerment through role modelling

When discussing the impact of the PSSs on the HF participants, the stakeholders emphasised the importance of role modelling. It was acknowledged that the extensity of personal experiences, commitment to rehabilitation and success of the recovery process, allowed PSSs to be seen by HF participants as someone who has 'been there' and who has faced, endured, and overcome similar adversity themselves.

'You have someone that's been there before and have done it. They could provide tips maybe or some strategies to prevent going into that crisis? It can only really have a positive impact' (PMVT SM 3)

PSSs were seen as mentors that possess similar traits viewed as credible and therefore provide a source of trust and hope. From stakeholders' perspectives, HF participants often conduct positive comparisons once they are affiliated with their peers. The comparison further enables motivation and self-efficacy for personal growth. Empowerment of the HF participants through peer comparison could be exemplified by the following reflection of a Director of Services: *'I suppose for you know when you were to compare the two different experiences, one being what was and one what can be, you know one is door is closing, the other is door is opening when we consider the concept of recovery and the involvement of the peer support specialist because they're in an active display of what a commitment can result in'* (PMVT DoS 1).

PSSs have an opportunity to exchange thoughts and techniques around self-care and resilience and aid the development of new coping behaviours among HF participants. PSSs often practice the provision of intentional support – providing further directions, beneficial for HF participants' recovery, empowerment and engagement:

'But again, someone who is through the system themselves would be probably better signposting somebody because they have been in a similar situation that they were in once and signposting to the areas that would be most beneficial for' (LA 2).

This sense of empowerment is also reflected through the provision of emotional and practical supports, where, *'[...] he would take the lads to the gym and he would do all that social side of things […]'* (PMVT SM 3). Identification of practical activities and adjustment to HF participants' needs, was seen as greatly beneficial in further independence and self-efficiency.

Impact on services

Insiders' perspective

Stakeholders emphasised that the unique role of a PSS provided multiple benefits for HF services and support staff.

Firstly, as was noted by the Director of Services, '*there is always the opportunity for our team to educate a peer support worker […] But equally for our peer supporter to provide, you know, and some lived experience to the team also'* (PMVT DoS 1). The mutual education between the PSS and other HF staff members can greatly benefit the PSS, the HF team, and, most importantly, the HF participants

themselves, as it enables all staff members to gain a better understanding of HF participants' needs and the supports required by them.

Secondly, the provision of an insider's perspective, allowed the HF team to gain genuine information on certain clients, their well-being and progress. As the Local Authority Representative revealed, *'When they (PSSs) report back to the service provider about how a certain client is getting on and that gives us the information as to what they are really getting on'* (LA 2).

Although PSSs were considered to be valuable assets to the HF team, a challenge to PSS integration into the HF team dynamic was also mentioned. As the Service Manager recalled, when he had previously worked with a PSS in another region, *'I remember getting a phone call off this particular participant. And asking was the peer support coming out instead of me one day and I said, well no, he's only out once a week. He links him with other people, whatever else, and he just didn't engage me at all, he kind of said: 'well, what would you know you haven't done that, and I want to link him with (peer supporter name) like uh, (peer supporter name) knows me better, (peer supporter name) done it before. You haven't done it'* (PMVT SM 3). A lack of 'insider knowledge' by the HF staff members, could potentially trigger negative reactions from the HF participants, where the HF staff's professionalism and expertise are being questioned. In turn, this could create negative effects on the relationships within HF service, where undermining the support provided by staff members could lead to negative effects on participants' recovery pathways.

Section 5: Key Challenges

Stakeholders in the Northeast region anticipated that three main categories of challenges could take place in PSS support provision within the HF sector.

Boundaries

Following the findings from previous discussions, Northeast stakeholders agreed that the establishment of boundaries was identified to be one of the main challenges. Considering that the role encourages PSSs to be open about their experiences and discuss personal aspects of their lives, issues of 'oversharing' and 'overinvestment' are cautioned to arise.

The establishment of boundaries between PSS and the HF participants was agreed to be essential, as the Director of Services indicated ,*'[...] the concept of them oversharing that may often be perceived as a supportive measure, but perhaps doesn't have the desired effect'* (PMVT DoS 1), followed by the Service Manager' reflection, *'I suppose when we think of the concept of being overly invested, what can happen is there can be the feeling of needing to fix something, but also to recognise that housing*

first is actually a journey.' (PMVT SM 3). Therefore, the stakeholders emphasised that receipt of appropriate training and supervision focused on boundaries would be greatly beneficial to all individuals involved in HF, including HF participants, PSSs, and HF service providers.

Risk of destabilisation

A potential challenge identified was the potential impact of the close contact between the PSS and the HF participants. Due to the nature of the engagement between the PSS and the HF participant, the challenges faced by the HF participant, may expose the PSS to a psychosocial environment which resembles their previous experiences. Being subject to vivid memories of former challenges and traumas could potentially trigger the onset of symptoms which may result in the destabilisation of the PSS.

'To put them back into a situation where they're facing people who are going through what they went through. Addiction is a lifelong thing. It's not something that just goes away after a particular period of time that there will be concern of them being drawn back into that world again' (LA 3).

The destabilisation of PSSs was seen as a significant challenge in the implementation of the PSS role. This could also negatively impact the HF participant, whom they were supporting, as their sense of hope and recovery may be damaged.

Practicalities of Role in Region

The stakeholders felt that HF Northeast services include a large geographical space, but with a lower population density than Dublin. Smaller communities can result in a greater risk of familiarity between PSSs and HF participants. The familiarity could have been by previously having direct contact with each other or due to previous socialisation within the same circles:

'Ireland's small I think if someone was to graduate from the Housing First programme, it would only be a matter of time before it gets a bit awkward' (PMVT SM 3).

Familiarity with PSS could potentially create challenges in developing a meaningful relationship with the HF participant, or it could serve as a barrier to the HF participant's receptiveness to the support offered.

The travel distance within the Northeast area was also discussed. It was anticipated that due to the geographical position, PSSs would often have to travel a much longer distance to accommodate meetings with the HF participants, which could potentially serve as a barrier to the frequency of the meetings, as well as added stress:

'That's essentially an hour and a half wasted of just driving like it is an awful lot of time on the road' (PMVT SM 3)

'[…] practicality and engagements on a daily basis of them of a peer support worker, sometimes travelling from one area to the other and the travel associated with that could potentially add an additional layer of commitment or perhaps stress that may impact them.' (PMVT DoS 1)

Section 6: Summary of Housing First Northeast Region

For a clear structure and brief summary of the key points within each topic of discussion for this region, please see Table 9 below.

Table 9. Summary of Housing First Northeast Region Results

Theme	Key Points
1. Nature of the PSS Role	• A ***lived expertise in addiction or homelessness*** is considered to be the main requirement for the PSS role. • Balancing ***self-regulation*** and ***self-awareness*** is highlighted to be necessary while undertaking the PSS role.
2. Recruitment	• Individuals with a ***history of substance abuse*** and ***previous graduates of HF programmes*** (with years of stabilisation and progression) are considered the most desirable candidates.
3. Supervision and Training	• ***Structured, mandatory, and regular*** supervision, led by ***internal*** and ***external*** supervisors is seen as essential for the role. • Training is suggested to be ***mandatory, well-structured, and monitored***, provided ***prior to*** and ***during the PSS employment*** contract. ***'Shadowing sessions'*** of previous PSSs and/or members of the HF support team are strongly encouraged. • Potential issues with maintaining boundaries should be reflected within supervision and training sessions.
4. Impact of the PSS Role	• The concept of ***'role model'*** is considered to make the greatest contributions to HF participant ***empowerment, self-efficacy,*** and ***further recovery.*** • ***PSS's knowledge*** and ***insights*** contribute to HF services by raising awareness of the needs of HF participants and gaining an in-depth understanding of the types of support required.
5. Key Challenges	• The main challenges identified to be are: establishing and maintaining ***boundaries*** in order to prevent 'oversharing'; the potential risk for ***destabilisation of PSS*** while supporting HF participants; and practical issues regarding ***travel*** between locations, and prior ***familiarity with HF participants***.

Chapter 6: Housing First Mideast Region

The following chapter examines key stakeholders' perspectives in the Housing First Mideast region on the implementation of the PSS role. Seven internal and external stakeholders were invited to attend, and six participants were present on the day (Table 10).

Table 10: Breakdown of the focus group participants

	Role	Pseudonym
PMVT service providers	Director of Services	PMVT DoS 2
	Head of Service	PMVT HoS 3
	Intensive Case Manager	ICM 4 ICM 5
	MDT	MDT 3
External stakeholders	HSE Social Care Worker	HSE 4
	Local Authority Representative	LA 3

Within this focus group, the nature of the required role, the recruitment pathways, and challenges were identified as key topics of relevance for the stakeholders involved. The results from the focus group discussions with key stakeholders are illustrated within four already established themes in the areas of 'Nature of the PSS Role', 'Recruitment', 'Supervision and Training', 'Impact of the PSS Role', and 'Key Challenges' (Table 11).

Themes are partially illustrated by participant quotes. Additional information from the focus group can be found in the Supplementary Text (Appendix VIb).

Table 11. Themes and subthemes

Theme	Sub-theme
1. Nature of the PSS Role	Experts by Experience Bridging the Gap
2. Recruitment	Pool of Applicants Pre-requisites Pathways of Recruitment
3. Supervision and Training	Supervision Structure

3. Impact of the PSS Role	Provision of Insider's Perspective Relationship Building Distribution of workload
4. Key Challenges	Boundaries Practicalities of Role in the Region

Section 1: Nature of the PSS Role

The nature of the PSS role was a prominent theme in this focus group. The current section highlights the characteristics and duties that would be required of a PSS in the Mideast region.

Expertise by Experience

The focal point of the stakeholders' discussion centred on the contributions that knowledge from lived expertise would bring to the HF infrastructure. The stakeholders illuminated the resources that would be available, and directly beneficial, to the HF participant cohort through the innate nature of the PSS role. For example, the Local Authority Representative for this region highlighted that *'I suppose the whole selling point here is somebody who's been through the system. This is somebody who has experienced this and who has in one way for, you know, been successful, at working through it, at getting through it'* (LA 3). A central characteristic of the role is to have a lived understanding of the current HF participant experience. The knowledge this would provide is an invaluable contribution to the HF dynamic.

Nonetheless, due to concerns on filling the role, the Mideast region stakeholders suggested that prospective PSSs would not necessarily need to have a direct experience of homelessness but could instead have a history of '*extensive poor mental health, history of chronic addiction or any other kind of trauma*' (PMVT HoS 3). PSSs do not necessarily need to have gone through homelessness services, but would have a lived understanding on certain elements of the participants' challenges.

With an emphasis on the impact a lived experience has on the role, it was also mentioned that a strong sense of self-awareness is required in – *'the preparation for them is as much as important as that of the client that they're going to go in and work with'* (HSE 4). An individual's abilities to self-monitor and implement self-regulation strategies is required for the role. This was further emphasised by the Health Service Executive Representatives stating, *'you are going back into the environment really that you might have seen yourself. You have to do an awful lot of recovery-based stuff to be very strong to go in, because elements of that with the client can remind people of their past. Although that could be very positive for some people, it can be very scarring and regression can happen as well'* (HSE 4). This

highlights that a significant characteristic required within the nature of the role is evidence of ongoing reflection, self-awareness and recovery maintenance strategies.

Bridging the Gap

The concept of bridging the gap in the Mideast regions was highlighted as a role in which the PSS would act as a link and support framework to meet the needs of participants who are stable and require less immediate and demanding supports from their PMVT ICMs.

As the Health Service Executive Representative summed up, *'the person that I would have called the peer support sweeper type role would see the clients that really might not get all the attention all the time. They would need to kind of just make sure everything's OK with them, maybe a cup of tea, maybe just come to some appointments that doesn't need intensive stuff, and I think that's badly needed.'* (HSE 4).

The requirements from the PSS role within the Mideast region centred on supporting the participants who are not in 'crisis mode' but require support in achieving small yet significant daily tasks. Although not urgent, the completion of these tasks contribute to overall improved wellbeing. The Local Authority Representative suggested that '*it's almost a hand holding thing for somebody availing of Housing First'* (LA 3). In this sense, the gap between facilitating the daily care of participants with lower demands, and the work requirements of the PMVT ICM can be met.

Section 2: Recruitment

Within this focus group, the recruitment of the PSSs was identified as a significant theme for the Mideast region. This theme highlighted that due to limitations in applicant availability, the pre-requisites and any proposed job-descriptions needed to be treated with flexibility and openness.

Pool of Applicants

The stakeholders highlighted significant potential limitations in available applicants for the role in the Mideast region. They suggested that, in contrast to Dublin, there is an even smaller pool of candidates with the required specific skillsets and willingness to take on the role.

'*I think that's going to be the real challenge because we can look at all of the adverts for peer support and we can have a really nice advert. But you know, if you don't get people applying for it, it's not going to be much use.*' (PMVT DoS 2)

The stakeholders felt that, while on the one hand, prospective candidates may be of the mindset *'I've come through a really difficult period in my life and I'm dying to get stuck in and work with people'*

(PMVT DoS 2), on the other hand, other potential candidates who have graduated from HF programmes have moved on and they're working in a field that would not put them back at risk in relation to their recovery. In addition to this, the Local Authority Representative highlighted that the PSS role is *'not something you can force on anybody'* (LA 3). The recruitment of a PSS requires careful planning, thought, and advertising, while taking into consideration the regional limitations that may exist. In order to recruit and fill the required roles the discussion moved onto expanding the scope of the job description and pre-requisites for the role.

Pre-requisites

In relation to pre-requisites for the role, it was mentioned that high educational attainments and a specific number of years in recovery are required for some advertised posts. It was suggested that for the Mideast region, this would significantly limit the abilities to recruit candidates, where the PMVT Director of Services mentions that '*I think we would find it very challenging in the regions to fill those roles if we were to go down that line*' (PMVT DoS 2). The stakeholders felt that there was a large variation in pre-requisites for previously advertised posts and that unattainable expectations for potential candidates within the region would limit the ability for the positions to be filled.

In line with the concept of pre-requisites, the type of person suitable for the role was discussed. Some of the stakeholders highlighted an emphasis on the lived experience qualities of the role, while others (mindful of potential difficulties that may exist with recruitment in the area) suggested that the role could be filled by someone with a passion and interest for the work. For example, as the Health Service Executive Representative suggested, '*the person that I would have targeted was somebody that just was interested in basically getting to know people from where they're at and didn't want the overall responsibility of having the case management or tenancy work or deal with the housing bodies when there was something going on because it preserved the relationship*' (HSE 4). The majority of stakeholders expressed a lived experience as a pre-requisite for the role, however, by widening the scope of potential candidates, the likelihood of the role being filled within the region increases.

A unique characteristic of a PSS identified for this region also centred on supporting participants engaged with the criminal justice system, where accompanying participants to court engagements would benefit the HSE and PMVT teams in managing their workload. The PMVT Head of Service highlights that *'it could really be a piece of work that a peer support worker could do and that's just to accompany this person to appointments. But it only means the accompaniment piece. It's not really a major advocacy piece'* (PMVT HoS 3). By having an additional team member responsible for the

companionship and accompaniment piece, other team members can direct their attention towards the clinical supports required for participants.

Pathways of Recruitment

The discussion on how PSSs could be recruited resulted in mixed views. For example, the Local Authority Representative strongly advised that the recruitment of a PSS be external to the local authority in the region, they say '*it complicates it, if it's coming within the local authority system*' (LA 3). However, due to the potential pre-requisites that would be needed for this roll (i.e., lived experience) and limitations on the pool of applicants, the Director of Services indicated, '*I think we're in a market where you don't put too many blocks and barriers on whether you're looking internally or externally'* (PMVT DoS 2). When the recruitment of PSSs is being considered, availability and access to a sample of potential recruits influences the nature of what the best approach to recruit the ideal candidate is.

Section 3: Supervision and Training

During the focus group, stakeholders were queried on what their perspectives were on the level of supervision and training they believed is required for the PSS role. First and foremost, the framework for supervision and training must be built on and reflect already existing successful frameworks where PSSs are used in other sectors of support. The Local Authority Representative for the region suggested that they should '*look at what system was – or what has happened already. We're not reinventing the wheel and there's a danger in doing it, I think. We need to learn from the experience of what's already there, what was already done'* (LA 3).

The stakeholders also emphasised how important it would subsequently be to ensure supervision is provided effectively and efficiently. The Director of Services affirmed this by highlighting that *'I suppose there's gonna need to be a very kind of tight support system in place around supervision*' (PMVT DoS 2).

Section 4: Impact of the PSS Role

Both internal and external stakeholders in this focus group discussed how involving the PSS role in the HF infrastructure would impact the staff, the services, and the nature of the working day.

Provision of Insider's Perspective

Possessing a wealth of personal experiences allowed the PSS to relate to an individual who is going through similar experiences. As a result, the PSS can provide unique insights and relay information on the participant's state of being to the HF team. For example, one Intensive Case Manager spoke about

how some participants felt as if the ICMs did not understand their current challenges thoroughly by mentioning that '*one participant in particular, would often say no offence or disrespect to what you're trying to do with me. But you don't understand what I'm dealing with right now,'* and the ICM recognised that '*I don't know first-hand what it feels like or what they're going through'* (PMVT ICM 4). As a result, the same Intensive Case Manager states that having an insider perspective would be *'very valuable'* (PMVT ICM 4). The PSS on a HF team would provide a deeper understanding on the internal mechanisms influencing participant wellbeing. The role of a PSS offered the HF infrastructure a unique opportunity to relate to the participant group.

Additionally, the lived experience was suggested to benefit the journey HF participants are currently undertaking. The Local Authority Representative mentions that, ideally, the role involves someone '*who's been through the system and can maybe encourage somebody if they feel that they're struggling if they feel they – they're not progressing, as maybe they thought they would at some stage'* (LA 3). The inside knowledge of the lived experience can act as a guide through times of stagnation and frustration in participant experiences with HF services. As such, the expertise PSSs can provide through their lived experience is considered a crucial element of the role in this region.

Relationship Building

The stakeholders also highlighted that PSSs are seen as a great addition to services, and their role allows them to bridge a gap between HF participants and other support workers. In the Mideast regions, for example, the PMVT stakeholders discussed their duality as the Approved Housing Body but also as the HF provider. With regards to this, the Director of Services mentioned that, for a variety of reasons, sometimes it is necessary for tenancies to be ended and it *'can be a tough one because you don't want to end peoples' tenancies*' (PMVT DoS 2). The Head of Service, in turn, highlighted that a PSS can make a significant contribution to maintaining the relationship between the organisation and participants, should the tenancy be terminated. They suggested that '*if we did have a peer support worker in place or a peer support specialist that they could be completing pieces of work in order to preserve the relationship of Peter McVerry Trust with the participants*' (PMVT HoS 3). The relationship building aspect of the role is crucial in supporting HF participants continued engagement with HF support services.

In addition to this, the Head of Service suggests how the relationship between the PSS and HF participant can be developed and maintained. They mention that '*you could have someone else delivering the messages around the tenancy sustainment pieces, complaints and antisocial behaviour, if there was any, and then the peer support worker doing totally different pieces of work so it would*

be very separate roles' (PMVT HoS 3). When tenancies are terminated, the PSS's role can contribute to a strong support framework in which the participant continues to engage with services needed.

Distribution of workload

When discussing the impact of the PSS on HF services, the stakeholders considered how and what tasks the PSS would undertake and how this could benefit the HF team. The Director of Services firstly expressed the contribution a PSS could make as '*having staff on the ground to have a lived experience of homelessness or addiction and I guess that's probably you know, it's great to have that support*' (PMVT DoS 2). The unique characteristics of the PSS role contributed to an additional support mechanism in which the HF team can utilise to best support the participants they engaged with.

The additional member of the team would also support the ICM in managing the day-to-day nature of their role. The Health Service Executive Representative suggested that the PSS '*would need to kind of just to make sure everything's OK with them (the participant), maybe a cup of tea. Maybe just come to some appointments that doesn't need intensive stuff, and I think that's badly needed*' (HSE 4). This highlighted that the distribution of the duties and responsibilities among the team is crucial, where '*it's about getting that balance really about what we want, what we want from the peer support, and what you know our clients want from peer support worker'* (PMVT DoS 2). The PSSs greatly contributed to reducing the demands on the HF infrastructure through providing an in-depth understanding of the participant experience, supporting the completion of important daily tasks and contributing to the redistribution and balancing of the workload for the entire team system.

Section 5: Key Challenges

The overarching challenges expressed for this region centred on the implementation of the PSS role within the region. *'I think our biggest challenge is really how we implement that not only in Dublin but also in the regions.'* (PMVT DoS 2). When the stakeholders expanded on this, they expressed that the main challenges for implementing a PSS would firstly centre on establishing boundaries required for the PSS with the HF participants, the HF team, and the local community. Secondly, the geographical spread of participants was identified as another significant challenge for the PSS role to function effectively.

Boundaries

Due to the limited HF services within this region, pre-existing relationships between PSSs and their potential HF participants or their extended family or friends may pose a barrier for the PSS role. '*Challenges that would come up would be the boundary piece and respecting the confidentiality and*

the dignity of the person, especially if the peer support worker is of the area that they're going to be working in.' (PMVT MDT 3). Stakeholders expressed that if potential candidates were identified from within the region, who have experience of homelessness (or related challenges such as addiction), they may need additional supports in setting strong boundaries with the HF participants. As the Multidisciplinary Team member pointed out, a PSS '*may be familiar with some of the participants already or might know a friend or someone*' (PMVT MDT 3). As a result, '*work would need to be done around just maintaining the confidentiality and the respect for the person at the centre of it all' (*PMVT MDT 3*)*. Implementing professional boundaries where they have not previously existed was identified as a significant challenge in effectively carrying out the PSS role within this region.

Practicalities of Role

The emphasis stakeholders expressed on recruitment demonstrated a desire to have the roll filled with appropriate candidates, yet an awareness of the limitations that pre-requisites for the role, and a small pool of applicants, can have on recruitment. One of the Intensive Care Managers highlights that '*I think we need to be realistic really about the types of potential candidates that might go for the role*' (PMVT ICM 4). In order to address the challenges to recruitment in the area, it was mentioned that pre-requisites, such as external or internal recruitment or high levels of education, should not limit eligibility to apply for the role.

In addition to this, the Local Authority Representative identified that the difficulties '*they (PSSs) are going to have, is linking up with different services'* (LA 3) and, building on this, the Local Authority Representative suggested that the PSS should have at their disposal knowledge on the right people to contact to provide the right type of tailored support for HF participants. For example, '*it's something simple like, well I call it simple, like finance or paying the rent or something like that, that's easy. But again, to have that contact for the more difficult ones, for maybe it's dual diagnosis or something maybe like that. It's the mental health supports. It's the addiction supports'* (LA 3). The Local Authority Representative indicated that, as a PSS would be an equal member of the HF team dynamic, they should have access to and be integrated into the HF communication infrastructure which would provide them with readily available expert knowledge to effectively support HF participants. The main challenge that emerged from conversations in the Midlands focus group centred on the resources and integration that would be needed to maximise the PSS impact on HF participants.

The final significant challenge mentioned for the practicalities of the role was identified as the distance between participant locations across all of the Mideast. Due to limitations in available infrastructure, such as public transport or availability of company cars, the practicality of reaching participants

becomes a significant challenge in fulfilling the role. *'Look, it's the challenges that all the staff are facing. You know you know the geographical spread of potential client groups*.' (PMVT DoS 2) As meeting with participants in person is integral to supporting participants' wellbeing and mitigating the potential impacts of loneliness and isolation, the large distances between participants' homes, and barriers to effective and efficient transport, are significant challenges in meeting the needs of participants and fulfilling the requirements of the role.

Section 6: Summary of Housing first Mideast Region

The table below provides a summary of the key points from each theme discussed in the Mideast region focus group (Table 12).

Table 12: Summary of Housing First Mideast Region Result

Theme	Key Points
1. Nature of Role	• Elements of a 'lived experience' related to homelessness are fundamental for the role. • ***Self-awareness*** and ***recovery maintenance strategies*** are essential for the role • The PSS role can ensure stable clients are ***engaged*** with at a ***continuous*** and ***consistent*** level.
2. Recruitment	• Serious ***concerns*** were highlighted on the ***availability of applicants*** to fill the role. • ***A direct experience of homelessness is not needed*** but experience of significant life challenge ***similar*** to that of the participants (***poor mental health, addiction or other trauma***) would be beneficial to the role.
3. Supervision	• The framework for supervision and training must be built on and reflect already existing successful frameworks where PSSs are used in other sectors of support.
4. Impact of PSS Role	• Through providing **an insider perspective**, **building relationships** and sharing **the workload of ICMs**, the PSS role has a significant positive impact on the HF infrastructure including on the HF participants, staff and the nature of the working day.
5. Key Challenges	• The challenges discussed were ***professional boundaries, integration into HF team dynamic*** and ***geographical spread*** of participants

Chapter 7: Housing First Midlands Region

This chapter focuses on Housing First in the Irish Midlands. The perspectives, experiences, and recommendations from a variety of key stakeholders are explored in relation to the implementation of a PSS programme in the region. Nine internal and external stakeholders were invited to attend and five related stakeholders were interviewed (Table 13).

Table 13. Breakdown of the focus group participants

	Role	Pseudonym
PMVT service providers	Director of Services	PMVT DoS 2*
	Head of Service	PMVT HoS3*
	Intensive Case Manager	PMVT ICM 6
External Stakeholders	HSE Representative Mental Health Nurse	HSE 5

**Both PMVT DoS 2 and PMVT HoS 2 are representatives of the Mideast and Midlands regions*

The results from the focus group discussions with key stakeholders are illustrated within four already established themes in the areas of 'Nature of the Role', 'Supervision and Training', 'Impact', and 'Key Challenges' (Table 14). The stakeholder voices on themes they found most prevalent are heard throughout the following pages. Further illustrating quotes can be found in the Supplementary Text (see Appendix VIb).

Table 14. Themes and subthemes

Theme	Sub-theme
1. Nature of the PSS Role	Bridging the Gap
2. Supervision and Training	Supervision Structure Training Elements
3. Impact of the PSS Role	Relationship Building Distribution of workload
4. Key Challenges	Practicalities of Role in Region

Section 1: Nature of the PSS Role

Both internal and external stakeholders involved with the PSS programme in the Midland regions reflected on what the purpose of the PSS role would be and what sort of candidate would be ideal for the role. All stakeholders recognised the value the role would bring to supporting HF participants in the region, with the Health Service Executive Representative emphasising that '*it is an invaluable*

resource that I'd be using, you know, on a daily basis' (HSE 5). The significance of the lived experience and bridging a gap were the prominent themes of discussion.

Bridging the Gap

When the concept of 'bridging the gap' in the Midlands was mentioned, the stakeholders' discussion featured elements with regards to the role of the PSS as a *'connection'* between the HF participant and the wider local community. By PSSs providing that additional personal support, an initial and crucially important stepping stone is reached with regards to participants' re-engagement into society The PMVT Director of Services proposed that '*just going to the gym or around. You know somebody helping into a new home and what that entails*' (PMVT DoS 2) was of great benefit. These initial stages can be instigated and supported through the PSS role, where the PSS acts as a pathway from the HF services back into the local community.

In the Midlands, while a PSS is not currently in place within PMVT HF services, both the internal and external stakeholders recognised the value this role brings and the unique characteristics that would benefit HF participants and the HF infrastructure within the region. With this in mind, the Director of Services also suggested that linking the PSS role with '*social prescribing*' (see Definitions) elements or personnel could further support the wrap-around supports available for HF participants. The Director of Services mentions that '*there's talk around social prescribing and doing that piece of work [*with potential PSSs*]'* (PMVT DoS 2). The awareness that a PSS would serve as a link to the wider community for HF participants highlights the necessity for the implementation of this role.

Section 2: Supervision and Training

The focus group conversations provided insight into the proposed nature of supervision and training that would be ideal for a PSS. The discussion centred on the supervision structure and the elements that should be included for effective training of a PSS.

Supervision Structure

Importantly, the Intensive Case Manager proposed that a prospective PSS should receive the same structure of supervision which all HF staff teams receive and pointed out that it should '*probably be the same as what I would get. So, my supervisions are once a month and its just kind of like what we're doing now. Just over zoom or over Microsoft Teams. Or something similar to that I suppose would work well'* (PMVT ICM 6). As a further means of supporting PSSs, stakeholders suggest that in addition to existing supervision frameworks, PSS support groups could be implemented where PSSs would all meet and share their experiences. As the Director of Service suggested, '*we do […] online supervision with staff teams, but I'm guessing the peer support staff probably need to come together as a group*

fairly regularly' (PMVT DoS 2). Creating a support network in which employed PSSs could share common experiences and support one another would be a great sustainable addition to pre-existing support frameworks within organisations.

Training Elements

The principal foundations considered when examining the training required for the PSS role centred on how best to support PSSs utilising the knowledge garnered from their lived experience and, transferring that awareness to the HF participant cohort. The Intensive Case Manager highlights this when mentioning, *'I think training definitely would be beneficial, but I feel like life experience has a lot to do with it'* (PMVT ICM 6). At the core of developing training for PSSs should be the recognition of pre-existing skillsets and knowledge that come from the lived experience.

Similar to the supervision, in order to facilitate appropriate training to maximise the strengths of PSSs' skillsets, stakeholders mention that basic training in line with that of those on the HF team would be beneficial. These include areas such as managing challenging behaviours and training in addiction. With this in mind, the Intensive Case Manager mentions that '*no one wants to be an addict, like, you know, it's kind of just something that consumes them, you know. Just training in relation to like kind of handle people who are going through addiction and things like that as well'* (PMVT ICM 6). In line with organisational standards and ethos, by ensuring basic staff training is available to prospective PSSs in the role, a high-quality standard of care for HF participants is assured.

Section 3: Impact of the PSS Role

Following on from the discussion on the training and supervision, the impact this role may have on the participants, HF teams, and the wider local community was addressed. The stakeholders expressed their views in relation to what a lived experience brings to the team dynamic, how PSS engagement with participants contributes to participants developing enhanced levels of trust with the PMVT organisation, and how PSS work interweaves into the wrap-around support framework instrumental to the efficiency of the HF programme.

Relationship Building

A crucial element that the PSS role influenced was the HF interactions with participants. It was highlighted by the stakeholders that the lived experience of a PSS would potentially help establish and maintain relationships with HF participants.

The Intensive Case Manager suggested that relationship-building is essential for the PMVT HF team and mentions that '*just in my experience, like some of them (HF participants) would tell you their whole life story with the first time meeting them. But then there's others that are only starting to come around to me now, and I suppose that's completely understandable, because it does take time to just build up that trust and stuff'* (PMVT ICM 6). A PSS can support the development of secure attachments with HF participants in order to support all their needs being met with openness and clarity.

In addition to this, the unique relationships that can be built between PSSs and HF participants can support HF participants in establishing and maintaining healthier life choices. The Director of Services emphasises that the role '*is desperately needed in relation to support our tenants in Housing First*' (PMVT DoS 2). With this in mind, the Intensive Case Manager also reflected that a PSS can '*kind of help them focus on whatever it is they're hoping to achieve. And I just feel like the more people that are linked in with them, the better'* (PMVT ICM 6). The role-modelling elements that are embedded in the PSS role can provide guidance on how HF participants lead their lives.

Distribution of workload

Having an additional HF team member who can focus on inspiring and motivating HF participants creates increased opportunities for the HF team to enhance the individualised and tailored care provided to the participants.

You have to kind of test the field like one thing might work for someone and it might not work for another individual like everyone's different. Uh, so you kind of have to just test things out.' (PMVT ICM 6)

By including a PSS on the HF team, the HF goals to support individuals out of homelessness can be actualised and result in enhanced participant wellbeing and healthier life choices.

Section 4: Key Challenges

With regards to identified challenges to fulfilling the PSS role, a variety of stakeholders discussed how the role would be shaped into the HF mould within the Midlands. The additional practical supports that would be needed to be put in place were identified as significant but resolvable challenges.

Practicalities of Role

In order to provide the best quality of care to the HF participants, the HF infrastructure is formatted as a multi-disciplinary dynamic. The expert knowledge and strengths of each team member is central to providing efficient and effective care. The stakeholders in this focus group suggested that inserting a new and novel element to the multi-disciplinary dynamic will be a challenge.

Section 5: Summary of Housing First Midland Regions

For a brief summary of the key points discussed within each theme, please see Table 15 below.

Table 15: Summary of Housing First Midland Region Results

Themes	Key Points
1. **Nature of the Role**	• ***A lived understanding of the current HF participant experience*** is essential for the role. • Through supporting HF participants in attending activities in the local community, the role serves as ***mechanism in which the HF participant can re-engage with society***
2. **Supervision and Training**	• ***Structured supervision*** that is ***integrated into the working week*** is essential for the role. • Training for PSSs needs to ***recognise pre-existing skillsets and knowledge*** that come from the lived experience.
3. **Impact of the PSS Role**	• The role contributes to participants ***developing strong and stable relationships with HF staff,*** supporting overall ***wellbeing***. • ***Wrap around supports*** can be enhanced and further *tailored* to participants needs when PSSs are involved
4. **Key Challenges**	• Key challenges identified are in ***embedding the PSS role into the HF communication infrastructure***

Chapter 8: Summary of PSS Role and Impact

The present report aims to gain an in-depth understanding of the PSS role and assess the perceived effectiveness of implementing the PSS programme. This is done to inform the development of a potential PSS Toolkit and organisational structure for supporting, embedding, and expanding the PSS role within HF.

For that purpose, 35 individuals, including 8 HF participants and 27 stakeholders across HSE, LA, and PMVT sectors were consulted. The consultations were carried out in late December 2022 and early January 2023 across four regions including Dublin, Northeast, Mideast and Midlands. A survey and a series of focus groups were utilised as the main methods of data collection.

Overall, the feedback from the stakeholders highlighted the importance PSSs on the lives of the HF participants and services overall. It was emphasised that a lived experience pertaining to the areas of substance abuse, mental health disorders, and/or homelessness serves as a main facilitator in offering support on a range of practical, social, and emotional issues to HF participants.

Section 1: Benefits to HF participants

The PSS role was primarily seen as a role model figure with an amplified benefit for HF participants. As a role model, PSSs employ their own experience and knowledge to provide opportunities for observational learning and further empowerment of HF participants' self-sufficiency and reintegration into society. PSSs also apply this experiential knowledge to form relationships founded on respect, shared responsibility, and a mutual agreement on what is helpful. These relationships allow PSSs to provide a variety of supports tailored toward the individuals they work with.

The supports provided by PSSs is summarised into two broad categories: emotional and practical support.

Emotional support

Emotional support is practiced through companionship and befriending, where PSSs communicated empathy and compassion to develop deep bonds with HF participants. HF participants often experience isolation and loneliness and find it difficult to re-engage with society. Therefore, the provision of emotional support further enables HF participants to feel accepted, respected, cared for, and motivated in establishing and reaching their goals. The emotional support also allows HF participants to enhance their self-esteem, confidence, efficacy, belonging, and social functioning.

Practical Support

Practical supports involved the provision of tangible day-to-day support, including attending scheduled appointments and activities, shopping and paying bills. The purpose of this is to help HF participants cope with immediate needs and isolation. The application of a tailored approach by PSSs directs HF participants towards making healthier life choices. This includes engaging in activities and hobbies of particular interest to the participants, as well as getting out for coffee or attending gym sessions. As a result, this type of support helps with re-engagement into society and the creation of social networks. This is considered to support the development of self-efficacy, social skills, and coping for HF participants.

Section 2: Benefits to HF Services

Throughout the regions there was a general consensus that PSSs contribute a wealth of additional knowledge and understanding of the HF participants, which as a result, significantly enhances the effectiveness of the HF service provision. The main mechanisms through which the role benefits services are in its capability to bridge gaps and provide an insider perspective.

Bridging the Gap

The PSSs' role and involvement are acknowledged as a great asset to HF and the Irish homelessness sector. The most valuable contribution to HF services' is identified as being able to 'bridge the gap' in two formats. One as a link between service providers and HF participants and two, as a connection between HF participants and the local community. The PSS role contributes to the much-needed additional level of wrap around supports. Through bridging these gaps, PSSs enhance the promotion of participant re-engagement into society, well-being and stabilisation too.

Insider Perspective

A unique and significant benefit that a PSS contributes to the HF infrastructure is an insider's perspective. An in-depth understanding of the needs of HF participants can be communicated to other HF support team members. PSSs provided insight and understanding to service providers into the lived experiences of HF participants. HF teams also benefit from seeking advice from PSSs on practical issues such as the mood of participants and when to engage with them on sensitive topics if needed. Essentially, PSS improved the connection between service users and service providers.

Chapter 9: Recommendations

In line with the aims of this report, the recommendation section sets out to highlight the future directions to best support the recruitment and effective implementation of the PSS role across the regions. All stakeholder views are considered and the resulting recommendation format is as follows:

1. **Recruitment**
    a. **Prior Experience**
    b. **Pathways of Recruitment**
2. **Employment**
    a. **Payment**
    b. **Training**
    c. **Supervision**
3. **Practical Supports in Role**

Recruitment of the PSS

All stakeholder focus groups highlight that a certain degree of lived experience relevant to the challenges faced by HF participants should be a mandatory requirement for the peer support role. These include experiences of homelessness, addiction, poor mental health or any other form of trauma. All HF participants also felt more willing to engage with PSSs due to this lived experience. However, mixed perspectives where prevalent on qualification requirements and recruitment pathways.

Prior Experience

In addition to experiential knowledge, the Dublin region stakeholders suggest that a successful candidate should also have a formal educational qualification. Individuals are recommended to have achieved a level 5 awards (NFQ5) or higher in fields related to the role such as social care, mental health or addiction studies.

With regards to the Northeast, Mideast, and Midlands regions concerns were highlighted about the availability of applicants. As such, it is suggested that educational qualifications should be seen as a desirable criterion rather than a pre-requisite for the role. Potential applicants who do not hold educational qualifications could be supported in relevant training courses (such as in IT skills and report writing) prior to beginning and during the PSS role (see *Training Section).* This would allow a candidate to be equipped with the required additional skills needed to fulfil the role.

Additionally, due to the lack of public transport infrastructure outside of Dublin, an essential recommendation would be for a PSS is to have a full clean drivers' license.

Pathways of Recruitment

Stakeholders across the regions considered both internal and external avenues of recruitment.

The internal recruitment pathway is suggested to target employing an individual who previously utilised the services within the organisation or was accommodated in a HF property and therefore considered to be a graduate of the HF program. The benefits of internal recruitment are organisational familiarity with the candidate, as well as recognition and awareness of the specific skills and knowledge that could be brought into the role, and the types of support that could be provided.

Significant strengths in external recruitment are also mentioned. By considering external candidates, a larger pool of applicants with a wider range of suitable training, qualifications, and experiences would be available. At the same time, external recruitment would guarantee impartiality and fairness, with the benefits of promoting transparency and equality throughout the process. The public advertisement of the position would allow the most appropriate candidate to apply for the role.

While Dublin stakeholders preferred internal recruitment, the stakeholders outside of Dublin suggested a preference for external candidates. This was mainly due to potential challenges that can arise from pre-existing relationships with the organisational staff and local communities.

Summary of Recruitment Recommendations

Prior Experience

- A pre-requisite for the role must be a lived experience related to that of current HF participants, including homelessness, mental health, and/or addiction.
- With regards to educational qualifications, it is advised to maintain flexibility around the level of attainment. A NFQ5 or higher is desirable but may not be essential.
- Potential candidates can be supported in developing skills required prior to initiating the role.
- Relevant areas of study include social care, addiction, and mental health
- Not all posts require a drivers' license, however it is strongly advised and would require a full clean driver's license.

Pathways of Recruitment

- Support internal and external recruitment of PSS candidates would allow the most appropriate candidate to be assigned to the position

Employment of the PSS

PSSs possess a wealth of knowledge and experience, and the importance of their role must be acknowledged within their work environment recommendations regarding PSS employment are categorised into three main areas: 'Recognition and compensation', 'Training' and 'Supervision and Support'.

Recognition and compensation

Stakeholders suggested that PSSs should be entitled to fair and equal treatment in the workplace, including recognition of their role, achievements, and overall contribution to the organisation and HF participants. It was strongly emphasised that PSSs should not undertake the role of a volunteer, rather they need to be employed as equal members of the HF multidisciplinary teams. Their experience and knowledge, as well as emotional and practical investment in their work, should match the pay scale of their colleagues and other professionals working in the area. An appropriate payment, recognition, and entitlements would improve PSS job retention, and allow further support and affirmation of their own recovery.

Training

Enrolment in the training programmes prior to and during the commencement of the PSS's employment is necessary to learn new required skills and update knowledge on supports needed by HF participants. Prior to undertaking the role of the PSS, adequate training should be provided to facilitate familiarisation with the HF IT and communication software, as well as relevant psychosocial and practical skills training that is provided to all staff. For PMVT, this includes training modules such as 'boundary training', 'managing challenging behaviour ', and 'Naloxone training'.

Once employed, two modes of training should be offered to PSSs: continued in-house training modules available to all support staff and additional training modules focused on support tailored to HF participants' needs. Materials for the training courses must be highly relevant to HF participants, focusing on the further development of PSSs' psychosocial skills (including Trauma Informed Care, Mental Health, and Motivational Interviewing training). Additional training specific to the PSS role should be considered, where PSSs would receive instructions on roles, boundaries, confidentiality, and safeguarding. Stakeholders suggests that, ideally, this training would be facilitated by an experienced PSS.

In this respect, the employment of peer support workers may create new opportunities for learning and development for departments within an organisation to work collaboratively with peers in developing and delivering training to a variety of support staff members. The provision of structured

training courses regarding the length of training, frequency, and type of training received was suggested. Greater attention should be placed on future directions. The expansion of the training curricula would provide greater possibilities in PSSs' career paths and further empowering and enhancing their prospects for employment.

Supervision and support

As highlighted, supervision and support mechanisms are considered to be imperative for successful peer support. The provision of structured supervision is seen as best practice across all regions. Currently within PMVT HF, supervision is available on a weekly and monthly basis. The supervision is facilitated during one-on-one and team meetings. Supervision is necessary in order to allow space and time for all concerns, issues, and dilemmas to be addressed and alleviated appropriately. The supervision methods should incorporate PSSs' individual needs, as well as exercise a tailored approach. Structured supervision with both internal and external personnel, with dedicated sources and time is highlighted as the main avenue in providing comprehensive means for PSS support.

In addition to structured and organised supervision, an external stakeholder in the Midlands region suggests the development of a PSS support group where PSSs across a variety of HF teams can meet to share their own experiences and lean on each other for support. This would especially benefit incoming PSSs who can be supported by experienced PSSs from other regions in the new role.

Going forward it was seen as beneficial to establish a manual on the specific nature of PSS supervision.

Summary of Employment Recommendations

Recognition and Compensation

- Appropriate salary reflecting recognition of skills and knowledge and on the same pay scale as other support professionals in the area

Training

- Provision of training programmes prior to and post commencement of PSS employment
- Availability of the training modules provided to all support staff members
- Delivery of training programmes focused on the development of PSS's psychological and practical skills, including Trauma Informed, Mental Health, Motivational Interviewing, First Aid, Harm reduction, and Naloxone training
- Establishment of future training directions focused on the empowerment of PSS and enhancement of their professionalism and employability
- Development of a framework for PSS training programme guided by experienced PSSs outlining training components, delivery, requirements, and prospects

Supervision

- Establishment of structured supervision where all the issues regarding challenges, boundaries and dilemmas can be addressed
- Provision of a variety of supervision methods, including internal and external one-on-one and group support meetings
- PSS peer groups across regions would support new PSSs in their roles
- Development of a manual for PSSs supervised support

Practical Supports in the Role

The information garnered from current PSSs in the role and HF participants engaging with PSSs have shaped how practical elements of the role can be supported and improved. These include the transportation infrastructure and time spent with participants

Transport

In all regions, the role requires significant time travelling between HF properties. For the Dublin region this involves public transport, for the other regions organisational transport must be facilitated. Both the PSSs and HF participants recommend that a company car be allocated exclusively to the PSSs. The benefits of this includes reduced travel time between HF participant locations and an increased range of potential activities that PSSs can attend with HF participants.

Due to the nature of the work organisations such as PMVT engage with, stigma surrounds the public perception of those engaged with the services. As such, all stakeholders involved in the discussion emphasise the need for discretion in working with HF participants and propose that any organisational transport provided be unbranded. This is to protect the anonymity of HF participants within the local communities they live in.

Time with Participants

The majority of HF participants contacted for this report requested that they receive more visits and longer time with their PSSs. In addition to improving transport, quality time with PSSs can be improved or ensured through firstly having a small PSS to HF participant ratio. The benefits of PSSs having a small number of HF participants to cater for allows for more time to be spent at each scheduled appointment and an enhanced ability for PSSs to dedicate time to organising and facilitating tailored activities and events for the HF participants.

Secondly, participant time with PSSs can be improved through ensuring communication on scheduled visits is clear and effective. Due to the significant travel time that is needed in the regions, scheduling routine weekly time slots is recommended. In addition, reminding HF participants of scheduled appointments prior to the agreed upon time, will be essential in guaranteeing their attendance and facilitating time spent with their PSS.

Summary of Practicalities of Role Recommendations

Transport

- Where possible, an unbranded company car should be exclusively allocated to the PSS in the region

Time with Participants

- Small PSS to HF participants ratios are advised to support quality time and engagement.
- Routine weekly time slots and sending reminders to participants is advised to ensure HF participant attendance.

Chapter 10: Conclusion

The present report aimed to provide insights into the nature of peer support within the homeless sector and further contribute to understanding the impact PSSs can on HF participants and services. In order to facilitate this, a survey and focus group consultations were administered with a variety of stakeholders. Both internal PMVT and external HSE and LA stakeholders contributed their extensive knowledge of the PSS role and/or experience working with a PSS and demonstrated the benefits and effectiveness of implementing the PSS role within the HF programme.

Peer support was identified as an effective approach which can have significant positive impacts on:

- HF participants – provision of emotional and practical assistance from PSSs helps HF participants to improve their quality of life, re-integrate into society, and engage with services and supports.
- HF services – support provided PSSs complements and enhances the knowledge and ability for professionals working in HF services to ensure tailored supports and practices. PSSs can also help in sharing workload of frontline staff.
- PSSs themselves – whereby practicing the role, PSSs have an opportunity to support the change in the lives of their peers, to further develop interpersonal skills, and gain greater recognition of their role and value.

From the findings of this report, the development of structured guidelines for PSS recruitment, training, monitoring, and supervision are recommended. In order to support the engagement, promotion, and integration of peer support within HF, this report identified the requirements for a well-structured and tailored supervision, combined with training sessions relevant to homelessness, substance misuse, and mental health, required for the PSS role. The guidelines would also aid to identify and address any further challenges associated with peer support.

The development and implementation of peer-led ongoing support programmes could be a central force in driving transformation in the homeless sector, reaching a fundamental realignment between an individual – support services- organisation, and ensuring the highest quality of person-centred care.

Bibliography

1. Mead S, Hilton D, Curtis L. (2001). Peer support: A theoretical perspective. *Psychiatr Rehabil J*, 25(2):134–141.
2. Health Service Executive [HSE]. (2021). HSE social prescribing framework. Mainstreaming social prescribing in partnership with community & voluntary organisations. Dublin: Health Service Executive.
3. Tracy K, Wallace SP. (2016). Benefits of peer support groups in the treatment of addiction. *Substance abuse and rehabilitation*, 7:143.
4. Bagnall AM, South J, Hulme C, Woodall J, Vinall-Collier K, Raine G, Kinsella K, Dixey R, Harris L, Wright NM. (2015). A systematic review of the effectiveness and cost-effectiveness of peer education and peer support in prisons. *BMC Public Health*, 15(1):1-30.
5. Repper J, Carter T. (2011). A review of the literature on peer support in mental health services. Journal of mental health, 20(4):392-411.
6. Barker SL, Maguire N. (2017). Experts by experience: peer support and its use with the homeless. *Community mental health journal,* 53(5):598-612.
7. European Federation of National Organisations working with the Homeless [Feantsa]. 2015. Peer Support: A Tool for Recovery in Homelessness Services. Brussels: Feantsa.
8. Miler JA, Carver H, Foster R, Parkes T. (2020). Provision of peer support at the intersection of homelessness and problem substance use services: a systematic ‘state of the art’review. *BMC Public Health*, 20(1):1-8.
9. Jacobson N, Trojanowski L, Dewa CS. (2012). What do peer support workers do? A job description. *BMC health services research*, 12(1):1-1.
10. Cyr C, Mckee H, O’Hagan M, Priest R. (2016). Making the case for peer support. *Ment Heal Comm Canada*, 16.

Appendix I: Participant Survey

Peer Support Specialist Consultancy 2022

Dear Participant,

We are doing a Housing First feedback survey on peer support, where we want to hear your opinions and experiences on the supports and services you receive from your Peter McVerry Trust Peer Support Worker.

This survey will take approximately 7 minutes to fill in.

All information you provide will be kept anonymous and confidential. Your answers will be used to write up a report for the Dublin Region Homeless Executive. We will ask for some personal details such as your gender, age, and previous years in homelessness for statistical purposes, however you are not obliged to share any information you do not want to share.

Your participation in the survey is your choice and you are not obligated to take part. Not participating in this survey will have no impact on the services you receive. Once you have finished the survey, the data will be kept private and confidential and will be deleted after 2 years or after final publication of the report, whichever is sooner. It may be possible that the information you provide will be used in future studies in a completely anonymized format, meaning no one will be able to identify you through it. If you have any concerns or questions,

- I understand the information above
- I consent to take part in the survey

Section 2: Demographic Profile

Q2.1 What is your gender?

- Male
- Female
- Transfemale
- Transmale
- Other (Please specify) ____

Q2.2 Age:

- 18 - 25
- 26 - 34
- 35 - 44
- 45 - 54
- 55 - 64
- 65 - 74
- 75+

Q2.3 What is your main employment status?

- Full-time employment
- Part-time employment
- Training and education
- Disability
- Full-time parent/caregiver

- Jobseeker
- CE Scheme
- Prefer not to answer
- Pension
- Unemployed
- Unknown

Q2.4 Prior to using Housing First services, how long had you been homeless?

- Less than 6 months
- 6 months - 1 year
- 1 - 2 years
- 2 - 5 years
- 5+ years

Q2.5 How long have you been using Housing First services?

- Less than 6 months
- 6 months - 1 year
- 1 - 2 years
- 2 - 5 years
- 5+ Years

Q2.6 How long have you had a peer support worker?

- Less than 6 months
- 6 months - 1 year
- 1 - 2 years
- 2 - 5 years
- 5+ years

Q2.7 In the past month, how often have you and your peer support worker been in contact (text, phone, meet in person)

- Once a month
- 2 to 3 times a month
- Once a week
- 2 to 3 times a week
- 4 to 5 times a week
- 7+ times a week
- We haven't been in touch

Q2.8 What is your main form of contact?

- In Person
- Phone calls
- Text messages

Section 3: Peer - Participant Relationship

Q3 Please think about the support you receive from your peer support worker: To extent do you agree or disagree with the following statements?

	Strongly Agree	Some what Agree	Neither Agree nor Disagree	Some what Disagree	Strongly Disagree
As a result of meeting with my peer support worker, I am clearer as to how I might be able to change	○	○	○	○	○
Working with my peer support worker gives me new ways of looking at any problems I have	○	○	○	○	○
I believe my peer support worker likes me	○	○	○	○	○
My peer support worker and I collaborate on setting goals for my support	○	○	○	○	○
My peer support worker and I respect each other	○	○	○	○	○
I believe the way we are working with my problem is correct	○	○	○	○	○
I feel that my peer support worker appreciates me		○	○	○	○
My peer support worker helps me stay out of trouble		○	○	○	○
My peer support worker and I agree on what's important for me to work on		○	○	○	○
I feel my peer support worker cares about me even when I do things that they do not approve of.		○	○	○	○

I feel that the things I do with my peer support worker help me to accomplish the changes I want	○	○	○	○
My peer supporter and I have established a good understanding of changes that would be good for me	○	○	○	○

Section 4: Healthy Behaviours

Q4 Do you think you are doing more healthy things since you started engaging with your peer support worker?

- ○ Yes
- ○ No
- ○ Unsure

Q4.1 If yes, can you list some of the healthy things you now do?

____

Section 5: Life Skills

Q5 Does your peer support worker help you manage things going on in your life? (e.g. stress, money management, shopping)

- ○ Yes
- ○ No
- ○ Unsure

Q5.1 If yes, what kind of areas/things does your peer support worker help you with?

____

Q30 Since you started engaging with your peer support worker, have you looked for any other sources of support (e.g. more programmes, agencies, people)?

- ○ Yes
- ○ No
- ○ Unsure

Q31 If yes, what sort of additional supports are you engaging with?

____

Section 6: Mental Health

Q6 Do you think having a peer support worker has helped your mental health?

- ○ Yes
- ○ No
- ○ Unsure

Q6.1 If yes, in what way?

____

Section 7: Overall Experience with Peer Support Worker

Q7 Do you attend any of the following activities with your peer support worker? (Please tick all that apply)

- Social Clubs (men's sheds, arts/crafts)
- Community Centres
- Coffee Shops/Eating out
- Leisure Centres/Gym
- Library
- Cinema
- Spiritual/Religious Worship
- Cultural Events
- Classes (e.g. cooking, yoga, mindfulness)
- Other Activities (Please Specify)

____

Q7.1 Would you like to receive any additional support from your peer support worker?

- ○ Yes
- ○ No
- ○ Unsure

Q7.2 If yes, how would you like to receive additional support from your peer support worker?

____

Q7.3 Please think about the support you receive from your peer support worker: To extent do you agree or disagree with the following statements?

	Strongly Agree	Somewhat Agree	Neither agree nor disagree	Somewhat Disagree	Strongly Disagree
The services I receive from my peer support worker help me deal more effectively with my problems	○	○	○	○	○
If my family or friends had a similar need, I would recommend they have a peer support worker	○	○	○	○	○

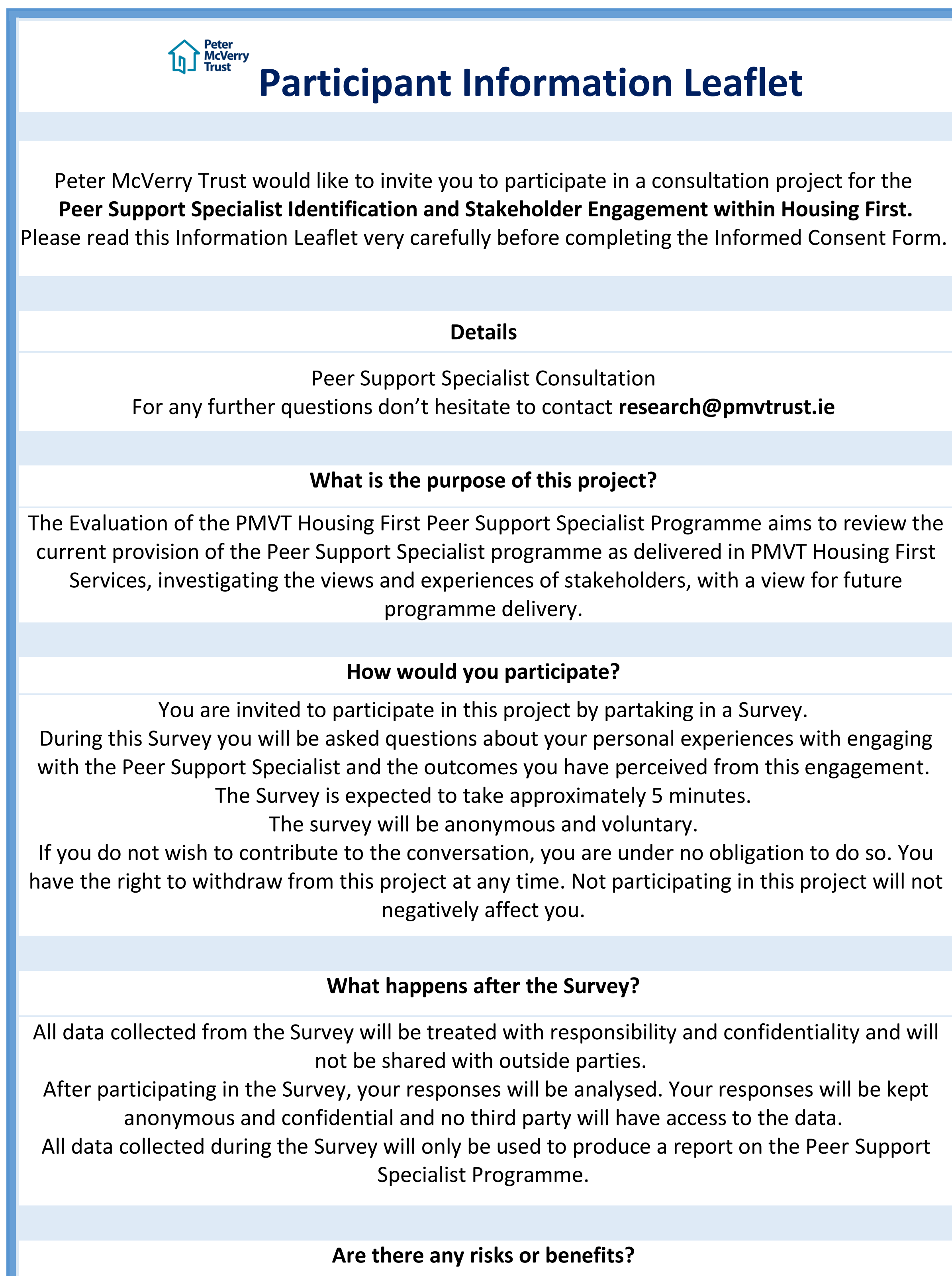
I feel better after being with my peer support worker	○	○	○	○	○
Overall, I am satisfied with the amount of support I receive from my peer support worker	○	○	○	○	○

End of Survey

The PMVT research team really appreciate the time you have taken to fill this out, thank you for participating.

Appendix II: Survey Information Sheet

a. Participant Information Sheet



Participant Information Leaflet

Peter McVerry Trust would like to invite you to participate in a consultation project for the **Peer Support Specialist Identification and Stakeholder Engagement within Housing First.** Please read this Information Leaflet very carefully before completing the Informed Consent Form.

Details

Peer Support Specialist Consultation
For any further questions don't hesitate to contact **research@pmvtrust.ie**

What is the purpose of this project?

The Evaluation of the PMVT Housing First Peer Support Specialist Programme aims to review the current provision of the Peer Support Specialist programme as delivered in PMVT Housing First Services, investigating the views and experiences of stakeholders, with a view for future programme delivery.

How would you participate?

You are invited to participate in this project by partaking in a Survey.
During this Survey you will be asked questions about your personal experiences with engaging with the Peer Support Specialist and the outcomes you have perceived from this engagement.
The Survey is expected to take approximately 5 minutes.
The survey will be anonymous and voluntary.
If you do not wish to contribute to the conversation, you are under no obligation to do so. You have the right to withdraw from this project at any time. Not participating in this project will not negatively affect you.

What happens after the Survey?

All data collected from the Survey will be treated with responsibility and confidentiality and will not be shared with outside parties.
After participating in the Survey, your responses will be analysed. Your responses will be kept anonymous and confidential and no third party will have access to the data.
All data collected during the Survey will only be used to produce a report on the Peer Support Specialist Programme.

Are there any risks or benefits?

There are no risks associated with participating in this project. All questions posed throughout the Survey will focus on your personal experiences with the Peer Support Programme and you will be asked to share only as much as you are comfortable with.

There are no direct benefits associated with participating in this project; however, by participating in this project, you are contributing to the ongoing quality assurance of our supports and services.

For any further questions about your participation in this project, please contact **research@pmvtrust.ie**

Stakeholder Information Leaflet

Peter McVerry Trust would like to invite you to participate in a consultation project on the **Peer Support Specialist Identification and Stakeholder Engagement within Housing First.** Please read this Information Leaflet before completing the Informed Consent Form.

What is the purpose of this project?

The project aims to review the current provision of the Peer Support Specialist programme within Housing First Services, investigating the perspectives and experiences of stakeholders, with a view for future programme delivery.

How would you participate?

You are invited to participate in this project by partaking in a Focus Group.
During this Focus Group you will be given the opportunity to speak openly about your views of and experiences with the Peer Support Programme alongside other PMVT HF Representatives.
The Focus Group is expected to take between 30 to 90 minutes.
During the Focus Group you and the other participants will be able to have a guided conversation about the Peer Support Programme.
The conversation will be recorded. The recording of the Focus Group will be treated with responsibility and confidentiality and will not be shared with outside parties.
If you do not wish to contribute to the conversation, you are under no obligation to do so. You have the right to withdraw from this project at any time. Not participating in this project will not negatively affect you.

What happens after the Focus Group?

After participating in the Focus Group, the recording of the conversation taken during the Focus Group will be transcribed and pseudonymised. The recording will be deleted and only the pseudonymised transcript will be used for the completion of the project.
All data collected during the Focus Group will be used to produce a report on the Peer Support Specialist Programme.

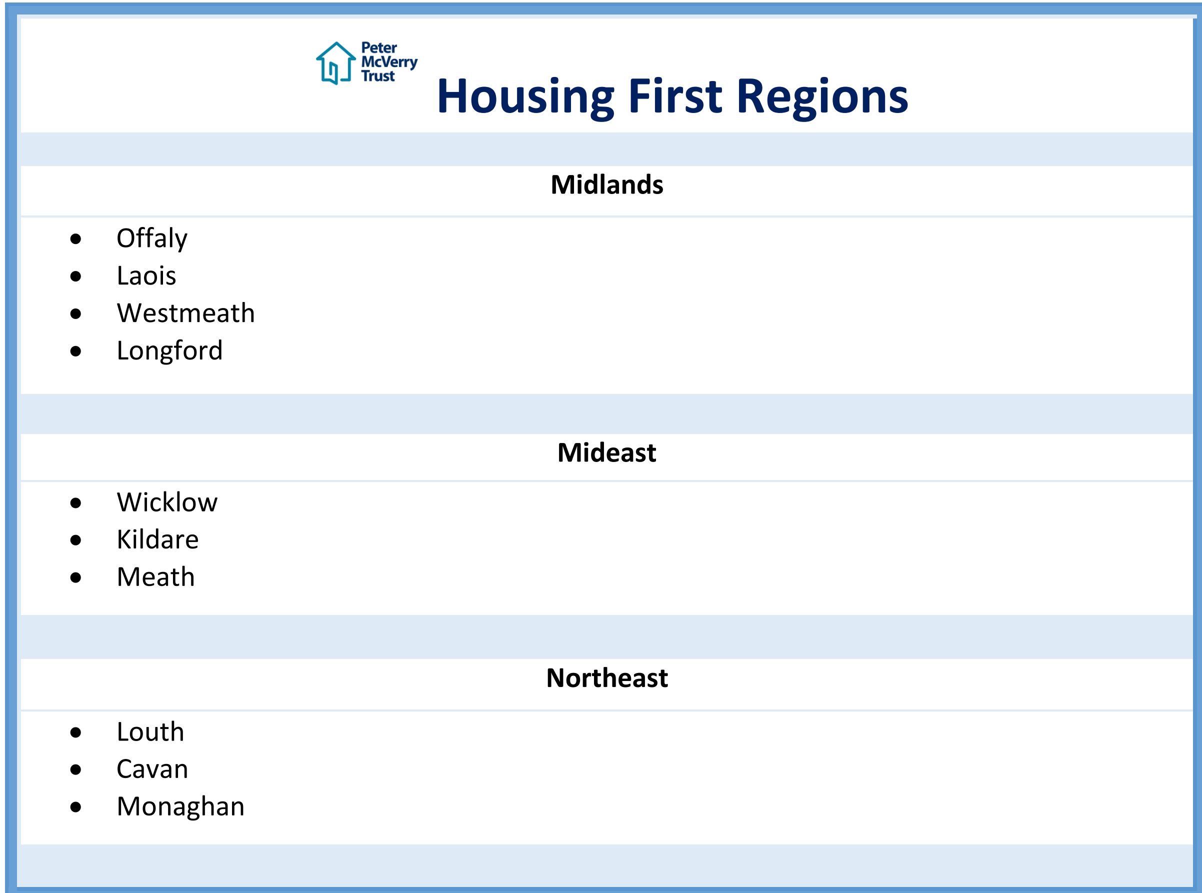
Are there any risks or benefits?

There are no risks associated with participating in this project. All questions posed throughout the Focus Group will focus on your personal opinions on the Peer Support Programme and you will be asked to share only as much as you are comfortable with.
There are no direct benefits associated with participating in this project; however, by participating in this project, you are contributing to the ongoing embedding, and expanding the PSS programme within HF and the inter-agency landscape.

For any further questions about your participation in this project, please contact **research@pmvtrust.ie**

b. Stakeholder Information Sheet

Appendix III: Housing First Regions



Housing First Regions

Midlands

- Offaly
- Laois
- Westmeath
- Longford

Mideast

- Wicklow
- Kildare
- Meath

Northeast

- Louth
- Cavan
- Monaghan

Appendix IV: Consent Form

Informed Consent Form

Peter McVerry Trust would like you to participate in our consultancy project titled **Peer Support Specialist Identification and Stakeholder Engagement within Housing First.**
Please read the provided information leaflet before completing this consent form.
If you have any question about this research study, please do not hesitate to ask the researcher.

Please tick the appropriate box for **each** of the statements below. It will be assumed that unticked boxes mean you **DO NOT** consent to that element of the study.

I have read and understood the **Information Leaflet** about this project. The information has been fully explained to me and I have been able to ask questions, all of which have been answered to my satisfaction.	**Yes** ϒ□	**No** ϒ□
I understand that I don't have to take part in this project and that I can opt out at any time. I understand that I don't have to give a reason for opting out.	**Yes** ϒ□	**No** ϒ□
I have been assured that information about me will be kept private and confidential.	**Yes** ϒ□	**No** ϒ□
I consent to participating in a Focus Group, and I understand and consent to my contributions to the Focus Group being audio-recorded.	**Yes**	**No**
I have been given a copy of the Information Leaflet and this completed consent form for my records.	**Yes** ϒ□	**No** ϒ□
I consent to take part in this project, having been fully informed of the risks, benefits and alternatives.	**Yes** ϒ□	**No** ϒ□
I give informed, explicit consent to have my data processed as part of this project.	**Yes** ϒ□	**No** ϒ□

Name: ___________________________ Signature: _____________________________

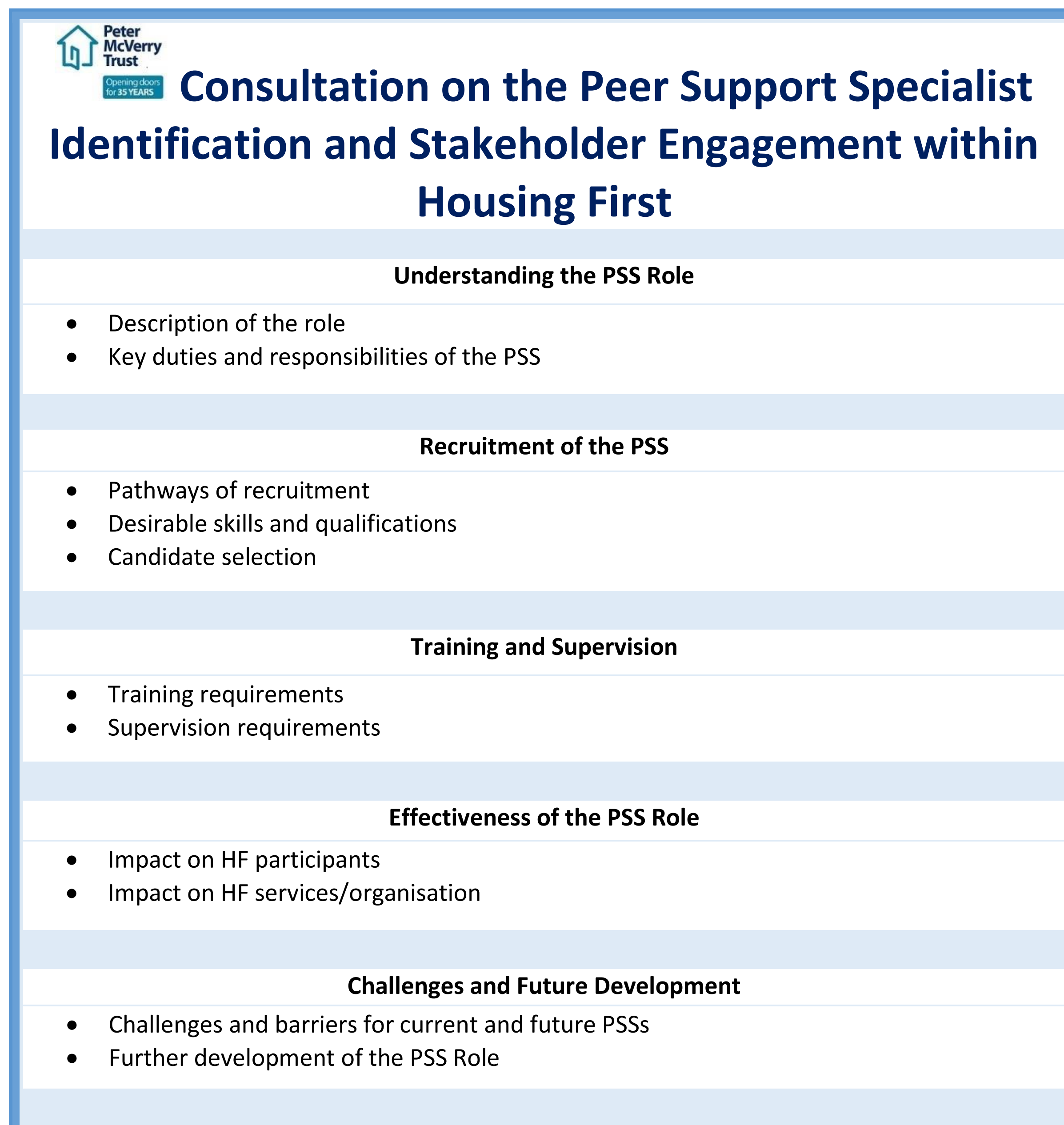
Date: _____________

You may also withdraw consent at any time if you wish to do so by signing below:
I (print name) ____ hereby withdraw my consent for participating in this project.

Name: ___________________________ Signature: _____________________________

Date: _____________

Appendix V: Focus Group Topic Guide



Consultation on the Peer Support Specialist Identification and Stakeholder Engagement within Housing First

Understanding the PSS Role

- Description of the role
- Key duties and responsibilities of the PSS

Recruitment of the PSS

- Pathways of recruitment
- Desirable skills and qualifications
- Candidate selection

Training and Supervision

- Training requirements
- Supervision requirements

Effectiveness of the PSS Role

- Impact on HF participants
- Impact on HF services/organisation

Challenges and Future Development

- Challenges and barriers for current and future PSSs
- Further development of the PSS Role

Appendix V

a. Dublin Focus Group Quotes

	Nature of Role	Recruitment	Supervision and Training	Impact	Key Challenges
PMVT Representatives – Management • Service Managers • Heads of Services	*'[…] it's more like a friend, kind of, that can bring them out for coffee, bring them to the local clubs, show them what's in their area and you know that can really have that time to delegate to them.'* (PMVT SM 2)	*'It will be internal and external and, like I had said, in terms of those individuals that would have come through Housing First specifically, and have had the lived experience of a Housing First participant may have graduated for the programme. And it's something that they're interested in.'* (PMVT HoS 1)	*'So there's Hub meetings, there's daily planning meetings, there's monthly planning meetings, there's also the peer support worker would participate in all of those pieces, particularly if you're seeing an individual.'* (PMVT HoS 1)	*'Whatever it is that it might be that they (PSSs) are in a good position as well to bridge some of them gaps between the ICM and the client, and to support a level of understanding between them both. And support the ICM and the client in recognising the perspective of each.'* (PMVT HoS 1)	*'Ideally like when our participants are engaging with peer support, they don't feel like they're engaging with Peter McVerry Trust Housing First, so to drive around in a branded van, a lot of our clients don't like that.'* (PMVT SM 2)
	'[…] ultimately what they're doing at the moment is a social prescribing programme. But it's more on a specialised 1 to 1 basis […], to provide that social prescribing programme then that's what we should be doing.' (PMVT HoS 2)		*'we'll always be looking towards where the need is and where most of the complexities and vulnerabilities lie. So, in general, we'll always look towards meeting those needs by way of training and upskilling the staff team, that's both for the peer support specialists, the ICM'S and the likes.'* (PMVT HoS 2)	*'[…] the organisation is so expansive. Uh, you know the benefit to having more Peer Support Specialist given the size and the range of Housing First at the moment would only be of benefit the organisation.'* (PMVT HoS 2)	*'I think that sometimes where Peer Support Specialists may struggle is in the fact that because they have that shared experience, there can be a – They may find it difficult, or, you know, to separate the sympathy from the empathy, you know, and where then they are overly involved.'* (PMVT HoS 2)
	'Just somebody there I suppose that's on the participants' side as well I feel that's the difference, where the participants really feel peer supported, they're there for them, they're advocating for them.' (PMVT SM 1)		*'When training comes out, everyone is offered the same training, you know, like mental health training, or the first aid, whatever it is when they have had time.'* (PMVT SM 2)	*'I think the ICMs are very stretched. They're carrying a lot, and they're also working with very difficult clients like 90% of the time. And they don't get to do that kind of positive piece like they would like to with their clients. And I think when we have peer support in doing it, it's a little bit less of a stress for the ICMs.'* (PMVT SM 2)	*'The locations and stuff I think they're, like, little challenges, like, not necessarily that you carry it as the work load, but, like, just being out in different properties at different times. And, you know, using even other services, like, you know bringing people to the gym and, like, little kind of things that you need to do to get up and running. But it's more minor little things like that.'* (PMVT SM 1)

	Nature of Role	Recruitment	Supervision and Training	Impact	Key Challenges
PMVT Representatives – Frontline • Multidisciplinary Team Members • Intensive Case Managers	*'We'd have a few people who would ask for more visits just down to loneliness but when we're there, there's nothing we can actually do with them, so then with Peer Support there's a lot more flexibility, they can dedicate more time to hobbies and getting actual experiences and going for longer walks or whatever.'* (PMVT ICM) *'I think with my role in addiction support I have a specific outcome for participants […], they want to go into treatment or they want to start a methadone programme or a programme to support their addiction or recovery. So there's that specific goal that we're working towards and my goal is like a short-term piece. […]. So then ideally when that gets done they just get moved back on to their ICM and my support then will decrease. And I think with peer support is less of a specific kind of outcome.'* (PMVT 2)		*'I think for peer support training only a peer support worker would be able to deliver training, because if someone stood here, no offence, but from research or someone fresh out from college, who has done psychology or having a training to be a support worker, to be a peer support worker the idea of this is my lived experience, you can't teach that. Yeah, I think you would have to have someone who has done peer support themselves.'* (PMVT ICM)	*'I think, it's just enjoyable [for the participant]. It's a bit of an escape when you just get to go do something fun and, you know, follow your interests or activities that in the past you wouldn't have had a chance to focus on.'* (PMVT MDT 1) 'I think a lot of our clients – well most of them - aren't working or they're on disability, so they can't work, and so there's just huge amounts of time, all the time, where they really have nothing to do. And that's probably one of the issues that I've seen the most in my clients.' (PMVT ICM)	*'People associate it (Peter McVerry Trust) with addiction straight away. And that's what our clients are trying to step away from that, and to integrate into society, and the last thing what they want is their neighbours discuss them in a way. You know. They could be miles away from that lifestyle and it could just be bringing it all up again.'* (PMVT MDT 2)

	Nature of Role	Recruitment	Supervision and Training	Impact	Key Challenges
PMVT Representatives - PSS	*'I would go out, then, and I will engage with clients at different levels. Some will be from mental health perspectives kind of just encourage them to be more proactive in in their self-awareness or just engaging with them. Having coffee or putting together certain kind of programmes for them, that they would need it, can be from the sporting programmes or it can be from likes of arts and crafts or whatever they need to kind of reintegrate back into society, and now that they have their housing.'* (PSS 1)		*'From my experience these past four months management have been very supportive to me, they've given me incredible leeway without micromanagement, which I think is the key to this role.'* (PSS 2) *'I got some training that has been available so far, but training around mental health and addiction, would be handy, because many suffer from those stuff.'* (PSS 1))	*'I've great relationships with the team and you just have to look after yourself within that and I think what's happening with Peer Support I think is fantastic.'* (PSS 1) *'It's different measures of progress, I suppose, If you ask like how we measure that, that's how we – I would say that's how we measure it. Every time it's different. You know it's not like, tick this box, like, it's not that clear cut.'* (PSS 2)	*'Yeah I would say what one of the biggest challenges is definitely transport'.* (PSS 2)
HSE Representatives	*'I think the role of a peer support specialist is most likely somebody who has been, you know, through the system. […]it's not an easy job. It's definitely not an easy job, but I think for people that are, you know, trying to get there trying to achieve it's a fantastic. It's a fantastic goal to aim for.'* (HSE Representative 2)	*'You'll find in services are covered in people that have been through the system have gone back to college who are working there.'* (HSE Representative 1)	*'I'm just thinking there what with the role being specific peer support. Would the supervisor would they have come from a peer background, do you think would what would the supervision be external or internal? Would someone get the option? I think got questions like that need to be asked.'* (HSE Representative 1)	*'I suppose we miss out on service users trust and services. And I think the peer support bridge that gap.'* (HSE Representative 1)	*'They can't help but be overly invested in a particular case and look the wheels of all these systems, they move very slowly, so that we've seen it before where even with the Ukrainian response, people are really overly invested in the people they are looking after and saying we can't it just happen quicker, this person really needs XY and Z and I think the peer support in terms of homelessness and housing first.* (HSE Representative 3)
Local Authority Representatives	*'We don't always have to try to fix people. People need to learn how to address or manage some of their needs. And I think they're able to pitch that, so it's combined the education level and it is also the experience.'*	*'You're doing a recruitment drive, uh, it's got a lot of what the ethos of the service would be to be able to look at where you should bring people in from so if it's an addiction background and you know, and a purely addiction service. It may be different, for the housing 1st. I think graduates that have come through the programme may be suitable candidates'*	*'I think it should be very structured, particularly at the start. It needs to factor in resilience. It needs to factor in the situations that they may occur and how that actually would make them feel and how they would deal with it.'*	*'You can't learn it, you live it. have that experience. And us as I would people that are working on behalf of housing first participants will also learn an awful lot from the peer support.'*	*'Our system may not respond to the needs as quickly as one would like and I think that would be very frustrating for a peer support worker just as much as any worker.'*

b – Regions Focus Group Quotes

	Nature of Role	Recruitment	Supervision and Training	Impact	Key Challenges
PMVT Representatives – Management • Director of Services • Head of Services	*"I suppose when there is a peer support worker as part of the team, there's an understanding, and there's also the potential for the peer support to be able to share some lived experience with the team […]"* (PMVT DoS 2)	*"The pool of potential candidates, staff candidates, might be quite small, especially in the regions, so I don't know whether we need to broaden that net in relation to, you know, using that mental health peer support worker."* (PMVT DoS 1)	*"I suppose there's gonna need to be a very kind of tight support system in place around supervision where they do probably, I know we do a bit of online supervision with staff teams and that but I'm guessing the peer support staff probably need to come together as a group fairly regularly."* (PMVT DoS 1)	*"I think that sometimes when we're the Approved Housing Body, but we're also the Housing First provider, that can be a tough one because you don't want to end peoples' tenancies. However, they have to have the capacity to live in the Community, and maybe there's a piece there. If we did have a peer support worker in place or a peer support specialist, that they could be completing pieces of work in order to preserve the relationship of Peter McVerry Trust with the participants."* (PMVT HoS)	*"I think our biggest challenge is really how we implement that not only in Dublin but also in the regions so."* (PMVT DoS in Mideast Region)
	'I'm just thinking like, I suppose, a Peer Support Specialist with Housing First doesn't necessarily, and maybe I'm wrong in saying this, but wouldn't necessarily need to be someone that has a history of homelessness specifically, but it could be, you know, extensive poor mental health, uh, history of chronic addiction or any other kind of trauma.' (PMVT HoS)		*'I think that it's 2-phased and as the ICM has already advised there is the layer in respects of the mandatory trainings and the standardised ones associated with housing first. But obviously they have an awareness that there is an additional vulnerability that must be supported in respects of training and otherwise specifically centred in and around the likes of boundaries.'* (PMVT DoS 2)	*'I think that's my understanding of it, and from what I've read, , I think it's worthy, and it's desperately needed in relation to support and our tenants or our, Housing First participants.'* (PMVT DoS 1)	

	Nature of Role	Recruitment	Supervision and Training	Impact	Key Challenges
PMVT Representatives – Frontline • Multidisciplinary Team Members • Intensive Case Managers • Team Leader	*"I think in like defining the role of a peer support worker is probably one of the most important parts […], it's quite difficult in Housing First because it's not just lived experience in addiction or lived experience in homelessness, or like, we're dealing with a multitude of people who are experiencing all of the above."* (PMVT MDT in Mideast Region)	*"I wouldn't necessarily say I'd be ruling anyone out from the Housing First programme. Definitely not. No. I just think there would have to be like a period of abstinence from the programme from the staff I. I think if they graduate, maybe in a two to three-year gap from the programme."* (PMVT TL in Northeast Region)	*"I wouldn't think, like, education on it as such, but like training just to bring you up to scratch with it, which I think would be beneficial."* (PMVT ICM in Midlands Region)	*"[...] someone that they can relate to on a certain level, and I just – It just would be like the more support that – like I just find that a lot of people I work with, the more people they're linked in with and the more support they're getting, the more it kind of helps them focus on whatever it is they're hoping to achieve. And I just feel like the more people that are linked in with them, the better."* (OMVT ICM in Midlands Region)	*"Challenges that would come up would be the boundary piece and respecting the confidentiality and the dignity of the person, especially if the peer support worker is of the area that they're going to be working in."* (PMVT MDT in Mideast Region)
	'Just to work alongside the participant themselves and just like be a support network for them and kind of give them options and alternatives and different solutions and ways they can go about it.' (PMVT ICM in Midlands Region)	*'I think it'd be trickier if they had graduated from our Housing First programme, coming back in. I think it might be smoother if they had a lived experience not inside of the housing first programme.'* (PMVT ICM in Northeast Region)	*'So there is an element of that kind of attachment you just got to be a bit careful with, but that again comes into the training. With the peer support training […], boundaries is a massive one, or the confidentiality, but boundaries definitely just to kind of pull yourself away, not to over share as the ICM said, and not to become too attached because it does blur the line and not even blur the line, but makes it awkward then for the casework to kind of keep working, if that makes sense.'* (PMVT TL in Northeast Region)	*'A peer support link worker between that service and the community, I think would be something really valuable because one guy in particular, UM, would often say no offence or disrespect to what you're trying to do with me. But you don't understand. What I'm dealing with right now and therefore he said it, it's very valuable.'* (PMVT MDT in Mideast Region)	*'I suppose it takes a while for a lot of the participants to kind of open up to you, and kind of like build that trust. Like, some of them, just in my experience, like some of them would tell you their whole life story with the first time meeting them. But then there's others that are only starting to come around to me now, and I suppose that's completely understandable, because it does take time to just build up that trust and stuff.'* (PMVT ICM in Midlands Region)

	Nature of Role	Recruitment	Supervision and Training	Impact	Key Challenges
HSE Representatives	*"For me it really just needs a support worker that can go into that role where it can just basically help the ICM. So, the ICM has caught up with the intensive stuff, the person that I would have called the peer support sweeper type role would see the clients. That really might not get all the attention all the time. They would need to kind of just to make sure everything's OK with them, maybe a cup of tea. Maybe just come to some appointments that doesn't need intensive stuff, and I think that's badly needed."* (HSE Representative in Mideast Region)	*"Actually, a lived experience might be – maybe it could work. But there might be some challenges in that too, for the guys we're trying to target, but see it's definitely needed. It just might need a little bit of tweaking to just have it like a peer support where there is a lot of challenges in this job. It's probably one of the most difficult sides of the addiction recovery piece, [...] "* (HSE Representative in Mideast Region)			*"[...] you are going back into the environment really that you might have seen yourself. You have to do an awful lot of recovery-based stuff to be very strong to go in, because is elements of that with the client that can remind people of their past. That could, although that could be very positive for some people. It can be very scarring and regression can happen as well."* (HSE Representative in Mideast Region)
Local Authority Representatives	*"The peer support worker is someone that is an expert and has lived experience they have lived through it. They are and can be a great benefit and the role is of benefit."* (LA Representative in Northeast Region)	*"Obviously there might be a possibility of recruiting from within. But I think you would need to broadly consult with all the various stakeholders."* (LA Representative in Northeast Region)	*"Training I would have thought is useful. Educational background – I wouldn't have thought it's a prior prerequisite, but certainly to have experienced it and certainly to have got a level of training I think is crucial, yeah."* (LA Representative in Midlands Region)	"I think it is actually useful." (LA Representative in Midlands Region)	"It's, I suppose, for the peer support specialist to have at the ready to have the right person to contact, you know, or the right support to be able to provide or to be able to guide the person who's experiencing the difficulties in the right way. Uh, so there's certainly going to be difficulties along that [...]" (LA Representative in Midlands Region)

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