UNIVERSITY OF CAMBRIDGE

Institute of Criminology

How do addiction peer-led services build trust with hard-to-engage service users?

Caragh Arthur

Homerton College

Candidate number: PEN-2323

Supervisor: Hannah Marshall

Submitted in part fulfilment of the requirements for the degree of Master of Studies in Applied Criminology, Penology and Management

January 2025

Abstract

This research investigates the complex nature of trust in addiction peer-led services for hard-to-reach users, stressing the importance of the subject matter. Based on the principles of attachment theory, peer support services, and trust building, the study proposes objectives focusing on identifying the factors affecting the trust processes. In terms of the methods, interviews and observations will be used to investigate these processes. On this basis, the received feedback underlines the usefulness of the presented model in terms of the attachment theory and the necessity of enhancing the therefore implemented literature analysis. Thus, this study aims not only to reveal the processes of trust-building within addiction peer-led services but also to advance knowledge that might lead to improved intervention effectiveness and, therefore, add value to the prospects of achieving better outcomes for those difficult-to-engage service users via Erikson's 8 stage developmental model.

Acknowledgements

Firstly, thanks to HMPPS for funding this course and allowing me to attend this prestigious university. Hannah Marshall, my supervisor, supported me through tough times when I struggled. Jack O Sullivan and Matt Grey gave me the hope to feel good enough to apply. Thanks to Liz Wheen, my Cambridge buddy, and Louise, my tutor. All the amazing people who taught us on this course and guests who lectured to make our experience more valuable. My husband Steve and son Tristan, who put up with my moods when I constantly stayed in a book or laptop, frequently coped with my study weeks away.

Thanks to friends and family who understood my social life was replaced by Cambridge study. Hopefully, we can now PARTY. Thank you to the beautiful soul, Clare Kennedy, her funny husband, and clever daughters who established Kennedy Street CIC and made me most welcome. Finally, thank you to the research participants at Kennedy Street, who trusted me with their stories, perspectives and time. I was utterly inspired and impressed by the people I met.

Contents

Contents

Introduction

This study aims to enrich the current body of research by demonstrating how peers can play a pivotal role in rebuilding trust. No current studies use Erikson's development model to address rebuilding trust and a more vigorous understanding of how it is broken through the life cycle. Trust-building has the potential to bring about positive outcomes for those struggling with addiction. Erikson's (1950) shame, doubt, guilt, inferiority, mistrust, stagnation, despair and confusion can all be understood as symptoms or manifestations of issues with trust because trust is a foundational psychological and social construct that underpins how we relate to ourselves, others, and the world. The main question is how peers build trust in peer-led services.

This study aims to understand the value of Lived Experience Organisations in building trust with recovery seekers. In addition, understanding how other support organisations can learn from or implement recovery tools and strategies that accelerate the trusted relationship required to fast-track the support service users need to recover.

Frequently, I hear policymakers state that they know that peer workers are instrumental in productive outcomes. Yet they downplay their involvement in supporting service users to recover, desist or get well. As a result, I was keen to understand what the key is to peer workers' success with those battling addiction. Based on understanding the service users' demographic and their intended shift away from society, I wanted to know what was critical to their decision to choose rehabilitation when working with peer-led services.

According to Lennox et al, (2021), peer support workers are individuals who have shared lived experiences of addictions and other adversity and who can effectively engage those who are hard to reach. These peers, having navigated the complexities of addiction, mental health, or the criminal justice system, possess a wealth of experiential expertise. Their unique

position allows them to effectively reduce barriers to engagement, accelerate trust building, and guide service users through a network of professionals and services best suited to their recovery or rehabilitation (Lennox et al,2021). Peers with relatable lived experiences serve as a bridge, connecting service users with professionals in a way that others may not be able to.

One initiative that employs a growing number of peer support workers (PSWs) is the NHS. The NHS 2023 census on peer support workers highlights a significant commitment to recruiting peer workers. As of March 2023, there were 1018 peer support workers (PSWs) within the NHS, with 50% of these at band 3. Notably, 62% of PSW coordinators and managers were above band 6. In addition to pay rates, 75% of peer support workers stated that someone with lived experience had trained them. The NHS aims to recruit 6500 PSWs by 2036/37 to work across mental health illnesses, highlighting the growing recognition of their importance in the healthcare system (NHS Benchmarking Network, 2023).

Historically, PSWs were utilised by mental health services at an earlier point to address barriers to engagement with those who suffered from mental ill health. This method of engagement was so successful that it was developed to meet the needs of those with poor health because of addiction and alcoholism (NHS Benchmarking Network, 2023). According to Gillard et al. (2024), there are current debates around addiction PSWs as they often operate in informal spaces with fewer boundaries. While this informal space increases engagement levels, it can also blur boundary lines, hence the need to formalise addiction peer support (Gillard et al., 2024).

A registered charity that has addressed these points of contention is ‘Implementing Recovery through Organisational Change’ (ImROC) in its 2022 report, which underscores the operationalisation of peer support within addiction services and the necessity to maintain authenticity and flexibility in meeting community needs. The report also highlights ongoing

debates about professionalising peers within a national strategy. Given the above, it is crucial to strike a balance to ensure that a national strategy does not compromise the ability of peer supporters to operate with the necessary flexibility without causing adverse violations. Their informal approach and agility are key in addressing the trust-building needs of untrusting service users. Given these individuals are vulnerable adults, the peer support workers must safeguard them with clearly established boundaries in line with current policy. If this is not abided by, professionals, service users, and stakeholders may have less trust in peer support workers, increasing the stigma against them as credible practitioners.

According to McCarthy (2021), peers must be accredited to ensure their ethical practice and increase public confidence in their roles. Stigma can be attached to peer support workers, given their background in addiction issues and a lack of accreditation. Lived experience is often invalidated and superseded by those who hold accredited qualifications (McCarthy, 2021). There is an irony here: those with experiential knowledge have learned and been educated through their lived experience. It may be this knowledge and relatability accelerates the inherent sense of belonging, which is harder to build with those who do not have a shared lived experience of addiction. Misconceptions and bias may affect professionals working with peer support workers.

This research explores the foundations of trust building and its importance in peer support addiction services. Trust is built with service users and won and lost by professionals, which can accelerate or inhibit service users' rehabilitative success. The debate around how professional peer support workers are included in rehabilitative service provision correlates significantly to the training and operationalisation of their roles. The consequence of not training peer support workers appropriately is that they may cause harm to vulnerable service users. In addition, peer support workers may lack knowledge of safeguarding this group.

Finally, perceptions by professionals that peer support workers lack capability may have a broader impact on the reputations of peer support services.

Furthermore, government reports introducing recovery, peer support and Lived experience indicate that recovery-oriented systems of care (Gov.uk, 2024 are operationalising peer support systems. The recovery-orientated systems of care identify a person-centred approach to rehabilitation. A person-centred approach enables people to work comfortably and facilitates trust-building more effectively. The government report of people required bespoke recovery journeys that were not time-bound or therapeutically mandated. Participants needed to control what they did, how they did it, where, and how quickly they did it to feel safe.

In conclusion, recovery is individualised, and people need to be empowered to own their recovery and not have it dictated if it is to be successful. Mancini (2008) argues that controlling or paternalistic approaches inhibit successful recovery. Often, traditional recovery methods are rule-bound and paternalistic, which usually causes this demographic to resist the tools of recovery and behavioural science. This is partially attributed to the lack of trust in these pressured programs that do not accommodate participants' need to work in a bespoke way. In contrast, peers working in peer-led services understand to a greater degree the need to secure service users with recovery tools that are designed to grow with them in a tailored way. Participants suggested this method enabled them to build trust with the organisation and the peers who had lived experience.

Literature Review

This literature review examines attachment and trust formation theories and their implications for trust building in the context of peer-led services. The review examines Bowlby's attachment theory, highlighting the formation and impact of trust during childhood. It then explores Erikson's eight-stage development model, offering a broader perspective on the significance of trust throughout the life cycle, from adolescence to old age and all that is between. While Bowlby's focus on early attachment provides valuable insights, sole reliance on this theory would be too narrow to explain how individuals with lived experiences of addiction rebuild trust across different stages of life. By incorporating literature on epistemic trust and mentalisation, the review demonstrates how secure relationships can foster the development of trust at any point in life, offering a dynamic theoretical framework for this study.

History of Peer-Led Support

Peer support became more organised and structured in the 1980s, influenced by global developments in the field. Its necessity emerged from grassroots groups responding to the over-medicalisation of mental distress. Peer support provided a platform for individuals to share their challenges and collaboratively develop solutions. It also identified gaps where professional services fell short in addressing individuals' needs. The collaboration between mental health professionals and peer supporters fostered service user involvement, shaping services more effectively tailored to engage and meet the needs of those they supported (Beales and Wilson, 2015). Further to the Peer Support Study by Beales and Wilson (2015), they discuss how Peer Support across the voluntary sector has been uniformly understood. In contrast, it seems appreciated for its valuable contribution by the statutory sector. The differing perspectives are viewed as support that is either informally offered by service users

to one another or formally offered by volunteers or paid peers. This research was limited to understanding how peer-led services build trust. However, there is a more organisational element of trust building between organisations and peers. This could be due to the credibility attributed to the medical model over the mobilisation of organic peer support. Perhaps understanding aspects of this in future studies could contribute further to how organisations enable peers to build trust. Finally, understanding trust as the first step to rehabilitation and restoration could allow services to fast-track people into recovery and being productive members of society.

Existing research on trust formation: a general overview

Trust is a multifaceted construct critical in interpersonal relationships and psychological development (Schilke et al., 2021). It can be broadly defined as the firm belief in the reliability, truth, ability, or strength of someone or something (Oxford English Dictionary, 2024). Thus, in psychology, trust is described and studied from different viewpoints – cognitive, affective, and developmental (Schilke et al., 2021). It is a logical evaluation of the other party's capabilities and reliability, frequently grounded on previous interactions and observations of stable behaviour (Saleem et al., 2020). It comes from the related values, affection, and the belief that the other party is interested in one's well-being (Saleem, et al., 2020). These dimensions of trust indicate how trust is formed and sustained through reason and affection.

The role of trust in human development has been stressed in several major psychological theories. The attachment theory by Bowlby (1982) seemed applicable to those who are abandoned in childhood. However, to those in addiction incarnate, regimens of trust may be lost at some different phase of the life cycle than that posed by Bowlby. Erikson (1963) supplemented and expanded upon Bowlby to examine trust formation in other stages of life.

Early-day attachment theory provides valuable insights where participants claimed to have lost trust in early childhood. Bowlby (1982) discusses and relates early infant stages of trust through attachment, where the child develops connections and relationships that advance their sense of security. Such concepts openly state that people who have strong early child-care attachment patterns are bound to control their emotions as grown-ups. According to Fearon and Roisman (2017), Bowlby's attachment theory, despite being critiqued for its determinism and cultural biases, provides valuable insights into understanding the developmental impact of childhood harm and trauma. He identified four stages of attachment, which are pre-attachment, forming an attachment where the bond is not evident, having a clear-cut attachment and finally, the formation of mutual bonds. Among the topics Bowlby emphasises, mutual interactions will be further investigated in this research, and the role of reciprocity in escalating the degree of trust will also be explored. It is worth highlighting that Bowlby's research was focused on children who experienced sickness or severe deprivation in the 1950s in the UK. Furthermore, cultural studies were incomplete, and attachment theory was built upon Western ideology (Vicedo 2017).

Extending and developing Bowlby's ideas, Erikson (Erikson, 1950) Examined processes of trust formation throughout the life cycle. Erikson's work was similar to Bowlby's in two early stages of attaining and losing trust: nonetheless, Erikson advanced Bowlby's in his eight-phase model. Since those in addiction indicate that at the various stages of the lifecycle of addiction, trust is violated, both Bowlby and Erickson synchronously stressed trust in the infancy stage as vital to adult success. However, Erikson went further to construct a trust model development throughout the entire life cycle.

Erikson's Psychosocial Stages

Stage	Basic Conflict	Virtue	Description
Infancy 0–1 year	Trust vs. mistrust	Hope	Trust (or mistrust) that basic needs, such as nourishment and affection, will be met
Early childhood 1–3 years	Autonomy vs. shame/doubt	Will	Develop a sense of independence in many tasks
Play age 3–6 years	Initiative vs. guilt	Purpose	Take initiative on some activities—may develop guilt when unsuccessful or boundaries overstepped
School age 7–11 years	Industry vs. inferiority	Competence	Develop self-confidence in abilities when competent or sense of inferiority when not
Adolescence 12–18 years	Identity vs. confusion	Fidelity	Experiment with and develop identity and roles
Early adulthood 19–29 years	Intimacy vs. isolation	Love	Establish intimacy and relationships with others
Middle age 30–64 years	Generativity vs. stagnation	Care	Contribute to society and be part of a family
Old age 65 onward	Integrity vs. despair	Wisdom	Assess and make sense of life and meaning of contributions

Erik Erikson's (Erikson 1950) stages of psychosocial development also include trust as the first stage of development, "Trust vs. Mistrust" (Maree, 2022). This stage occurs in infancy, predicting caregivers' impact on children forming trust bonds. If this stage is successful, children gain hope and confidence; if not, they become anxious and distrustful. Studies on attachment patterns have revealed an increased probability of secure attachment in children raised in environments that provide consistent and responsive caregiving; this strengthens the child's trust (Maree, 2022), which benefits his or her social and emotional growth.

In Erikson's stages, the element of trust is valuable throughout all the stages, especially in the issue of identity development during the adolescent stage (Miller, and Lang, 2022). The fifth stage is Identity vs Role Confusion, which occurs between 12 to 18 years of age and focuses on forming one's identity. In this stage, adolescents seek different roles, values, and even personal identities and try to fit all of these into one unified and constant self. This stage is closely related to trust as it follows it in several ways (Abubakar, 2023). First, adolescents

who have built confidence in earlier stages are likely to have higher self-esteem, trust and security levels. This trust allows them to try out various elements of their selves and not worry much about failure (Carducci, 2020). The more adolescents have trust in their caregivers and peers, the more likely they are to trust advice and critique, which is crucial for the development of identity. They can be themselves and are not pressured to fit in with those deviating from societal norms.

Conversely, if the person embarks on adolescence with mistrust concerns from the previous stages, they may experience role transition problems (Khairani, and Maemonah, 2021). Lack of trust hinders a person from establishing constructive relationships. These adolescents may have issues with their social identity, shifting between various positions, making them vulnerable to addiction or offending. Trust is also vital in forming fidelity, which Erikson defines as the individual's ability to be faithful to the life trajectory he or she has chosen, regardless of the contradictions in the values systems (Khairani and Maemonah, 2021). Fidelity is the positive consequence of the Identity vs. Role Confusion stage. The successful outcome of this stage and resolving the resulting conflicts allow the young person to commit to specific values, beliefs, and goals, hence attaining identity cohesion (Khairani and Maemonah, 2021). This is because the trust formed in the initial stages is well cemented.

Erikson's work emphasises those who were emotionally neglected or physically harmed during their childhood are likely to present with symptoms of this past trauma in adulthood (Boullier and Blair, 2018). Hien et al. (2023), further reveal that those with addictions and trauma were more inclined to self-harm, to attempt suicide and to be in a hospital for longer than others. The impacts on this group of society were even worse; they could not adhere to treatment regimens that would enable them to minimise their substance use and their trauma.

According to Dunkel and Harbke (2017), Erikson's research was conceptionally exceptional yet was based on theoretical assumptions rather than empirical research. Erikson observed human behaviour during his clinical practice, which was a cause for critique because no systemic empirical study was conducted. Given the lack of empirical research, Dunkel and Harbke (2017) argue that there is no validation that the eight stages can be operationalised. Accordingly, this study will help to address the need for more empirical research that tests the application of Erikson's work in real-life settings.

For this study, attachment theory would limit understanding of how trust could be built in peer-led services, given its narrow focus on childhood. Erikson's work covers the entire life cycle, offering a broader lens through which to explore trust building. People who fall into addiction can do so at any point in their life. According to the Office of National Statistics data, in 2024, 16.5 % of people aged 16-24 were experimenting with drug use, which reduced to 7.9% between the ages of 25-59. This may indicate young people are testing out drugs, but by the age of 25, many stop. The data offered in these statistics does not connect drug use with attachment theory, trust or background trauma. Young people's substance misuse treatment statistics 2022- 2023 reported girls were more likely to engage in substance misuse due to childhood sexual abuse or underlying mental health. 5% of young women or girls have been sexually abused, and 11% were looked after in care. This demonstrates how valuable attachment theory is in understanding addiction in young people and broken trust; however, it offers less understanding for those who use substances later. Trust may not be a direct cause of addiction; however, it may often co-exist with addiction and complicate social interactions. Trust issues can arise during addiction whereby people mix with those committing crimes or those reducing their moral compass in the pursuit of drugs. As a result of trust eroding during addiction lifestyles, repairing trust and understanding it across the lifecycle is helpful.

Mentalisation and Epistemic Trust

Drawing on Fonagy et al. (2021), it is possible to identify a model that can help explain how members of' complex to reach' groups interact with peer workers and the knowledge offered (Duschinsky and Foster, 2021). Epistemic trust refers to people's confidence in the delivered information and its applicability. This concept is most important in the psychological process and therapeutic environment. Epistemic trust is the belief in the other person's sincerity, the relation of the information to the task at hand, and the benevolent motive behind the information given (Campbell, et al., 2021). It extends the concept of acceptance of facts to include the interactional practices through which the knowledge is produced and communicated. According to Fonagy, epistemic trust is an early-developing construct established during the child's interactions with caregivers (Fisher et al., 2022).

Fonagy's theory is incomplete without the concept of mentalisation, which is the appreciation of the psychological processes of oneself and others (Rumeo, 2022). To this end, mentalisation, deemed effective, leads to epistemic trust, enabling individuals to understand the motives behind correctly conveying information. When individuals have good mentalisation, they can accept and believe the information they receive from others (Duschinsky and Foster, 2021). Fonagy's study shows that problems in early attachment and caregiving are related to developing epistemic trust. Adverse childhood experiences such as trauma, abuse, and erratic care can make people suspicious of people's motives and question the information given to them (Duschinsky, and Foster, 2021). This is especially important for the so-called 'hard to engage' service users, who often have early-life attachment issues and trauma. 'Problem populations', including people with multiple traumas or severe mental disorders, have various difficulties with the formation and development of epistemic trust.

Such individuals may have developed a coping mechanism that includes non-acceptance of other people's communication to avoid further suffering (Duschinsky, and Foster, 2021). Thus, it is necessary to develop approaches to restore epistemic trust to involve these populations in therapeutic and social activities.

Epistemic trust is thus connected to the general concept of trust in the psychological and developmental literature (Duschinsky and Foster, 2021). For instance, Erikson's childhood stages stress that trust lays a strong foundation for secure bonding and a coherent self (Brandell, 2010). In doing so, Fonagy's epistemic trust goes further than the concept of trust by concentrating on the relational and communicative processes of trust.

Research demonstrates that the building of epistemic trust in therapeutic contexts can be achieved through the following ways (Brandell, 2010). It is crucial to be consistent and reliable since only this way can therapeutic practices gain epistemic trust. Reliability and relatability in peer-led services were the highest-ranking themes to emerge in trust building. Reliability is, therefore, an imperative factor that must be accorded to practitioners to become sources of information and help. These are also important because empathy in communication enhances the service user's sense of being heard and acknowledged and, thus, contributes to the service user's trust in the therapist's motives and the importance of the data provided (Fonagy et al., 2022).

The service user may have a feeling of mistrust when it comes to therapy because they have been let down by the people who were supposed to protect them in the past (Lawson et al 2017). This connects with a secure base in relational attachment (Fonagy et al., 2022).

Furthermore, another process of helping service users to think about their own and others' mental states, which is called facilitating mentalisation, also contributes to restoring epistemic trust. This entails directing service users to the perceptions and motives of other people to enhance their confidence and participation in the healing process (Fonagy et al., 2022). By addressing these elements, therapeutic interventions can reconstruct epistemic trust, improving treatment outcomes for 'hard to reach' populations (Fonagy et al., 2022). This complex conception of trust underlines its significance in psychological growth and therapeutic interventions and, thus, offers helpful recommendations regarding cultivating trust in different relations.

Fonagy's epistemic trust is closely related to the general discussion of trust in the context of Erikson's stages of development, especially stages of "Trust vs. Mistrust" and "Identity vs. Role Confusion" (Fonagy and Allison, 2023). This connection is significant for comprehending how trust established in childhood affects people's capacity to interact with other people's knowledge and information, particularly in therapeutic contexts. Erikson's first stage, the "Trust vs. Mistrust" stage, sets the basis of trust through the availability of caregivers (Fonagy and Allison, 2023). This early form of trust is predicated on epistemic trust. Thus, infants who receive predictable and sensitive care form a secure base with their caregivers and the information and knowledge they are given (Milesi et al., 2023). Thus, trust in interpersonal relationships is the foundation of trust in knowledge.

In the fifth stage of Erikson's model, "Identity versus Role Confusion", trust remains relevant for people as they develop (Kitchens, and Abell, 2020). They are in the process of identity formation, and the epistemic trust established earlier is used to find one's way in the social and informational environment. They require assurance that the information they get from

their social environment is genuine and has a bearing on forming their identity (Kitchens, and Abell, 2020).

Fonagy's notion benefits the 'hard to reach' population who tend to have had unstable early object relations and unsteady nurturing. These experiences can cause significant damage to the development of two types of trust: basic and epistemic (Berástegui Pedro-Viejo, and Pitillas Salvá, 2024). For such individuals, mistrust can take the form of a protective shield against any future relational betrayal. Hence, they are likely to be sceptical of the information they receive from other people, including healthcare and social service givers.

Accordingly, it is essential to re-establish epistemic trust to work with these populations properly. Professionals should develop predictable and trustworthy relationships with their service users so that the service users can feel safe (Berástegui Pedro-Viejo, and Pitillas Salvá, 2024). This process is like Erikson's initial trust in the developmental stages of an individual (Abubakar, 2023). Thus, the practitioner can help the service user regain confidence in interpersonal interactions and the truthfulness of the information exchange process.

The strategies to build epistemic trust stem from Erikson and Fonagy's work (Abubakar, 2023; Fonagy, and Allison, 2023). Thus, the elements of stability and continuity in the processes of therapeutic communication are critical since they reflect stability in caregiving, which is essential for building trust. Abubakar (2023) stressed the importance of empathy and attunement with the service users to make them feel that they are being understood and listened to, thus building affective trust that forms the basis for epistemic trust (Fonagy and Allsion 2023).

This literature review has identified a gap in understanding trust-building in peer-led services, highlighting the need for a broader life-cycle lens. Erikson's psychosocial model was chosen for its applicability across the lifespan, allowing the development of questions to explore how trust is built for diverse individuals. In contrast, while valuable, Bowlby's attachment theory is limited to early childhood experiences. Critiques of Erikson's model note its theoretical nature and call for more empirical application. Although this study is small, it suggests that Erikson's model could be a valuable framework for examining trust-building in peer-led services more broadly.

Existing research on peer support services

Some of the populations who are difficult to engage are those with multiple trauma backgrounds or severe mental health problems, and they struggle with trust due to poor early childhood attachments and unpredictable care (Fonagy, et al., 2022). Such individuals may question other people's motives and the authenticity of the information they receive, which may play a role in their reluctance to participate in therapeutic activities. Peer support has become a potential solution to the above challenges since it offers services from peers with similar issues as service users, including the populations mentioned earlier. (Fonagy, et al., 2022). Several reasons can explain why peer-led services are efficient in establishing epistemic trust.

Peer supporters are considered more credible and authentic because they are close to the target audience and have personal experience dealing with and overcoming such issues. This creates a sense of common ground, thus creating an understanding of the service user's

situation and feelings (Mead and MacNeil, 2006). Peer-led services can also create a less bureaucratic culture where peer support is more equal than in standard services (Gillard et al., 2016). This will ensure that the participants are comfortable sharing their ideas and experiences, especially for those who have had a bad experience with leaders or those in authority. These people provide hope to the service users, showing them there is a way to improve (Gillard, et al., 2016). This increases confidence and creates hope in the service users, encouraging them to participate in the services offered.

Sun et al. (2022) have shown that peer-led interventions result in higher engagement, retention, and satisfaction among service users compared to traditional services. For example, a systematic review of peer support in mental health services found significant improvements in hope, empowerment, and quality of life among participants (Sun et al., 2022).

Peer-led services align with the theoretical frameworks of Fonagy and Erikson by providing a secure and attuned environment where individuals can rebuild epistemic trust through consistent, reliable, and empathetic support. This approach addresses the foundational need for secure attachments and a supportive environment described by Erikson in the early developmental stages (Abadi et al., 2021). Moreover, the authenticity and relatability of peer supporters enhance the mentalisation process, helping service users understand and interpret the intentions behind communicated knowledge accurately.

Despite the importance of third-sector voluntary organisations, peer services have not received as much attention. Peer services mitigate the divide between service users and professionals (Abadi et al., 2021). “Additionally, peer service provision may aid the recognition of service users’ abilities to self-organise, thereby countering the disrespect and

oppression experienced by service users (Carrier and Erickson, 2012). Furthermore, peer service provision may help service users negotiate other services. Aakerblom and Ness (2021) emphasise that non-critical peers whose services respect users' discretion and pace increase service user motivation and engagement in addiction services.

Despite reviewing the available literature regarding peer-led services, it is seemingly complex to identify any theory about trust-building. However, specific components emphasize the novelty and the beneficial aspects of peer-based services. Thus, Shalaby & Agyapong (2020) established that service users appreciated power sharing and viewing peers equally. Equality and power-sharing enabled them to obtain peer-structured services and uncover their self-worth. This attribute was among the positive themes that formed the basis for determining how trust could be cultivated. This way, the service users also believed it assisted in sharing lived experiences reciprocally, preparing the ground for building trust. Shalaby and Agyapong (2020) stressed the importance of the discussed themes; however, the authors did not describe the stages of trust formation in peer-led services. However, identifying power sharing, value, and reciprocity in this research might help construct some useful elements for trust repair.

The exchange of people's lived experiences enhanced bonding and commonalities and promoted acceptance among the learners, hence, faster trust development (Shalaby and Agyapong 2021). Lansing et al. (2023) posited that strategies such as intervening at the right level of targeted individuals' development, establishing a climate of generic benevolence, and facilitating social decision-making helped foster service engagement. Research also points to the development of trust and its sub-tenets, another element being to meet people where they are. For instance, professional service insists on the mandatory assessment of the service user

during prescriptive hours when the user is less likely to need services. In some cases, the services provided by professional services can also contain a certain amount of time lag and waiting time, which is comparatively rigid. Those, in addition, generally depend on other similar users to get what they require in a more flexible manner, which can help in the creation of trust in peer-led services.

Current Policy on Lived Experience in Addiction Services.

According to the Office for Health Improvement and Disparities, Incorporating lived experience into policy development and service delivery is vital for creating systems of support and care for those leaving addiction. The UK government's guidance on recovery-oriented systems highlights the role of lived experience in supporting individuals recovering from substance misuse. Lived experience peers provide unique insights that ensure services are designed to meet the real-world needs of those seeking recovery. By embedding lived experience into decision-making processes, policies and services are more inclusive and help in addressing the challenges individuals face in recovery.

Local alcohol and drug treatment partnerships play a crucial role in fostering the growth of recovery support services and lived experience recovery organisations (LEROs). It's important that all services collaborate with one another to ensure service users benefit from peer support and professional support. Initiatives often begin as volunteer-led efforts but can develop into fully operational peer support services that deliver essential programs and employment opportunities for those exiting addiction. To ensure their long-term sustainability and effectiveness, these organisations and charities require robust support at every stage of their development. This includes offering appropriate training, resources, and oversight to ensure the safe and effective operation of lived experience initiatives.

The government's guidance highlights the importance of asset mapping and identifying gaps within existing care systems. By understanding the resources available and their

interconnections, partnerships can build strengths and address weaknesses within the community. Such systems allow for bespoke and responsive support, ensuring that individuals in recovery receive the help they need.

Furthermore, the sustainability of lived experience initiatives depends on secure funding and long-term support from local authorities, other stakeholders and professionals working in the sector. By investing in these initiatives, communities can create spaces better equipped to address the complexities of recovery. The formal recognition and integration of lived experience also help to bridge the gap between policy and practice, fostering trust and engagement with those in recovery.

By supporting lived experience initiatives, communities can create environments where recovery is possible and sustainable. This approach ensures that recovery-oriented systems remain person-centred, empathetic, and responsive to the evolving needs of individuals. The Office for Health and Disparities signals how vital working together is to ensure rehabilitation from addiction (Gov, 2025).

Research questions

To address the gaps in the research literature described above, this study will explore the following research questions:

1 How do peer-led services establish trust with service users?

2 How do peer-led services navigate trust-related challenges, such as relapse or conflicts within the community?

Methodology

Kennedy Street: The study location.

Initially, three potential research sites were considered: The Hepatitis C Trust is a national service headquartered in London. They provide support to reduce the spread and infection of Hepatitis C across prisons and within the community by seeking out hard-to-reach individuals (The Hepatitis C Trust, 2025). The hard-to-reach group is usually in the intravenous drug-injecting community. This charity was considered, given its ethos, to run a sizeable peer-led service with over 150 paid staff, of which 90% had Lived experience of Hepatitis C infection, drug addiction or time in custody. The researcher had previously worked with the charity some years ago and preserved supportive relationships. The Director of prisons has agreed to act as a gateway to enabling this research. The difficulty with conducting research at the site was multi-faceted; for example, not everyone had experience of addiction. Some people had contracted Hepatitis C before the 1990s, whereby infected blood led to the blood infection scandal (Hepatitis C Trust, 2025). In addition to that some people only had lived experience of having been to prison. Given the study was to research how peer-led services build trust in addiction services this charity did not qualify.

Secondly, a peer-led service in North London was identified as a possible research site. This service is called BUBIC (Bringing Unity Back into the Community), and they work with peers in the community who are attempting to leave their addiction and reduce addiction. The service does not require individuals to be substance-free, given the harm-reduction principles of the charity (BUBIC, 2025). The service has 10 paid staff and 15 volunteers who run a day and night service for individuals across the Haringey borough. Individuals access groups that help them to socialise, learn skills and build emotional intelligence. The night service deals with more prolific addiction and street homeless individuals who exhibit higher levels of risk

behaviour. Given the harm reduction ethos at BUBIC, there was an increased possibility of participants being under the influence of substances. As a result of this increase, seeking consent would be precarious and could be harmful to research activity. In addition, had the study taken place in London, the researcher would have returned to her home and back to her family which would interrupt the research thought process.

Finally, the chosen research site was Kennedy Streetan independent peer-led addiction charity established in Brighton, UK, in 2014 to help service users interested in recovery from addiction (Kennedy Street, 2025). Kennedy Street seeks to support service users who are attending to build confidence through peer support group work, one-to-one peer support, speaking engagements, and social activities. The service is in a diverse urban environment that hosts various recovery activities discussed below. While Kennedy Street works with those who have had addictions and are a Lived Experience Charity, they have policies to ensure anyone accessing the day is not under the influence of substances. This secured their position as the research site.

Kennedy Street: The Study Location

In this section, I present an overview of my observational research at Kennedy Street. When you arrive at the charity, you are welcomed by the smell or sight of fresh bread, cakes and pastries and a lovely cup of tea or coffee. The website of Kennedy Street further mirrors the offer of having tea and coffee with individuals who care about helping people desist from addiction. I stayed close to the research site location in Brighton for the duration of the study; by doing this, the entire experience, both on and off-site, was devoted to doing, thinking or drafting notes about what was taking place.

During the research week of participant observation at Kennedy Street, I fully immersed myself in the everyday operations and rhythms of the service. I arrived at 10 am on the first day. This gave a good indication of the pathways those seeking the recovery offer at Kenndey Street may have taken. I wondered what distractions service users may have away from reaching their destination at Kenndy Street or what feelings they may have had on arrival as lone service users seeking guidance to change. I noted my own reflections on having sought out similar hubs in the hope that I may access something better than addiction. As I arrived, I saw a bright sign, a colourful and welcoming space upon which to enter.

Kennedy Street's recovery workers are connected to various recovery services such as Alcoholics Anonymous, Gambling Anonymous, and Narcotics Anonymous. The CEO Clare Kennedy, herself in recovery, leads the organisation alongside trustees at different stages of their recovery journeys. In addition to trustees, her husband, the Patron, is Kevin Kennedy, who was formerly known for many public roles in film and theatre. Both Clare and Kevin wanted to provide their community a space to seek recovery given their own personal journeys with addiction. This leadership structure sets a powerful example for those accessing the service, reflecting the possibility of change and success. The first interview completed was with Clare, this was intentional to get an overarching sense of how the charity was set up and what demographic of participants would be on site. Clare explained why she set the charity up. I reflected that her leadership is exceptional as not only does she really care about helping people seek a trusted recovery space, but she also has the theoretical skills to ensure a well-equipped, competent service. For example, she would smile fondly and compassionately when speaking of Kennedy Street successes and with an assertive maternalistic power.

(*Photo from website*)

Kennedy Street is open from 10 am- 6 pm, Monday to Friday, and it is also open on Saturdays depending on events. Kennedy Street offers a range of 15 different programmes, including an introduction to recovery workshops, creative writing, employment and entrepreneurial skills. The study observed a strong sense of trust being developed between participants. Through conversations, it became evident that participants were allowed to access the service if they were not using illicit drugs or misusing prescribed substances. In one of the kitchens, the CEO uses a coffee machine to teach participants barista skills and customer service skills, providing a practical foundation for future employment and customer services.

During the week, observations of behaviours and thought patterns emerged as participants began reinforcing positive changes in their lives to one another. For example, on the first day of observation, it was clear that participants knew each other and had made connections. People dropped in and out of discussions with small subgroups of people. One individual spoke about a book they were reading, and another mentioned a college course they attended. The activities they discussed were enveloped in a childish excitement of pride and enthusiasm. There was a reawakening of emotions and senses that motivated people who had formally been suppressed by addiction. Activities like studying and reading allow the brain to activate reward pathways previously stimulated only by addiction (Hyman et al. 2006). People discussed other peer-led services that they were attending, such as Narcotics Anonymous (NA), Alcoholics Anonymous (AA) and multiple other Anonymous programs. These fellowship programs maintained the support system accessed at Kennedy Street outside their 10 am to 6 pm opening hours. During informal discussions with those observed, I was informed that participants would meet up later at Anonymous meetings. I am also a member of Anonymous meetings and therefore understood how the addiction community at

Kennedy Street would extend into external similar recovery communities that adopted similar recovery principles.

Research Design & Methods

Gaining access was assisted by my existing professional networks in the addiction community and being personally known to the CEO. Participation observation was chosen as the research methodology for this study due to its advantages in understanding cultural and social dynamics within the community being studied (Bryman, 2016). This approach was particularly suited for examining the trust-building process within Kennedy Street Recovery because it allowed for a deep, immersive understanding of interpersonal relationships and organisational culture through the lens of service providers and users. The ethnographic focus on a small, engaged community enhanced understanding and facilitated a deeper analysis of interpersonal and organisational trust processes (Miles, Huberman and Saldana, 2014). I conducted the participation observation openly and ensured all participants had been advised beforehand through email, verbal briefings and posters of the research parameters.

During the research, I took frequent breaks to ensure notes were taken and no critical field notes were omitted. Given the short duration of the research activity, this research was known as micro-participation observation and had a very narrow focus (Wolcott, 1990b).

Following the observational phase, 12 semi-structured interviews were conducted, capturing diverse perspectives across staff, service users, and staff members with addiction backgrounds. This method helped triangulate data from different sources, enhancing the credibility and depth of the findings (Flick, 2018). The aim was to do the interviews face-to-face; however, given the flexibility of technology, one had to do it at an online meeting. According to Bryan (2016), online technology cannot always be reliable, for example, when

the internet fails or computers crash. The online method was trustworthy in this instance, and the researcher, having already built trust with the participants, could build rapport during the online team session just as well as face-to-face.

The study was designed as semi-structured interview questions using Erikson's 8-stage development model as a framework; please see the interview schedule in Annex A. Erikson's theory of psychosocial development, particularly the stages relevant to adult trust-building, such as 'Identity vs Role Confusion' and 'Trust vs Mistrust,' provided a theoretical framework to analyse how recovery services help individuals navigate these stages, rebuilding identities. Each stage of Erikson's models listed one or two questions that aimed to understand how trust was built. In addition to these questions, three of the questions listed were Appreciative Inquiry (AI) questions. Appreciative Inquiry (AI) questions in research are valuable because they focus on strengths and positive experiences, encouraging participants to reflect on what works well rather than dwelling on problems. This approach fosters trust, collaboration, and engagement, which is particularly useful in sensitive research contexts like this. By highlighting successes and envisioning future possibilities, AI uncovers hidden insights and inspires participants to co-create actionable solutions, promoting change and transformation. AI aligns with ethical research practices by respecting and empowering participants, making it especially effective when working with vulnerable groups. As Liebling (2004) notes, an appreciative approach allows researchers to build rapport and uncover rich, nuanced understandings, particularly in challenging environments such as prisons, where strengths and positive experiences may be overlooked.

During the process of conducting the interviews, some questions elicited the same response type. Based on this, I chose to either omit specific questions or combine them. Reflecting on the process, I recognise that conducting a pilot study beforehand would have been beneficial.

Piloting the questions would have allowed testing their relevance and refining them to focus solely on those most critical to addressing the research objectives. This approach might have streamlined the process by eliminating fewer effective questions, potentially freeing up time for additional interviews and expanding the dataset.

Research sample.

The sample for this ethnographic study consisted of 45 service users who attended Kennedy Street Recovery throughout the week. Additionally, there were five staff members, the CEO and five volunteers, all of whom have lived experience of addiction. Given the size of the study, nonprobability convenience sampling was chosen, given that the study relied on available people. Of the 45 people who attended, 15 were female, 30 were male. Age groups ranged from 18 through to 70. Nonprobability convenience sampling was efficient given that time constraints, lack of a budget, and logistical constraints made implementing other sampling methods challenging (Novosel, 2023). According to Golzar et al. (2022), this sampling fails to be adequate when researching hidden or hard-to-reach groups. That was not the case, given the researcher's knowledge and relationships with this community. Despite this, many participants were from a specific geographical location, and insights may differ across regions. Many participants were keen to talk about their experiences, which may indicate some bias; it would be recommended that this study be repeated in another region, perhaps in a non-lived experience organisation, to see if the results align.

The fact that I disclosed my lived experience of addiction reduced potential barriers to engagement with the research, and I felt immediately accepted. Having a productive and keen gatekeeper made the research access relatively straightforward. Although observation provided valuable insights into group interactions, the interviews proved more effective in addressing the research questions.

Positionality

Having spent 20 years in active addiction and facing mental health difficulties, I found the research both profoundly inspiring and emotionally demanding. The participants' stories of hardship, trauma, and recovery resonated strongly with my own experiences, enabling a shared understanding that facilitated empathy and trust. As Bradbury-Jones (2021) notes, researchers with insider knowledge often navigate the delicate balance between compassion and professional detachment, a challenge I encountered as I experienced personal emotions while observing participant stories. I used my psychosocial networks to discuss some of the emotions that arose and my ability to ensure they did not remain with me post-research. These were networks that had a deep understanding, both personally and professionally, of addiction. One individual is a registered psychotherapist and supported me to reflect on the research and close each day in a supportive space.

My ability to relate directly to participants' struggles helped build rapport, supporting what Sultana (2021) calls the "ethics of care," where the researcher's personal experience enhances the depth of connection with participants. However, this same connection also presented challenges. As Berger (2020) suggests, when researchers share lived experiences with participants, they may be at risk of over-identifying with certain narratives, potentially introducing bias into their observations. I remained aware of this tension, utilising professional training and experience to navigate these issues.

Ethical issues

Focus was paid to ethical considerations, particularly consent and confidentiality issues. I was very careful not to embark on emotionally difficult topics; however, was able to generally understand discussions like, "*What happened to me as a child should never have happened",*

as being some form of traumatic abuse or neglect. Participants were informed about the study's aims and rights, and consent was obtained before participation. Anonymity was preserved in all published and shared results to protect participants' identities and personal information (Bryman, 2016). The researcher refers to each participant as a male or female to protect anonymity.

To avoid discussions with anyone under the influence, while the service does not allow entry to those who are under the influence, I also would not seek consent from anyone who appeared under the influence.

I was keen to capture the emotional impact and connection with the project to avoid any bias or harm, and I kept a diary of any bias. Researchers with personal experiences of addiction may need help to maintain professional boundaries, risking over-identification with participants or being perceived as peers rather than researchers. This can complicate the researcher-participant relationship and potentially influence data interpretation. That said, I did not struggle with the emotions of the study but did feel empathy towards participants and used her psychotherapeutic support to offload and reflect on these.

Regarding participants' consent giving, the research was explained in various communication styles through staff volunteers and the researcher. A poster with pictures and a WhatsApp message with verbal content was sent to ensure everyone understood the research, dates, methods, and options to opt-out and consent as required by the General Data Protection Act 2018 (Kurteva et al. 2021). Participants were informed of how their confidentiality would be maintained and their ability to withdraw at any time was intact.

This was reiterated to everyone to ensure they understood the consent given the vulnerability of the addiction community, and great lengths were taken to ensure they understood how

their data would be saved, stored, anonymised, and retained. Transcripts were saved on an encrypted password-protected hard drive. After the degree marks have been issued, all data will be irretrievably destroyed. Confidentiality would only have been broken if someone was a risk to themselves or another. However, this was not required (Surmiak 2020).

The research was designed to purposefully exclude any sensitive lines of query or taboo subjects (Dempsey et al. 2016), as evidenced in Annex A questions. Furthermore, I observed participants for changes in body language and tone that could indicate distress (Patterson, 2011). The environment was comfortable, and participants had support staff on hand. Questioning was upbeat and positively linked to building trust. A shared collective duty between the researcher and CEO was to ensure participants' support on the day was available if required.

Before each day, the researcher and CEO briefed to ensure no participants or staff were stressed that day; there was a debriefing at the end of each day, too. This ensured the researcher could iterate approaches and comfort participants at all stages. Finally, the literature reviews uncovered power relations as key. Therefore, participants will be consistently reminded of their choices and power in the research.

Data analysis

The researcher used Glean software to record and transcribe interviews, ensuring compliance with the General Data Protection Regulation (GDPR, 2018). Initial data gathering transpired through observations and then interviews. According to Braun & Clarke (2006), researchers immerse themselves in data collection through these methods. Once the research had been completed, coding (Terry et al., 2017) and segmenting the data into themes was possible using NVIVO-enabled reflectivity and an interpretive approach to allocating themes.

At one point, saturation was met, and the researcher sought a discussion with her supervisor to remove redundant themes. The themes removed were those that did not contribute to answering the research questions.

Findings

“This chapter discusses data from observations and semi-structured interviews to answer the three key research questions outlined above: how do peer-led services establish trust with service users? How do peer-led services navigate trust-related challenges, and what are the ethical considerations for building trust in peer-led addiction services? The chapter briefly discusses participants' contexts and life histories before addressing each research question. The chapter concludes by connecting these findings back to existing theories of trust-building, with a focus on Erikson’s 1950 model.”

Participants in this study expressed having trauma in their lives or as children, those points in time eroding their trust and severing their trust in society or people. They often explained a lack of confidence in authority, from schoolteachers to priests, parents and the police. When trust is broken with key societal figures, it can make deviating or isolating from society more acceptable to them. This deviation or isolation can cause societal harm and a lack of healthy inclusion or productivity. It is also linked to risks of mental health and social dysfunction that can lead to crime and anti-social behaviour. It was, therefore, vital to understand how peers can help rebuild and repair trust in ways others cannot. The second question is how peers navigate trust-related challenges.

Peoples Past

For many individuals at Kennedy Street, the path to addiction is paved with trauma, loss, and unresolved childhood experiences. These elements of the past often resurface during recovery and the trust-building process. One individual shared, *“When I started this journey 28 years ago, I didn’t know where to go. I didn’t know who to speak to; I didn’t trust anyone. My life was one difficult experience after another, and I didn’t realise I was creating my problems”.* For some, the healing journey involves learning to trust again after a lifetime of betrayal or

neglect. In a peer-led service, gradually breaking down these barriers can help people reintegrate back into safe pockets of society.

Childhood experiences were often a recurring theme in recovery discussions, as early-life instability or adverse environments contributed significantly to patterns of addiction or behavioural issues like isolation. Erikson's first stage of development identifies the importance of trust and mistrust in infancy. One participant shared the contradiction of growing up without structure, while another contrasted their experience with the strict expectations of Victorian-era grandparents. One individual spoke about not being accepted for their sexual identity by their family and the impact that had on separating them from family ties. In such cases, childhood memories become a source of unresolved pain and mistrust that may have fuelled poor coping mechanisms, including substance use, later in life. The absence of stability and positive reinforcement can leave individuals grappling with a lack of self-worth, a challenge that often resurfaces during the recovery journey. Erikson's eight-stage model is particularly valuable for studying trust in addiction services because it considers the entire lifecycle, offering insights into how trust is developed or compromised at different stages of life. Unlike attachment theory, which often focuses on mistrust stemming from early infancy and relationships, Erikson's framework recognises that mistrust can emerge at any point in life. This broader perspective is essential in understanding addiction, as not all individuals in recovery experienced mistrust or disrupted attachment in early childhood.

One service user expressed that people in their recovery network were *"very willing to help me feel loved and less broken."* These simple gestures of acceptance and care counteract the often-intense self-doubt and shame many carry from their pasts.

An essential aspect of dealing with one's past is confronting the social anxiety, fear of judgment, and emotional wounds that often linger from unresolved issues. One participant shared how a life of introversion had grown into social anxiety, leading them to feel physically uncomfortable in group settings. Despite these challenges, this individual was able to engage with the recovery community and develop healthier relationships gradually. This story illustrates the struggle of re-entering society with a past marked by isolation and how, even in recovery, overcoming social anxiety becomes a critical step toward healing and self-acceptance. Eriksons stage of autonomy vs shame was present in these stories; participants felt shame for isolating, shame impacted their trust in society, and the symptom of doubt was a product of mistrust. Kennedy Streets volunteer program supports rebuilding autonomy through independent purpose, culminating in a reduction of shame. Volunteers were service users allowed to give back to the addiction community. They supported new arrivals, facilitated workshop delivery, and ran the service smoothly. Volunteers explained how volunteering enabled them to feel of service; they would help others using their Lived experience of addiction. They volunteered with autonomy and spoke about a shame reduction. One volunteer explained, "Volunteering here gives me purpose; I come every day to give back; I have a real purpose of helping *people that were struggling like I was.".*

The cycle of trauma and addiction is often a generational one (Meulewaeter et al 2019), where unresolved issues are passed down in ways that profoundly affect individuals from a young age. One person shared the painful reality of their past, describing how their mother's struggles with substance use left lasting scars: *"This was something that was gifted to me not as a nice gift, but it was passed down to me because my mum was an intravenous drug user who had my sister and me, that was our reality."* Another participant expressed his feelings, *"I've been failed in my life by a lot of people from a very young age, and those traumas have placed me on the addiction trajectory."* Confronting these inherited pains can be a pivotal

step toward reclaiming control over one's life, allowing individuals to move forward without the weight of their family's struggles holding them back. Kennedy Street refers to longer-term therapeutic support when people wish to address past trauma or difficulty.

Acknowledging past experiences is challenging but also a pathway to empathy and connection within the recovery community. One participant captured this shared understanding with the metaphor of *"crocodiles chomping at our toes,"* representing each person's burdens. Within the supportive environment of Kennedy Street, individuals can share these experiences without fear of judgment, fostering a culture where everyone's past is recognised and respected. This shared understanding helps build stronger, more empathetic connections, as individuals can relate to one another's struggles, creating a sense of unity and acceptance often lacking outside these supportive spaces.

How do peer-led services establish trust with service users?

HOPE

Service users at Kennedy Street found hope vital to the trust-building process. For example, one of the participants stated, "*So, different people's stories help me. You think, oh, that's good, it worked for you, and so maybe it will work for me".* This indicates how other peers become beacons of hope for others; another person suggested, *"They have come out the other side, and so you have clear hope examples to follow".* Being invited into the service as a place to begin the recovery journey was a signal of hope for the participants interviewed. In some ways, leaving addiction and coming into the safe space of Kennedy Street was like being reborn; they were being conceived into their recovery, where they could create a future and build trust. Hope, alongside other elements of trust building, was multi-faceted; for example, while the aim was to instil hope in those in active addiction, workers felt mutual hope in their professional ability when they saw their interventions working in those

embarking on their recovery journey. This hope helped workers hone their skills as peer support workers, translating to an increased sense of purpose as practitioners. *"It's good that you're doing work with people, and it's just when you see somebody's eyes light up and they start to come back to life, there's like nothing like that feeling; it helps keep hope alive that this is working".* Another staff member said, "*Somebody came in and she was really down and had been in tears and then like 45 minutes later, she just seemed like a completely different person and that was just from sitting down, having a chat and a cup of tea".* Erikson's sixth stage of generativity vs stagnation is visible here, whereby individuals choose to volunteer or work, generating hope in service users. They also sow very initial seeds with those born into their recovery; Erikson's first stage, Trust vs Mistrust, was evident when peers showed new entrants the way and tentative steps to building trust were being formed. Hope appeared to be the first clear step of trust building, inspiring a step to act, with that often being to step through the door to respond to a request by fellow peers and Kennedy Street staff to access the service and be included.

Inclusivity

For many service users at Kennedy Street, feeling included is a foundational part of building trust within the service. The atmosphere at Kennedy Street was one of warmth and mutual care. The informal environment allowed participants to understand what stage they were on in their recovery. Some expressed frustration with more formal services like Change Grow Live aimed at supporting recovery; one participant stated, *"CGL keep giving people methadone; this does not free us from addiction but holds us hostage the methadone prescription, which is not recovery*". According to Frank et al. 2021, methadone maintenance is akin to invisible handcuffs correlating to an inability to progress, build trust and become abstinent. While maintenance programs aim to reduce crime and blood-borne viruses,

Kennedy Street peers felt the program did not have the user's best interests at heart. It caused a level of distrust between service users and professional prescribing services.

Business advisors also played an essential role at Kennedy Street, guiding participants through self-employment opportunities. This advisory programme, designed by individuals with lived experience from HMP Lewes, quickly became a successful initiative within the centre. Watching these business sessions, I noticed an atmosphere of mutual respect and shared understanding, where participants could learn from one another. This type of activity helped people learn about business and industry. All course participants advised me that learning entrepreneurial skills aided them in achieving employment opportunities or progressing to aspirations to one day have their own business. All stated their confidence had increased due to this course and others offered at Kennedy Street. Building skills supported confidence building, which mirrors Erikson's fourth stage, Industry vs Inferiority, which is often built during the ages 7-11 at school. Through courses like this, participants were given second opportunities to develop competence and trust in themselves and others. One of the participants said, "*I have more confidence now that I know how to manage my taxes*" Another said, "*Just being on this course has helped me grow and trust other people; I want to try another course or maybe even go to university".*

Kennedy Street's communal aspect extended beyond formal meetings and into daily rituals. People arrived early in the morning, sharing breakfast and discussing recovery, life goals, and personal challenges. Sharing food became vital to building social bonds, allowing more profound participant connections. On Mondays, the space was filled with the comforting aromas of pastries and home-cooked meals, reinforcing the familial atmosphere. Conversations ranged from recovery progress to driving lessons and even plans for open mic nights. According to Davies 2019, individuals who eat together have a social exchange that

promotes well-being. Similarly, food sharing in informal settings (such as family dinners) and formal ones (like communal feasts) reinforces social bonds and helps establish participant trust. Intimacy vs Isolation, Erikson's sixth stage, explores intimacy and isolation; here, isolation is reduced and intimacy increased. Participants and observations highlighted trust-building by creating intimacy through sharing breakfast, aspirations and connections.

The Kennedy Street environment is structured to make individuals feel like they are not only welcomed but also essential members of a supportive community. This inclusion extends beyond mere participation; it involves being seen, acknowledged, and invited to contribute meaningfully. One participant shared, *"Absolutely, you are part of something,"* indicating the sense of belonging fostered within the group. From the outset, new service users are encouraged to engage fully with the program, reinforcing that their presence matters and that they are integral to the community's overall structure, traversing initiative vs Guilt, industry vs inferiority, and generativity vs stagnation.

Establishing trust through inclusion also involves providing avenues for individuals to connect with different recovery communities and resources. This multifaceted approach allows people to find support from various sources, including fellowship groups like NA (Narcotics Anonymous) and others that cater to different recovery needs. One participant emphasised, *"When you come here, you're encouraged to get involved as much as possible,"* highlighting how staff and volunteers actively work to integrate individuals into the community recovery network. The opportunity to participate in various group activities serves as both a practical support and a symbolic gesture, emphasising that users are more than recipients of services; they are vital contributors to the community.

Observing Trust

Watching trust play out with others through observation and participation helped service users identify trust traits they wished to adopt. Watching others in the program, understanding their dedication, and witnessing their vulnerability fostered a sense of belonging and trust. One participant described their initial experience: "*I came here and listened rather than interacted; I watched other people build relationships, new identities and confidence."* The initial observation allowed newcomers to understand the group dynamics and witness firsthand the support others offer one another, easing their path to engaging more fully. For many individuals, this opportunity to watch others navigate their recovery gave them confidence in the community's ability to help them secure and create new versions of trust built on positive experiences.

Training within peer-led service further reinforced this trust, building confidence and empathy among service users. Training often provides individuals with skills to support others, increasing their sense of purpose and belonging. One person noted that the training *"did help me know how to support people that came into the service; the training I had was very much customer service focused, trauma-informed and boundary specific."* This process of learning and engagement allows individuals to see the positive impact they have on others, which can be transformative. Another participant said, *"When you see somebody's eyes light up, and they start to come back to life... there's nothing like that feeling."* This exchange of learning and connection builds trust as individuals witness the changes that can occur through supportive, empathetic relationships.

For some, observing trust in action within the group also helps to build personal connections that might have been lacking in other parts of their lives. One participant shared, *"My brain tells me all these people aren't like me... but there was so much connection between them,*

almost like a family, when I share with them, I realise how similar we are." This deep sense of community fulfils a need for belonging, creating bonds akin to family ties. Erikson's seventh stage, Generativity vs Stagnation, draws attention to societal contribution and family cohesion. At Kennedy Street, community care is visible, enabling service users' access to rebuild what feels like family, which was another cog on the wheel of trust building in peer-led services. Such connections are vital, allowing individuals to feel accepted within a community that genuinely understands their struggles. For some, the realisation that others share similar experiences can be a turning point, sparking a newfound sense of security and openness.

A significant aspect of observing trust is the role of mentorship, as individuals watch those with more experience navigate their recovery journeys. By witnessing how others handle challenges, newcomers learn strategies they can adopt. *"Watching other people and the way they do it... the way they own it and practice their program,"* one participant noted. This observational learning allows individuals to absorb valuable lessons without direct instruction, making the experience both organic and empowering. As they observe others succeeding in their recovery, they also see that lasting change is possible.

For some, trust extends beyond the peer group and into a more spiritual realm. As one participant described, developing a connection to a "higher power" can deepen their sense of belonging and purpose. *"When I started discovering my higher power... I felt like I'm not alone in this,"* the participant shared. This spiritual element adds a layer of trust, providing individuals with a source of strength and reassurance that extends beyond human relationships. Such spiritual connections can be significant for those who may have felt isolated, offering them a grounding presence that supports their recovery.

Finally, trust was further cultivated as individuals observed the growth and progress of others over time. As one participant explained, watching others progress on their journeys, *"I then get to watch these people in fellowship and the community... watch them grow."* This ongoing observation of change reinforces the notion that recovery is achievable and sustainable. As service users witness these transformations, they become more inclined to trust the process, the community, and themselves.

At Kennedy Street, abstinence is encouraged as part of the long-term recovery goal. Self-responsibility is essential to recovery and building trust, which was reflected in the interactions I observed. Peer conversations were filled with advice, encouragement, and shared experiences, mainly during group meetings. In one group session I attended, the leader read from Hazelden Meditations, and participants had the opportunity to share and receive feedback. Some spoke of isolation, while others reflected on how Kennedy Street felt like a second family to them. From a developmental perspective, Kennedy Street's structure enabled service users, volunteers, and staff to adopt pro-social modelling behaviours that can be trusted, which were discussed during one-to-one interviews.

Relatability

According to Morris et al., (2023), one of the features of therapeutic interaction is relatability, particularly in recovery settings when people can struggle with mistrust. *"I valued meeting people with similar stories to mine. Because I felt a connection with people even though I wasn't connecting, I didn't need to actively connect as I was connecting indirectly because they had things in common with me: they knew trauma, they knew addiction, and they had been isolated. I woke up last year, tubes were coming out of me. I don't know how I got there, and a doctor said, if you ever drink again, you'll die. Many people here were at death's door;*

we all shared that or similar rock bottoms. To build trust, I needed to be around people who knew my struggle".

Building relatability in these contexts also depends critically on pro-social modelling. Bandura's social learning theory holds that people pick up behaviours by seeing and interacting with role models (Bandura, 1969). Service users were motivated to engage in similar activities and attitudes when they saw others conquering obstacles with the help of sympathetic sources or professional services. Initially, service users were cautious of those in authority, but based on peer recommendation, this could, at pace, be overcome. Another participant stated, *"I decided to do therapy because my mentor here recommended someone good, and they were also in recovery."* This modelling reinforces the belief that change is achievable by helping people be resilient and actively participate in their rehabilitation.

"It's easier for me to trust people with Lived Experience as they know the difficulty and the way out; they are not reading from a textbook. You don't get judged by your kind, but people who don't have lived experience do judge. You can empathise a little if you're a kind professional. Still, it will never be the same as someone who lived it". Another person said, "*When I was in rehab, there were people who were counsellors; some were in recovery and others not; we always related better to the ones who had recovery, there is just a shared level of knowing that gives you comfort".* In Erikson's eighth stage, Integrity vs Despair, individuals with longer recovery journeys demonstrated integrity by offering wisdom to those beginning their recovery. Although Erikson associated this stage with trust development in those aged 65 and older, the value of wisdom shared among experienced peers aligns with the principles of this stage.

Relearning Trust

"Once I started going to groups, I started to learn more about people's stories and realised I'm not alone even though nobody talked about gambling but the drink and drugs they discussed; you could 'relate to all addiction, though gambling was my primary". This lady spoke about the depths her gambling brought her to, how she had stolen from her family and let them down due to gambling. She explained at one point, she had such a mental breakdown that she was hospitalised. Her family relationships were broken, and she became estranged from those she loved. "*Eventually, through access groups here, I built up my confidence; I learnt to trust myself and others through taking small steps. I did nice things for myself. After a year, my family could see the difference; I had learned to trust myself, and they then learned to trust me, too. They didn't throw the door back open, but we took baby steps.* Another person said learning about emotional intelligence was vital to their ability to learn about the feelings of others and have empathy for the impact their addiction had on others. Many of the Kennedy Street participants spoke about relearning what trust is and what it should be and could be. They talked about trust being a two-way street, whereas, in addiction, all that mattered was taking and using drugs. Maghawry et al. (2024) conducted a study involving 100 participants, comprising 50 individuals with addiction and 50 without. Their findings revealed that those with addiction exhibited lower levels of emotional intelligence compared to their non-addicted counterparts. Kennedy Street was a space where people could practice learning about the value of emotions in others and how their actions could impact others. It was a space where many adopted new behaviours and learned the value of trusting one another. Another participant spoke about the value of learning to trust themselves through deepening their emotional intelligence.

I can't imagine what else would have helped me learn about the importance of emotional resilience besides my peers. I watched and listened to them, learning how to build everything

that has been lost kind of comes up in groups here. People teach one another emotional intelligence, and you then realise that perhaps what you did before was wrong. I have academic intelligence, but that hasn't helped me build positive relationships. Erikson's seventh stage, Generativity vs Stagnation, typically occurs during middle adulthood (ages 40–65). In this stage, individuals focus on contributing to the well-being of others, particularly the next generation, through caregiving, mentoring, and creative endeavours. Generativity reflects a commitment to nurturing and guiding others, while stagnation involves self-absorption and a lack of contribution.

Time to build trust

"You've got to take your time. You've got to do this right, and I'm exposing myself to different situations that I couldn't have done last year—a friend DJs at pubs. I've heard his music and listened to him with a couple of alcohol-free drinks and some of my peers from here. It's nice. Just getting me out and socialising after 30 years of isolation. It's good being in a social situation without being off my face. I like that about here, too, as they do sober socials, for example, karaoke and social events for people free of addiction". This participant explains how learning to socialise for them takes time; they are attempting to relearn their social position without the use of drink or drugs. Most services, especially professional ones, don't offer exploration of learning to build trust in social situations.

Building trust and taking time extended from volunteering to sharing in a group setting. An individual explained how hard it is to trust people will keep your confidence and why forcing trust earlier than organically willing can be counterproductive. *"If I am pushed to do something before, I am ready, I feel triggered, and I almost become deliberately defiant, and it just sets me back; deep down, I have been so hurt that I need to come to people rather than be pushed".* The trust-building spans collective trust, external professional trust and trust

with self. Another said, "*people loved me here until I could love myself*, *the people here are the same as me*". People showed varying degrees of trust-building; this research did not aim to understand levels of hurt which impacted or delayed trust-building. Instead, it teased out general trust-building themes. Some came in and took directions to attend meetings quite quickly, while others needed to sit back and build trust more slowly. One commonplace thing was the worker's and volunteers' objectives to sow as many seeds of hope as possible, culminating in getting people to trust as soon as possible.

Smart Goals

The SMART Specific, Measurable, Achievable, Relevant, and Time-bound goals allowed a female to direct her behaviour and improve her sense of responsibility in the trust healing process. Clearly expressing her ambitions by setting specific goals enabled her to concentrate her efforts on improving her mental health. Many service users had lived very chaotic lives on the hop, being impulsive and having no real plan or destination. Many workers and volunteers explained that paying a bill can feel overwhelming for many service users. Often, the service users have neurodiversity, trauma backgrounds and disabilities that can impact healthy decision-making; therefore, having one-to-one support and group reflections with peer feedback helps them plan. Breaking activities or tasks down into small, achievable goals helps build their confidence and trust in themselves and their peers. One participant said he broke his day out into segments, managing what he would wear the next day, what he would do before lunch, where he would go and what meeting he would attend. It helped him to stay on track and get another day drug-free. Building in reflection, prayer, gratitude and meditation time ensured that people made conscious decisions and were present. Participants advised that because everyone here had lived experience, trusting them felt accelerated because they knew these people were on the same path.

How do peer-led services navigate trust-related challenges, such as relapse or conflicts within the community?

Navigating Challenges

Navigating trust-related challenges in peer-led services often involves addressing the complexities of community dynamics. Relapses, for instance, are a part of many individuals' recovery journeys, and Kennedy Street's inclusive environment mitigates feelings of isolation that often accompany setbacks. One participant noted, *"You know, you feel invited, like welcome, and you can be who you are in there; if I slip, I can be honest and get advice about it from people who know, that help me get back on track,"* reflecting the nonjudgmental atmosphere that underpins the service's supporting one another. Even when facing personal challenges, service users feel encouraged to return without fear of stigma, allowing the group to navigate relapse-related issues collectively, with empathy and understanding.

However, from an ethical perspective, the notion of inclusion triggers issues of confidentiality and professionalism as many peers are learning to build boundaries. The focus on people's unity is not overshadowed by attempts to establish confidentiality with service users. Volunteers are learning in action, which may give rise to ethical concerns if a robust training program does not exist; however, at Kennedy Street, participants remarked on robust training.

Diverse and fully open to general communication with other services, Kennedy Street emphasises that inclusion does not mean the need to share private data with others; on the contrary, it recognises the individuality of every user within a sphere of trust. They are encouraged to share inclusively as little or as much as needed when ready. Navigating the complex challenges of addiction recovery is no easy feat, as every person encounters unique obstacles along the way; for individuals facing addiction, relapses, self-doubt, and even tricky

confrontations with others are shared. Learning to handle these hurdles is often crucial to long-term recovery. Many service users express that no one is “turned away unless they’re using drugs or drink.” In these cases, individuals are encouraged to return when they are not actively using substances. This approach protects the safety of others in the community, promoting a space where everyone can focus on their healing journey. By establishing such boundaries, peer-led services help people understand that there are accountability expectations, which often serve as a helpful structure for those navigating the early, vulnerable stages of recovery.

The journey to recovery is rarely linear. Failures and setbacks are part of the experience, and peer support groups encourage individuals to see these as learning opportunities rather than reasons for despair. One participant shared a powerful perspective: "*Don’t beat yourself up... it’s progress, not perfection.”* By embracing an outlook that views mistakes as growth experiences, individuals can focus on their progress rather than their missteps. Encouragement from others reinforces the belief that setbacks, though painful, do not erase one’s progress. Another participant echoed this sentiment: *“Every time something goes wrong, we have something to learn... and that experience can help others as well.”* Relapse, while often disheartening, becomes less of a failure and a stepping stone toward understanding triggers, building resilience and ultimately helping others who might encounter similar challenges.

Honesty is a pillar of recovery. Service users are encouraged to be transparent about their struggles, as this transparency enables others to offer more effective support. *“The most important thing is you’ve come back, and you’ve been honest... because if you’re not honest, you can’t get help,”* one participant explained. This culture of honesty nurtures mutual respect as individuals learn to confront their challenges openly without fear of judgment. Being honest also strengthens the individual’s connection to the community. For many,

having someone who "holds you accountable" is invaluable, as it provides a form of support that feels personal and dependable.

The recovery process requires individuals to learn from their challenges, recognising that each hurdle can contribute to growth. As one user noted, *"You've just got to get back up and dust yourself off and keep walking... recovery is this journey you're stepping forward."* This perspective offers a profound insight into the resilience that sustains many individuals through difficult times. Those in recovery must often develop tools for self-care, such as self-reflection and recognising triggers. For example, one participant explained, *"I can put in safeguards... and just having that safeguard awareness helps me given in certain situations I might get triggered."* This proactive approach and support from others who have walked similar paths equip individuals to handle future challenges with greater awareness.

One-to-One Relationships

One-to-one relationships form a cornerstone in addiction recovery, often providing the personalised support needed to tackle deeply rooted issues. In peer-led recovery services, these relationships offer a safe space for individuals to express their needs and develop customised plans for their recovery. One counsellor shared, *"My job is for you to tell me what you need, and then I'll help you achieve that if you think it's going to be positive and enhance your future."* This approach shifts the focus from merely abstaining from substances to fostering a recovery that actively builds a better future. Through open dialogue, service providers enable individuals to set achievable goals and explore personal growth pathways aligning with their vision of a sober life.

These one-to-one relationships are designed to offer stability and trust, especially for individuals who might initially be uncomfortable in group settings. For many, the personal connection established in one-to-one meetings becomes a gateway to engaging with larger

support groups. One service user reflected, *"It was the one-to-ones where I could start picturing being able to do something… I just really clicked with my recovery coach."* This initial connection gave the individual the confidence to consider group sessions, knowing they had someone specific to turn to for support and encouragement. Through the consistency of these sessions, individuals feel less isolated in their journeys, gaining reassurance that they are not navigating recovery alone.

These private sessions allow for deeper exploration of complex emotions and navigating challenges, enabling individuals to process their feelings in a secure, non-judgmental environment. Another participant noted, *"Somebody came in and thought their trust had been breached; they talked it through with a worker one-to-one-on-one and realised any breach of confidence had probably come from another lived experience fellowship.* The transformative power of these sessions often comes from the simplicity of focused attention and a safe space to express vulnerabilities.

However, some participants have voiced concerns about needing these one-to-one sessions to remain intimate and individualised. One participant shared, *"There should be many more one-on-one conversations… but sometimes too many people get involved."* This observation underscores the importance of maintaining boundaries and respecting the privacy of these relationships, ensuring they remain safe spaces for honest discussion. In a recovery context, maintaining this focus can be particularly vital, as the challenges of addiction often require a unique understanding and trust that might not flourish in more extensive group interactions. For many individuals, having Kennedy Street as a place of safety was highly valuable. Learning together and observing one another was key to success; however, those with more entrenched trauma or trust-building issues required one-to-one space. They were often so distrustful that they required one-to-one support. This one-to-one support enabled them to build a trusting relationship with one individual. This intense support helped them to

understand how to model what they were learning in one-to-one when in their own lives, whereby they had to be with groups.

What are the ethical considerations in peer-led addiction services for building trust, particularly concerning confidentiality and boundaries?

Ethical considerations

Early-stage volunteering in recovery programmes offers benefits but also presents ethical risks that require careful consideration. One concern is individuals' readiness and emotional capacity in the early stages of recovery. Premature involvement in volunteer roles may lead to burnout, relapse, or feelings of failure, potentially hindering their recovery process. Additionally, early-stage volunteers may inadvertently provide incorrect or unhelpful advice to other vulnerable individuals. Without adequate training or supervision, this risk can harm both the volunteer and the recipient of their support. Programmes must balance the desire to empower early-stage participants with the need to ensure safe and practical guidance. The potential for exploitation of vulnerability is also significant. Enthusiastic but emotionally fragile individuals may feel pressured to contribute more than they are ready for, risking undue emotional strain. They may feel expected to broker relationships with other parts of the community for those new to recovery. Additionally, they may be perceived by the new service user to be more skilled and capable than they are (White 2007). White continues to suggest how to mitigate these risks with structured frameworks for volunteering, including comprehensive training, supervised roles, and gradual engagement, which are essential to ensure ethical and effective implementation of the volunteer role. Such measures protect vulnerable participants and enhance peer-support programmes' overall quality and sustainability. At Kennedy Street, volunteers are provided with robust training when ready to take on a more significant role in volunteering. Early volunteers are tasked with making tea

for people, asking people who may be nervous if they want to come in. No pressure is applied to newly appointed volunteers; those with more experience are consistently available for direction and support.

A peer worker described this process: *"Once they've engaged in abstinence and are committed to recovery, I get them involved straight away in our volunteer program."* By encouraging individuals to take on roles within the community, whether through volunteer work or simple acts of service like preparing coffee, users experience a shift from being beneficiaries to becoming active participants. This progression reinforces trust in the program and their capacity to contribute meaningfully. Kennedy Street has used the identity of volunteers as a mechanism to enable people to feel of service and value. The feel of service assists in rebuilding identities and trust. Identity vs Confusion is Erikson's fifth stage, and at Kennedy Street, people spoke about their role in supporting their identity development. One person said, "*I am a proud volunteer*", pointing to his badge. Another said, "I started volunteering here 18 months ago, now I am working, but I always come back here *and give back as this is where I found my recovery".*

Boundaries

Boundaries and confidentiality were presented as highly valued; participants suggested that all volunteers and peers be trained to ensure confidentiality in interactions. Kennedy Street participants implemented confidentiality statements ahead of all groups. On one occasion, an individual told me that someone was attending the service to seek them out sexually. *"I felt very uncomfortable when a person started attending; they were not seeking recovery. As I had been quite promiscuous in my past, linked to my addiction, I felt their attendance at the service was predatory. You can't do that here; everyone is so protective. Everyone has lived experience and has a seventh sense of picking up concerning behaviours. I spoke with my*

peer support worker, and he helped me put a plan in place to protect myself. With support, I was encouraged to highlight unwanted behaviours. This person eventually left". Another individual identified the following: "*We will have people come and go; some people will come here and try to take us, hostage, get us back on drugs, but we are close and tight-knit as a recovery community, and we protect each other. We will give all newcomers a chance, but if they are not coming to attend groups or be of service, then they are idle, and the devil makes work for idle hands*". Implementing boundaries seemed linked to ensuring that everyone at Kennedy Street was encouraged to take personal accountability. Taking personal accountability was vital in ensuring that all participants could make informed decisions and give supporting advice to one another. Beyond peer support, the CEO, a trained counsellor, would provide structured interventions that advanced the Kennedy Street model of personal accountability. The thread of personal responsibility was another vital ingredient that assisted participants, volunteers, and peer supporters in building trust with each other and the service they were attending. Confidentiality and keeping confidence were also linked to boundaries for participants. When participants were asked how they define trust, multiple people suggested that when they told people something, it was kept in confidence that supported trust building. Participants shared many childhood traumas in one-to-ones or groups, and preserving this confidence was a stepping stone to deeper trust levels.

OVERALL CONCLUSION

Summary of findings

Several themes emerged in answering how trust is built in peer-led services. Hope, Inclusivity, Observing Trust, Relearning Trust, Relatability, Time to Build Trust and Smart Goals were vital to building trust. Service users require hope to inspire their ability to trust and transform. Through the lens of service users, hope was the first step in believing that trust in self and others was possible. Hope symbolised a rebirth process, re-entry to life and social inclusion. Inclusivity and being a part of something bigger than yourself helped service users to trust others, rebuild relationships, and problem-solve with new trusted networks. Inclusion enabled service users to recreate their identity with those around them and the broader organisation. Part of the inclusion process to build trust was facilitating workshops and learning opportunities that encouraged service users to try new opportunities and expand their comfort zone and sense of self. Increased confidence through various courses supported building trust in self. In addition to formal learning spaces, informal social interactions such as eating and sober socials helped individuals how to have fun in trusting and holding value in building social structure trust. Observing Trust and Relearning Trust helped service users take new risks and use a pro-social model in all interactions to attain recovery capital successfully. Finally, relatability and a shared empathetic understanding of the barriers to recovery injected an immediate level of trust. Service users had an automatic level of trust if you had their shared Lived Experience of Addiction.

Understanding how peer-led services navigated trust-related challenges was enveloped in the ethos that each challenge is an opportunity to learn or grow. Service users and peers have an optimistic view, enabling them to see challenges positively. By doing this, they dismissed negative patterns of behaviour, such as being the victim or seeing challenges as an opportunity to give up. They held a healthy attitude and relationship with overcoming

challenges. The service users utilised the peer's experiences of overcoming challenges in this way as a method of mitigating harm to themselves or others through relapse or poor mental health connected with challenges. Stigma is considered a community challenge that disabled service users with addiction backgrounds re-entering society. Kennedy Street, however, fostered an environment conducive to building trust as they adopted a welcoming space. Those who were not stigmatised felt better able to overcome the challenges they faced in rehabilitation and community integration. A foundational part of overcoming challenges was the erection of clear boundaries and one-to-one support provision. One-to-one support ensured service users with high levels of mistrust were provided with a space to work this through with one person they trusted. Regarding ethical considerations, less came up in the study regarding this question. What was not anticipated was the role of volunteering and the ethics of doing so in early recovery. Many services will have policies preventing early-stage volunteering; however, this study revealed the benefits of enabling early-stage volunteering. For example, people were proud of their ability to be part of something and give back to others. They had a responsibility, even if welcoming people to Kenedy Street and providing a smile and a cup of tea. The service has created a volunteer program that allows all people to volunteer at a pace that is right for them. All volunteers were provided training for their responsibility level. This volunteering was critical in creating a new identity and building support for the organisation, the brand, and the service. Finally, the organisational boundaries of volunteering at Kennedy Street offered discipline for many who had once been chaotic and now required an anchor through volunteering. Being part of something bigger than themselves was a powerful mechanism for establishing trust.

The utility of Erikson's model for understanding trust building in peer-led services

While Bowlby's attachment theory provides foundational insights into the development of trust in early childhood, it is limited in its applicability to understanding trust across the

lifespan. Erikson's psychosocial model expands on this by offering a life-cycle perspective, highlighting the continued importance of trust formation and repair throughout various stages of life for adults in a peer led addiction service.

Furthermore, the incorporation of Fonagy's concepts of mentalisation and epistemic trust further develops the theoretical framework by demonstrating how trust can be re-established in therapeutic and peer-led contexts. Peer-led services are particularly effective because they foster credibility, relatability, and shared experiences, which address service users' scepticism and mistrust stemming from past trauma and inadequate professional care. These services enable trust-building through consistent, empathetic, and equal interactions, which align with Erikson's and Fonagy's theories of relational trust.

This study highlights the role of trust as a foundation for rehabilitation, recovery, and reintegration, advocating for peer-led services as an essential complement to traditional therapeutic approaches. Trust, as examined through Erikson's eight-stage psychosocial development model, provides a comprehensive framework for understanding its formation and repair throughout the lifespan. Unlike Bowlby's attachment theory, which focuses primarily on early childhood, Erikson's model emphasises trust as a recurring and evolving construct central to each developmental stage of peers accessing Kennedy Street. This approach is particularly relevant for peer-led services, as it acknowledges that trust can be disrupted and repaired at any life stage, making it more adaptable to the varied experiences of individuals in recovery or rehabilitation.

Erikson's stages, beginning with "Trust vs. Mistrust," lay the foundation for understanding how early life experiences with caregivers shape one's ability to trust others and oneself. However, subsequent stages—such as "Identity vs. Role Confusion" in adolescence and "Generativity vs. Stagnation" in adulthood—highlight how trust plays a crucial role in

forming identity, establishing meaningful relationships, and contributing to society. For individuals with lived experience of addiction or trauma, disruptions in trust may occur at various stages, reflecting life events such as neglect, abuse, or social exclusion. Erikson's model provides a structured way to explore these disruptions and how they can be addressed in recovery.

The benefit of Erikson's model lies in its dynamic nature, offering a framework to identify where trust was initially compromised and where opportunities for repair and growth exist. For example, in peer-led services, fostering trust aligns with Erikson's emphasis on reciprocity, empathy, and the shared meaning of experiences, which can rebuild confidence in relationships and promote personal development. Trust, when nurtured through these stages, supports identity cohesion, fosters resilience, and enables individuals to re-engage with their communities, thus facilitating long-term recovery and social reintegration.

This life-cycle approach makes Erikson's model particularly beneficial for designing interventions within peer-led services. It encourages practitioners to tailor trust-building efforts to the individual's current stage of development, addressing their specific needs while recognising the broader trajectory of their recovery journey. By framing trust as an ongoing developmental process, Erikson's model provides a robust theoretical foundation for understanding and enhancing the effectiveness of peer-led services.

Progression within the Erikson lifecycle is a chronological trajectory, where the variables of age match the amount of time progressed. However, what has emerged from the data during the research is that Erikson's stages of development can be used as a framework for understanding how those in recovery can rebuild trust with their peers.

The research identified that at some point in time, those following the chronological trajectory of differing lifecycles points in time became 'stuck' either becoming maladaptive or having some form of trauma. From the data, it is logical to propose that for a service user to resume on the chronological pathway to metaphorically 'catch up,' they may have to perform the Erikson trajectory in an alternative order that is not chronological.

The study identified some resistance to trusting psychological services that were not peer-led or supported. The research uncovered that service users felt structured professional services did not have the flexibility to cater to their broader needs, often dependent on building trust as a first step. Having a framework such as Erikson's felt more adaptable for peer-led services to understand service users' needs and why trust is paramount to rehabilitation. A study by Dekkers et al. (2021) supports the value of trust-building in recovery services, hope and trust in new futures, trust in self, trust in others and setting goals that can be achieved, which build trust and confidence.

Recognising that recovery does not follow a fixed trajectory; services should allow individuals to navigate Erikson's stages in a way that aligns with their unique needs and experiences. For instance, service users might revisit earlier stages like Trust vs. Mistrust during periods of vulnerability or leap to Identity vs. Role Confusion when working on their self-concept. Flexibility in peer-led services is highly valuable to recovery seekers; they found having unstructured access to support incredibly beneficial. Participants commented on how genuine and meaningful this support felt to them. Ensuring support services are flexible and less formal may increase the rate at which trust can be built and reduce barriers to rehabilitation.

Brown et al. (2019) identify peer support workers as paraprofessionals who connect those seeking recovery with their communities, much like Kennedy Street peers, who not only

support their service users back into the community but also educate the community to understand those lost to addiction. This education reduces stigma and makes integration a more straightforward process. Unlike professional services, Kennedy Street is highly motivated to help its service users succeed. The tiny but mighty service requires more recognition and resources to support structured services less trusted by the people they serve.

The shared understanding of addiction accelerates trust building, which cannot be mirrored through other structures. Services aimed at addressing rehabilitation in recovery settings would benefit from the deployment of Lived Experience peers that bridge the gap of trust that is visible.

Recommendations

Trauma-Informed Approaches

Implementing policies that recognise the role of trauma in addiction and recovery. Develop training for staff and volunteers in trauma-informed care, focusing on the impact of adverse childhood experiences and life events on trust-building, in addition to ensuring that peers who work with those still in active addiction are offered clinical supervision to mitigate against any trauma triggers for them. Ensure therapeutic support services are available for addressing unresolved trauma, as this is foundational for rebuilding trust and fostering long-term recovery.

Peer-Led Support and Relatability

A key recommendation is to establish peers with lived experience (LE) as a foundational pillar in trust-building within addiction recovery services. Their unique relational ability and

deep understanding of service users' life issues make them exceptionally credible and effective in fostering initial engagement. Professional services must recognise that individuals with Lived Experience possess an authenticity and shared understanding that traditional professionals often cannot replicate, particularly in the early stages of recovery.

Case studies: Demonstrating this value to professionals through data, case studies, and collaborative training opportunities is essential to bridging this gap and embedding the peer role as an indispensable component of recovery services.

Expand the use of peer-led services, emphasising the value of lived experience in fostering trust and relatability. Ensure that policies intentionally recruit and employ individuals with lived experience. Understanding that these types of employees bring relational and engagement excellence but may require enhanced training to upskill in boundaries, safeguarding, IT and report writing. Peers can lend credibility to professional services by advocating them as helpful to this community. Policies should formalise the role of peer mentors and volunteers, ensuring they receive adequate training and supervision to prevent burnout and ethical breaches. Operationalising the peer role will highlight that traditionally formal professionals recognise and value the unique expertise of modern informal peer roles, which derive their professionalism from lived experience.

Encourage role modelling and observational learning as key strategies for service users to build trust and adopt pro-social behaviours. For those with deep-rooted trauma and trust-related issues or those naturally introverted, being able to work at your own pace is vital to trust-building.

Structured Volunteer Programs: Develop structured volunteer pathways, starting with low-pressure roles (e.g., welcoming newcomers) and progressing to more responsible tasks as

individuals gain confidence and stability. Incorporate identity-building opportunities into volunteer roles to help participants develop a sense of purpose and self-worth, addressing Erikson's stages of identity vs confusion and generativity vs stagnation.

Inclusion and Community Building

Promote inclusivity within rehabilitation services by fostering warm, supportive environments where service users feel valued and integral to the community. Shared meals, communal activities, and group rituals should be embedded in rehabilitation practice to strengthen social bonds. Soft furnishings that create a gentle environment akin to a family one were observed to create better conditions for trust building. Establish pathways for service users to connect with broader recovery networks, such as fellowship groups, to enhance their sense of belonging and access to resources in the wider community.

Hope as a Foundation of Trust

Frame hope as a central tenet of recovery policy, ensuring services provide tangible examples of recovery success and opportunities for individuals to visualise their progress. These examples can be peers in service, successes published in newsletters or accolades achieved on posters up and around the service. Integrate hope-driven practices into training programs for staff and volunteers, reinforcing their role in fostering optimism and resilience among service users.

Emotional Intelligence and Trust Relearning

Offer workshops on emotional intelligence, focusing on recognising and managing emotions, building empathy, and repairing relationships. These programs should emphasise how emotional intelligence supports self-trust and trust in others. Encourage reflection and

gratitude practices to help service users internalise positive experiences and reinforce trust-building behaviours.

Confidentiality and Boundary Training: Mandate robust training on confidentiality and boundaries for all staff and volunteers to address ethical concerns and create safe spaces for trust-building. Develop clear policies for managing breaches of trust, such as inappropriate behaviour or confidentiality violations, with transparent accountability mechanisms.

Handling Relapse and Setbacks: Adopt a non-judgmental approach to relapses, framing them as learning opportunities rather than failures. Peer-led services should guide understanding triggers and building resilience after setbacks. Establish clear policies that allow individuals to return to services post-relapse while maintaining the safety and integrity of the recovery community.

Personal Accountability Frameworks: Embed personal accountability as a core principle in rehabilitation practices, encouraging service users to set SMART goals and take ownership of their recovery journey. Ensure one-to-one support is available for those with significant trust-building challenges, providing a foundation for gradual reintegration into group settings.

Ethical Oversight: Create ethical oversight committees within peer-led services to monitor volunteer readiness, manage risks, and ensure the delivery of high-quality support. Regularly review and adapt training programs to address emerging ethical and practical challenges in peer-led addiction services.

Limitations

This research demonstrates that peer-led services improve engagement, retention, and outcomes by creating an environment of shared power, reciprocity, and hope. However, gaps

remain in understanding these services' specific stages and mechanisms of trust formation, given the minor nature of the study. Future research could explore these processes in greater detail, focusing on how organisational structures and peer support frameworks can further enhance trust-building.

The findings of this study are rich in insight but come with some limitations. While valuable for understanding individual journeys, relying on subjective lived experience narratives limits generalisability to broader populations or diverse service contexts. The study's focus on a single peer-led service, Kennedy Street, also means that findings may not reflect practices or outcomes in other recovery settings. The absence of quantitative data and limited input from traditional professionals also present gaps, making it challenging to fully validate the claims about the superiority of peer-led approaches in trust-building. In addition, knowledge of Erikson's 8-stage development model as a framework to understand trust building may benefit from further research and quantitative research methods. Furthermore, the emphasis on positive outcomes may overshadow potential challenges, such as breaches of confidentiality or the complexities of integrating peer roles with professional services.

To address these gaps, future research should explore the long-term impact of peer-led trust-building on recovery outcomes and examine the scalability of these approaches across different cultural, geographical, and service contexts. A mixed-methods approach incorporating qualitative and quantitative data would provide a more robust evaluation of peer-led interventions. Additionally, studies comparing the effectiveness of multidisciplinary teams that combine peer-led and professional expertise could help establish best practices for integrating these roles. Such research would strengthen the case for embedding peers as a foundational component of addiction recovery services.

References

Aakerblom, K.B. and Ness, O., 2021. Peer support workers in co-production and co-creation in public mental health and addiction services: Protocol for a scoping review. *Plos one,* 16(3), p.e0248558.

Abadi, M.H., Barker, A.M., Rao, S.R., Orner, M., Rychener, D. and Bokhour, B.G., 2021. Examining the impact of a peer-led group program for veteran engagement and well-being. *The Journal of Alternative and Complementary Medicine,* 27(S1), pp.S-37.

Abubakar, B.U., 2023. Erik Erikson's Psychosocial Theory: As a Tool for Promoting Early Childhood Education in Nigeria. *African Journal of Humanities and Contemporary Education Research,* 10(1).

Alavi, S., Nishar, S., Morales, A., Vanjani, R., Guy, A. and Soske, J., 2024. 'We Need to Get Paid for Our Value': Work-Place Experiences and Role Definitions of Peer Recovery Specialists/Community Health Workers. *Alcoholism Treatment Quarterly,* 42(1), pp.95-114.

Allen, G. and Tunnicliffe, R., 2021. Drug crime: Statistics for England and Wales.

Arnal, A.R. and McNeill, F., 2023. Exploring social re/habilitation and developing a new conceptualisation of re/integration. In *Social Rehabilitation and Criminal Justice,* pp. 251–267. Routledge.

Barnabas, A., Shah, S., Halford, R., Dusheiko, G. and Agarwal, K., 2023. Results of a model of delivering hepatitis C care in a homeless metropolitan population in England. *Official journal of the American College of Gastroenterology | ACG,* 118(6), pp.991–1000.

Bandura, A., 1969. Social-learning theory of identificatory processes. In *Handbook of socialization theory and research,* pp. 213–262.

Beales, A. and Wilson, J., 2015. Peer support – the what, why, who, how and now. *The Journal of Mental Health Training, Education and Practice,* 10(5), pp.314–324.

Berger, R. (2020). Now I See It, Now I Don't: Researcher's Position and Reflexivity in Qualitative Research. *Qualitative Research*, 20(2), 219-234.

Berástegui Pedro-Viejo, A. and Pitillas Salvá, C., 2024. Family Keyworker as a non-clinical and democratic figure to support hard-to-reach families from an attachment perspective.

Bevington, D., Fuggle, P. and Fonagy, P., 2015. Applying attachment theory to effective practice with hard-to-reach youth: the AMBIT approach. *Attachment & Human Development,* 17(2), pp.157–174.

Boullier, M. and Blair, M., 2018. Adverse childhood experiences. *Paediatrics and Child Health,* 28(3), pp.132–137.

Bowlby, J., 1982. *Attachment: Attachment and Loss.*

Bradbury-Jones, C., 2021. Reflexivity in Qualitative Research: A Guide for Researchers. *Nursing Standard,* 35(12), pp.45–50.

Brandell, J.R., 2010. Contemporary psychoanalytic perspectives on attachment. *Psychoanalytic Social Work,* 17(2), pp.132–157.

Braun, V. and Clarke, V., 2006. Using thematic analysis in psychology. *Qualitative Research in Psychology,* 3(2), pp.77–101.

Braun, V. and Clarke, V., 2020. Reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health.*

Braun, V. and Clarke, V., 2021. Can I use TA? Should I use TA? Should I not use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches. *Counselling and Psychotherapy Research,* 21(1), pp.37–47.

Bryman, A., 2016. *Social research methods.* Oxford University Press.

BUBIC (2025) 'Who we are' [Online] Available at: https://www.bubic.org.uk/ (Accessed 20.01.2025)

Campbell, C., Tanzer, M., Saunders, R., Booker, T., Allison, E., Li, E., O'Dowda, C., Luyten,

P. and Fonagy, P., 2021. Development and validation of a self-report measure of epistemic trust. *PLOS ONE,* 16(4), p.e0250264.

Carducci, B.J., 2020. Erik H. Erikson. *The Wiley Encyclopedia of Personality and Individual Differences: Models and Theories,* pp.45–49.

Davies, A.R., 2019. Introduction: the significance of food sharing. In *Urban Food Sharing: Rules, Tools and Networks,* Bristol University Press, pp.1–10.

Dempsey, L., Dowling, M., Larkin, P. and Murphy, K., 2016. Sensitive interviewing in qualitative research. *Research in Nursing & Health,* 39(6), pp.480–490.

Dingle, G.A., Cruwys, T. and Frings, D., 2015. Social identities as pathways into and out of addiction. *Frontiers in Psychology,* 6, p.153612.

Duschinsky, R. and Foster, S., 2021. Mentalizing and epistemic trust: The work of Peter Fonagy and colleagues at the Anna Freud Centre. Oxford University Press.

Earnshaw, V.A. and Quinn, D.M., 2012. The impact of stigma in healthcare on people living with chronic illnesses. *Journal of Health Psychology,* 17(2), pp.157–168.

Ellis, C., 2004. *The Ethnographic I: A Methodological Novel about Autoethnography.* Walnut Creek, CA: AltaMira Press.

Erikson, E.H., 1950. *Childhood and Society.* New York: W.W. Norton & Company.

Erikson, E.H., 1963. *Childhood and Society* (2nd ed.). New York: W.W. Norton & Company.

Fearon, R.M.P. and Roisman, G.I., 2017. Attachment theory: Progress and future directions. *Current Opinion in Psychology,* 15, pp.131–136.

Ferguson, H., Warwick, L., Disney, T., Leigh, J., Cooner, T.S. and Beddoe, L., 2022. Relationship-based practice and the creation of therapeutic change in long-term work: social work as a holding relationship. *Social Work Education,* 41(2), pp.209–227.

Fisher, S., Zilcha-Mano, S. and Fonagy, P., 2022. Conceptualizing epistemic trust in psychotherapy: A triadic model. *Psychotherapy Bulletin,* 57(2), pp.29–35.

Flick, U., 2018. *An Introduction to Qualitative Research.* London, UK: Sage.

Fonagy, P. and Allison, E., 2023. Beyond mentalizing: Epistemic trust and the transmission of culture. *The Psychoanalytic Quarterly,* 92(4), pp.599–640.

Fonagy, P., Hepworth, M. and Campbell, C., 2022. Theoretical models of psychodynamic psychotherapy. In *Gabbard's Textbook of Psychotherapeutic Treatments,* p.3.

Frank, D., Mateu-Gelabert, P., Perlman, D.C., Walters, S.M., Curran, L. and Guarino, H., 2021. "It's like 'liquid handcuffs'": The effects of take-home dosing policies on Methadone Maintenance Treatment (MMT) patients' lives. *Harm Reduction Journal,* 18, pp.1–10.

Gillard, S., Foster, R. and Turner, K., 2016. Evaluating the Prosper peer-led peer support network: a participatory, coproduced evaluation. *Mental Health and Social Inclusion,* 20(2), pp.80–91.

Gillard, S., Foster, R., White, S. et al., 2024. Implementing peer support into practice in mental health services: a qualitative comparative case study. *BMC Health Services Research,* 24, p.1050.

Gross, Y., 2020. Erikson's stages of psychosocial development. *The Wiley Encyclopedia of Personality and Individual Differences: Models and Theories,* pp.179–184.

GOV.UK, 2024. Part 1: Introducing recovery, peer support and lived experience initiatives. Available at: www.gov.uk (Accessed: 18 June 2024).

Harding, N., 2018. Places on Probation: An Auto-Ethnography of Co-Produced Research with Women with Criminal Biographies. Wilmington, DE: Vernon Press.

Hepatitis C Trust, 2025. Infected Blood and Blood Products: Infected Blood Inquiry. Available at: https://www.hepctrust.org.uk (Accessed: 6 January 2025).

Hien, D.A., Morgan-López, A.A., Saavedra, L.M., Ruglass, L.M., Ye, A., López-Castro, T., Fitzpatrick, S., Killeen, T.K., Norman, S.B., Ebrahimi, C.T. and Back, S.E., 2023. Project Harmony: A meta-analysis with individual patient data on behavioral and pharmacologic

trials for comorbid posttraumatic stress and alcohol or other drug use disorders. *American Journal of Psychiatry,* 180(2), pp.155–166.

Hinderliter, B.A., 2022. Individuation Through Myth: An Exploration of Self and Attachment (Master's thesis, Pacifica Graduate Institute).

Kerslake, R., 2022. Theories of Human Development. In *Revision Guide for MRCPsych Paper A,* pp.45–59. Routledge.

Khairani, K. and Maemonah, M., 2021. The Nature of Psychosocial Development in Early Childhood According to Erik Erikson's View. *Jurnal Kajian Gender dan Anak,* 5(2), pp.151–161.

Kitchens, R. and Abell, S., 2020. Ego identity versus role confusion. *Encyclopedia of Personality and Individual Differences,* pp.1254–1257.

Kurteva, A., Chhetri, T.R., Pandit, H.J. and Fensel, A., 2021. Consent through the lens of semantics: State of the art survey and best practices. *Semantic Web,* (Preprint), pp.1–27.

Lansing, A.E., Romero, N.J., Siantz, E., Silva, V., Center, K., Casteel, D. and Gilmer, T., 2023. Building trust: Leadership reflections on community empowerment and engagement in a large urban initiative. *BMC Public Health,* 23(1), p.1252.

Liebling, A., 2004. *Prisons and their Moral Performance: A Study of Values, Quality, and Prison Life.* Oxford University Press.

Marchand, K., Foreman, J., MacDonald, S., Harrison, S., Schechter, M.T. and Oviedo-Joekes, E., 2020. Building healthcare provider relationships for patient-centred care: a qualitative study of the experiences of people receiving injectable opioid agonist treatment. *Substance Abuse Treatment, Prevention, and Policy,* 15, pp.1–9.

Maree, J.G., 2022. The psychosocial development theory of Erik Erikson: critical overview. In *The Influence of Theorists and Pioneers on Early Childhood Education,* pp.119–133.

Maghawry, H.F., Darwish, A.M., Mohammed, N.A.E., Abd El-hameed, N.A.E.G. and

Ahmed, G.K., 2024. Assessing emotional intelligence domains and levels in substance use disorders. *The Egyptian Journal of Neurology, Psychiatry and Neurosurgery,* 60(1), p.19.

Mancini, A.D., 2008. Self-determination theory: A framework for the recovery paradigm. *Advances in Psychiatric Treatment,* 14(5), pp.358–365.

Martinelli, T.F., Nagelhout, G.E., Bellaert, L., Best, D., Vanderplasschen, W. and van de Mheen, D., 2020. Comparing three stages of addiction recovery: Long-term recovery and its relation to housing problems, crime, occupation situation, and substance use. *Drugs: Education, Prevention and Policy,* 27(5), pp.387–396.

Mead, S. and MacNeil, C., 2006. Peer support: What makes it unique. *International Journal of Psychosocial Rehabilitation,* 10(2), pp.29–37.

Meulewaeter, F., De Pauw, S.S. and Vanderplasschen, W., 2019. Mothering, substance use disorders and intergenerational trauma transmission: An attachment-based perspective. *Frontiers in Psychiatry,* 10, p.728.

Meyerson, B.E., Russell, D.M., Kichler, M., Atkin, T., Fox, G. and Coles, H.B., 2021. I don't even want to go to the doctor when I get sick now: healthcare experiences and discrimination reported by people who use drugs, Arizona 2019. *International Journal of Drug Policy,* 93, p.103112.

Miles, M.B., Huberman, A.M. and Saldana, J., 2014. *Qualitative Data Analysis: A Methods Sourcebook.* Thousand Oaks, CA: Sage.

Milesi, A., De Carli, P., Locati, F., Benzi, I., Campbell, C., Fonagy, P. and Parolin, L., 2023. How can I trust you? The role of facial trustworthiness in the development of epistemic and interpersonal trust. *Human Development,* 67(2), pp.57–68.

Miller, S.A. and Lang, D., 2022. Psychosocial Theory: Erikson. In *Individual and Family Development, Health, and Well-being.*

NHS Benchmarking Network (2023) 'Peer Support Workers Census 2023 Summary Report'

Nixon, S., 2020. ‘Giving back and getting on with my life’: Peer mentoring, desistance and recovery of ex-offenders. *Probation Journal,* 67(1), pp.47–64.

Novosel, L.M., 2023. Understanding the Evidence: Non-Probability (Non-Random) Sampling Designs. *Urologic Nursing,* 43(5), 245+. Available at: https://link-gale-com.ezp.lib.cam.ac.uk/apps/doc/A770556764/AONE?u=cambuni&sid=bookmark-AONE&xid=51ec755e [Accessed 5 January 2025].

Nowell, L.S., Norris, J.M., White, D.E. and Moules, N.J., 2017. Thematic Analysis: Striving to Meet the Trustworthiness Criteria. *International Journal of Qualitative Methods,* 16(1).

Official Statistics Crime outcomes in England and Wales, 2022 to 2023.

Orenstein, G.A. and Lewis, L., 2022. Erikson's stages of psychosocial development. In *StatPearls [Internet].* StatPearls Publishing.

Oxford English Dictionary, 2024. Trust. Available at: https://www.oed.com/ (Accessed: 26 December 2024).

Patterson, M.L., 2011. *More than words: The power of nonverbal communication* (Vol. 4). Aresta.

Patton, M.Q., 2002. *Qualitative Research & Evaluation Methods.* Thousand Oaks, CA: Sage.

Pickard, H., 2020. What we're not talking about when we talk about addiction. *Hastings Center Report.*

Ragins, M. and Sunkel, C., 2024. The recovery model and other rehabilitative approaches. In *Tasman’s Psychiatry,* pp.3395–3441. Cham: Springer International Publishing.

Rumeo, C., 2022. A Critical Review of Measures of Mentalization from Peter Fonagy’s Conceptual Framework (Master's thesis, University of Waterloo).

Saleem, F., Zhang, Y.Z., Gopinath, C. and Adeel, A., 2020. Impact of servant leadership on performance: The mediating role of affective and cognitive trust. *Sage Open,* 10(1),

p.2158244019900562.

Schilke, O., Reimann, M. and Cook, K.S., 2021. Trust in social relations. *Annual Review of Sociology,* 47, pp.239–259.

Simply Psychology (n.d.) Erik Erikson's stages of psychosocial development. Available at: https://www.simplypsychology.org/erik-erikson.html (Accessed: 26 January 2025).

Shalaby, R.A.H. and Agyapong, V.I., 2020. Peer support in mental health: Literature review. *JMIR Mental Health,* 7(6), p.e15572.

Sun, J., Yin, X., Li, C., Liu, W. and Sun, H., 2022. Stigma and peer-led interventions: A systematic review and meta-analysis. *Frontiers in Psychiatry,* 13, p.915617.

Sultana, F. (2021). The Unbearable Heaviness of Climate Coloniality. Political Geography, 88, 102404.

Surmiak, A., 2020. Should we maintain or break confidentiality? The choices made by social researchers in the context of law violation and harm. *Journal of Academic Ethics,* 18(3), pp.229–247.

Swann, C., Jackman, P.C., Lawrence, A., Hawkins, R.M., Goddard, S.G., Williamson, O., ... and Ekkekakis, P., 2023. The (over) use of SMART goals for physical activity promotion: A narrative review and critique. *Health Psychology Review,* 17(2), pp.211–226.

Tan, A.J.H. and Lee, K.Q., 2023. Working with drug abusers. In *Correctional Rehabilitation and Psychological Interventions in Singapore: Practitioners' Experiences in Singapore Prison Service,* pp.79–108.

Terry, G., Hayfield, N., Clarke, V. and Braun, V., 2017. Thematic analysis. In *The SAGE handbook of qualitative research in psychology,* 2(17–37), p.25.

UK Government (2025) 'Part 3: how to develop systems of care that support recovery'. Available at: https://www.gov.uk/government/publications/recovery-support-services-and-

lived-experience-initiatives/part-3-how-to-develop-systems-of-care-that-support-recovery (Accessed: 10 January 2025).

Office for National Statistics (2024) 'Drug misuse in England and Wales: year ending March 2024'. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/drugmisuseinenglandandwales/yearendingmarch2024 (Accessed: 02 January 2025).

UK Government (2023) Young people's substance misuse treatment statistics 2022 to 2023 report. Available at: https://www.gov.uk/government/statistics/substance-misuse-treatment-for-young-people-2022-to-2023/young-peoples-substance-misuse-treatment-statistics-2022-to-2023-report (Accessed: 26 January 2025).

Vicedo, M., 2017. The Strange Situation of the Ethological Theory of Attachment: A Historical Perspective. In *CogNet Special Collection.* MIT Press.

Wangensteen, T. and Hystad, J., 2022. Trust and collaboration between patients and staff in SUD treatment: A qualitative study of patients' reflections on inpatient SUD treatment four years after discharge. *Nordic Studies on Alcohol and Drugs,* 39(4), pp.418–436.

White, W.L., 2007. Ethical guidelines for the delivery of peer-based recovery support services.

Willis, G.M. and Ward, T., 2024. Evidence for the Good Lives Model in supporting rehabilitation and desistance from offending. In *The Wiley Handbook of What Works in Correctional Rehabilitation: An Evidence-Based Approach to Theory, Assessment and Treatment,* pp.299–309.

Wolcott, H.F., 1990b. Making a study more ethnographic. *Journal of Contemporary Ethnography,* 19, pp.44–72.

Zomer, L.J., Voskes, Y., Van Weeghel, J., Widdershoven, G.A., Van Mierlo, T.F., Berkvens,

B.S., Stavenuiter, B. and van der Meer, L., 2020. The active recovery triad model: A new approach in Dutch long-term mental health care. *Frontiers in Psychiatry,* 11, p.592228.

ANNEX A

Developmental StageInterview Question specifies whether it is for service users; otherwise, it is written for staff, volunteers, and peers.

How do you define trust?

Infancy – Trust vs. Mistrust

(AI) Can you provide the best example of when a new service user (you) first engages with the peer-led service?

What initial steps do/did you/they take to establish a foundation of trust with them (or here)?

Early Childhood – Autonomy vs. Shame/Doubt

How do you handle situations where service users (you) hesitate to engage in the program?

a) What methods foster a sense of autonomy?

b) What methods foster a sense of confidence in their (your) decision to seek help?

Preschool Age – Initiative vs. Guilt

How do you encourage service users to take initiative in their recovery process?

a) How do you support them in overcoming feelings of guilt, especially after setbacks like relapses?

b) How do you support them in overcoming feelings of failure, especially after setbacks like relapses?

School Age – Industry vs. Inferiority

How do you assist service users in setting and achieving recovery goals? (AI) Could you share the best example of how accomplishing these goals has impacted their/your trust in the service?

Adolescence – Identity vs. Role Confusion

(AI) Can you give me the best example of how the service helps you to build a positive identity? How do these efforts help in building trust?

Young Adulthood – Intimacy vs. Isolation

Could you discuss how peer-led services develop healthy, intimate relationships among service users and how this might help mitigate feelings of isolation?

Adulthood – Generativity vs. Stagnation

What opportunities do you provide for service users to contribute back to the community or help others in their recovery journey? How does this impact a sense of trust and community involvement?

Old Age – Integrity vs. Despair

For long-term service users, how do you help them/yourself reflect on their/your life and recovery journey? How does this reflection help reinforce trust in the service and themselves?

Across All Stages

What ethical considerations does your service uphold, especially regarding confidentiality and boundaries? How do these practices build trust with your users?

Challenges and Navigation

Can you share a challenge related to trust that the service has faced? How was this addressed, and what was the outcome?

Name	Description
Being forced	Ruins trust, prevents natural progress to trust
Being judged	Triggers and prevents trust
Boundaries	Required to build trust and feel safe
Confidentiality	Taken seriously at Kennedy Street, robust training.
And that gives me the confidence to share more.	
Control	OCD enables control; people need an element of control to trust.
Equality	
Gift of desperation	Being in hospital near death forced entry to Kennedy Street
Hope	Listening to other people's hope helped repair trust.
Included	Being included helps build relationships which in turn build trust
Lack of relatability	People were concerned that professionals without addiction pasts could not understand them.
Meditation	Being given tools to trust yourself and rely on yourself.
Navigating challenges	Relapse and failure to teach success.
Observe trust	Watched trust transpire organisationally and in smaller 1 1s
One-to-one relationships	Some people need 1:1 space and a person who is their key mentor.
Past's	How trust was broken, how childhood and life cycle issues
Personal accountability	Peers helping me to take responsibility.
Prosocial modelling	Showing each other the way forward
Relatability	People had similar backgrounds, which helped increase trust.
Relearning trust	The opportunity was provided to learn skills

Name	Description
Rely on people	Relying on others and building networks supported trust-building
Smart goals	Achieving goals enabled people to build trust in themselves and others
So, things like meditation and yoga are also good. So, I do them alone, but now I go to groups and meet people outside.	Several people commented on meditation helping them build trust in themselves and a higher power
Sober socials	Food and fun activities build trust in socialising activities.
Social influence	Referrals from people they trust to professionals held more weight.
Stigma	Individuals commented on feeling less stigma from people with past addictions
Suggestions	People highlighted potential options that worked for each other to one another
Time to build	Trust takes time to build and should be at the individual's pace. 9-5 services can facilitate this as they are too structured and inflexible.
Trust	People felt trust was built when people listened to them and followed through on what they promised to do consistently.