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Employee support: Where have we come from, and where are we going?

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ABSTRACT

Peer involvement has been supporting people experiencing mental health and other psychosocial problems for over a hundred years. As the influence of peers increases in primary and secondary health care as well as within organisations, there is a need to evaluate the effectiveness of using peers to deliver support for a range of psychosocial conditions. This paper reviews the emergence of peer support from the United Kingdom's social welfare and the American social justice movements. There are some well-established benefits to taking support as close as possible to those in need through peers provide clinical support without adequate training and assistance. Whilst this paper was written with policing in mind, the principles would apply to any organisation considering introducing a peer support program.

Key Words Police peer support; well-being; evaluation.

INTRODUCTION

During the 21st century, there has been a dramatic increase in employees seeking to become involved in improving their colleagues' and peers' health and well-being. Many, after a few days of training, have become Mental Health First Aiders (Kitchener & Jorm, 2002), Wellbeing Ambassadors (Goldman et al., 2017), Wellbeing Coaches (IAFPD, 2020), Critical Incident Stress Debriefers (Mitchell & Everely, 2001), Trauma Incident Management Assessors (Jones et al., 2017), and Psychological First Aiders (Shultz & Forbes, 2014). Organisations have spent significant sums of money training workers in one or more of these approaches to address rapidly rising levels of psychosocial problems in the workplace when access to psychological interventions through the National Health Service (NHS) is restricted (Punton et al., 2022). Despite the high expectations and glowing reports on peer models, most evaluations (e.g., Price et al., 2022; Chinman et al., 2014; Repper & Carter, 2011; Dieltjens et al., 2014) have found a lack of evidence to demonstrate the effectiveness of peer-delivered support. This paper will explore the origins and development of peer-led support programs from their roots in the early 19th century to the establishment of the approaches found uneasily cohabiting in today's organisations.

The interest in this area of study stems from the wish to develop a suitable Peer Support program for the National Police Wellbeing Service (NPWS) in the United Kingdom (UK) that is context sensitive, scalable and attractive to those implementing the programme. Police services in many other jurisdictions continue to seek ways to better support the wellness and recovery of their own members, and peer support programs will often form an important part of those services. A thorough understanding of the history of these programs, the variations among them, and the experience people have had with them, along with many of the important considerations arising from that experience, will help to inform decision-makers and practitioners alike.

Peer Support for Mental Health

For centuries, people with mental health problems were incarcerated in lunatic asylums, where their treatment was harsh and inhumane; patients were neglected, abused, and viewed as objects of ridicule (Ruggeri, 2016). In 1792, William Tuke, a Quaker, built the Retreat in York, pioneering a "moral treatment" of mental health based on humane conditions, sound, caring medical treatment, and a minimum of physical restraint (Pearce, 2020). Five years later, Philippe Pinel, a physician at a mental asylum for men in Paris, described the principles of a humane method for treating mental health problems. Pinel believed mental illness could be cured and required his physicians to make diagnoses by observing behaviour and listening to and recording their stories. Pinel emphasised the importance of understanding the natural history of the disease and precipitating events. One of Pinel's patients, Jean

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Baptiste Pussin, treated for scrofula (a form of tuberculosis), was appointed as an assistant to Pinel. Under Pussin's influence, other recovering inmates were used to support their fellow asylum inmates; chains were removed and replaced with strait jackets. Pinel's records provide the first recorded evidence of recovering patients being used to support mental health patients' clinical treatment (Weiner, 1992).

Today, one of the most influential peer-based movements is Alcoholics Anonymous (AA), which began in 1935 in the United States based on the experiences of two alcoholics whom a clergyman helped to become sober and maintain sobriety by working with other alcoholics (Alcoholics Anonymous, 2022). Early in 1939, an introductory textbook called *Alcoholics Anonymous* explained the philosophy and methods, the core of which was the now well-known Twelve Steps of recovery. Central to the AA model is the use of peers who have been through the Twelve Steps model to support peers starting the process. Other groups have followed this approach to respond to addictive behaviours, including gambling and drug abuse. Other self-help and peer support models were established, including in 1967 a community mental health care model involving non-professional peers employed to help with the development, implementation, and evaluation of the approach (Cowan et al., 1967).

Occupational Welfare Support and Social Well-Being

The origins of peer support within organisations also have a long history. In the nineteenth century, workers faced dangerous and harsh conditions and treatment. In response to this situation, in 1802, Sir Robert Peel introduced the regulation of working conditions and the appointment of factory inspectors to protect the health and welfare of workers (Blayney-Thomas, 1949). Some far-sighted industrialists, including the Salt, Cadbury, and Lever families, were concerned for the well-being of their workers and created Saltaire, Bourneville, and Port Sunlight villages in the mid-nineteenth century. Together with housing and health care, social welfare services were provided for workers. The first employee welfare service was created in 1886 by the chocolate manufacturer Rowntree's in its York factory; this idea spread, and by 1913, the Welfare Workers Association was formed (Edmonds, 1991). Welfare officers were selected from the workforce based on their skills and aptitude for helping others. They were required to adhere to a code of ethics which included a responsibility to respect the dignity of their clients, to enhance the quality of life of those they helped, to act without prejudice on the grounds of origin, sex, age, nationality, colour, religion or status, to maintain confidentiality, and not to abuse their position for personal gain. Founded at the end of the nineteenth century, welfare officers were the first peer supporters in the workplace.

In 1946, strains appeared in the Welfare Workers Association, and those concerned with the efficiency and effectiveness of the workforce formed the Institute of Personnel Management, leaving the welfare officers providing help, advice, and guidance to their colleagues to create an occupational welfare service (Martin, 1967). The Institute of Welfare flourished for many years, providing training, standards, and accreditation for welfare officers. Many private and public organisations, including the emergency services, military, manufacturing, retail, and civil service, recruited welfare officers internally and organised training through the Institute of Welfare to give them essential welfare qualifications and skills (Martin, 1967).

Twenty-five years ago, concerns were raised about the future of welfare services (Tehrani, 1997) due to the lack of product definition and the inability of the service to adapt to changing needs. In response to these concerns, the Post Office launched an Employee Support Service (Tehrani, 1998). The framework was developed to introduce a more effective method of service delivery, clearly designed and promoted products and services to meet the needs of the organisation and its employees, regular assessments of the competence of the employee supporters, and tools to monitor and evaluate services. Seven core services were defined: Well-Being Information, Problem Assessments, Short-Term Interventions, Employee Education, Manager Training, Specialist Trauma, and Counselling Interventions. A peer listening scheme was introduced to respond to bullying and harassment, where the peer listeners listened to their colleagues and provided information on the choices available to them to resolve their problems (Rains, 2001).

During the past 25 years, the principles established in Welfare Services and refined in Employee Support have continued to adapt and respond to changing organisational and employee needs. Peer welfare services have been delivered in many settings, including retail (Tehrani et al., 2001), insurance and banking (Tehrani et al., 2007), emergency services (Hesketh & Tehrani, 2018; Tehrani, 2017), prison service (Ruck et al., 2013), civil service (Tehrani & Welch, 1992), and many more. With the growth of trauma-informed care and trauma-informed organisations (Bloom, 1997), peer-delivered evidence-based interventions have been clearly defined and supported by professionally qualified and registered psychology, occupational health, and counselling professionals to ensure that supervisors and peer supporters were able to undertake their role without risk to themselves or those they wish to support.

Peer Support Movement

Peer Support Movement emerged in the United States in the 1960s as a response to pressures from consumer and social justice activists. The social justice movement views mental illness in terms of human rights, claiming that the "medical model" created a suppression of difference where expressions of personal experiences were medicalised and individual rights removed (Mead et al., 2001). In its extreme form, the social justice model rejects the validity of research methodologies and hypothesis testing. Its adherents claim that such methodologies are founded on the belief that people cannot recover from mental illness and are only capable of functional healing (Curtis, 2000). The social justice belief is that the medicalisation of human experience fails to recognise opportunities for wellness, growth, and the achievement of personal goals. The social justice view rejects assessments and evidence-based interventions, proposing that recovery is achieved by engaging with recovering peers' experiences, awareness, and understanding to bring about positive outcomes and healing for others (Segal et al., 1993). This approach has been widely adopted in the United States with the development of the Substance Abuse and Mental Health Services Administration (SAMHSA), the US-led body, to reduce the impact of substance

abuse and mental illness. SAMHSA has promoted a range of peer-delivered services, including Critical Incident Stress Management and Alcoholics Anonymous (SAMHSA, 2022). Peer support is beginning to be adopted in the UK and supported by the NHS, where mental health peer support workers are employed (Health Education England, 2020).

Who Are Peer Supporters?

There are two main groups of peer supporters: first, those who come from a social justice framework, with their belief that it is essential for peers to have experienced mental ill-health and to be in or have achieved recovery. In their role, social justice peers (SJP) use their personal experiences to facilitate, guide, and mentor another person's recovery. The second type of peer supporter emerged from the social well-being movement, where social welfare and well-being peers are recruited based on their knowledge, aptitude, and interest in supporting others. Social well-being peers (SWP) recognise the need for peers to work with and respect practitioners from various disciplines and are willing to adhere to best-practice principles in delivering evidence-based support and interventions. Despite the differences between the two groups, their espoused values are similar (Statford et al., 2019; Sunderland et al., 2013; Health Education England, 2020). Table I provides a summary of the key peer values.

The stance of the SJP movement is that "if it is a role that can be done without lived experience of mental health issues, it cannot be peer support" (Beales & Wilson, 2015). The alternative position of the SWP group is that, to become a peer supporter, one must demonstrate personal skills, background, and aptitude for the work (Martin, 1967). For SWPs, there is no requirement to have experienced the same adversity or condition as the person they support; for example, it is not necessary to have been raped to help someone who has experienced rape. However, it is recognised that experience of working within a similar role or industry is essential.

A Canadian review of the types of peer support available in that country (Price et al., 2022) identified three models: 1) peer-led, where the peers lead and deliver support without the involvement of others, 2) peer-enabled, where peers are led by professional mental health practitioners and supported by other peers, and 3) a peer partnership, where an external organisation, such as the International Critical Incident Stress Foundation, provides training for a peer-delivered Critical Incident Stress Management program. Price and colleagues reviewed 11 training manuals and found no recognised definition of a peer. A peer could have one or more of the following characteristics:

- Shared life experience or condition: e.g., substance abuse or mental health problem
- Similar working role: e.g., emergency responder, nurse, or teacher
- Same job: e.g., train driver, bank clerk
- Working in the same organisation: e.g., the NHS or Local Authority
- Similar demographic characteristics: e.g., age, sexual orientation, cultural background.

Price and colleagues (2022) noted the absence of research into the effectiveness of peer support and the lack of consistency and fidelity in the delivery, accountability, and adherence to training and suggested that there should be national regulation, standards, and accreditation of peer support.

Effectiveness of Peer Support Programs

To assess the efficacy of peer support programs, it is essential to identify the tools to measure any changes, determine the nature of the changes, and establish whether they are due to peer support. Without evidence, it is impossible to understand any support program's effectiveness. Some attempts have been made to evaluate the effectiveness of peer-delivered support; however, the results have been inconclusive, with randomised controlled trials reporting no difference or, in one case, a negative outcome (van Vugt et al., 2012). Researchers have highlighted several common concerns (Price et al., 2022; Chinman et al., 2014; Repper & Carter, 2011), including the need to be more rigorous in adhering to practice standards and the lack of a defined peer support model. It was also recommended that training should be improved with the introduction of competency standards and regular personal supervision.

It is perhaps not surprising that, given the rejection of evidence-based practice by the SJP adherents, there is a reluctance to seek symptom-based evidence of effectiveness. However, this leaves other non-symptom-related measures such as sickness absence, work engagement, and job satisfaction as proxies for clinical significance. Davidson et al. (2012) provided the following questions as consistent with the SJP approach:

1) Do interventions provided by peers differ from services provided by non-peers?
2) Are there any interventions that peers cannot provide without lived experience?
3) What critical features of peer support produce positive outcomes?

TABLE I Values of peer support

Inclusivity	Acknowledging the worth of all people regardless of background, preferences or situation	Mutuality	Understanding a person's experience from their perspective. Feeling a sense of solidarity
Respect	Building an accepting respectful relationship. Respecting background, culture or group	Self-Determination	Recognising that people know the best path to recovery, and that they have a choice
Reciprocity	Sharing experiences to learn from each other. Contributions are of equal value	Strengths-Based	Helping people to learn from their experiences. Focusing on strengths
Safety	Ensuring a safe, non-judgmental environment. Safety in sharing difficult experiences	Self-Defined Recovery	Helping to make sense of experience in the context of their life. Creating hope and empowerment

Many peer-delivered approaches, including critical incident stress debriefing, psychological debriefing, trauma risk management (TrIM), and psychological first aid, fall within an SWP approach where it is not essential for peers delivering services to have lived experience to support others. The designers of these interventions are willing to use clinical measures for evaluation. It has been shown that the results from these interventions are generally positive and well regarded by users (Richins et al., 2020). Still, high-quality evidence is lacking (Dieltjens et al., 2014).

Concerns for Peers Supporters

Surveys of peer supporters show that most are satisfied with their roles and benefit personally from working with others with similar mental health conditions (Brooks et al., 2022). However, there are challenges, including problems with boundaries, particularly for peers who have experienced mental health problems that are the same as or similar to those of the person they are supporting. The problem of re-triggering unresolved trauma increases as the SJPs are encouraged to self-disclose and share intimate stories from their own experiences of mental health difficulties. Repper and Carter (2011) expressed concerns over peers becoming friends with the people they were supporting; they found evidence of peer supporters socialising, drinking, dancing, and forming romantic relationships; however, Mead et al. (2001) regarded this kind of social interaction as an opportunity for both peers to develop meaningful and reciprocal relationships, failing to recognise the ethical issues involved. (It needs to be remembered that this behaviour is explicitly forbidden in the ethical standards of most professional regulating bodies, with severe sanctions, including the removal of the right to practice.)

Concerns were also expressed regarding the stress and reactivation of personal traumas (Chinman et al., 2006); some peers reported being shocked by the level of disturbance experienced by the people with whom they worked and becoming distressed by the stories they heard. The impact of these experiences, often accompanied by feelings of incompetence and failure, is understood by counsellors and therapists, for whom the principles of secondary trauma, parallel process, transference, and countertransference are significant elements of training (Sedgewick, 1994; Page, 1999).

There needs to be some recognition by the SJP movement of the considerable body of evidence that psychological injuries can be caused to anyone fulfilling a supportive role (Morrissette, 2004); where peers are selected based on having experienced or recovering from a mental health problem, the danger of developing compassion fatigue and secondary trauma is dramatically increased (Figley, 1995). In organisations, the use of peers with previous mental health problems in delivering services to colleagues with similar issues creates an organisational duty of care and legal responsibility should these vulnerable peers find themselves being harmed by the role in which they have been placed.

Training

Training and evaluation are essential for all learning, particularly where the training exposes the trainees to information and experiences that could be harmful if not handled appropriately. The level and depth of training are determined by the trainees' existing skills, aptitude, and preparedness, plus the complexity and challenges of the learning.

Training for Peers with Lived Experience of Mental Health Problems

Where peers use their lived experiences as the basis for the support they provide, this will require significant self-awareness and ongoing personal supervision due to their increased vulnerability (Hawkins & Shohet, 2006).

Two guidance documents on training for peer supporters who use their personal life experiences to support others were identified, one Canadian and one British. The Mental Health Commission of Canada guidance was developed based on the practice and training of peer supporters (Sutherland et al., 2013). The guide has 17 learning units arranged within three blocks. This model has been adopted by several organisations in Canada, including the Ottawa Police:

1) Fundamental principles: lived experience, self-determination, values, ethics, and principles of practice, trauma-informed practice, and applying principles in diverse environments
2) Social and historical context: historical context, prejudice, discrimination and stigma, diversity and social inclusion, social determinants of health
3) Concepts and methods that promote effective peer-to-peer support: interpersonal communication principles and methods, building supportive relationships, the process of recovery and change, building resilience through self-care, limits and boundaries, crises and strategies, connecting with community resources, awareness of possible symptoms and side effects of medication

The second framework was developed at University College London for the National Health Service (Health Education England, 2020). The competency framework is more comprehensive than the Canadian version, with seven blocks and 28 units:

1) Understanding the values of peer support and principles which underpin its implementation: values of peer support workers, principles of peer support
2) Knowledge for peer support workers: mental health, trauma-informed care, local services, professional, legal, and ethical frameworks, confidentiality, consent, and data protection, safeguarding and suicide prevention
3) Core relational skills: recovery focus, drawing on and sharing lived experience, maintaining a reciprocal relationship, active listening and working with difference
4) Supporting people as peer supporters: personal recovery, engaging in meaningful activities, coping and problem-solving, support options, recovery plans, access to care, transitions
5) Working with teams and protecting rights: working as part of a team, working with organisations and systems, personalised recovery, promoting rights
6) Self-care and support: reflection on work, effective use of supervision
7) Meta-competencies for peer support workers: ability to reflect on one's own thinking processes (theory of mind)

Neither framework gives a timescale for the training, but it seems unlikely to take less than 6 months to achieve a basic level of competence.

Training for Specialist Welfare Peers

Some organisations have retained specialist welfare peers. The United Kingdom's Ministry of Defence (2017) outlined a diploma level qualification made up of five mandatory units; this assessed course is open to peers. The units include:

1) Analysing a welfare case
2) Communications and principles of practice in welfare work
3) Concepts and theories to support welfare work
4) Presenting issues
5) Professional practice in welfare work

This qualification in specialist welfare work creates the opportunity to progress into research degrees, such as a master's degree.

Training for Peers Operating within a Stress and Trauma-Informed Framework

An alternative peer support model is based on a stress and trauma-informed care and treatment (STRICT) approach (Bloom, 1997). Organisations need to develop stress and trauma-informed employees, cultures and interventions to achieve STRICT status. There are three levels of stress and trauma training:

1. **Informed:** all employees to be given a basic knowledge of the signs and symptoms of stress and trauma
2. **Skilled:** training modules for well-being peers and supervisors in problem assessment, organisational and personal well-being assessment, demobilisation, defusing and post-incident support
3. **Enhanced:** training for occupational health practitioners in assessment and structured interviewing

Each skilled module for peers builds on the previous module, with opportunities to choose which intervention is most suited to the peer's skills and interests. Although some of the knowledge is similar to that found in the Canadian and NHS peer training, the role of the peers is placed under the clinical guidance of mental health professionals, and the interventions are restricted. In the STRICT approach, peers are trained to deliver specific intervention models with clear guidelines, competencies, and monitoring to prevent peers from straying into areas that could harm them and those they are trying to help.

DISCUSSION

The use of peer support in working with employees with psychosocial problems is important. Taking support as close as possible to those in need has significant benefits in terms of accessibility of help, understanding personal and organisational settings, and creating stress- and trauma-informed culture. There is mounting evidence that when peers engage with stress and trauma, the oxytocin system is stimulated through the creation of social systems of support (Olff, 2012). As described, there have been two routes leading to the introduction of peer supporters into the workplace, the first and oldest being the development of the Social Welfare model, with its roots in the activities of the enlightened industrialists of the eighteenth century, which gave rise to the Welfare Services prominent in the delivery of employee well-being and support in the UK and other countries. The second route emerged from social justice, where sympathetic recovering and recovered survivors of severe mental health conditions were recruited to support those at an earlier stage of recovery.

For organisations considering introducing a peer support approach, there is a need to fully assess the potential risks and benefits of using peers with lived experience of a severe social or mental health condition to support others with the same or similar condition. Having experienced and recovered from alcoholism, suicide attempts, eating disorders, gambling, domestic violence, or non-recent child abuse may give insight into the plight of others, and this may be reassuring, as has been found in some self-help groups (Watkins, 2017). Still, there is a risk that unresolved issues and trauma may be transferred, which can increase the exposure to traumatising thoughts and images by the recipient of support and the reactivation of unresolved trauma and secondary traumatisation of the peer providing the support.

Having decided to introduce "peers by experience" within an organisation, determining the organisation's responsibility to ensure that the peer support program "does no harm" (General Medical Council | Medical Schools Council, 2015) is the guiding principle behind all bio-psychosocial interventions. To reduce, as far as is reasonably possible, all risks of increasing mental health problems in "peers by experience," the level of training, support, screening, and monitoring required to prevent injury to themselves and the people they support would be significant. This burden would be more manageable in clinical settings such as the program developed within the NHS (Health Education England, 2020), where the mental health peers would be working full time in the role and well supported by a range of clinically qualified colleagues.

As described earlier in this paper, a significant problem with the peer support programs in operation today is the lack of definition of the role, the intervention, and the evaluation. Consideration needs to be given to screening, training, monitoring, and deployment of peers to ensure they are resilient and able to work safely. Where the peer role is an additional responsibility to an existing job, working within a clearly defined intervention model with training to determine the range and limits of activities is effective in terms of the resources required in the training and management of the support program. Adopting a more closely defined and monitored approach can eliminate many of the identified problems, and the benefits of peer support can then be fully achieved and demonstrated.

As more police services consider, further develop, or expand their use of peer support, more confidence can be achieved by placing greater emphasis on the key learnings and important considerations highlighted by the experiences in other sectors, and the growing body of work and literature that presents both cautions and encouragement. At the same time, understanding and giving the required attention to the many unique aspects of policing culture and the lived experiences of police members must form a core part of all such considerations.

CONFLICT OF INTEREST DISCLOSURES

The authors have no conflicts of interest to declare.

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REFERENCES

Alcoholics Anonymous (Great Britain and English Speaking Continental Europe). (2022). Historical Data. Retrieved from: https://www.alcoholics-anonymous.org.uk/About-AA/Historical-Data

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

Blayney-Thomas, F. J. (1949). *Welfare in Industry.* Caxton.

Bloom, S. (1997). *Creating sanctuary.* Routledge.

Brooks, J.M., Wu, J-R, Umucu, E., Storm, M., Chiu, C-Y., Walker, R., Fortuna, K.L. (2022) *Psychiatric Rehabilitation, 44*(3), 212–218

Chinman, M., Preethy, G., Dougherty, R. H., Daniels, A. S., Ghose, S. S., Swift, A., & Delphin-Rittmon, M. E. (2014). Peer support services for individuals with serious mental illnesses: assessing the evidence, *Psychiatric Services, 65*(4), 429–441.

Chinman, M., Young, A., Hassell, J., & Davidson, L. (2006). Towards the implementation of mental health consumer provider services. *The Journal of Behavioural Health Services and Research, 33*(2), 176–195.

Cowen, E. L., Gardner, E. A., & Zax, M. (1967). *Emergent approaches to mental health problems.* Appleton-Century-Crofts.

Curtis, L. C. (2000). Practice guidance for recovery-oriented behavioral healthcare for adults with serious mental illnesses. In M. D. Towson (Ed.), *Personal outcome measures in consumer-directed behavioral health* (pp. 25–42). The Council on Quality and Leadership for Persons with Disabilities. Maryland, National Leadership Consortium

Davidson, L., Bellamy, C., Guy, K., & Miller, R. (2012). Peer support among persons with severe mental illnesses: A review of evidence and experience. *World Psychiatry, 11,* 123–128.

Dieltjens, T., Moonens, I., Van Praet, K., De Buck, E., & Vandekerckhove, P. (2014). A systematic literature search on psychological first aid: Lack of evidence to develop guidelines. *Plos One, 9*(12), e114714. http://doi.org/10.1371/journal.pone. 0114714

Edmonds, M. (1991). Exploring company welfare, *Employee Counselling Today, 3*(3), 26–31. https://doi.org/10.1108/13665629110136893

Figley, C. R. (1995) Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatised. Routledge.

General Medical Council | Medical Schools Council. (2015). First, do no harm: Enhancing patient safety teaching in undergraduate medical education. Retrieved from: https://www.gmc-uk.org/-/media/documents/First_do_no_harm_patient_safety_in_undergrad_education_FINAL.pdf_62483215.pdf

Goldman, M. L., Bernstein, C., Chilton, J. & Aggarwal, R. (2017). Toolkit for wellbeing ambassadors: A manual. American Psychiatric Association.

Hawkins, P., & Shohet, R. (2006). Supervision in the helping professions. McGraw Hill.

Health Education England. (2020). The competency framework for mental health peer support workers. Retrieved from: https://www.hee.nhs.uk/our-work/mental-health/new-roles-mental-health/peer-support-workers

Hesketh, I., & Tehrani, N. (2018) Psychological trauma risk management in the UK police service. *Policing, 13*(4), 531–535.

International Academy for Professional Development (IAFPD). (2020). Diploma in health & wellbeing coaching. Retrieved from: www.centreforhealth-coaching.com/diploma-in-health-coaching/

Jones, N., Burdett, H., Green, K., & Greenberg, N. (2017). Trauma Risk Management (TRiM): Promoting help-seeking for mental health problems among combat exposed UK military personnel. *Psychiatry, 80,* 236–251.

Kitchener, B. A., & Jorm, A. F. (2002). Mental health first aid training for the public: Evaluation of effects on knowledge, attitudes and helping behaviour. *BMC Psychiatry, 2,* 10. https://doi.org/10.1186/1471-244x-2-10

Martin, A. O. (1967) Welfare at work. BT Batsford Ltd.

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

Ministry of Defence (UK). (2017). Qualifications handbook for DAO level 7 diploma in specialist welfare work. Retrieved from: www.gov.uk/government/publications/dao-qualification-handbooks-level-7-courses

Mitchell, J. T., & Everly, G. S. (2001). Critical incident stress debriefing: An operations manual for CISD, defusing and other group crisis intervention services. Chevron Publishing.

Morrissette, P. J. (2004). The pain of helping: Psychological injury of helping professionals. Brunner-Routledge.

Olff, M. (2012). Bonding after trauma: On the role of social support and the oxytocin system of traumatic stress. *European Journal of Psychotrauamtology, 3.* https://doi.org.10.3402/ejpt.v3i0.18597

Page, S. (1999). The shadow and the counsellor: Working with darker aspects of the person, role, profession. Routledge.

Pearce, J. M. S. (2020). The beginnings of humane psychiatry: Pinel and the Tukes. *Hektoen International: A Journal of Medical Humanities.* https://hekint.org/2020/06/04/the-beginnings-of-humane-psychiatry-pinel-and-the-tukes/

Price, J. A. B., Ogunade, A. O., Fletcher, A. J., Ricciardelli, R., Anderson, G. S., Cramm, H., & Carleton, R. N. (2022) Peer support for public safety personnel in Canada: Towards a typology. *International Journal of Environmental Research and Public Health, 19.* https://doi.org/10.3390/ijerph19095013

Punton, G., Dodd, A. L., & McNeill, A. (2022). "You're on the waiting list": An interpretive phenomenological analysis of young adults' experiences of waiting lists within mental health services in the UK. *PloS ONE, 17*(3), e0265542. https://doi.org/10.1371/journal.pone.0265542

Rains, S. (2001). Don't suffer in silence: Building an effective response to bullying at work. In Noreen Tehrani (Ed.), *Building a culture of respect: Managing bullying at work* (pp. 155–164). Taylor Frances.

Repper, J., & Carter, T. (2011). A review of the literature on peer support in mental health services. *Journal of Mental Health, 20*(4), 392–411.

Richins, M., Gauntlett, L., Tehrani, N., Hesketh, I., Weston, D., Carter, H., & Amlôt, R. (2020). Early post-trauma interventions in organisations: A scoping review. *Frontiers in Psychology, 11,* 1176.

Ruck, S., Bowes, N. J., & Tehrani, N. (2013). Evaluating trauma debriefing within the UK prison service. *Journal of Forensic Practice, 15*(4), 281–290. https://doi.org/10.1108/JFP-09-2012-0018

Ruggeri, A. (2016). How Bedlam became London's most iconic symbol. BBC.com. Retrieved from: https://www.bbc.com/culture/article/20161213-how-bedlam-became-a-palace-for-lunatic

Sedgewick, D. (1994). The wounded healer: Countertransference from a Jungian perspective. Routledge.

Seegal, S. P., Silverman, C., & Temkin, T. (1993). Empowerment and self-help agency practice for people with mental disabilities. *Social Work, 38*(6), 705–712.

Shultz, J. M., & Forbes, D. (2014). Psychological first aid. *Disaster Health, 2*(1), 3–12.

Stratford, A. C., Halpin, M., Phillips, K., Skerritt, F., Beales, A., Cheng, V., Hammond, M., O'Hagan, M., Loreto, C., Tiengtom, K., Kobe, B., Harrington, S., Fisher, D., & Davidson, L. (2019). The growth of peer

support: An international charter. *Journal of mental health, 28*(6), 627–632. https://doi.org/10.1080/09638237.2017.1340593

Sutherland, K., & Mishkin, W. (2013) Guidelines for practice and training for peer support, Calgary, AB: Mental Health Commission of Canada. Retrieved from: https://www.mentalhealthcommission.ca/wp-content/uploads/2021/09/Guidelines-for-the-Practice-and-Training-of-Peer-Support.pdf

Abuse and Mental Health Services Administration (SAMHSA). (2022). About Us. US Department of Health & Human Services. Retrieved from: https://www.samhsa.gov/about-us

Tehrani, N. (1997). Internal counselling provisions for organisations. In M. Carroll & M. Walton, (Eds.), *Handbook of Counselling in Organisations.* Sage. https://dx.doi.org/10.4135/9781446217009

Tehrani, N. (1998). Counselling in the workplace: The organisational counsellor. *Counselling Psychology Quarterly, 11*(4), 23–32.

Tehrani, N., MacIntyre, B., Maddock, S., Shaw, R., & Illingworth, R. (2007). Rehabilitation: Maintaining a healthy workforce. In M. Scott & H. Jonathan, (Eds.), *Health Psychology: European perspectives on research, education and practice* (pp. 143–168). ISMAI.

Tehrani, N., & Welch, R. (1992). Counselling in the post office. In R. Jenkins & N. Coney (Eds.), *Prevention of mental ill-health at work.* HMSO.

Tehrani, N. (2017). Counselling psychology for trauma in emergency service occupations. In D. Murphy (Ed.), *Counselling psychology: A textbook for study and practice.* Wiley.

Tehrani, N., Walpole, O., Berriman, J., & Reilly, J. (2001). A special courage: Dealing with the Paddington rail crash. *Occupational Medicine, 5*(2), 93–99.

Van Vugt, M. D., Kroon, H., et al., Delespaul, P.A.G.E., & Mulder, C. L. (2012). Consumer-providers in assertive community treatment programmes: Associations with client outcomes. *Psychiatric Services, 63, 477–*481.

Watkins, J. (2017). The value of peer support groups following terrorism: Reflections following the September 11 and Paris attacks. *Australian Journal of Emergency Management, 32*(3), 35–39.

Weiner D. B. (1992). Philippe Pinel's "Memoir on Madness" of December 11, 1794: A fundamental text of modern psychiatry. *The American Journal of Psychiatry, 149*(6), *725–732*. https://doi.org/10.1176/ajp.149.6.725