

Title: Organisational Readiness and Preparedness for Trauma-Informed Practice Across UK Frontline Services: A Mixed-Methods Study

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Abstract

Background: Frontline professionals in health, social care, and emergency response settings are routinely exposed to potentially traumatic events. Trauma-informed practice (TIP) frameworks highlight two key elements. Organisational readiness refers to the structural, cultural, and leadership conditions that support trauma-informed approaches. Organisational preparedness reflects the practical ability to recognise trauma exposure, respond effectively, and support staff. Despite growing policy attention, little empirical evidence describes how frontline workers experience these factors in organisations.

Objective: This study explored frontline staff experiences of TIP across UK services. It focused on organisational readiness, including policies, leadership, systems, and cultural responsiveness, and preparedness, including psychological safety, confidence to seek support, clarity of support pathways, and stigma. The aim was to identify strengths, gaps, and priorities for improvement.

Method: A cross-sectional online survey was completed by 325 frontline workers across NHS, social care, and emergency response sectors. The survey assessed organisational readiness and preparedness across four clusters: organisational structures and systems, workplace culture and psychological safety, leadership and workforce capability, and wellbeing and access to support. Quantitative data were summarised descriptively and integrated with qualitative themes derived from reflexive thematic analysis.

Results: Participants reported partial organisational readiness, including access to Employee Assistance Programmes, informal peer support, and visible leadership endorsement of staff wellbeing. Preparedness to respond to trauma exposure was uneven. Psychological safety was often limited, with many participants unsure where to seek support or reporting concerns

about confidentiality and professional consequences. Leadership training in TIP principles appeared limited, and communication about support pathways and organisational expectations was frequently unclear.

Conclusions: Frontline services show some strengths in trauma-informed readiness, but important gaps remain in organisational preparedness. These relate particularly to psychological safety, managerial capability, stigma, and access to support. Strengthening leadership capability, improving communication, and creating safe and consistent help-seeking pathways are essential for sustainable trauma-informed workplaces.

Highlights

- Frontline services demonstrate uneven organisational readiness for trauma-informed practice (TIP), with some foundational structures in place but unclear systems, inconsistent responses, and widespread uncertainty about how to access support following trauma exposure.
- Organisational preparedness remains limited; psychological safety is inconsistently embedded, and fears of judgement, confidentiality concerns, and perceived professional consequences continue to constrain disclosure and help-seeking.
- Advancing TIP requires moving beyond readiness alone towards practical organisational preparedness, including trauma-literate leadership, clear and visible support pathways, and reliable, psychologically safe responses to trauma exposure in everyday work.

Keywords: trauma-informed practice; organisational readiness; preparedness; psychological safety; frontline workers; wellbeing; trauma exposure; leadership; mixed methods

1. Introduction

Exposure to workplace trauma is an endemic occupational hazard for professionals working across health, social care, and emergency response services (Billings, 2024). Frontline workers routinely encounter critical incidents, human suffering, and situations associated with moral injury, cumulative stress, and secondary trauma (Thibodeau & Cutforth, 2025). These experiences contribute not only to acute psychological distress but also to a cumulative burden of occupational trauma that impairs wellbeing, functioning, and workforce retention (Cogan et al., 2024; Greenberg et al., 2021). Although the COVID-19 pandemic intensified awareness of these risks, organisational readiness and preparedness to embed Trauma-Informed Practice (TIP) remain inconsistent across sectors, with persistent gaps in policy coherence, leadership capability, and psychological safety (Billings et al., 2021; Brooker & Mack, 2026; Cogan et al., 2024; Peddie et al., 2025).

TIP provides a systemic framework for recognising the pervasive impact of trauma on workforce functioning and emphasises organisational environments that promote safety, empowerment, collaboration, and cultural humility (SAMHSA, 2014; Sweeney et al., 2016). Contemporary scholarship highlights that TIP depends less on discrete interventions and

more on relational and organisational conditions, including trust, transparency, choice, and collaboration (Berring et al., 2024). The model is commonly conceptualised through the “Four Rs”: realising the impact of trauma, recognising signs, responding by integrating trauma knowledge into policies, practices, and leadership behaviour, and resisting re-traumatisation (Fallot & Harris, 2009; Harris et al., 2024; SAMHSA, 2014). As a whole-system approach, TIP positions organisational culture, leadership capability, and psychologically safe relationships as central to preventing harm and supporting recovery (Fisk & Daoust, 2025; Seaton et al., 2025). Work on organisational trauma systems further highlights how organisations can either buffer or exacerbate trauma exposure, highlighting the interaction between structures, leadership behaviours, and cultural norms in shaping how trauma is experienced (Hettiaratchy et al., 2010; Smith et al., 2007).

Evidence from post-pandemic analyses emphasises the importance of visible and responsive leadership, coherent support pathways, and organisational alignment in sustaining workforce wellbeing (Linville & Onosu, 2023). Successful implementation of trauma-informed practice (TIP) is closely associated with organisational readiness and preparedness, including trauma-literate leadership, clear mechanisms for disclosure, and predictable responses to trauma exposure (Eng et al., 2025; Knox et al., 2023). Organisational readiness is conceptualised as a necessary precursor to organisational preparedness, occurring earlier in organisational development: readiness reflects whether appropriate structures, systems, and policies are in place, whereas preparedness reflects whether those structures can be enacted safely, consistently, and confidently in everyday practice (Weiner, 2009; SAMHSA, 2014). In practice, however, readiness and preparedness are often unevenly developed. Quantitative indicators of uncertainty around reporting processes, leadership capability, and access to support are echoed in qualitative accounts describing fear of repercussions, inconsistent organisational responses, and reliance on peer support, illustrating systemic ambiguity that undermines organisational preparedness (Greer, 2024).

Trauma-informed organisations are characterised by transparent systems, psychologically safe cultures, and leadership capable of modelling and reinforcing TIP principles (Berring et al., 2024; Cogan, 2026). When organisational expectations and pathways are unclear or inconsistently communicated, frontline workers may normalise distress, internalise emotional strain, and delay help-seeking (Auth et al., 2022; Brooks et al., 2016). Conversely, environments marked by relational trust, predictable responses, and visible leadership strengthen both readiness, defined as the presence of structural foundations, and preparedness, defined as the practical and cultural capacity to enact emotionally safe and consistent responses to trauma exposure (Cogan et al., 2022b; Huilgol et al., 2024). Although organisations have adopted a range of wellbeing initiatives, including psychological support, reflective practice, supervision, peer networks, and digital tools (Cogan et al., 2025a; De Kock et al., 2021; Galway et al., 2025), evidence consistently indicates that TIP is sustained through organisational commitment, clear pathways, and shared cultural expectations rather than the provision of individual initiatives alone (Billings, 2024; Cogan et al., 2024; Peddie et al., 2025). Without psychological safety, leadership endorsement, and clear communication, such initiatives are unlikely to be accessed or sustained. The central challenge for frontline

services therefore lies not simply in selecting supportive resources, but in creating environments in which workers feel safe to use them.

Despite growing policy and practice interest, there remains limited empirical evidence describing how frontline workers experience organisational conditions for TIP across sectors. Much of the existing literature is conceptual or policy-driven, with fewer studies examining how organisational readiness and preparedness are enacted in everyday working environments (Ross et al., 2025). This gap is particularly salient in frontline contexts characterised by persistent traumatic stress exposure, where cumulative demands, moral injury, and stigma shape help-seeking and organisational trust (Cogan, 2026). Understanding how staff experience organisational structures, leadership responses, psychological safety, and access to support is therefore essential for identifying strengths, gaps, and priorities for supporting responsive and sustainable trauma-informed care.

2. The present study

The present study addresses this gap by examining how frontline health, social care, and emergency response workers across the UK experience organisational readiness and preparedness for TIP. The first aim is to explore how staff perceive key organisational conditions within everyday working environments, including access to support, leadership capability, communication of expectations, and psychological safety. The second aim is to identify organisational factors that enable or constrain the enactment of TIP in practice, with particular attention to workers' experiences of organisational structures, leadership responses to trauma exposure, and the clarity and usability of support pathways, roles, and expectations. A further aim is to clarify system-level priorities for improvement to support psychologically safe and responsive care in contexts of persistent traumatic stress exposure.

Psychological safety and confidence in help-seeking are central to this analysis, given the influence of stigma, confidentiality concerns, and organisational culture. By capturing perspectives from multiple frontline sectors, this study aims to provide system-level evidence to inform organisational development and the sustainable embedding of TIP. Its contribution lies in illuminating how trauma-informed intentions translate into lived organisational experience and in identifying practical and cultural priorities for strengthening both readiness and preparedness so that trauma-informed approaches can be enacted more consistently, confidently, and effectively.

3. Method

A cross-sectional mixed-methods survey design was used to investigate organisational readiness and preparedness for trauma-informed practice across health, social care, and emergency response settings in the UK. This approach enabled the integration of quantitative indicators of organisational functioning with qualitative accounts of everyday experience, providing both breadth and depth in understanding how trauma-informed approaches are embedded within services.

3.1. Participants

Eligible participants were frontline professionals employed within health, social care, or emergency response services across the UK. Inclusion criteria required participants to be engaged in roles involving direct service delivery, clinical care, managerial responsibilities, or organisational functions relevant to TIP, with a minimum of six months' experience in their current role. These included individuals working in frontline provision, clinical support, leadership, and workforce wellbeing. There were no exclusion criteria beyond current employment in a relevant sector, the required length of service, and the ability to provide informed consent.

3.2. Survey instrument

A bespoke mixed-methods survey was developed to assess trauma-informed practice, psychological safety, leadership readiness, and organisational support. The survey was intended to generate descriptive and exploratory insight into organisational conditions rather than to serve as a psychometrically validated measure. It was designed collaboratively by an interdisciplinary expert group, including researchers with expertise in clinical psychology, psychiatry, trauma-informed practice, mental health interventions, and organisational leadership, alongside frontline professionals working in trauma-exposed services. Survey development was informed by established trauma-informed frameworks (NHS Education for Scotland [NES], 2021; 2023; SAMHSA, 2014) and contemporary literature on organisational culture, psychological safety, and leadership (Cogan et al., 2024; Edmondson, 2018; Peddie et al., 2025). Recent reviews have highlighted the absence of standardised organisational tools capable of capturing the relational, cultural, and system-level features of trauma-informed practice across frontline settings. In response, this bespoke survey was developed to reflect these dimensions, drawing on established frameworks and contemporary empirical evidence (Champine et al., 2019; Wathen et al., 2023).

The survey comprised fifteen domains that reflected core dimensions of trauma-informed organisational functioning, including workplace trauma exposure, perceptions of physical and psychological safety, trust and transparency, choice and control, collaboration and mutuality, staff wellbeing, cultural competence, leadership capability, organisational systems, access to support, help-seeking behaviour and barriers to care. Items were presented using a combination of fixed-response formats (binary, multiple-choice and Likert-scale items) alongside open-ended questions to capture nuanced descriptions of organisational experience. This approach aligns with methodological recommendations that TIP should be assessed through multidimensional frameworks integrating organisational structures with lived and relational experience, rather than relying on single-format measures (NES, 2023; National Trauma Transformation Programme, 2024).

Domains were organised into broader conceptual clusters representing overarching elements of organisational readiness and preparedness. These clusters related to organisational structures and systems, workplace culture and psychological safety, leadership and workforce capability, and wellbeing and access to support. The clustering was developed

iteratively with input from an interdisciplinary expert group, including frontline professionals, to enhance conceptual coherence and interpretability. The framework for these clusters, informed by SAMHSA’s (2014) TIPs and contemporary empirical work, is presented in Table 1.

Table 1
Trauma-Informed Practice Cluster Framework

Cluster	Description	Included Domains
1. Organisational Structures and Systems	Formal processes, policies and organisational mechanisms that underpin TIP.	Trauma exposure identification; organisational systems, policies and procedures; access to psychological support; feedback and development structures.
2. Workplace Culture and Psychological Safety	Cultural conditions that shape emotional safety, openness, stigma and trust within the organisation.	Physical and psychological safety; trustworthiness and transparency; mental health help-seeking and barriers; cultural responsiveness.
3. Leadership and Workforce Capability	Leadership behaviours, organisational readiness and workforce competencies necessary to embed TIP principles.	Leadership and managerial capability; collaboration and mutuality; shared decision-making and choice.
4. Wellbeing and Support Access	Supports that promote wellbeing, recovery and resilience following exposure to difficult or traumatic events.	Sensitisation to trauma responses; access to peer and professional support networks; physical activity and wellbeing practices.

Note. Clusters were developed by mapping the 15 Trauma-Informed Practice domains to SAMHSA’s (2014) trauma-informed principles and contemporary organisational trauma frameworks.

3.3. Procedure

The survey was hosted online using the Qualtrics platform and was open between November 2024 and October 2025. Recruitment and dissemination occurred through multiple channels, including NHS staff bulletins, professional networks, social care forums, emergency response organisations, and key sector stakeholders, using a combination of formal communications, newsletters, and targeted outreach to frontline services. This approach was used to support representation across sectors and roles. Participation was voluntary, and informed consent was obtained electronically before the survey commenced. Participants were provided with an information sheet explaining the aims of the study, the voluntary nature of participation, and sources of support should any distress arise. The survey took approximately 20 to 30 minutes to complete, depending on the length of responses to

open-ended questions. Participants completed the survey at a time and location of their choosing to minimise disruption to professional duties. No incentives were offered.

3.4. Analysis

A mixed-methods analytic approach was used to integrate quantitative organisational data with qualitative accounts of staff experience. Quantitative responses were exported from Qualtrics and analysed using IBM SPSS Statistics (Version 29). Descriptive statistics (frequencies, percentages, means and standard deviations) were used to summarise participant characteristics and responses across the fifteen domains of TIP. Given the exploratory aims and heterogeneity of the workforce sample, analyses were intentionally limited to descriptive summaries rather than inferential testing.

Qualitative free-text responses were analysed using reflexive thematic analysis (RTA) following Braun and Clarke's six-phase approach (Braun & Clarke, 2019, Braun et al., 2023). RTA was selected for its suitability in examining patterns of meaning within trauma-exposed organisational contexts and its capacity to capture both semantic and latent themes (Braun & Clarke, 2021). Initial inductive coding was conducted by the lead researcher, with codes and developing themes iteratively discussed within the research team to support reflexivity, challenge assumptions and enhance analytic rigour. This process generated a coherent thematic structure reflecting the complexity of participants' experiences. The use of RTA with large-scale survey datasets, including workforce free-text responses, is well supported in recent empirical literature (Månsson Sandberg et al., 2023; Urban et al., 2023). Findings from the quantitative and qualitative strands were integrated using a convergent mixed-methods approach. Quantitative patterns, such as indicators of psychological safety, leadership visibility, and access to support, were examined alongside qualitative narratives to contextualise barriers and facilitators. This integration enabled a comprehensive understanding of organisational readiness and preparedness for trauma-informed practice, consistent with best-practice recommendations for mixed-methods research and APA guidance on integrating qualitative and quantitative evidence in psychological research (Creswell & Plano Clark, 2018; Levitt et al., 2018).

3.5. Ethics

Ethical approval was granted by the University of Strathclyde Ethics Committee (Reference number: UEC22/92). All procedures complied with the Declaration of Helsinki and the University's Research Integrity and Governance policies. Participation was voluntary, and informed consent was obtained electronically via Qualtrics after participants reviewed the Participant Information Sheet. Participants were informed of their right to withdraw at any point prior to submitting responses. The survey was considered to pose minimal risk, and participants could omit any question they preferred not to answer. No identifiable data were collected. Data were stored securely on encrypted university servers in accordance with the University of Strathclyde Data Protection Policy and the UK General Data Protection Regulation. Only the research team had access to the anonymised dataset.

4. Results

4.1. Participant characteristics

A total of 325 participants completed the survey representing a broad cross-section of the UK frontline workforce. Participants ranged in age from early adulthood to late career ($M = 39.7$ years, $SD = 11.8$ years). The majority identified as female (60.0%), followed by male (36.6%), with a small proportion identifying as non-binary or preferring not to disclose (3.4%). Respondents worked across diverse professional roles. Nursing and clinical support roles constituted the largest groups, followed by allied health professionals, mental health practitioners, social care staff, medical professionals, emergency responders and managerial or administrative personnel. Seniority levels ranged from entry-level positions to executive leadership, with most participants identifying as mid-level or senior professionals. Most participants were employed within the NHS, reflecting its central position as a major employer of frontline staff. Others worked in social care services, third-sector organisations, private healthcare, education, local authorities and emergency response agencies. The sample also included individuals who opted not to disclose their employment sector. Ethnic diversity within the sample included participants identifying as White (77.5%), Black or African or Caribbean (8.0%), Asian (8.9%), mixed or multiple ethnic backgrounds (1.2%) and other ethnic groups (2.2%), with a minority declining to state their ethnicity. Professional experience varied widely, spanning early-career entrants through to highly experienced practitioners with several decades of service. This diversity provided a robust foundation for examining trauma-informed organisational readiness and preparedness across multiple sectors of the UK frontline workforce (see Table 2).

Table 2

Participant Characteristics (N = 325)

Characteristic	Category	n (%)
Age (years)	$M = 39.7, SD = 11.8$	—
Gender	Female	195 (60.0)
	Male	119 (36.6)
	Non-binary / prefer not to say	11 (3.4)
Ethnicity	White	252 (77.5)
	Black, Asian, or minority ethnic	66 (20.3)
	Prefer not to say	7 (2.2)
Employment sector	NHS	215 (66.2)
	Social care	35 (10.8)
	Other sectors*	66 (20.3)
	Not disclosed	9 (2.8)
Professional role	Nursing/clinical support	95 (29.2)
	Allied health professionals	60 (18.5)

	Mental health practitioners	55 (16.9)
	Social care staff	40 (12.3)
	Medical professionals	30 (9.2)
	Emergency responders	25 (7.7)
	Managerial/administrative	20 (6.2)
Seniority	Entry-level / early career	80 (24.6)
	Mid-level professional	140 (43.1)
	Senior / executive leadership	105 (32.3)

Note. Percentages are based on available responses; missing data were excluded pairwise.

**Other sectors include third-sector organisations, private healthcare, education, and local authorities.*

4.2. Quantitative Findings

Quantitative findings are summarised in Table 3, which provides an overview of key indicators of organisational readiness and preparedness for TIP across four cluster domains: organisational structures and systems, workplace culture and psychological safety, leadership and workforce capability, and wellbeing and support access. Narrative interpretation of these patterns is presented in the following sections.

4.2.1. Organisational Structures and Systems

Quantitative findings highlighted substantial gaps in the organisational mechanisms necessary for TIP. Trauma exposure was most frequently identified through informal routes, with the most common pattern involving mixed combinations of self-disclosure, manager observation and incident reporting (29.2%). No single structured system was dominant, indicating variability and inconsistency in organisational processes. Only 41.2% of respondents reported any form of ongoing monitoring of trauma exposure, while 24.3% stated that no monitoring occurred and 23.8% were unsure. Although 63.4% identified a formal reporting mechanism, subsequent responses suggested these were generic incident-reporting processes rather than trauma-specific pathways. Endorsement of structured post-incident support was low across all categories, with each option (i.e. immediate psychological support, debriefing, flexible adjustments, peer-support mechanisms) receiving <10% consistent endorsement.

Table 3

Key Quantitative Indicators of Organisational Readiness and Preparedness for TIP

Domain	Indicator (Readiness / Preparedness)	Key finding, n (%)
Organisational structures and systems	Ongoing monitoring of trauma exposure (<i>Readiness</i>)	Yes: 127 (41.2); No/unsure: 148 (48.1)
	Formal reporting mechanism (<i>Readiness</i>)	Present: 196 (63.4); Absent/unsure: 79 (25.5)
	Access to structured post-incident support (<i>Preparedness</i>)	Each option endorsed by <10%
Workplace culture and psychological safety	Feeling safe to raise trauma concerns (<i>Preparedness</i>)	Always safe: 102 (31.4); Sometimes/rarely/unsure: 223 (68.6)
	Trust in leadership decision-making (<i>Preparedness</i>)	High/often: 148 (45.7); Low/very low/unsure: 177 (54.3)
Leadership and workforce capability	Perceived leadership capability (<i>Preparedness</i>)	Sufficient skills: 162 (49.8); Lacking/unsure: 106 (32.6)
	Visible trauma-informed leadership behaviours (<i>Preparedness</i>)	No or unsure: 37 (11.3); Clear examples: rare
Wellbeing and support access	Peer support availability (<i>Preparedness</i>)	Available: 138 (42.5); Not available/unsure: 130 (39.9)
	Digital mental health tools (<i>Preparedness</i>)	Available: 123 (37.8); Not available/unsure: 144 (44.3)
	Formal psychological support (<i>Preparedness</i>)	Consistently available: <10%; Not available/unsure: ~40–60%
Overall organisational preparedness	Uncertainty across preparedness indicators	“Unsure” responses commonly exceeded 20%

Note. Readiness indicators reflect the presence of organisational structures and systems. Preparedness indicators reflect the practical, cultural, and relational capacity to enact trauma-informed practice in everyday work. Percentages reflect available responses; missing data were excluded pairwise.

4.2.2. Workplace Culture and Psychological Safety

Workplace culture indicators revealed notable concerns about psychological safety. Only 31.4% of respondents reported feeling consistently safe to raise trauma-related

concerns, while 43.4% felt safe only “sometimes” and 7.1% did not feel safe. Trust in leadership and decision-making processes was also modest: 11.4% reported high trust, 34.3% reported trust “often,” while the remainder expressed ambivalence or low trust. Stigma emerged as a major barrier, with many respondents reporting fears of appearing weak, burdensome or professionally compromised if they disclosed distress or sought support.

4.2.3. Leadership and Workforce Capability

Leadership capability was marked by significant uncertainty. Nearly half (49.8%) of respondents believed their leaders possessed adequate skills to respond to trauma exposure, yet 12.3% believed leaders lacked such skills and 20.3% were unsure. Responses to items assessing reflective practice, supervisory guidance and leadership communication were characterised by large clusters of *unsure*, *none* or *not applicable* responses, often accounting for 15–20% of answers. When asked to identify trauma-informed leadership behaviours, 30 participants (9.2%) reported no observable behaviours and only isolated respondents offered concrete examples. Although 42.5% reported the presence of *supportive managerial structures*, these were experienced primarily through leadership accessibility and interpersonal support rather than formalised systems and therefore reflect variable organisational preparedness rather than consistent readiness. By contrast, 17.5% reported the absence of such support, reinforcing the uneven enactment of trauma-informed leadership in everyday practice

4.2.4. Wellbeing and Support Access

Peer support was the strongest and most consistently available wellbeing resource. Forty two percent of respondents reported access to peer support, contrasting with 17.5% who lacked access and 22.4% who were unsure. Formal psychological support presented a markedly different pattern: “no” and “unsure” responses commonly accounted for 20–30% of participants across support-related items. Access to digital tools was moderately endorsed, with 37.8% reporting availability, but 44% either lacked access or were unsure. Wellbeing initiatives such as physical activity programmes, stress-management resources, or health-promotion activities demonstrated uneven availability and low organisational visibility, with uncertainty frequently exceeding 20%.

4.3. Qualitative Findings

Reflexive thematic analysis generated six overarching themes capturing how frontline workers experience trauma exposure, interpret organisational responses, and navigate wellbeing demands. These themes are summarised in the thematic table (Table 4).

Table 4

Themes and Illustrative Quotes Describing Organisational Experiences of TIP

Theme	Description	Illustrative quote
Navigating	Trauma exposure is cumulative and	“It’s not one big incident, it’s the

trauma in everyday work	embedded in routine frontline work, with distress normalised as part of the role.	constant emotional hits day after day that wear you down.”
Inconsistent organisational responses to trauma	Organisational support and reporting processes are fragmented, inconsistently applied, and poorly communicated.	“Sometimes there’s support, sometimes there isn’t - it depends who’s on shift or what’s happening that day.”
Psychological safety as conditional and uneven	Disclosure of distress is shaped by fear of judgement, confidentiality concerns, and team-level culture.	“If you say you’re struggling, people think you’re not coping. I worry it will affect my job.”
Leadership capability as a structural weak point	Leaders are often perceived as caring but under-skilled, with limited visibility of trauma-informed behaviours.	“My manager means well but doesn’t know how to deal with trauma, they avoid the conversation.”
Peer support as the backbone of coping	Colleagues provide the most reliable emotional support, frequently compensating for organisational gaps.	“It’s my coworkers who get me through, we debrief with each other because there’s nowhere else to go.”
Uneven access to wellbeing resources	Wellbeing provision varies widely and is constrained by workload and lack of protected time.	“Even when support is offered, we’re too busy to attend. There’s no time to step away.”

Note. Themes were generated using reflexive thematic analysis and reflect patterns of meaning across participants’ accounts of organisational responses to trauma exposure.

The six themes were: navigating trauma in everyday work; inconsistent organisational responses to trauma; psychological safety as conditional and uneven; leadership capability as a structural weak point; peer support as the backbone of coping; and uneven access to wellbeing resources. The qualitative themes further illustrate how frontline staff navigate trauma exposure within organisational environments that are emotionally demanding yet unevenly supported. Participants consistently described trauma as a routine and cumulative feature of their work, often normalised to the extent that emotional distress was viewed as an expected professional burden. While this normalisation appeared to support endurance and occupational resilience, it simultaneously discouraged help-seeking, limited disclosure and masked the need for organisational support. Distress was frequently internalised or managed informally rather than recognised as warranting a structured organisational response. As a result, formal responses to trauma were experienced as inconsistent, fragmented and poorly communicated, leaving many staff unsure how to report trauma exposure or access structured support. Psychological safety was similarly variable; while some teams fostered trust and openness, many participants described environments where disclosure felt risky due to fears of judgement, confidentiality concerns or potential professional consequences.

Leadership capability emerged as a critical yet fragile component of organisational culture, shaping whether trauma exposure was acknowledged, supported or implicitly normalised. Staff frequently experienced leaders as well-intentioned but under-trained, with limited confidence or clarity in responding to trauma-related needs. The invisibility of trauma-informed leadership behaviours reinforced uncertainty about organisational priorities. In contrast, peer relationships formed the most reliable source of emotional and practical support, compensating for systemic gaps but also placing substantial emotional labour onto colleagues. Access to wellbeing resources, whether psychological services, physical activity programmes or digital tools, remained uneven and constrained by workload pressures and limited protected time. Collectively, these themes depict a workforce coping through interpersonal solidarity in contexts where organisational structures for trauma-informed practice remain insufficiently developed.

4.4. Integrated Interpretation of Quantitative and Qualitative Findings

The combined quantitative and qualitative findings reveal a consistent picture of frontline work characterised by strong interpersonal support but limited organisational readiness for TIP. The quantitative patterns of low psychological safety, uncertain leadership capability and inconsistent access to structured supports were echoed in staff narratives describing environments where disclosure often felt risky, processes were unclear and organisational responses to trauma were fragmented. High reliance on peer support in the survey data aligned with qualitative accounts portraying colleagues as the primary and most dependable source of emotional support, frequently compensating for gaps in formal systems. Uncertainty emerged as a defining feature across both strands: staff were unsure whether monitoring processes existed, whether leaders possessed the skills to respond to trauma exposure, or what wellbeing resources were available to them. This uncertainty was reinforced qualitatively through descriptions of poor communication, inconsistent leadership presence and an organisational culture that often normalised emotional strain rather than addressing it. Similarly, the uneven access to psychological support, wellbeing programmes and digital tools reflected not only limited provision but also structural barriers such as workload, staffing pressures and lack of protected time (Table 5).

Table 5

Integration of Quantitative and Qualitative Findings Across Trauma-Informed Practice Domains

Domain	Quantitative pattern	Qualitative pattern	Integrated interpretation
Organisational structures and	Monitoring and reporting mechanisms	Pathways for reporting and	Although elements of organisational readiness were

systems	present for some staff, but structured post-incident support was rarely accessed and uncertainty was high	support described as unclear, fragmented, and inconsistently applied	present, limited communication and inconsistent enactment undermined preparedness to respond effectively to trauma exposure
Workplace culture and psychological safety	Fewer than one third consistently felt safe to raise trauma-related concerns; stigma evident	Disclosure perceived as risky, shaped by fears of judgement, confidentiality breaches, and professional consequences	Cultural readiness alone was insufficient, as psychological safety remained conditional and constrained help-seeking
Leadership and workforce capability	Approximately half perceived leaders as capable; substantial uncertainty and few observable trauma-informed behaviours	Leaders viewed as caring but under-skilled, inconsistent, or inaccessible	Leadership readiness was uneven, limiting preparedness through gaps in training, confidence, and behavioural modelling
Wellbeing and support access	Peer support most available; formal psychological and digital supports often uncertain or unavailable	Peer relationships compensate for organisational gaps; workload and time pressures restrict engagement	Wellbeing provision reflected partial readiness, but lack of integration and protected time reduced practical preparedness
Cross-cutting organisational preparedness	High proportions of “unsure” responses across domains	Limited awareness of available supports, processes, and expectations	Weak translation of readiness into preparedness emerged as a systemic issue, with uncertainty functioning as a barrier to access and use

Note. Integration reflects convergent mixed-methods analysis combining quantitative indicators with qualitative accounts across core domains of trauma-informed organisational functioning.

Together, these integrated findings depict a workforce managing significant emotional demands within systems that are inconsistently equipped to support TIP. While interpersonal relationships provide stability, the broader organisational infrastructure remains underdeveloped, insufficiently communicated and unevenly embedded. This convergence of evidence highlights critical areas where organisational investment, leadership development and clearer TIPs are required to strengthen staff wellbeing and organisational resilience.

5. Discussion

This study examined how frontline health, social care, and emergency response workers across the UK perceive organisational readiness and preparedness for trauma-informed practice, focusing on access to support, leadership capability, communication of expectations, and psychological safety. The findings depict a workforce that is emotionally capable, peer-connected, and highly committed, yet operating within organisational environments that often lack the structural clarity, leadership visibility, and psychological safety required for sustained trauma-informed practice. Although interpersonal support and peer relationships were consistently strong, they frequently functioned as compensatory mechanisms rather than being embedded within formal organisational systems. This reliance on peer support reflects evidence that informal relational resources can mask systemic gaps in organisational preparedness (Cogan et al., 2022a).

Clear gaps were evident across both organisational readiness and preparedness. While some elements of readiness were present, including formal reporting mechanisms and wellbeing initiatives, these foundations were uneven, fragmented, and inconsistently communicated. Preparedness was more substantially compromised, with limited psychological safety, uncertainty about support pathways, and variable leadership capability undermining organisations' capacity to respond safely and predictably to trauma exposure in everyday practice. Importantly, these findings do not indicate an absence of trauma-informed intent or effort. Rather, they highlight the limitations of partial readiness when not accompanied by consistent preparedness in practice. Core readiness elements, such as coherent systems and clear pathways, alongside preparedness factors including safe disclosure, predictable responses, and accessible support, were inconsistently developed. These patterns align directly with the study's aim of identifying organisational conditions that enable or constrain trauma-informed practice.

Psychological safety emerged as a central theme across both analytic strands. Despite routine exposure to distressing and potentially traumatic events, only a minority of participants felt consistently safe to disclose concerns or seek support. Many described workplace cultures in which emotional difficulty was perceived as risky or professionally compromising. This mirrors wider UK evidence that frontline workforces are often socialised into norms prioritising resilience, stoicism, and task performance over vulnerability (Peddie et al., 2025; Sumner & Kinsella, 2021; Walker, 2025). Such norms can delay help-seeking, encourage internalisation of distress, and undermine organisational preparedness. Psychological safety therefore represents a core determinant of trauma-informed readiness, shaping whether staff trust organisational systems and engage with available support.

Leadership capability emerged as a critical yet underdeveloped mechanism linking organisational readiness to preparedness. While almost half of respondents believed their leaders possessed adequate skills to respond to trauma exposure, uncertainty and limited visibility of trauma-informed leadership behaviours were common. Qualitative accounts described leadership that was often well intentioned but under-trained, with limited confidence in responding to trauma-related needs. This aligns with evidence that sustainable trauma-informed care depends on trauma-literate leadership embedded within coherent

organisational strategy (Fisk & Daoust, 2025; Sebton et al., 2025). Organisational systems for recognising and responding to trauma exposure were similarly inconsistent. Although some respondents identified formal reporting pathways or wellbeing initiatives, many were unsure what support was available, indicating gaps in communication and implementation. High levels of uncertainty suggest that staff cannot access or trust systems they do not understand or know exist, consistent with trauma-informed care literature emphasising transparent and accessible organisational frameworks (Berring et al., 2024).

Wellbeing provision varied markedly across organisations. Peer support was the most reliable form of assistance, highlighting relational strengths within frontline teams. However, reliance on informal networks places substantial emotional labour on colleagues and offers limited protection against cumulative trauma (Yehene et al., 2024). When organisational systems are unclear or underdeveloped, this emotional labour is often redistributed within teams, placing additional demands on individuals perceived as approachable, empathic, or psychologically knowledgeable. Evidence from wider workforce research suggests this burden is not evenly distributed, with staff from ethnic minority backgrounds and other marginalised groups frequently undertaking disproportionate informal support work, often alongside extended working hours and additional emotional labour. Such patterns risk compounding stress, reinforcing inequities, and further obscuring the need for structured organisational responses to trauma exposure.

Although formal psychological services, digital tools, and wellbeing initiatives were reported in some settings, their use was often constrained by workload pressures, lack of protected time, and inconsistent communication. This reinforces evidence that service-level resources alone are insufficient without a coordinated, system-wide trauma-informed strategy (Keesler et al., 2025). Taken together, these findings suggest that trauma-informed readiness and preparedness should be understood not only as organisational responsibilities, but as part of a wider whole-systems and whole-society response to persistent occupational trauma. Frontline trauma exposure is structurally embedded within service design, workforce expectations, and public demand, positioning trauma-informed practice as critical infrastructure rather than an optional enhancement. Within this context, trauma-informed systems provide the foundation for safe and ethical innovation in psychotraumatology, including digital and AI-enabled supports (Cogan, 2024; Cogan et al., 2025b). Without psychological safety, clear pathways, and trusted leadership, such innovations risk reproducing the same barriers to disclosure, access, and trust identified in this study (Goldstein et al., 2024; Griffith et al., 2023).

6. Conclusion

This study highlights a clear mismatch between the emotional demands placed on UK frontline workers and the organisational structures available to support TIP. While strong peer relationships provide an important foundation for coping, organisational systems, psychological safety, leadership capability, wellbeing infrastructure, and preparedness remain

unevenly developed and inconsistently communicated across services. Integrated quantitative and qualitative findings indicate that partial organisational readiness alone is insufficient. What is required is genuine organisational preparedness, defined by a reliable capacity to recognise trauma exposure, respond safely and consistently, and provide timely, stigma-free access to support. Clear, visible, and accessible trauma-informed pathways, supported by skilled leadership and coherent organisational strategies, are essential in services where trauma exposure is routine. Embedding TIP at scale requires organisations to move beyond reliance on interpersonal goodwill or informal peer support towards systematic and sustainable approaches that recognise trauma as a core feature of frontline work. Strengthening psychological safety, enhancing leadership capability, improving communication, and ensuring consistent access to wellbeing resources emerge as key priorities. Practical preparedness, including predictable responses and culturally safe disclosure routes, must be developed alongside policy and training. These findings offer a roadmap for UK organisations seeking to advance trauma-informed practice. Investment in both cultural and structural change is necessary to support workforce wellbeing, sustain quality care, and retain staff in trauma-exposed frontline services.

Disclosure statement

The authors report no conflicts of interest.

Data availability statement

Due to the sensitive nature of the material and ethical requirements for participant confidentiality, the data that support the findings of this study are not publicly available. Aggregated data and materials may be made available upon reasonable request to the corresponding author.

Author contributions

NC conceived the study, designed the methodology and led the analysis. NC and SW contributed to data interpretation. NC drafted the manuscript. All authors reviewed and approved the final version.

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Ethical Approval

Ethical approval was granted by the University Ethics Committee, reference number [UEC22/92].

Informed consent

Informed consent was obtained from all participants.

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