MANAGING TRAUMA IN THE WORKPLACE

Evolving workplace mental health practices for a changing world

A report from The National Forum for Health and Wellbeing at Work

MANCHESTER 1824
The University of Manchester
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The National Forum for Health and Wellbeing at Work

What is the National Forum for Health and Wellbeing at Work?

In 2016 a group of Chief Medical Officers and HR directors of leading global companies and major public sector institutions created the Forum with a central mission to improve workplace health and wellbeing. Today, dozens of major global organisations are members of the Forum representing a vast range of business sectors including retail, banking, oil and gas, healthcare, IT, construction and media.

The Forum's vision is to reinforce the evidence and belief that good health is good for business, and good business is good for health. It aims to inspire people and organisations to challenge their thinking about the opportunities that healthy high-performing people bring to work, while also creating shared values that both business and employees can realise.

The Forum aims to bring the most innovative evidence-based thinking to organisations, and integrate the 'psychosocial determinants' of health that create a healthy work culture. These include productivity, leadership, decision-making, behavioural safety, performance indicators, diversity and inclusion, financial wellbeing and the impact of digitisation.

In recent years the Forum has produced a number of position papers, run high profile networking events, and contributed to government policy papers and consultation exercises.

Find out more at **www.alliancembs.manchester.ac.uk/research/health-wellbeing-forum/**

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*This report explores the impact of trauma within workplace settings and includes discussion of potentially distressing topics. While it does not contain graphic detail, readers may encounter references to sensitive issues that could evoke discomfort or distress. We encourage readers to engage with the material at their own pace and to take breaks or seek support if needed.

FOREWORD

Trauma is not a niche issue. More than 70% of people will experience at least one traumatic event in their lifetime and almost a third will experience four or more.

Such statistics mean that trauma is a business issue. Estimates from Deloitte suggest that poor mental health costs UK employers up to £51bn a year.

Trauma is likely a hidden contributor to these costs, often underpinning more visible conditions such as depression, anxiety and burnout, yet often remaining undetected or undisclosed.

This means employers may be absorbing trauma-related costs without recognising the root cause. Confusion can also arise around what counts as trauma, how common it is, and when to step in and how to support recovery.

The guidance in this report translates evidence into a practical framework for trauma informed practice which is designed to strengthen and align with existing wellbeing strategies rather than add another layer of work. It is written for HR and wellbeing professionals and occupational health teams across all sectors, including those in organisations not routinely associated with trauma exposure.

Trauma informed practice is an organisational capability – not a clinical intervention – focused on designing cultures and processes that avoid harm and help people feel safe, connected, and able to recover so they can contribute meaningfully at work.

Professor Sir Cary Cooper CBE

50th Anniversary Professor of Organisational Psychology and Health, Alliance Manchester Business School

EXECUTIVE SUMMARY

Trauma is common, often invisible and relevant to every workplace

Over 70% of people worldwide will experience at least one traumatic event in their lifetime[1]. While about 4-6% meet diagnostic criteria for post-traumatic stress disorder (PTSD)[2] many more live with sub-threshold effects that erode wellbeing and performance such as recurrent distressing thoughts of the trauma, avoidance of trauma reminders, hypervigilance, or unhealthy coping strategies such as overworking or substance use[3]. NICE refers to these as clinically important symptoms of PTSD, noting that in some cases they may require treatment[4].

Trauma can follow acute incidents involving actual or threatened death, serious injury or sexual violence accumulated over time in the context of repeated exposure to severe threat or harm (e.g. domestic violence or the occupational exposures faced by child protection or emergency responders)[5, 6]. It can also arise vicariously when repeatedly hearing about or witnessing others' traumatic experiences[7] or emerge as a consequence of moral injury when core beliefs or values are violated[8]. Because stigma persists and signs are often misread as performance issues, persistent trauma-related distress is easily missed or mishandled. As the term 'trauma' is increasingly used to describe a wide range of difficult experiences, this report centres on the DSM-5 and ICD-11 definitions to maintain clarity about what constitutes a traumatic event.

Why this matters for employers

Exposure to trauma is not confined to the military or emergency services. Across sectors, staff may be exposed to traumatic events such as serious accidents, sudden deaths, violent incidents or disasters. It can also affect those with roles that involve repeated contact with others' traumatic experiences. Most adults will bring some degree of trauma history to work and the culture they return to – whether compassionate or indifferent – strongly shapes recovery.

Employers therefore have legal, moral, reputational and economic reasons to protect psychological as well as physical health, manage psychosocial risks and make proportionate adjustments under equality law. Meeting these obligations is less about clinical treatment and more about shaping cultures and systems that reduce harm and enable recovery.

For full list of references see page 54.

What works

The essence of trauma is disempowerment and disconnection. Recovery comes with time and depends on restoring safety, trust and control. Well-intentioned but uninformed actions (such as compulsory psychological debriefs) can do harm by pathologising normal reactions and eroding trust.

Instead, NICE (2018) and WHO (2012)recommend a strategy of "active monitoring" and flexible support during the first month allowing natural recovery while ensuring timely professional help if symptoms persist. Consistent findings show that people turn first to friends, family, colleagues or managers rather than clinicians (Misra *et al.* (2009)), underscoring the importance of supportive workplace relationships and psychologically safe leadership.

Trauma-informed practice (TIP)

Trauma-informed practice translates this evidence into everyday culture. It embeds six principles – safety, trust, peer support, collaboration, empowerment and cultural awareness – into leadership, systems and daily interactions. It recognises that trauma is widespread and context-dependent, and that workplace culture can either enable recovery or compound harm.

Like disability-inclusive design, trauma-informed approaches improve conditions for everyone, not only those with a diagnosis. TIP does not replace wellbeing strategy but strengthens it, much as suicide prevention (once considered too specialist) is now integral to workplace mental health guidance. In this sense, TIP reflects a wider shift in wellbeing from reactive interventions to proactive, systemic approaches grounded in psychosocial risk management.

This report follows the 4Rs framework – ***Realise, Recognise, Respond, Resist*** – to guide practical application.

Realise – explores prevalence, definitions and how trauma manifests at work, introducing a typology for identifying potential exposure.

Recognise – examines how culture and systems can either exacerbate harm or promote recovery, linking to psychosocial risk management and the business case for trauma-informed practice.

Respond – outlines evidence-based approaches for embedding trauma-informed practice and the key roles involved in sustaining it in organisations (crucially, this is not solely HR's responsibility).

Resist – provides practical tools to help organisations beginning their journey, including an impact assessment, maturity model and lifecycle audit, alongside case studies from multiple sectors.

UNDERSTANDING TRAUMA

70% *of people will experience at least one traumatic event in their lifetime.*

In this report, traumatic events are defined in line with DSM-5 and ICD-11 as exposure to actual or threatened death, serious injury or sexual violence, or to events of an extremely threatening or horrific nature. This includes direct experience, witnessing such events, learning of them occurring to close others, or repeated and prolonged exposure to their aversive details[9]. Trauma is not confined to extreme events or certain professions. It is a widespread public health and workforce issue.

Estimates from international epidemiological studies suggest over 70% people will experience at least one traumatic event in their lifetime[10], and nearly a third will experience four or more[11]. In England, the APMS 2023/24 reports that over a third of adults have experienced a traumatic event[12]. Common trauma exposures include: witnessing death or serious injury, the unexpected death of a loved one, robbery, life-threatening car accidents and serious illness or injury[13]. These are not rare anomalies, but part of the fabric of human life, making their impact on workplaces inevitable.

Symptoms and workplace relevance

Trauma can undermine workplace performance even in the absence of a formal diagnosis. Employees may experience marked reductions in functioning, with some emergency responders reporting perceived performance as low as 37% of their usual level post-incident[14].

The effects can include reduced productivity, errors, rework costs and safety concerns, as well as team conflict, disrupted collaboration, increased HR escalations and sickness absence. At an individual level the impacts of trauma may manifest as intrusive memories or reminders, withdrawal or avoidance, heightened threat responses such as irritability, hypervigilance and disrupted sleep, and cognitive difficulties with concentration, memory or decision-making[15].

Without a trauma-informed lens, these behaviours may be misrepresented as performance or conduct issues, leading to unnecessary escalation and missed opportunities for early support. Understanding these effects also requires clarity on how trauma is defined and experienced.

A modern definition of trauma

Our understanding of trauma has evolved. Originally meaning 'wound' in Greek, it was first used medically to describe physical injury before psychological interpretations emerged in the 20th century through terms such as 'shellshock' and 'war neuroses'. Post-Traumatic Stress Disorder (PTSD) was formally recognised after the Vietnam War in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders*, marking an important milestone in recognising psychological trauma as a distinct condition[16].

A systems-based view, often used in health and policy contexts, uses the '3Es' framework (see right)[17] to describe how the impact of a qualifying traumatic event can vary between individuals. This framing can help organisations understand both the personal and systemic dimensions of how traumatic events are felt and how workplaces can respond in practical, compassionate ways.

The '3Es'

The Event: Threats to safety or agency, whether human (serious abuse, assault, sexual exploitation) or natural (disaster, displacement), and whether direct, indirect (witnessing/learning about) or cumulative (e.g. severe domestic abuse). In workplace contexts, exposure spans from routine high-risk roles such as emergency services staff, to unpredictable incidents affecting retail, transport or office workers, to prolonged interpersonal harm like threats of sexual violence.

The Experience: Two people may live through the same event (e.g. road traffic accident, combat) yet experience it differently, shaped by identity, history and support. Responses may also shift across lifetimes as skills, resilience and personal circumstances change[18].

The Effect: Symptoms vary from intrusive and distressing memories of the event, nightmares, feeling as if the event is happening again, avoidance of trauma-reminders, hypervigilance and increased jumpiness. Associated difficulties may include emotional dysregulation and strained relationships to cognitive difficulties, withdrawal or exhaustion. Impacts are highly individual, influenced by previous adversity, identity and recovery environment. Some recover quickly while others face prolonged difficulties, particularly when trauma goes unrecognised or unsupported.

Unequal exposure and early adversity

Risk of trauma exposure is uneven due to systemic inequalities[19]. Women face higher rates of sexual violence, LGBTQI+ people face higher violent assault, and racial minorities and indigenous communities experience higher trauma exposure and more barriers to care. Childhood adversity also matters for today's workforce as it shapes coping and emotional regulation into adulthood[20], influencing how employees respond to stress, leadership, organisational culture and change.

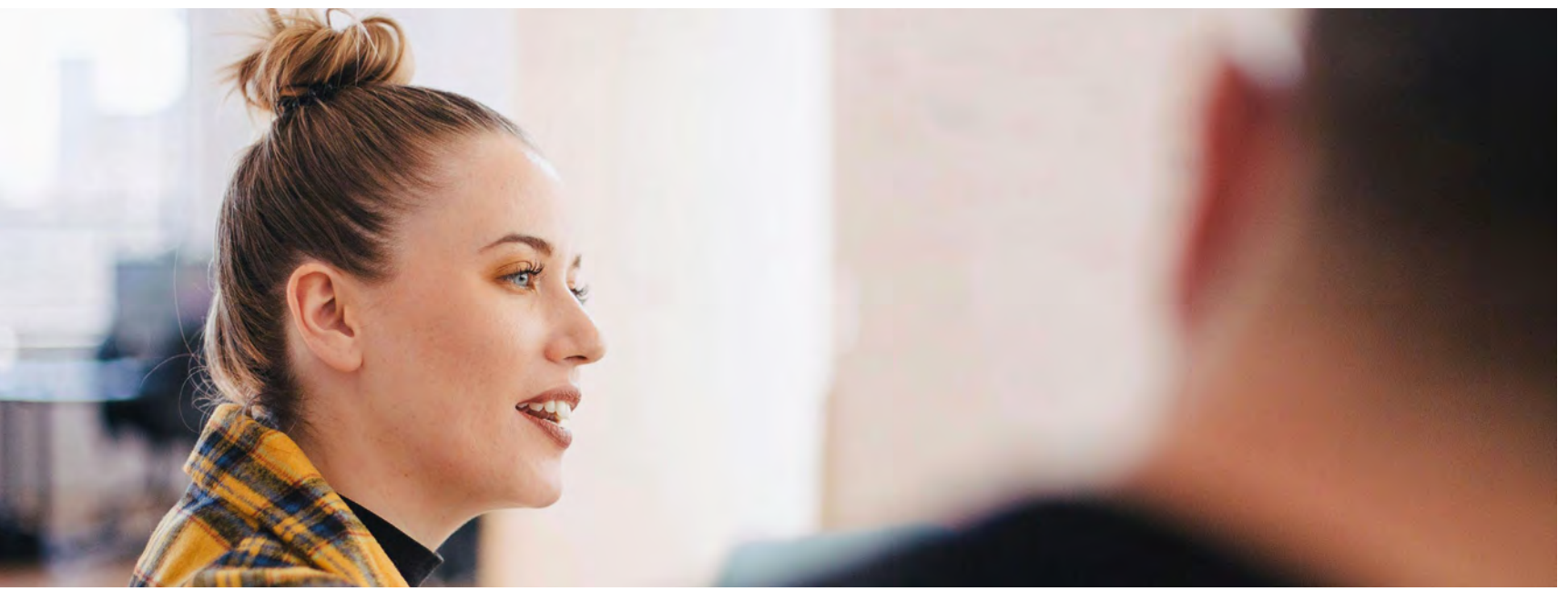
The scale is considerable. One in five UK adults report abuse in childhood[21] and approximately 60% of adults globally report at least one adverse childhood experience[22], which is strongly associated with absenteeism and presenteeism in adulthood[23]. Unequal exposure and recovery mean that trauma risk sits alongside other dimensions of inequality at work, and employers who recognise this can better anticipate where additional support or policy may be needed to meet their duty of care and ensure equitable outcomes.

Not everyone exposed to trauma develops PTSD, but many are affected

Globally, fewer than 6% of people exposed to trauma will meet diagnostic criteria for PTSD[24], though prevalence varies by population and context (1% to 12%)[25, 26]. Women are twice as likely as men to develop PTSD (8% vs 4%)[27], and rates are especially high among transgender and non-binary people, reaching up to 40% in some studies[28]. Younger adults also face greater risk (36.6% aged 16–24 compared with 17.6% aged 65–74)[29].

Prevalence rises markedly in conflict settings with the WHO estimating a rate of 15.3% for populations affected by war[30]. PTSD rates among US veterans are estimated at around 7%[31] and UK data shows a similar pattern with rates that are only slightly higher than civilians, yet rise to around 17% for those who have served in combat roles[32].

Beyond those meeting full diagnostic criteria, trauma-related symptoms are far more common. For instance, around one in four people experience sub-threshold trauma symptoms that affect daily functioning[33] and up to 15% of PTSD cases have delayed onset, emerging months or even years after the original event[34]. In practical terms, this means many employees may carry unseen effects of trauma before a diagnosis is ever made.



Trauma as a driver of mental and physical health burden

Unresolved traumatic stress can still affect health and functioning even when a person does not meet full diagnostic criteria for PTSD. NICE describes these as 'clinically important symptoms of PTSD', noting that they may still require support or treatment. Over half (53%) of adults with common mental health conditions report a major trauma history[35], while mental and addictive disorders together account for 7% of the global burden of disease and 19% of all years lived with disability[36].

Trauma is also linked to physical health. Some 45% of those with limiting long-term physical health conditions had a trauma history and were three times as likely to screen positive for PTSD (10.1% vs 3.4%)[37]. Trauma also increases risk of cardiovascular disease, substance misuse and mortality[38], and in war-affected regions PTSD ranks among the leading contributors to years lived with disability (YLD)[39]. This underscores that trauma is not only a mental health concern but also a driver of long-term wellbeing, productivity and healthcare costs.

Trauma in occupational contexts

Trauma can enter the workplace in many forms. While emergency responders and the military have long recognised the risks of repeated exposure, many other roles face similar risk.

For instance, train drivers involved in suicides, retail staff threatened with violence, journalists covering distressing cases, call handlers hearing traumatic disclosures, healthcare staff working in intensive care or emergency departments, and safeguarding or investigative teams dealing with violent crime, abuse or sudden deaths.

Given that most adults will experience at least one traumatic event in their lifetime, every organisation is likely to include people with lived experiences of trauma, and certain workplace situations may inadvertently trigger distress or affect wellbeing. Recent global pressures (from the pandemic and economic uncertainty to geopolitical conflict, racial injustice and hostility toward frontline staff) have layered additional strain, leaving many with invisible burdens that erode health, relationships and performance.

Trauma is not a niche or rare concern, it is woven into workforce life. While employers cannot control these events, the culture employees return to – whether compassionate or indifferent – strongly shapes their capacity to cope. The typology outlined on page 16 of this report offers a practical starting point for organisations to identify where trauma is most likely to arise and to assess whether systems and cultures are equipped to respond proportionally and effectively.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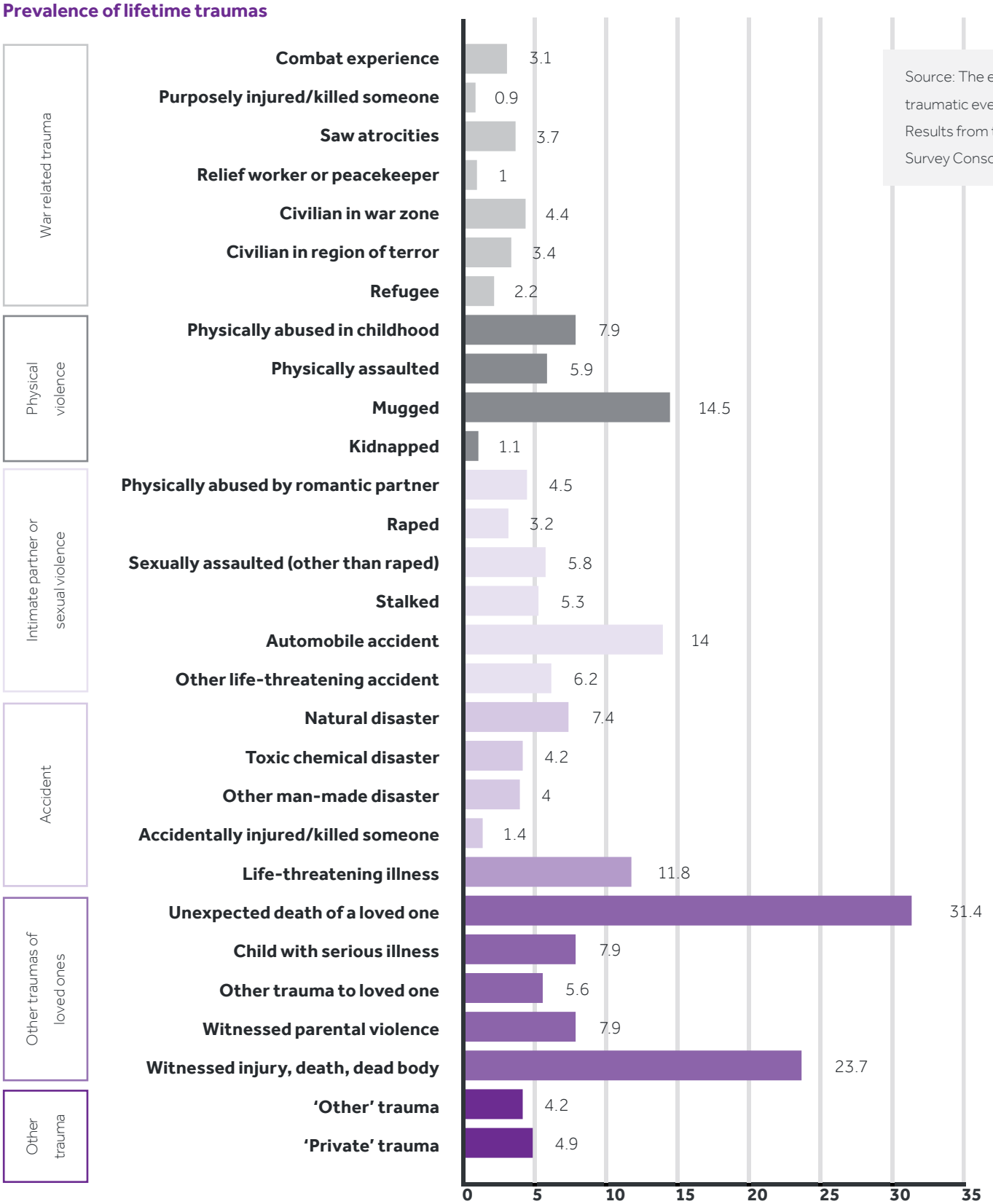
Prevalence of lifetime traumas



Source: The epidemiology of traumatic event exposure worldwide: Results from the World Mental Health Survey Consortium (Benjet 2016)

A trauma typology

What it is:

Helps organisations map the types of exposures most relevant to their context. While not exhaustive or hierarchical, it offers a practical lens to assess where trauma may occur and how well-equipped current systems are to respond.

Action:

Use this to map trauma exposure within your organisation to understand where it is most likely to arise and tailor interventions accordingly.

Typology	Examples	Key Characteristics	Evidence Base	Organisational Implications
Routine primary trauma exposure	Emergency services, armed forces, ICU or A&E staff, humanitarian workers.	Repeated direct exposure to traumatic events as part of core duties.	Early intervention is effective when culturally aligned, includes peer support and is backed by leadership[40].	Needs embedded trauma-informed policies, peer models (such as Trauma Risk Management), clinical oversight and regular psychological safety interventions.
Intermittent critical incidents	Retail workers exposed to theft or customer violence, office workers impacted by on-site suicide, transport staff facing accidents or assaults.	Trauma exposure is unpredictable but high impact incidents can occur.	Crisis response (e.g. psychological first aid) is beneficial, especially when targeted to affected teams[41].	Crisis response protocols, psychological first aid (trauma informed) and trained managers essential for rapid, compassionate support.
Vicarious or secondary trauma risk	Journalists covering war, violence or abuse, call centre staff handling distressed customers, HR professionals (ER teams).	Indirect but emotionally intense exposure through repeated hearing, reading or reviewing of traumatic narratives.	Researchers acknowledge vicarious and secondary trauma as a risk requiring organisational awareness, supervision, workload controls and reflective practices[42].	Requires emotionally literate leadership, access to trauma-aware supervision, boundaries and psychosocial support. Involve colleagues in shaping support strategies and fostering peer support, and organise regular check-ins with managers/peers/ welfare focused staff.

Typology	Examples	Key Characteristics	Evidence Base	Organisational Implications
Workplaces employing trauma survivors	Any organisation hiring from refugee populations, care-experienced backgrounds, or those from addiction, abuse or exploitation, or ex-offender schemes.	Trauma is non-work related but may impact work functioning or be re-triggered.	Over 70% people globally will experience at least one traumatic event in their lifetime[43].	Focus on psychologically safe cultures, trauma informed HR policies, and manager confidence to support disclosure and adjustments. Involve survivors in shaping support strategies, fostering peer support.
Moral injury	Healthcare workers during COVID-19, ER professionals unable to offer support due to legal / financial constraints, journalists pressured to publish ethically conflicting content, debt recovery enforcement.	Experienced in high-responsibility roles where systemic limitations constrain moral agency.	Studies during and after the COVID-19 pandemic have shown that being unable to act in alignment with ethical or professional standards can lead to profound emotional distress[44].	Requires a focus on frank preparation of staff for likely moral challenges, active management of distressed workers, and moral repair including acknowledgement of harm, and space for ethical dialogue and leadership accountability.
Conditions that can increase vulnerability and organisational risk*	Bullying, harassment, coercive leadership, gaslighting, exclusionary practices, protracted uncertainty, toxic leadership, restructures, mass redundancies, high-stakes investigations or conflicts.	Persistent interpersonal or systemic stressors that can erode psychological safety, magnify distress or impede recovery after a traumatic event.	Based on survivor accounts[45] and occupational health research on supporting mental health and wellbeing in the workplace.	These conditions are not traumatic events, but they do weaken psychological safety and increase vulnerability. A trauma-informed organisational approach, with fair processes and consistent leadership, helps reduce the risk and supports staff more effectively.

**Note:* This category refers to interpersonal and organisational conditions that erode psychological safety and heighten vulnerability to traumatic stress. These merit organisational and leadership action but should not be labelled as trauma.

CREATING CONDITIONS FOR RECOVERY: WHAT EMPLOYERS CAN DO

While trauma is often framed as a clinical concern, the evidence shows recovery is shaped far more by supportive conditions than by treatment alone, making it directly relevant to the workplace.

Restoring safety, connection and agency

Most people exposed to traumatic events recover over time and without complex intervention, provided they have safe environments and supportive relationships[47, 48]. Judith Herman, a leading trauma psychiatrist, explains that the core experience of trauma is disempowerment and disconnection from others - recovery therefore is based on the re-establishment of control. Healing occurs 'within the context of relationships' and unfolds across three phases: re-establishing safety, processing loss, and reconnecting with life through restored agency, identity and intimacy[49].

Social support

A consistent theme across trauma studies is that people prefer to confide in those they trust (i.e. friends, family, colleagues) rather than seeking professional help immediately. This is also backed by strong evidence linking social support to better health outcomes[50]. Following the 7 July 2005 London attacks, only 1% of the public reported needing professional help. Most turned to personal networks, and survivors who contacted family, friends or colleagues within hours of the event were significantly less distressed even six months later[51]. These findings helped shape UK government guidance on trauma response[52].

Active monitoring

Research shows that mandatory group debriefs immediately after a traumatic event can sometimes make things worse by forcing premature discussion, medicalising normal reactions or interrupting natural coping processes[53]. Instead, NICE (2018) recommends active monitoring and support in the first month after exposure. As Greenberg (2011) explains, most people who will recover naturally do so within this period and for *"most of those who will become unwell to have developed sufficiently clear symptoms to allow their disorder to be diagnosed by a suitably trained practitioner"*.

> ***"A consistent theme across trauma studies is that people prefer to confide in those they trust - friends, family, colleagues - rather than seeking professional help immediately.***

From recovery to growth

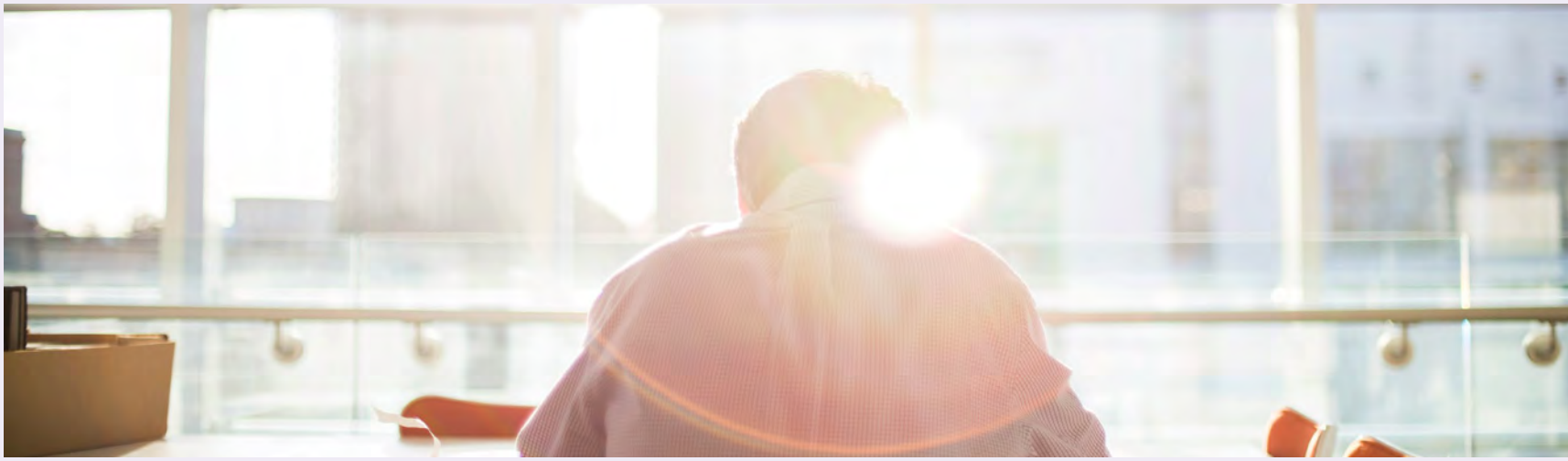
While much focus righty falls on preventing harm and supporting recovery, there is a glimmer in the evidence. For some, trauma can be a catalyst for positive change – a process known as Post-Traumatic Growth (PTG). This is reflected in stronger relationships, greater resilience and a renewed appreciation for life[54]. Research suggests that traits linked to PTG such as openness and emotional literacy can be intentionally developed through psychological skills training and compassionate leadership[55].

How workplace context shapes recovery

Workplaces have a unique opportunity not only to mitigate harm but also to foster resilience and growth. By embedding the right conditions for recovery – safety, connection and agency – into everyday culture, employers can help staff process events, rebuild trust and resume normal life[56].

Research reinforces this point. Brooks *et al.* (2019) identify workplace factors that heighten the risk of post-traumatic stress, including poor relationships with managers or colleagues, inadequate incident training, perceived lack of safety, and lack of post-incident support.

Personal vulnerabilities such as previous trauma, low social support outside work, sustaining an injury, the loss of a colleague, or significant personal or professional disruption post incident also increase risk. Long-term recovery from trauma at work depends less on clinical treatment and more on the psychosocial environment. Workplaces that provide psychological safety, enable supportive peer connections, and respect individual agency through flexible policies and compassionate leadership are far more likely to foster resilience and reintegration.



LEGAL AND REGULATORY CONTEXT FOR TRAUMA-INFORMED WORKPLACES

Global momentum towards trauma informed policy

In many countries trauma is not explicitly named in workplace law. Yet its effects on mental health and functioning fall within existing frameworks on occupational health, safety, equality, disability and data protection.

Increasingly regulators are framing employer responsibilities through the lens of psychosocial risks – the aspects of how work is designed, organised and managed that can harm psychological health. Reforms worldwide now place psychological health on a par with physical safety, with countries such as Australia, Belgium, Denmark, Italy, Estonia, Croatia, Hungary, the Netherlands, Lithuania, Latvia, Mexico, Peru, and El Salvador adopting standards-based approaches to primary prevention of psychosocial risks[57].

This shift is also evident at policy level internationally. The United Kingdom[58], United States[59], Australia[60] and Canada[61] are embedding trauma informed principles across health, education, justice and workplace contexts. Similarly, multilateral bodies including the World Health Organization[62], the International Committee of the Red Cross[63] and United Nations agencies[64] integrate trauma-informed approaches into humanitarian response, mental health policy and protection protocols.

Positioning trauma within psychosocial risk management

While not always caused by work, trauma's prevalence and impact means it intersects with psychosocial risks and falls within the scope of employer responsibility. Regulatory shifts are beginning to reflect this, from Australia's psychosocial hazard controls[65] (which explicitly list trauma), to trauma-informed frameworks in the United States[66] and the EU[67].

The psychosocial risk approach distinguishes between the organisational factors that create risks and the resulting health outcomes. It takes a holistic view of mental health, recognising that distress does not need to reach diagnostic thresholds to merit action. Sub-threshold states such as disrupted sleep, hypervigilance or low mood can still erode wellbeing and performance, particularly when compounded by excessive demands or poor workplace culture.

Many of the factors already captured under psychosocial risks frameworks - workload, low autonomy, poor social relations, emotional demands, value conflicts or job insecurity - can intensify the effects of trauma or hinder recovery. For this reason, trauma is directly relevant to prevention efforts under occupational health and safety law. Employers should therefore include trauma within their psychosocial risk assessments and design systems, policies and leadership practices that minimise psychological harm and support recovery.

Legal considerations and employer duty of care

In the UK courts now recognise that workplace factors such as unmanaged stress, bullying and excessive workload can contribute to mental health deterioration and, in rare cases, suicide. The legal position is that where such harm is deemed reasonably foreseeable and linked to an employer's failure to act, a claim may be upheld.

In *Corr v IBC Vehicles Ltd* (2008), for example, the courts found that suicide could be a foreseeable consequence of an employer's breach of duty following an incident that led to depression[68]. Employers are expected to provide training and support that enables early intervention, create safe and confidential processes for raising concerns, and ensure that systems of work themselves are not causing or exacerbating mental ill health.

THE BUSINESS CASE FOR ACTING NOW

Trauma has a measurable impact on key organisational performance indicators from absence and turnover to engagement and healthcare spend, yet its contribution to mental health-related costs is often hidden and underestimated.

Organisational impact on key workforce metrics

Evidence from (Richins, 2020) and (Nachmias S. K.-M., 2022) shows trauma-related symptoms directly affect core workforce metrics:

Absenteeism: Time off is often needed to recover or access support, increasing pressure on teams and temporary staffing costs.

Presenteeism: Employees may be physically present but cognitively or emotionally compromised, reducing productivity.

Turnover: Mishandled trauma contributes to attrition.

Healthcare claims: Unresolved trauma can contribute to chronic health issues, driving up occupational health referrals, insurance costs and sick pay.

Engagement: Trauma undermines psychological safety, a known foundation for collaboration, innovation and risk management.

The financial case for mental health investment

Deloitte UK's 2024 report on mental health in the workplace[69] estimates the total cost of poor mental health to UK employers at up to £51bn annually, including:

- £24bn attributed to presenteeism
- £20bn to turnover
- £7bn to absenteeism

Trauma is likely a hidden contributor to these costs. It often underpins more visible conditions such as depression, anxiety and burnout, yet remains undetected or undisclosed due to stigma, fear of career impact or a lack of psychological safety[70]. This means employers may be absorbing trauma-related costs without recognising the root cause or providing the support needed to mitigate them.

Yet evidence also shows that investing in mental health works. Deloitte estimates that on average employers can realise a £4.70 return for every £1 invested in workplace mental health[71].

Trauma-informed approaches support recovery and performance

A review in Frontiers in Psychology found that supportive trauma interventions including peer support, Trauma Risk Management, and supervisor training were most effective in reducing mental ill health and absence when embedded in organisational culture and backed by leadership commitment[72].

Further evidence shows strong return on trauma-informed interventions such as:

- In the Australian Fire and Rescue Service, manager training produced a £10 return for every £1 spent. The intervention, a four-hour psychosocial training session, improved manager confidence, reduced sick leave and strengthened engagement[73].
- The REACTMH programme in the UK demonstrated that a brief, evidence-based intervention for healthcare supervisors significantly improved confidence in supporting staff experiencing distress[74].

FOUNDATIONS OF TRAUMA INFORMED PRACTICE

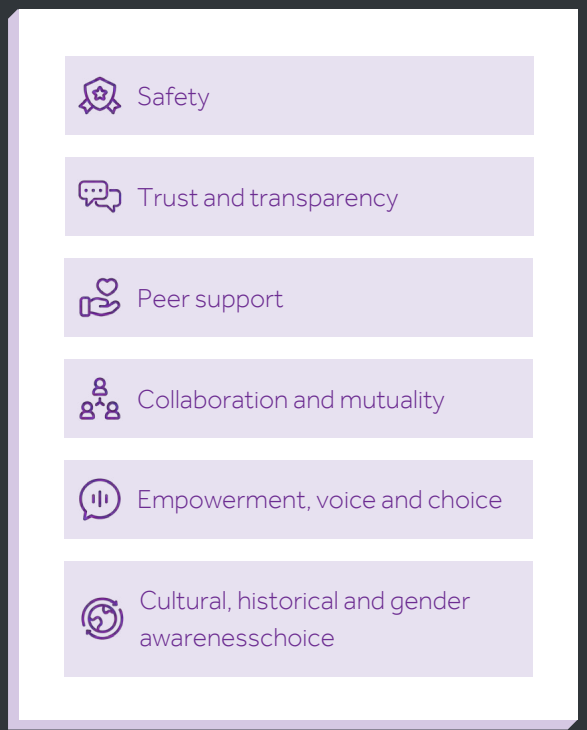
Two complementary approaches have shaped trauma informed practice:

Trauma-exposed sectors (military, emergency services, healthcare) emphasise preparedness, structured response, peer-led support and manager involvement[75].

Trauma-informed principles rooted in survivor advocacy and mental health reform acknowledge the likelihood of trauma even where it is not disclosed and focus on everyday systems that prevent re-traumatisation.

Developed first in healthcare, education and justice, these approaches promote six core values: safety, trust, peer support, collaboration, empowerment and cultural responsiveness [76].

One provides tools for incident response, the other on everyday culture. Both are essential, together creating the conditions for preventing harm and sustaining recovery. During COVID-19, for example, reflective practice groups, peer support and compassionate leadership buffered healthcare staff against chronic stress and moral injury[77].



Six core principles of trauma informed practice

This section adapts the six core principles more broadly to workplaces, drawing on international guidance, workplace research led by Professor Neil Greenberg and Professor Sir Simon Wessely, and survivor research led by Dr Stefanos Nachmias.

Safety

Safety means creating environments where people feel secure, distress is met with compassion, and help can be sought without fear. Guidance from NICE[78] and the WHO[79] recommend 'watchful waiting', more recently re-termed active monitoring, in the aftermath of a traumatic incident. This includes reassurance and clear access to support which helps maintain safety while allowing natural recovery to unfold[80].

Evidence from military settings shows how safety can be operationalised. The PIES model (Proximity, Immediacy, Expectancy and Simplicity) focuses on rapid stabilisation close to the site of trauma, restoring basic functioning and containment rather than emotional processing. A study of Israeli veterans found that those who received PIES-informed support were significantly less likely to develop chronic PTSD[81]. Wessely notes this echoes Blitz-era guidance that emphasised rest, information, and practical care within the first 36 hours[82].

For employers, the takeaway is that stabilisation and practical care matter more than forcing disclosure. Organisations should prioritise calm, confidential spaces, clear guidance on support routes, and training leaders to de-escalate distress and foster safe workplaces. Crucially, safety also includes psychological safety – the ability to speak honestly without fear of blame or humiliation[83]. Embedding this in everyday routines (through open dialogue, check-ins and peer support) allows proportionate, early responses before distress escalates[84].

Trust and transparency

Trust rests on honest communication, predictability, and consistent follow-through. When silence or vague messaging follows traumatic events, mistrust can grow.

Research shows how euphemistic messaging after deaths or critical incidents can deepen distress[85]. Coinbase's initial silence on George Floyd's death, for example, led to walkouts as Black staff felt silenced, showing how 'performative allyship' undermines credibility[86, 87].

Survivors also consistently highlight the importance of everyday behaviours and the role of clear communication, consultation, and reliable follow-up in restoring confidence. By contrast ambiguity, complex policies or overly bureaucratic processes - especially during change or return to work - can rapidly erode trust. Because trust is often fragile for those affected by trauma, organisations need systems and compassionate pathways that do not rely on disclosure and need to focus on understanding the impact on work and wellbeing rather than probing the causes[88].

Peer support

Peers are often the first to notice subtle changes in behaviour or mood. Peer support strengthens psychological safety by offering validation, reducing stigma and normalising distress, while also bridging the gap between informal support and clinical care[89]. Procedural referrals to Employee Assistance Programmes (EAPs) without dialogue, however, can signal avoidance and leave staff feeling they are 'too much to handle'.

Research shows that colleagues are ideally placed to provide social support that buffers the pressure individuals experience after a traumatic event[90]. Effective peer support programmes are voluntary (supported by leadership) and integrated into wellbeing or incident response systems[91]. To ensure sustainability and safety, programmes should include role clarity, agreed boundaries (including escalation protocols), training (e.g. trauma awareness, active listening, confidentiality, diversity awareness) and supervision, thereby protecting both those receiving and those providing support. Crucially, peer support must supplement and not replace professional or managerial roles.

Collaboration and mutuality

Collaboration means sharing power and co-designed solutions rather than imposing them. Survivors preferred being asked 'What would be helpful for you right now?' over a policy driven response[92]. Employers can operationalise collaboration through co-designing recovery plans, involving staff in post incident learning reviews and engaging employees in policy or wellbeing programme design. At a broader level, this approach shifts organisations from transactional, top-down responses to relational practices that strengthen psychological safety, relevance and buy-in.

Empowerment, voice and choice

Trauma undermines an individual's sense of control and empowerment helps to restore it by offering choice in pace, participation and recovery. Rigid reintegration plans, mandatory leave or inflexible HR processes can unintentionally replicate the loss of agency experienced during trauma. In contrast, even small work goals can help rebuild competence and confidence essential to recovery[93, 94].

Survivor-led research emphasises the importance of phased, individually tailored return to work planning rather than administratively driven processes. Effective interventions prioritise personalised regulation strategies that enable people to manage symptoms and re-engage safely rather than relying solely on time away from work. This may include adjusted work rhythms, sensory accommodations, structured peer support, or grounding techniques based on individual need.

Cultural, historical and gender awareness

Trauma is shaped by identity and inequality. Marginalised groups – people of colour, LGBTQ+ staff, care leavers, disabled colleagues – are more likely to experience trauma and face additional barriers to recovery. Experiences of racism, sexism, homophobia, transphobia, ableism or class bias influence whether workplaces feel psychologically safe[95]. Organisations must look beyond symptoms to respond to the whole person[96]. Culturally responsive practice requires more than empathy - it involves reviewing policies for cultural safety, embedding intersectional training and aligning trauma-informed practice with DEI strategy. Without this systemic reflection, organisational blind spots can unintentionally reinforce inequity.

Models and methods of support

This section summarises interventions in the research literature and should be reviewed against organisational context, needs and risk profile. Each approach serves a distinct purpose, with some building cohesion and reducing stigma, while others identify risk and enable referral.

Effective strategies are typically layered, combining early response, peer connection and leadership capability. Interventions should always be voluntary, sensitively timed to avoid re-traumatisation, and embedded within clear policy frameworks with governance, follow-up and leadership accountability.

References to specific models such as REACTMH, Trauma Risk Management (TRiM), and Psychological First Aid (PFA) does not constitute an endorsement.

Further Reading and Practical Guidance

For organisations looking to explore trauma support approaches in greater depth, the following resources provide practical, evidence-based guidance:

- UK Post-Traumatic Stress Society. (n.d.). Traumatic stress management: Guidance for organisations whose staff work in high-risk environments (Produced in association with the European Society for Traumatic Stress Studies). **https://ukpts.org/ukpts-guidance-on-traumatic-stress-in-the-workplace/**
- Tehrani's "*Managing Trauma in the workplace*" (2010) provides detailed insight into recognising trauma risks and developing supportive organisational responses.

Immediate incident response

Intervention	Trauma context	When it is most useful	Key organisational requirements
Critical Incident Stress Management (CISM) A coordinated organisational response involving team debriefs, education about trauma responses and follow-up support after serious incidents.	Acute trauma, immediate crisis response.	Following major or high-impact incidents in operational command structures or high-risk environments (e.g. emergency response, clinical care, blue-light services). Evidence supports multi-component organisational programmes but cautions against standalone debriefing sessions[97].	Structured programme including preparation, follow-up and clinical referral pathways. Governance oversight. Trained facilitators and integration into incident management systems.
PIES Principles (Proximity, Immediacy, Expectancy, Simplicity) A set of guiding principles that shape how early trauma support is delivered, emphasising rapid, local, practical and recovery-focused support.	Fieldwork trauma, security, humanitarian crises.	During or immediately following traumatic or high-stress events where early reassurance, team connection and normalisation of distress are prioritised. Suited for military, humanitarian and security sectors. Evidence from military settings links PIES-aligned support to stronger recovery outcomes[98].	Training staff and leaders to apply principles consistently. Embedding into incident response protocols. Ensuring support is delivered early, locally and without unnecessary medicalisation.
Psychological First Aid (PFA) Practical one-to-one emotional and practical support delivered immediately after distressing events.	Acute trauma, secondary trauma, vicarious trauma.	Immediately following traumatic or crisis events affecting individuals or teams, including acute trauma or vicarious exposure. Relevant for any sector, especially those with dispersed teams or chronic stress exposure. Recognised internationally as best practice for early stabilisation and linking individuals to further support[99].	Requires training and integration into incident response processes. Clear signposting to further support services.

References to specific models such as REACTMH, Trauma Risk Management (Trim), and Psychological First Aid (PFA) does not constitute an endorsement.

Monitoring and recovery pathways

Intervention	Trauma context	When it is most useful	Key organisational requirements
TRiM (Trauma Risk Management) A peer-led system where trained colleagues check in with staff after incidents to monitor coping and identify those needing additional support.	Critical incidents, cumulative trauma, occupational trauma.	Where staff experience repeated or occupational exposure to trauma, particularly in team-based operational environments. Evidence shows improved early identification of risk and reductions in trauma-related sickness absence[100].	Peer training and role clarity. Governance and monitoring processes. Ongoing organisational commitment.
Peer Support Groups Regular facilitated or informal spaces where colleagues share experiences and provide mutual support.	Cumulative stress, vicarious trauma, recovery from past trauma.	Where staff share exposure to cumulative stress, vicarious trauma or recovery from challenging work. Evidence indicates peer support helps normalise distress and strengthen psychological safety[101].	Clear governance and supervision. Defined purpose and trained facilitators. Must complement, not replace, professional support services.
Recovery, readjustment and reintegration programme (R3P) Facilitated team sessions focused on reflection, meaning making and early help seeking.	Operational and deployment related trauma.	Following sustained crisis response, high intensity deployment or prolonged organisational pressure. A real time monitoring model that helps leaders identify emerging stressor and use insights to adapt preparation, training and support. Evidence suggests improved leadership communication, earlier help-seeking and stronger recovery outcomes[102].	Protected organisational time. Leadership participation. Peer delivery supported by welfare pathways. Integration into organisational learning processes.

Leadership and cultural capability

Intervention	Trauma context	When it is most useful	Key organisational requirements
REACTMH (Recognise, Engage, Actively listen, Check risk, Talk support). Manager training that teaches leaders how to recognise distress, hold supportive conversations and signpost help.	Acute distress, burnout, cumulative work stress.	Where managers are likely to be first responders to staff distress, including burnout, cumulative stress or early psychological strain across sectors. Evidence shows improved manager confidence from <50% to >80% post-training a month after delivery[103].	Short structured training. Clear referral pathways. Integration into wellbeing strategy. Leadership endorsement and psychologically safe culture.
Schwartz Rounds Facilitated group sessions where staff reflect on emotional and ethical aspects of their work through shared stories.	Moral distress, cumulative emotional strain.	Where staff share exposure to cumulative stress, vicarious trauma or recovery from challenging work. Evidence indicates peer support helps normalise distress and strengthens psychological safety[104].	Needs skilled dual facilitation (leader plus psychologist). Protected time. Clear boundaries and psychological safety. Ongoing organisational commitment (not one off – usually monthly).

SHARED RESPONSIBILITY FOR TRAUMA INFORMED SUPPORT

Trauma-informed practice is most effective when woven into everyday systems and relationships across the whole organisation, rather than confined to HR or reactive, case-by-case responses. Without this integration, interventions can feel inconsistent or tokenistic instead of forming a coherent approach.

The **IGLOO** framework, developed by the University of Sheffield and Affinity Health at Work, provides a structure for distributing responsibility across five interconnected levels: **individual, group, line manager, organisation, and 'overarching' leadership**.

Proportion and timing matter. Evidence shows that support needs evolve over time. In the immediate aftermath, stabilisation and peer presence are most effective, while within the first month 'watchful waiting' supports natural recovery without pathologising normal reactions. Longer term, structured return-to-work plans, team reflections and cultural learning embed resilience and prevent recurrence.

Teoh's three-level model (CIPD/SOM, 2023) complements IGLOO, together showing how **prevention**, proportionate **support**, and longer-term **restoration** can be woven through the employee experience.

Crucially, trauma informed practice is not about new layers of process but about applying a trauma informed lens to strengthen existing wellbeing, people management, training and inclusion strategies. Taken together, these frameworks show how to translate evidence into everyday practice, thereby creating conditions that support recovery, reduce risk and sustain organisational health.

Distributed responsibility

- Individual
- Group
- Line manager
- Organisation
- 'Overarching' leadership

Three levels of intervention

- Prevention
- Support
- Restoration

Individual –
support and self-agency and recovery

At the individual level, trauma-informed practice focuses on enabling recovery and self-management without requiring disclosure. This includes confidential access to wellbeing support, flexible working options that do not depend on medical certification, and clear guidance on adjustments such as temporary changes in duties or work environment. Trauma literacy resources - offered at induction and revisited throughout employment - help normalise distress, build understanding and encourage early help seeking.

- **Prevention** relies on embedding mental health literacy and anti-stigma training across the workforce.
- **Support** involves flexible options such as temporary workload adjustments or 'watchful waiting' in line with NICE guidance, allowing recovery without premature escalation.
- **Restoration** includes phased return-to-work plans or longer-term adjustments developed collaboratively with the employee.

Group –
peer relationships and collective support

Teams are a vital buffer against distress. Everyday peer connection reduces isolation, normalises emotional responses, and enables informal check-ins after high-stress events. Structured mechanisms such as peer support networks or reflective spaces (e.g. TRiM facilitators) can extend this further, provided they are properly trained, resourced and governed.

- **Prevention** at the group level involves establishing team norms that promote psychological safety such as including permission to signal overwhelm and regular structured check-ins.
- Immediately after an incident, **support** centres on presence, listening, and opt-in reflective spaces.
- Over time, **restoration** occurs through team reflections or post-incident reviews that embed learning, strengthen cohesion, and improve collective readiness.

Line manager – relational first responder

Supportive managerial behaviour is linked to higher engagement, lower absence and improved performance, while poor handling of distress can prolong sickness and drive attrition[105]. A person's relationship with their line manager is one of the strongest determinants of their health and wellbeing. Positive, supportive management is a major predictor of employee wellbeing (Myers, 2003 as cited in Misra, M. & Cooper, C. 2025), with clear links to how people feel physically and mentally both at work and long after.

With appropriate skills and organisational backing, managers can notice early signs of strain, agree proportionate adjustments, and maintain trust without overstepping into clinical territory. Strong managerial support is one of the most protective factors for frontline workers' mental health, as shown in studies (Brooks *et al.*, 2018). COVID-19 research across paramedics, police, nursing and child protection staff (Robert *et al.*, 2021) is also insightful. In these settings, workers reported depression, anxiety and burnout rates two to three times higher than the general population, with many considering leaving their roles, reinforcing the need to equip managers to respond to stress and distress effectively[106].

- **Prevention** involves integrating trauma-awareness and relational skills into standard management training.
- In the immediate aftermath of an incident, managers can apply 'watchful waiting' (checking in regularly, offering discretion and short term flexibility while avoiding pressure to disclose).
- **Restoration** focuses on co-designing phased recovery plans and linking into occupational health or peer support as needed[107].

Training and confidence: Targeted training such as REACTMH[108] or Psychological First Aid[109] builds manager confidence and competence to support staff appropriately. When managers feel equipped, they are more likely to check in early, act proportionately and prevent escalation[110].

Compassionate leadership: Compassionate leadership is especially important for staff affected by trauma, moving beyond empathy (feeling) to action (alleviating harm) through deep listening, validation and responding with care[111]. This is a learnable skill and evidence links it to higher trust, collaboration and psychological safety, and lower burnout[112].

Discretion and flexibility: Managers should feel empowered to exercise discretion. Many underestimate the value of small, proportionate adjustments (such as altering workload, hours or expectations) which can significantly aid recovery even without a formal diagnosis. Organisations can legitimise this by embedding it into policy, and clarifying that situational judgement is part of good people management.

Supporting managers: Managers need structured support in the form of access to reflective supervision, peer forums, and timely advice from HR, occupational health, or EAP specialists. Protected time for reflection, recognition of emotional labour, and guidance on DEI and culturally sensitive issues are also essential. These resources should be integrated into core leadership, employee-relations and wellbeing training, and not treated as specialist add-ons.

Role boundaries: Clear role boundaries are essential because managers are not counsellors. Their remit is to provide psychological safety, proportionate flexibility and signposting. They also need protection from vicarious trauma through reflective supervision and clear escalation pathways.

Organisation –
systems, policy and infrastructure

For trauma-informed practice to be sustainable, it must be built into systems, policies and infrastructure, not just in individual relationships.

- At the **HR** level, this means ensuring policies allow for adjustments without requiring a formal diagnosis, integrating trauma-sensitivity into grievance, performance and return-to-work processes, and creating safe routes for disclosure.
- In terms of **Occupational Health** it means providing clinical and risk expertise, including assessment, rehabilitation planning, and complex case reviews.
- In terms of **EAPs** it means contributing to short-term counselling and crisis support. EAP services should be promoted routinely, so staff know how to access them before a crisis.

- **Prevention** comes through reviewing policies for fairness and flexibility, auditing physical and digital environments for safety, and embedding trauma-awareness into DEI strategies.
- **Support** involves enabling confidential access to multiple modes of help (e.g. EAP, OH, peer networks) and ensuring proportionate adjustments are available even without disclosure.
- **Restoration** focuses on structured return to work plans, team reflections, and reviewing complex cases to embed lessons learned. Governance underpins all of this through monitoring adjustment requests and outcomes, reviewing uptake of peer support, and auditing policies for cultural safety, thereby ensuring trauma-informed practice is embedded in organisational accountability.

Overarching (senior leadership) –
cultural and strategic enablers

Senior leaders set the tone for organisational trust. Their visible commitment determines whether trauma-informed practice feels meaningful or tokenistic.

- **Prevention** at this level comes through embedding trauma-informed values into governance, wellbeing and DEI strategies.
- **Support** is demonstrated when leaders model openness, discuss mental health with candour, and sponsor initiatives that prioritise psychological safety.
- **Restoration** is reinforced when boards oversee evaluation of support systems, allocate resources, and commission intersectional reviews to identify structural barriers. Leadership presence after critical incidents also matters. Acknowledgement, compassion, and clarity from the top signal that wellbeing is a shared organisational priority. Without visible senior commitment, even well-designed systems risk losing credibility.

AN INSIGHT DRIVEN APPROACH TO TRAUMA INFORMED PRACTICE

The following section offers a structured starting point for organisations seeking to build trauma informed practice and embed principles over time.

Impact and insight review

What it is:

A structured process to evaluate whether trauma-informed policies, support systems and responses are effective in practice. This tool encourages a data-informed, relational approach where numbers shape hypotheses, and conversations test and deepen understanding.

Action:

Combine quantitative data (e.g. uptake of EAP, absence, turnover) with lived experience insights from staff, managers and peer groups. Use the findings to identify strengths, blind spots and improvement priorities.

Impact assessment Measure whether responses and systems are effective over time.

- Monitor uptake of support (EAP, OH, peer support) and timeliness of access
- Track organisational indicators such as sickness absence, attrition, turnover, psychological safety scores, and pulse survey data
- Alongside these indicators, teams can also remain alert to shifts in output or performance that may signal reduced capacity or distress
- Use a data-informed approach to generate hypotheses, and then test these with affected staff, managers, and lived experience groups to build a rounded understanding

Combining data with lived perspectives ensures reviews reflect how policies and support are working in practice.

Experience and voice Gather input from staff, managers and peer networks to understand how systems are felt.

- Use anonymous surveys, safe debriefs, or structured forums (e.g. Schwartz Rounds)
- Explore disclosure experiences, perceived fairness, impact on recovery, and gaps in support
- Safeguards are essential: informed consent, confidentiality, and avoidance of detailed trauma recounting, with trained facilitators to ensure safety and prevent harm

Listening directly to staff builds trust and highlights blind spots that are often invisible through metrics alone.

Policy and process audit
Review organisational systems for alignment with trauma-informed principles.

- Check grievance, performance, return-to-work and absence policies for plain language and compassionate tone
- Ensure reasonable adjustment guidance explicitly includes trauma-related needs and allows managers to act flexibly without excessive sign-off
- Confirm escalation pathways, referral processes and post-incident protocols are proportionate, timely, and evidence-informed
- Benchmark policies against external guidance (WHO, NICE) and confirm compliance with equality, disability and data protection law
- Assess whether managers, HR, and peer facilitators have guidance on maintaining boundaries and role clarity when supporting staff in distress

Policies should empower managers and staff with clear parameters and discretion, rather than constrain them with rigid rules that risk delay or inconsistency.

Provider and support review
Ensure internal and external providers meet trauma-informed standards.

- Assess EAP/OH providers for trauma expertise (e.g. PTSD, vicarious trauma) and cultural responsiveness
- Confirm peer supporters, line managers and supervisors are trained in early, proportionate responses (e.g. TRiM, REACTMH, Psychological First Aid)
- Check senior leaders are briefed on trauma-informed responsibilities and expectations
- Monitor uptake, satisfaction, and diversity of support options to ensure choice

Providers and internal systems must work as a connected whole. Fragmentation or siloed delivery undermines trust and reduces effectiveness.

Forward planning and governance
Translate findings into action, with clear accountability for improvements.

- Establish multidisciplinary review groups with representation from survivors, peer supporters, employee networks, line managers, HR, occupational health, EDI and wellbeing leads
- Prioritise actions based on impact and feasibility, and ensure they are logged within organisational risk registers or governance structures
- Provide regular reporting to leadership teams (and relevant boards/panels) on psychological safety indicators and emerging risks
- Incorporate survivor and staff voice in governance reviews, either directly or through anonymised feedback

Governance ensures trauma-informed practice is not treated as optional or discretionary, but as part of core organisational risk management.

Feedback loops and reporting Close the loop between staff experience and organisational learning.

- Run scenario testing or 'mystery shopper' reviews of referral pathways
- Conduct pulse surveys or audits following critical events
- Feed lessons into policy, training, and governance forums
- Share anonymised case reflections internally to normalise learning and reduce stigma
- Communicate transparently on improvements made to demonstrate responsiveness and build credibility

Transparent feedback loops show employees their input leads to tangible change, reinforcing trust in the organisation's commitment.

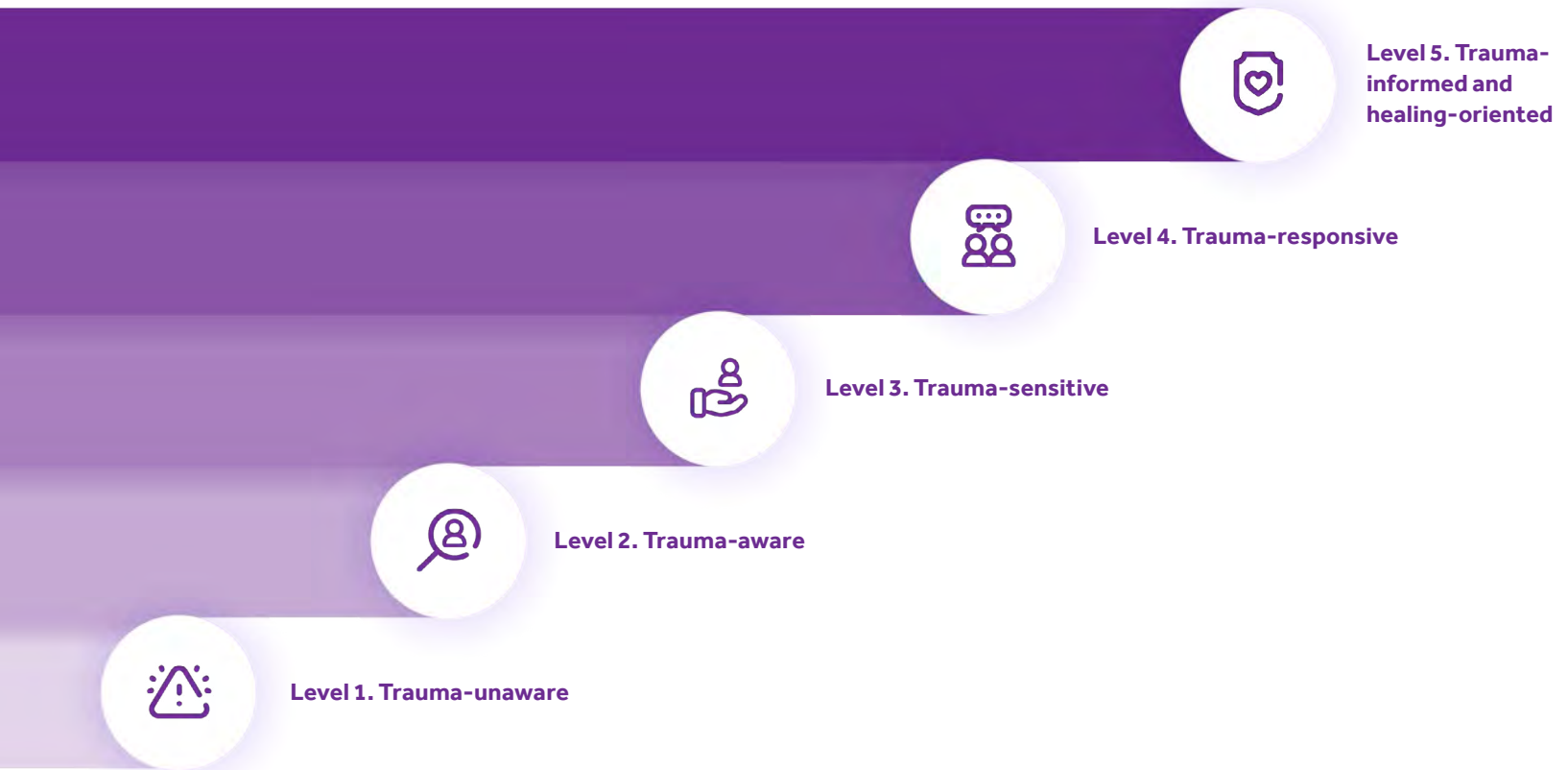
A trauma-informed maturity model

What it is:

Sets out a pathway to align behaviours, systems and infrastructure around trauma informed practice. It allows for self-assessment and planning, anchored in tangible outcomes and workforce wellbeing indicators.

Action:

Use this to benchmark your current state, identify quick wins and guide strategic investment.



Adapted from (Choitz),(Substance Abuse and Mental Health Services Administration (SAMHSA), 2014) and (Missouri Department of Mental Health, 2019)

Choitz, V., & Wagner, S. (n.d.). A trauma-informed approach to workforce development. National Fund for Workforce Solutions. **https://nationalfund.org/wp-content/uploads/2021/04/A-Trauma-Informed-Approach-to-Workforce.pdf**

Missouri Department of Mental Health. (2019). Missouri Department of Mental Health. Retrieved from The Missouri Model: A Developmental Framework for Trauma-Informed Approaches: **https://dmh.mo.gov/media/pdf/missouri-model-developmental-framework-trauma-informed-approaches**

Substance Abuse and Mental Health Services Administration (SAMHSA). (2014, July). SAMHSA's concept of trauma and guidance for a trauma informed approach. Retrieved from library.samhsa.gov: **https://library.samhsa.gov/sites/default/files/sma14-4884.pdf**

Level	Workplace culture and leadership Values and modelling of trauma informed behaviours	People practices Behaviours, relationships and support actions	Systems and infrastructure Formal structures that operationalise trauma informed practice
5. Trauma-informed and healing-oriented Trauma informed practices are embedded into people strategy and aligned with broader organisational values and leadership behaviours.	> Trauma-informed values are embedded across leadership behaviours, wellbeing, inclusion and people strategy > Senior leaders model psychological safety and relational leadership and trauma-informed thinking is reflected in how the organisation sets priorities around people and culture	> Staff report high levels of psychological safety, trust and inclusion > Peer-led and manager-led support models embedded across teams. > Equity lens applied to trauma-informed training and support	> Trauma-informed design embedded across systems (e.g. recruitment, DEI, health and safety, hybrid working etc) > Policies co-created or reviewed with those impacted > Data informs continuous learning and adaptation > External recognition or sector contributions shared
4. Trauma-responsive Trauma informed values are embedded into wellbeing, mental health and inclusion strategies.	> Trauma-informed culture is embedded in leadership expectations and values > Leaders actively review decisions through a trauma-informed lens	> Most managers trained and confident in providing support during or after distressing events > Adjustments offered proactively and equitably > Lived experience input into policy and support offering	> Key people processes reflect trauma-informed principles > Governance includes trauma-informed reviews > Uptake and impact of supportive offers monitored and evaluated
3. Trauma-sensitive Trauma informed understanding starts to shape policies, training and culture.	> Leadership starts modelling inclusive behaviours and acknowledges the emotional impact of work > Conversations around psychological safety are encouraged	> Manager training includes skills for recognising distress and responding supportively (e.g. REACTMH) > Staff experience of trust, belonging and psychological safety explored via surveys/ focus groups	> Updated HR policies include trauma-informed language and adjustment option > Trauma disclosure process introduced and tested. Peer support or reflective practice piloted in high-risk teams
2. Trauma-aware Organisation begins to explore relevance of trauma.	> Senior leaders begin to acknowledge trauma as a workplace issue > Early champions or advocates emerge	> Some managers receive basic trauma-awareness or mental health training > Initial wellbeing or DEI briefings begin referencing trauma-related concepts	> One or more HR policies reviewed for alignment with trauma principles > Staff feedback mechanisms begin to capture psychological safety
1. Trauma-unaware Trauma not seen as relevant to the workplace, responses are reactive and compliance driven.	> Leaders do not view trauma as relevant to workplace functioning > Culture prioritises performance and compliance, silence or stigma around distress/mental ill health	> No training for managers on trauma-informed support > Minimal awareness of psychological safety, wellbeing or relational support	> HR and governance policies lack reference to trauma or flexible response > No defined process for trauma disclosure, adjustment, or recovery

Employee lifecycle audit: Embedding trauma informed practice

What it is:

A practical checklist to embed trauma-informed thinking at each stage of the employee experience.

Action:

Review each touchpoint for psychological safety, fairness and flexibility and identify those that might inadvertently trigger distress.

Attraction & recruitment → **Onboarding** → **Learning & Development** → **Reward, Performance & Benefits** → **Retention** → **Exit & Separation**

Recruitment and hiring

- Use clear, inclusive language in job descriptions, signalling commitment to wellbeing and flexibility
- Clarify support is available regardless of diagnosis/disclosure without need for personal trauma details
- Avoid practices that may replicate power imbalances (e.g. last-minute changes, inconsistent panels, lack of follow-up/feedback after interviews)

Onboarding

- Create a psychologically safe first impression with clear support routes and manageable pacing
- Introduce peer buddies or trauma-aware welcome contacts
- Emphasise confidentiality, autonomy and access to services from the start
- Invite new hires to express preferences for how they engage with wellbeing services, buddy systems or check-ins

Physical and virtual workspaces

- Design quiet or decompression spaces with sensory wellbeing in mind (e.g. lighting, acoustics, accessibility)
- In virtual or hybrid settings, clarify working norms, allow flexibility with cameras and offer digital safe spaces
- Avoid sensory overload or cultural assumptions in layout, signage or digital presence

Team meetings and culture

- Use regular check-ins, not just task updates, to build relational safety
- Incorporate grounding rituals or reflective space post-stressful events
- Set and revisit team norms that reflect psychological safety

Performance and development

- Approach appraisals as relational, not purely evaluative
- Include structured wellbeing check-ins and opportunities for feedback
- Recognise relational skills, peer support and resilience as part of leadership and promotion frameworks
- Managers should be supported with clear guidance to ensure performance processes don't inadvertently penalise trauma-related distress

Policies and processes

- Review policies through a trauma informed and equity lens e.g. performance, sickness, grievance, capability, absence and return to work
- Invite input from lived experience groups
- Ensure support isn't contingent on diagnosis
- Embed psychological safety. Disclosure is safe and optional
- Policies should explicitly state that adjustments can be offered without a formal diagnosis. Disclosure is optional

Training, leadership and promotion

- Embed trauma-awareness into mental health and DEI training
- Provide culturally responsive trauma training to line manager training
- Promote leaders who embody inclusive, empathetic practices
- Offer reflective leadership development and supervision
- Provide trauma informed training and supervision frameworks for peer support groups

Health, leave and life events

- Apply inclusive, flexible approaches to health-related needs, parental leave, miscarriage, caring responsibilities or chronic illness
- Avoid one-size-fits-all policies. Individualise support based on the employee's experience
- Revisit adjustments regularly as needs evolve
- Empower managers to make relationally appropriate accommodations

Access to support and services

- Provide multiple support routes (peer, professional, digital, in-person)
- Ensure EAPs, OH, DEI and HR services are trauma-informed (vet providers for trauma capability)
- Make support visible and easy to access, especially during high-pressure periods (map referral pathways)

Redundancy, restructure and change

- Communicate early and clearly, with opportunities for staff to ask questions
- Offer emotional as well as logistical support
- Avoid legalistic or overly corporate language
- Develop safe spaces for dialogue and psychologically safe debriefs

Return to work and re-entry

- Make phased returns flexible and collaborative
- Respect privacy and avoid repeated disclosure while offering ongoing check-ins and reintegration support (e.g. one trusted point of contact coordinates support)

Conflict, grievance and resolution

- Ensure processes are safe, impartial and trauma sensitive
- Offer alternative reporting routes and emotional support throughout
- Train investigators and mediators in psychological safety, cultural sensitivity and trauma informed practice
- Escalation routes must be safe, confidential, and sensitive to trauma. Governance should ensure consistency and fairness

Exit, offboarding and after care

- Offer dignified, clear offboarding processes that include closure and emotional support if needed
- Provide exit interviews that focus on safety and consent and ensure feedback informs governance reviews
- Maintain connections where appropriate, especially after critical incidents or mental health leaves

High-risk touchpoints for re-traumatisation

Awareness of these moments helps HR, line managers and leadership teams proactively reduce harm:

- Redundancy or organisational restructure
- Disciplinary or grievance investigations
- Return to work after trauma-related absence
- Anniversaries of previous incidents (e.g. suicides, assaults, public failures)
- Abrupt contract endings or poor exit handling
- Microaggressions or systemic exclusion in DEI-sensitive contexts

CASE STUDIES

The NHS

A co-ordinated, trauma-informed workforce wellbeing strategy

Source: **NHS Employers** and NHS Wellbeing Resource Hub.

Context

The NHS, as the UK's largest employer, operates in a high-pressure environment with high rates of stress, burnout and trauma exposure. Recognising the link between staff wellbeing and patient care, the NHS developed a coordinated, system-wide approach grounded in trauma-informed principles[113].

The challenge

Time pressures and operational intensity often limited access to early mental health support. Trauma-informed tools were not always visible or embedded in daily practice and psychological safety was inconsistently modelled. The challenge was to embed a trauma-informed culture that was accessible, preventative and not solely reliant on clinical intervention.

Action taken

- Wellbeing guidance: The **supporting Our NHS People** hub provides frameworks to understand emotional load, shift work and trauma impact, encouraging early help-seeking
- Practical wellbeing tools: Campaigns on **beating burnout**, **managing stress**, ***Sleep, fatigue and the workplace*** explore how culture-specific ways of working intersect with health outcomes and share practical wellbeing tips
- Trauma-specific interventions: NHS promotes TRiM and REACTMH for early, evidence-based support in high-risk clinical settings (embedded within the above)
- Accessible communications: Infographics such as ***Shift work in healthcare*** and ***Mental wellbeing in the workplace*** distil complex messages into digestible visuals, reaching frontline teams where time and bandwidth are limited
- Leadership modelling: **Compassionate leadership** encourages psychological safety through curiosity, presence and humility
- Occupational Health - wellbeing collaboration: As per this **case study from NHS Employers** the organisation ensures support is holistic and not reduced to clinical assessment alone. This is enabled through phased returns, flexible adjustments and psychological check-ins
- COVID-19 redeployment guidance: **Trauma-informed redeployment** stressed preparation, choice and pacing to reduce psychological harm

Key learning points

Operationalise trauma-informed principles: Integrate safety, trust, empowerment, peer support and cultural responsiveness into daily practice

Link strategy with practice: Visible communications, manager training and governance alignment ensure trauma literacy reaches every level

Protect staff as people, not just professionals: Individualised support plans and redeployment considerations show what person-centred systems look like at scale

Sustainability depends on wellbeing: Investing in trauma-informed infrastructure is not just ethical, it's essential for long-term performance and retention

> ***The challenge was to embed a trauma-informed culture that was accessible, preventative and not solely reliant on clinical intervention.***

Responding to trauma exposure in retail

Context

In a supermarket a series of shoplifting incidents caused growing unease among staff. Although no formal sick leave or occupational health referrals occurred, employees expressed feelings of being unsafe and unsupported.

The challenge

The exposure did not meet the traditional thresholds of trauma, yet its emotional impact was clear. Staff voiced moral distress, anger and helplessness. A lack of police follow-up and unclear protocols left staff feeling exposed and disempowered, a pattern increasingly noted across the UK retail sector. This aligns with growing evidence from the retail sector linking shopfloor incidents to rising rates of mental health-related sickness absence, particularly anxiety and depression.

There is growing evidence from the retail sector linking shopfloor incidents to rising rates of mental health-related sickness absence, particularly anxiety and depression.

Action taken

A deputy branch manager consulted occupational health and was advised to hold a meeting. Attendance was notably higher than usual, and staff openly shared their experiences and a range of responses including fear, anger and guilt (about not confronting thieves or supporting one another).

The following practical, peer-suggested solutions emerged:

- Body-worn cameras
- In-store headsets: To discreetly flag suspicious behaviour
- Reaffirming safety boundaries: Affirming that no member of staff was expected to physically intervene
- Encouraging police presence: Via hospitality incentives at the café
- Even before implementation staff reported improved morale and greater trust, and the issue remained a standing agenda item for follow up. No shoplifting-related sickness absence was recorded and anecdotal reports indicated a decline in theft incidents following these steps.

Key learning Points

Psychological safety can be protective: Creating a space where staff can voice fears and frustrations without judgement is a core trauma-informed principle.

Not all trauma is clinical: The intervention prioritised relational support and collective action over medicalisation (preventing escalation without formal diagnosis or referral).

Peer-informed solutions work: Culturally relevant actions from within the team often outperform top-down mandates.

Early recognition is key: The manager's early recognition of psychological risk, despite a lack of formal absence data, demonstrates mature trauma awareness.

For additional research and evidence-based practice guidance on supporting colleagues impacted by trauma in the retail sector, please see the Violence and Aggression Research Network.

https://www.ashtoninstitute.ac.uk/research/networks/violence-and-aggression-research-network/

Despite significant investment in wellbeing initiatives, many police forces struggled to articulate what a comprehensive trauma system should include.

UK Policing (Oscar Kilo)

A tiered trauma response framework

Source: **Oscar Kilo – National Police Wellbeing Service**, ESTIP programme overview and personal correspondence on Trauma Support Model.

Context

Police officers and staff are regularly exposed to potentially traumatic incidents. While the Emergency Services Trauma Intervention Programme (ESTIP) established a structured four-stage framework (demobilising, defusing, trauma intervention meetings and follow-up monitoring), responses across policing remained fragmented. Oscar Kilo, the National Police Wellbeing Service, has since expanded this work into a Trauma Support Model that connects multiple interventions across the employee lifecycle to form a coherent 'safe system' of care.

The challenge

Despite significant investment in wellbeing initiatives, many police forces struggled to articulate what a comprehensive trauma system should include. Individual components - such as ESTIP, peer support, psychological screening, and occupational health - were often delivered in isolation, creating gaps and inconsistency. Forces needed a unified framework that linked prevention, peer and clinical support, and aftercare, ensuring that trauma awareness, response, and recovery were embedded throughout.

Action taken

Oscar Kilo developed the Trauma Support Model to integrate these processes into an organisation-wide approach spanning recruitment, active service, family support, and transition out of policing

- **New Starters:** Trauma literacy is embedded into training for recruits and line managers and alongside practical modules covering sleep, fatigue, and recovery
- **In Service:** The model combines peer and specialist interventions, including Trauma Risk Management, post-incident welfare support for firearms and misconduct cases, Trauma Impact Prevention Techniques training, and OK9 wellbeing dogs. This is all underpinned by EAPs, occupational health, psychological risk assessments, and 'wellbeing vans' offering accessible and confidential help
- **Family Support:** Recognising the ripple effects of trauma on families, Oscar Kilo created digital family toolkits and social media campaigns on mental health and wellbeing
- **Leavers:** A structured two-year plan supports officers through transition out of service, including occupational health follow-ups and psychological support as needed
- **Enablers:** Trauma Risk Management is underpinned by professional codes of practice and frameworks, ensuring governance, data consistency, and accountability across forces

The Trauma Support Model is embedded within Oscar Kilo's broader **Wellbeing Toolkit**, which includes a dedicated **Trauma Awareness** section with practical checklists, early warning signs and self-care guidance.

Complementary resources, such as the **Suicide Postvention Guide**, further strengthen organisational readiness and support teams following the complex trauma of a colleague's death. Together, these tools create a cohesive, trauma-informed ecosystem that promotes proportionate, context-sensitive support across the organisation.

Key Learning Points

Connect the system: Integrating trauma support across the employee lifecycle creates clarity, consistency, and trust. A whole system approach gives employees a clear consistent pathway to proportionate support relevant to their current situation.

Embed early education: Building trauma literacy and self-care into induction and leadership training supports prevention and early recognition, reducing long-term impact.

Strengthen peer and family networks: Peer supporters and family toolkits extend the reach of wellbeing culture beyond the workplace, supporting sustainable recovery.

Design for continuity: Transition and post-service support are part of duty of care. Sustaining contact and providing tailored aftercare can protect long-term wellbeing and preserve institutional trust.

CBC News, Canada

Embedding trauma awareness in newsrooms

Source: **Taking Care Report** and interviews with investigative journalist and mental health advocate Dave Seglins

Context

Dave Seglins, an investigative journalist with CBC News, experienced post-traumatic stress symptoms in 2010 while covering a distressing court case. His diagnosis revealed a lack of trauma-awareness in Canadian newsrooms and catalysed his mission to improve mental health literacy in journalism. He later co-led *Taking Care*, the largest national study of trauma exposure and wellbeing in Canadian media.

The challenge

Journalists are routinely exposed to traumatic content, yet mental health concerns are often overlooked. *Taking Care* found widespread symptoms of anxiety, burnout, moral injury and depression, especially among freelancers and precarious workers with limited access to support. Its findings included:

- Over 50% of respondents had sought medical help for work-related stress
- One in ten had contemplated suicide following trauma exposure at work
- The majority lacked access to trauma training or structured support
- Job satisfaction remained high, but often coexisted with significant emotional strain
- A persistent newsroom culture of stoicism and under-reporting of distress left many unsupported. Editors, meanwhile, felt ill-equipped to respond, with little access to trauma training or organisational guidance

Action Taken

The *Taking Care* project surveyed over 1,200 media professionals across print, broadcast and digital sectors. It quantified the psychological toll of journalism and amplified voices long silenced by stigma. In parallel, Seglins and colleagues developed a freely accessible toolkit of trauma-informed resources. Key resources, as highlighted by IJ Net include:

- Self-care tips for journalists
- Working with traumatic imagery
- Frameworks for ethical engagement with sources who have experienced trauma
- Tools to help newsroom leaders build psychologically safe cultures

All materials, along with the full Taking Care report, are freely available via the Canadian Journalism Forum on Violence and Trauma: **www.journalismforum.ca**

Key Learning Points

Acknowledge trauma-exposed work: Trauma exposure should be treated as an occupational risk, not a personal failing.

Train leaders at all levels: Trauma-informed leadership must extend across editorial and managerial roles, not just HR.

Support precarious workers: Include freelancers and contractors in mental health initiatives to reduce inequity and risk.

Promote peer-led solutions: Resources that embed ethical practice and trauma awareness empower both individual reporters and newsroom culture.

Foster non-stigmatised dialogue: Destigmatising distress leads to healthier teams and more sustainable careers in high-empathy professions.

> ***Journalists are routinely exposed to traumatic content, yet mental health concerns are often overlooked.***

Markel

Managing vicarious trauma in insurance claims

Source: Organisational input and workforce wellbeing initiatives at Markel

Context

Markel is a global insurance firm whose workforce is not routinely exposed to trauma as part of core duties. However certain roles, particularly within claims handling, investigations and complex case reviews involve periodic exposure to distressing or traumatic material, including serious injury, death, abuse, catastrophic loss and criminal activity.

This exposure is typically indirect, arising through written documentation, images, audio recordings or detailed case narratives, rather than directly through involvement in traumatic events. As such, risk is often less visible and can accumulate over time.

The challenge

As awareness of mental health and wellbeing increased across the organisation, feedback from colleagues highlighted that exposure to traumatic claim content was affecting some individuals' wellbeing, concentration and emotional resilience.

- Limited shared language to describe trauma-related impact in non-frontline roles
- Inconsistent recognition of traumatic content within case materials
- Lack of clear mechanisms to anticipate or mitigate exposure.

> ***Trauma exposure is not limited to frontline sectors. Indirect exposure through documents, images or testimony can still have significant psychological impact.***

Action Taken

Building trauma awareness and capability: Markel worked with a clinical psychologist to develop a mental health awareness programme that explicitly included trauma literacy. This helped normalise discussion of indirect trauma, clarify symptoms of vicarious exposure, and equip managers and teams to recognise early signs of strain.

Strengthening access to support: Alongside training, Markel implemented a coordinated programme to increase visibility and uptake of existing organisational resources, including the Employee Assistance Programme (EAP). Communications focused on reducing stigma, clarifying confidentiality, and encouraging early, voluntary support.

Process and systems design: To reduce unintended exposure, Markel introduced a 'traumatic content' flag within relevant documentation and case-handling processes. This enabled colleagues to anticipate potentially distressing material and exercise discretion over timing, pacing or support needs.

Choice and role alignment: From a capability and resourcing perspective, Markel also considered individual preferences and tolerance when allocating work. Where possible, colleagues could opt out of roles or teams with higher likelihood of exposure to traumatic content, reinforcing agency and psychological safety.

Key Learning Points

Trauma exposure is not limited to frontline sectors: Indirect exposure through documents, images or testimony can still have significant psychological impact.

Design matters: Simple process changes, such as content flags, can materially reduce harm without adding bureaucracy.

Capability beats crisis response: Building trauma awareness upstream supports prevention and early self-regulation.

Choice supports recovery: Allowing staff discretion over exposure helps sustain wellbeing and retention.

Use what you already have: Trauma-informed practice often strengthens existing resources rather than requiring new ones.

Ministry of Defence

A structured approach to mental fitness, trauma prevention and psychological recovery

Source: Health and Wellbeing policy team, MoD

Context

The Ministry of Defence (MoD) encourages personnel to consider their mental fitness as equally important as their physical fitness, in order to promote good mental resilience and mitigate the negative impacts of potential traumatic experiences. The MoD adopts a proactive and holistic approach to supporting the psychological health of service personnel, embedded within the *Defence People Health and Wellbeing Strategy (2022–27)*.

The strategy addresses physical, mental and social health to improve overall wellbeing across defence and takes a through-life approach to mental health support.

The challenge

Service personnel can be subject to increased exposure to potentially traumatic experiences either directly, such as during operational or humanitarian deployments, or indirectly through secondary exposure, for example when supporting deploying units or handling sensitive information. The MoD recognises the need to promote mental resilience, encourage early identification of mental health challenges, reduce stigma around help-seeking, and ensure personnel can access appropriate support at different stages of service, including during deployment, recovery and transition.

> ***A real-time surveillance model ensures leadership are aware of emerging stressors so learning can inform education, support and pre-deployment training.***

Action Taken

The MoD delivers its 'promote and prevent' mental fitness and resilience activity through several integrated components:

Education and awareness: Personnel receive briefings before, during and after deployment to highlight stressors and available support. The MoD encourages early identification and intervention and promotes a culture in which personnel feel comfortable seeking help without stigma.

Training initiatives: Personnel at all ranks receive training on managing stress and increasing resilience. The MoD provides tools to support individual improvements in resilience and mental wellbeing and facilitates access to a range of internal engagement options for those who may be struggling.

The MoD provides training that enables peers to support one another following potentially traumatic events. The Trauma Risk Management (TRiM) process empowers non-medical staff to identify and support colleagues affected by traumatic events.

Leader-led reflective practice: The Recovery, Readjustment and Reintegration Programme (R3P) provides organisationally protected, leadership-led reflective practice. This validates and celebrates personnel achievements, includes a psychological briefing, and supports group reflection to help individuals make sense of and find closure in their experiences. A real-time surveillance model ensures leadership is aware of emerging stressors so learning can inform education, support and pre-deployment training.

Access to specialist mental healthcare: For personnel requiring dedicated mental healthcare, Defence Medical Services (DMS) provides a responsive, flexible and accessible treatment service. Defence Mental Health Networks (DMHNs) across the UK offer specialist community-based care delivered by psychiatrists, psychologists and mental health nurses, aligned with national best practice. Support focuses on recovery, return to duty where appropriate, or transition to civilian life.

Key Learning Points

The MoD approach illustrates how mental fitness, trauma prevention and psychological recovery can be supported through a coordinated system that combines education, training, peer support, leadership-led reflection and access to specialist care. Emphasis is placed on prevention, early identification, organisationally protected time, and ensuring individuals know how to recognise mental ill-health in themselves and others, and how to access appropriate support.

International Committee of the Red Cross (ICRC)

Protecting psychological health in high-risk humanitarian roles

Source: Psychosocial support team, ICRC

Context

The core role of the International Committee of the Red Cross (ICRC) is to protect and assist victims of armed conflict and other situations of violence. This includes activities such as protection work in conflict settings, visits to detainees and efforts to restore family links for people separated by violence or displacement. While many staff work directly in these environments, others operate in coordination, back-office or support roles. Across the organisation, there is recognised exposure to psychosocial risk, including secondary or vicarious trauma, arising from sustained proximity to human suffering, distressing information and crisis response activity.

The challenge

Research on humanitarian work consistently shows that psychological strain arises not only from exposure to conflict and human suffering, but also from cumulative occupational and organisational stressors. Alongside direct and secondary exposure to traumatic material, humanitarian staff may experience high workloads, moral tension, interpersonal strain and prolonged periods of uncertainty or pressure.

Evidence indicates that these factors interact over time, shaping vulnerability, recovery and retention, and that organisational conditions (such as leadership support, workload management and autonomy) play a decisive role in moderating psychological impact. This supports the need for whole-organisation approaches that address both crisis response and the wider psychosocial context in which humanitarian work is carried out.

Action Taken

The ICRC defined a Staff Health Strategy, with a strong emphasis on health promotion, prevention and access to support. As part of this, the organisation identified the need for a structured, organisation-wide approach to crisis management and critical incident response, with a focus on stabilisation, early support and recovery. The strategy included:

Adoption of a whole organisation IGLOO-based approach: Recognising that effective trauma response requires action at individual, group, leader, organisational and external support levels, rather than relying solely on individual coping or clinical services.

Use of an evidence-informed framework: Drew on psychological research to support natural recovery following distressing or traumatic exposure. Rather than focusing on clinical treatment, these principles guide how leaders, peers and support functions communicate, respond and create conditions for psychological stability and recovery across diverse roles and contexts including:

- Safety: Protection from further harm
- Agency: Choice and control
- Connection: Supportive relationships
- Calm: Reduced distress
- Hope: Confidence in recovery

Ongoing review of relevance and effectiveness: The Staff Health Strategy was informed by multiple data sources, including colleague surveys, external research and publications, demographic data, and patterns of support uptake.

Expansion of trauma response framework: Includes responses for staff impacted by secondary trauma, reflecting the realities of humanitarian work beyond frontline exposure. Practical resources were also developed, including clear guidance for managers on supporting staff during and after crises, and guidance for individuals, including tools such as the window of tolerance, to support self-awareness and regulation.

Key Learning Points

- **Trauma-informed approaches are most effective** when embedded within a wider organisational mental health and wellbeing strategy, rather than implemented as isolated interventions.
- **Evidence-informed frameworks** can help translate complex psychological concepts into practical, accessible guidance for both managers and individuals.
- **Regular review using workforce data** and feedback supports proportionality, relevance and continuous improvement of trauma response approaches over time.
- **Explicitly addressing secondary trauma** helps organisations recognise and support roles that may not be traditionally viewed as trauma-exposed but carry significant psychological risk.

Trauma-informed approaches are most effective when embedded within a wider organisational mental health and wellbeing strategy, rather than implemented as isolated interventions.

CONCLUSION

Trauma is not the exception in modern workplaces but a common and often overlooked reality. Over 70% of people globally will experience at least one traumatic event in their lifetime, and many bring those experiences into work. Experiences of trauma, whether from critical incidents or reactivated past events, can affect health, relationships and performance.

When unrecognised or unsupported, trauma can contribute to absenteeism, presenteeism, disengagement and staff turnover, all with measurable financial and cultural impact. Deloitte estimates that poor mental health costs UK employers up to £51bn annually and traumatic stress is likely an under-recognised contributor.

While most people recover naturally, the quality of their social and organisational environment, particularly relationships with managers and peers, strongly shapes that recovery. Managers and colleagues are often more influential than formal interventions, and their everyday actions determine whether the workplace becomes a source of healing or harm.

Shared responsibility

This report has shown how trauma-informed principles (safety, trust, peer support, collaboration, empowerment and cultural awareness) can reduce harm, support recovery and strengthen organisational culture. Yet trauma-informed practice is not just another wellbeing initiative. It is an organisational capability that aligns culture, systems and leadership around psychological safety and equity. Importantly, this is not only the role of HR or mental health leads. It involves shared responsibility across leadership, people functions, managers, peers and partners such as occupational health or EAPs.

Effective trauma informed workplaces do four things:

- **Realise** the prevalence and impact of trauma.
- **Recognise** its signs and the ways organisational systems can exacerbate harm or promote recovery.
- **Respond** proportionately using evidence-based approaches.
- **Resist** re-traumatisation by embedding safe, fair and compassionate processes into daily life.

Ultimately, trauma-informed approaches are not about doing more, but doing things differently, reshaping how organisations understand wellbeing, leadership and sustainable performance.

If there is one takeaway for employers it is this: equip managers to listen, respond proportionately and act with care.

At its core, trauma informed workplaces uphold three foundational commitments in daily practice[114]:

Acknowledgement: "I will be heard."

Support: "I can get the help I need."

Trust: "I will be treated fairly."

Together they define what a psychologically safe, trauma-aware organisation feels like in practice.

"Whether through critical incidents, chronic stress, or reactivated past experiences, trauma affects health, relationships and performance.

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