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The perspectives of peer practitioners and psychologists on the effectiveness of a trauma support programme for healthcare workers

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Abstract

Purpose – This study explores the implementation of a staff trauma support pathway (TSP) within a large acute hospital in England. The TSP is a peer-based initiative designed to support healthcare workers following potentially traumatic events (PTEs). We aimed to understand how the pathway supports individuals and contributes to a supportive organisational culture while examining its perceived benefits and challenges.

Design/methodology/approach – We carried out semi-structured interviews with five peer practitioners and four psychologists involved in the TSP. The interviews focused on their experiences of training, delivering support and the pathway's impact. Thematic analysis was used to identify key insights.

Findings – The TSP helps healthcare staff by normalising their emotional reactions to trauma, offering a space to reflect and improving awareness of mental health resources within the organisation. It also fosters a more compassionate workplace culture by reducing stigma and encouraging help-seeking behaviours. Peer practitioners reported professional growth and enhanced confidence, while psychologists noted a more efficient use of resources. However, participants highlighted challenges, including managing the pathway alongside existing responsibilities, the pressure to not let others down and ensuring equitable access for staff.

Originality/value – This study adds to the growing evidence on peer-led trauma support systems in healthcare, shedding light on their dual benefits for individuals and organisations. By emphasising early intervention and shared understanding, the findings offer practical insights into sustaining and scaling such initiatives in high-pressure environments with ramifications for intervention development in other sectors as well.

Keywords Peer interventions, Peer practitioners, Trauma support, Healthcare workers, Organisational interventions, Reflective space, Psychological well-being, Intervention implementation, Intervention evaluation, Post-traumatic stress disorder

Paper type Research paper

Introduction

Exposure to traumatic and adverse events is a common occurrence in healthcare (Busch *et al.*, 2020; Slade *et al.*, 2020; Fall *et al.*, 2024). A potentially traumatic event (PTE) can occur through situations involving medical and surgical complications, errors, unexpected patient outcomes, violence and aggression or exposure to significant levels of distress (Seys *et al.*, 2013; Busch *et al.*, 2020). This is concerning given that healthcare workers exposed to PTEs have been linked to high levels of psychological distress, including post-traumatic stress disorder, anxiety, depression and fear (Seys *et al.*, 2013; Anderson *et al.*, 2020; Busch *et al.*, 2021). It is

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also associated with increased sickness absence and leaving the profession (Busch *et al.*, 2020; Burlison *et al.*, 2021). From a patient perspective, such exposure can undermine the quality and safety of the care provided (Busch *et al.*, 2021; Schrøder and Assing Hvidt, 2023).

While specialised trauma-focused psychological interventions (e.g. trauma-focused cognitive behaviour therapy, CBT/eye movement desensitising and reprocessing/EMDR) remain vital for those with persistent symptoms of heightened distress meeting criteria for PTSD (Lewis *et al.*, 2020), a more comprehensive approach entails earlier intervention to support healthcare workers who have experienced a PTE (Schrøder and Assing Hvidt, 2023). This has seen a move towards peer-based support systems, which are based on providing and receiving help through shared responsibility, respect and a mutual agreement of what is helpful (Mead *et al.*, 2001). This is important, as how well supported an individual is after a PTE is an important antecedent factor of subsequent psychological distress (Greenberg, 2011), with early support from supervisors and colleagues found to reduce the likelihood of psychological ill-health in military (Jones *et al.*, 2012) and healthcare (Seys *et al.*, 2013) settings.

The importance of peer support lies in the shared understanding and empathy that workers might have (Shapiro and Galowitz, 2016). Peer supporters help normalise and validate the emotional fallout after adverse events by providing empathy and validation from others familiar with the context (Fall *et al.*, 2024). This is important considering the stigma around mental health and help-seeking in the healthcare sector (Kinman *et al.*, 2020; Teoh *et al.*, 2022). The less formal nature of a peer-based approach also reduces concerns around potential medical-legal consequences (Fall *et al.*, 2024). As such, a peer support approach can complement more formal and specialised support services by serving as a bridge to additional resources (Busch *et al.*, 2021).

Peer-based support systems improve accessibility by being more readily available, allowing for quick and informal support (Schrøder *et al.*, 2022). Timely and effective support early on can help individuals manage their reactions and reduce the likelihood of distress escalating (Edrees *et al.*, 2016). This can be done by educating those affected about normal psychological and physical reactions to a PTE, which helps assure the individual of a typical recovery journey (Greenberg, 2011). By normalising the physiological response, peers can reassure individuals by putting these feelings and symptoms into context. This helps mitigate against unhealthy coping strategies, additional stress or anxiety from symptoms or a perceived lack of control – all of which could exacerbate the risk of subsequent psychological ill-health (Hobfoll *et al.*, 2007; Colville *et al.*, 2017).

It is from this that trauma support programmes have started to train individuals to provide initial support and signposting to colleagues who may have experienced a PTE (Shapiro and Galowitz, 2016; Agarwal *et al.*, 2020; Schrøder *et al.*, 2022). Growing evidence attests to the potential efficacy of such an approach, with one systematic review of group-based early intervention support reporting that 74% of interventions had supported recovery or had reported a positive experience (Richins *et al.*, 2020). There has also been increased focus on peer support systems as a means of supporting healthcare staff since the COVID-19 pandemic (Flaherty and O'Neil, 2022; Connors *et al.*, 2023). However, despite this research, several gaps remain – particularly in relation to transfer into practice.

First, peer support programme evaluations have primarily focused on the extent of their use (El Hechi *et al.*, 2020; Fall *et al.*, 2024) or their effectiveness (Agarwal *et al.*, 2020). For example, surgeons in a programme offering peer support post-adverse event report high levels of satisfaction with the programme, including that it had a positive impact on the safety and support culture (El Hechi *et al.*, 2020). As such, there is little understanding of the process and mechanisms of how and why such programmes may lead to beneficial outcomes. A better understanding not only tests and validates some of the theoretical frameworks and principles in practice (Roodbari *et al.*, 2022) but also potentially explains the diversity and inconsistency in the findings related to the programme designs, structure and setup (Anderson *et al.*, 2020).

Second, most trauma support programmes have focused on non-healthcare settings (Solomon and Benbenishty, 1986) or then on single occupational groups such as surgeons

(El Hechi *et al.*, 2020; Fall *et al.*, 2024), midwives (Schrøder *et al.*, 2022) or clinicians (Edrees *et al.*, 2016). This raises questions about its applicability to a large hospital where support must be provided across multiple professional groups. Given that the value of peers lies in the ability to relate with the experience of the individual exposed to a PTE (Seys *et al.*, 2013; Busch *et al.*, 2021), would this basis still hold where the person providing the support is a colleague from a different function or occupational group?

Finally, most evaluations have focused on the individuals exposed to a PTE (Seys *et al.*, 2013; Edrees *et al.*, 2016). This is understandable given that they are the target group for the programme. Nevertheless, other relevant stakeholder groups warrant consideration. These include (1) staff who volunteer to be trained as peer practitioners as part of such programmes and (2) mental health professionals responsible for the design of the programme and/or the specialised support of participants. Where these stakeholders' experiences are congruent with that of individuals taking part, it provides further validation of the underlying principles and theories involved (van Urk *et al.*, 2016). Crucially, the sustainability of such a programme is undermined if these stakeholders do not believe in its efficacy and process (Bryson, 2004; de Lange *et al.*, 2024), which may result in a lack of volunteers or the withdrawal of resources and attention.

Recognising these identified gaps, we evaluated the implementation of a staff trauma support pathway (TSP) set within an acute hospital trust in England. The aim of TSP is to provide an initial, peer-based response to support colleagues who have experienced a PTE. This is done by providing some early peer-led support (normally after 72 h to allow for natural processing) that helps colleagues understand common post-event psychological reactions and serves as a potential referral to more specialist support for those in need. The TSP also covers training in peer-led debriefings of teams, training in trauma awareness and support with coordinating support after a major event – although these activities are beyond the scope of this article. In doing so, this study aims to explore the views of both peer-support practitioners and psychologists involved in the delivery of TSP to identify how the pathway supports individuals and the organisation as well as the potential benefits it has on individuals and the organisations.

Method

The programme design

Drawing on the research and practice evidence on post-trauma support, TSP takes a three-stage approach to support individuals who may have experienced a PTE. Typically, individuals who have directly been involved in a PTE, although it is possible for this to occur vicariously or through a secondary exposure. The first stage is a personalised email from psychologists in the staff trauma support team to the individual acknowledging that a PTE had happened. Individuals are provided a leaflet on the typical post-event symptoms and offered the opportunity for a peer check-in, alongside other support mechanisms. This contact is triggered through self-referrals or referrals from managers and colleagues. The hospital's online system (i.e. "Datix") to report incidents and risks also allows for PTEs and associated individuals to be flagged to the staff psychology team.

The second stage occurs when individuals accept a peer check-in. Now, a call is put out to a pool of volunteer trauma support peer practitioners who would directly contact the individual to arrange a check-in. There are 33 peer practitioners in the hospital from various clinical (e.g. nursing and medicine) and non-clinical (e.g. medical education and resuscitation officer) backgrounds. Peer practitioners take this role in addition to regular duties and undergo a two-day training session that covers the trauma pathway and the peer practitioner role, guidance and practice in facilitating a check-in and signposting additional support, psychological risk assessment and maintaining the network. A 2.5-h session is run annually as a refresher.

A typical check-in lasts 30–45 min, where the peer practitioner works through a protocol that explores the impact the event has had on the individual both inside and outside work, psychoeducation around normal reactions to traumatic events (such as hypervigilance and

increased emotions), risk, coping strategies and support. The protocol gives the person space to be heard and understood, explores what they need and reassures them about how they might be feeling. It also looks out for warning signs that the person may need further support. At the end of the check-in, individuals can be offered a follow-up session approximately two weeks later. This draws on the principle of "active monitoring" (NICE, 2018), allowing time for those able to recover to have done so or the escalation of individuals who may still be distressed.

The first two stages of the pathway facilitate local, quick and simple support that aims to help individuals manage their expectations, congruent with the PIES (proximal, immediacy, expectancy and simplicity) principles in supporting those exposed to a PTE (Jones *et al.*, 2017). In the military context, the application of PIES principles was associated with fewer post-traumatic symptoms (Solomon and Benbenishty, 1986) and being able to return to the same deployment (Jones *et al.*, 2017).

Stage three covers the specialised support provided by the staff psychology team and occurs where those who experience ongoing distress and compromised coping after the second check-in are referred to. However, peer practitioners can escalate an individual for specialised support earlier on if concerned.

The three stages broadly map onto a three-tiered approach for supporting healthcare workers exposed to trauma: local support focused on information and normalising reactions (tier 1), support from trained peers (tier 2) and professional support (tier 3) (Scott *et al.*, 2010; Schrøder and Assing Hvidt, 2023). In describing the University of Missouri Health Care's approach to the trauma support system, Scott *et al.* (2010) found that 60% of participants in their intervention programme were satisfied with the support at tier 1, 30% needed support at tier 2 and 10% needed support at tier 3. This staggered approach not only supports early intervention but also allows the triaging and saving of specialised resources for those most in need (Seys *et al.*, 2013).

Study procedure

All peer practitioners and psychologists involved in TSP were invited to take part in a study evaluating their experiences being part of the pathway. Interested participants were asked to contact an external independent researcher to express their interest and provide informed consent. Semi-structured interviews were carried out online via Microsoft Teams by the external researcher between March and May 2024. The interview guide was developed by the research team, with variations depending on the staff group. The guides for peer practitioners covered the training received, their experience of delivering a check-in, and the impact of the check-in. For psychologists, this covered their views of the usefulness of the pathway, facilitative and hindrance factors and usefulness of the pathway.

This study was classified as a service evaluation by the organisation and did not require formal ethical approval. It received both Clinical Effectiveness Application and Caldicott approvals from the organisation. In carrying out this study, we adhered to the ethical principles of the British Psychological Society.

Participants

Nine participants (five peer practitioners and four psychologists) were recruited. The interview ran between 37 and 68 min (mean = 48 min). For the peer practitioners, two came from a medical education/training background, with one each a doctor, a matron and quality improvement. Between them, they carried out approximately 23 check-ins, ranging from none to 12 (mean = 4.6) check-ins. These check-ins covered a range of PTEs, including traumatic events (e.g. stabbings, cardiac arrests and suicide attempts), clinical adverse events (e.g. untoward medical occurrence) and other work-based incidents (e.g. violence). However, some participants highlighted situations where individuals referred to were not suitable, as they had been through a different form of a challenging work event (e.g. bullying and harassment) or a personal event. These would not be part of the TSP and are not explored in this paper.

Data analysis

Transcripts from recorded interviews were generated automatically before being manually checked and corrected. Using thematic analysis (Braun and Clarke, 2019), this formed part of the first stage of familiarisation through multiple readings of the transcripts. An inductive approach was to identify codes about how participants thought and felt about the research question. Codes were then organised into broader themes. The research team provided commentary on the codes and thematic categories to provide researcher triangulation (Patton, 1999). Data collection and analysis was carried out by the first author, who was external to the organisation and not involved in the design and delivery of the programme.

Findings

The themes from the interviews are structured according to the two study aims and presented in Table 1, and are underlined and elaborated on below.

How the pathway supports individuals and the organisation

TSP helps individuals who have experienced a PTE by normalising their stress reaction. This involves understanding what a natural reaction to the situation might be, symptoms that may develop and potential coping strategies:

> I think a lot of it is the normalising of the experiences they're having, things like flashbacks, nightmares, you know that those are really distressing things to experience. And I think actually realising through talking to a peer practitioner that, that's something we'd expect to happen after a traumatic event, I think is so important in people being able to kind of understand their reaction and feel more able to cope with that. I think that's a huge, huge part of it (Psychologist)

This process helps validate the experience of the person that experienced the trauma, and that traumatic experiences and reactions are common within healthcare, as "*just reassuring them that to have a wobble after a traumatic event is nothing to be ashamed of or anything*" (Peer Practitioner). The individual can then understand that the symptoms they experience were likely to be expected. Doing so would hopefully minimise additional distress or concern and allow the individual to better cope. This normalisation helps challenge the stigma around mental ill-health, signalling the importance and acceptance of getting help where "*it's not viewed as a weakness to ask for support and that's been a big mind-shift*" (Peer Practitioner).

Knowing that the support is available is important, as it provides reassurance to employees that support is available if needed. It also exists as a resource for managers to use in supporting their teams.

> I think managers, leaders, they find it reassuring we're there, they go in a bit panic mode when something bad happens and then e-mail us. [. . .] So, I think a lot of it can be around reassurance. And I think people find that safety net good. (Psychologist)

Table 1. Overview of themes related to the study aims

How does the TSP support individuals and the organisation?	What impact does the TSP have?
1. Normalises the stress reaction	1. Positive reactions
2. Knowing that support is available	2. Staff well-being
3. More rapid and proactive support	3. Popularity of the service
4. Providing space and time to reflect	4. Improved awareness
5. Peer support	5. Pressure of not letting others down
6. Better utilisation of resources	

Source(s): Created by authors

Moreover, this extended to the wider organisation, whereby the presence and investment into such a support programme indicated that the organisation was concerned about the individual involved. The prospect of being contacted and support offered via an email or peer check-in engendered feelings of value and recognition: "*Somebody seeing you in the organisation, . . ., I felt that it would be quite empowering*" (Peer Practitioner). This feeling is compounded by the TSP being developed in-house being important, as it considered the needs and interests of the local workforce.

By offering several routes where individuals who experienced a PTE are flagged to the TSP allows for a more rapid and proactive support to be provided to those in need, with initial contact with referrals typically made within 24 h. This not only normalises post-traumatic stress reactions after a traumatic event, as detailed above but also helps mitigate the build-up of long-term trauma and distress. The check-ins also allow those who are in need of more immediate specialised support to be flagged up to the staff psychology team for quicker support that allows them to be seen much quicker:

> A trauma support peer practitioner might [. . .] be really worried about this person [. . .] [and so a psychologist] might just say yes, I can see them tomorrow and then they've scooted in front of everyone else. (Psychologist)

The provision of this additional support outside of the staff psychology team by peer practitioners provides an additional entry point to the staff psychology team for those who otherwise might not have engaged with this resource.

The opportunity to check-in with a peer provides space and time to reflect, giving individuals a chance to process what they had been through and to ask questions about their responses to the situation. Although this may appear intuitive, multiple participants mentioned having to create the space and time to reflect because of how shifts and teams are set up – or even how the physical building is laid out – which means that for many employees there are few chances to interact and obtain support as part of their standard workday. In doing so, participants have:

> . . . that space [. . .] to think about: 'actually what do I need right now? How do I look after myself? It almost gives that permission to step back and say what do I need in this moment? Do I need a bit of time off? Do I need to connect with friends, family?' I think it can help to really steer people in the direction of those kind of quite normal coping skills that we all use day-to-day. (Psychologist)

The pathway's focus on peer support is crucial as it draws on theoretical evidence that "*support from peers and managers is important in buffering the negative effects that can come from experiencing witnessing and traumatic events*", and that speaking to a peer means having someone who "*understands and works in that area, works in healthcare, knows the challenges and can provide a listening ear*" (Psychologist). The intention is not for a specialist advisory service, but instead, for employees to have the opportunity to talk through their thoughts and experiences with someone who can relate to them.

The final theme was on the better utilisation of resources within the organisation. Where peer practitioners were taking on the more low-level cases, it freed up the capacity for psychologists to see those experiencing higher levels of distress, as echoed by several of the psychologists interviewed:

> We are probably being utilised a lot better considering that you know, we see the people who really do need that specialist support because a lot of people who kind of come through the path, they actually do just need that peer support, that conversation with a peer practitioner and that's what kind of makes difference in that moment. (Psychologists).

However, there was also an acknowledgement from psychologists that managing the TSP itself was fairly time-consuming, as it involved training and coordinating peer practitioners as well as being on hand to respond to incoming queries. In addition, the higher visibility of the

staff psychology team and the programme meant that it could be that more employees were being referred to the service.

What impact does the trauma support pathway have?

From the interviews, five outcomes were associated with the TSP (Table 1). The most evident impact lies in the immediate positive reactions that participants received or observed, with descriptions of gratitude, thankfulness and relief being shared:

> by the time you get to the end of the conversation, the person says to you, 'do you know I feel a little bit better already, just having talked about it' [. . .] You can kind of see a slight change and you have [. . .] a glimmer of hope it's a little bit better at that at the end of it which from that sort of side of it is quite nice. (Peer Practitioner)

This links to other aspects where people may engage with the TSP, including those in Stage One who are contacted via email:

> We've had people come back to us and say [. . .] I was really rattled by that I was really shaken. It was helpful to read through that leaflet, but actually, do you know what I'm actually doing OK now and actually just knowing that there's support there has made a difference but for me. (Psychologist)

Importantly, these are feelings that for some people, appear to hold over a much longer period:

> It's lovely if you do get to see them, you know, a few weeks or a month down the line and that they actually say, do you know, I just feel so much better. (Peer Practitioner)

Although the consequential impact of these impacts cannot be determined, interviewees still shared their beliefs that the work that they were doing would have a further impact on staff well-being by reducing sickness absence, turnover, levels of psychological distress and post-traumatic stress disorder:

> They probably would have ended up quite poorly, like PTSD, distressed off work . . . One of the ladies I saw recently, she was involved in horrible case, and she came through, had a trauma support check-in [. . .] she [later on] invited me to go and speak alongside her [. . .] and I just thought it was so nice because actually I'm not sure she'd have stayed in in her job. (Psychologist)

The benefit of the pathway is also evident in the growing popularity of the service being offered. For example, where after the TSP is accessed by a certain function or team, there are subsequent referrals from the same function or setting:

> It's almost like they have gone back and shared that. That's been a really good and helpful process because we then sort of see people from the same teams or the same groups. (Peer Practitioner)

This is compounded by the waiting list for training in this area. There is also increased awareness as teams recognise the importance of the TSP and make space for training in this area, embed the information into their training and the sharing of resources, highlighting how people are valuing it and seeing the importance of it. For example:

> I noticed there was a really massive poster up on the wall [in theatre] with [. . .] staff trauma support on there. [. . .] that didn't come from us. So, it's obviously known out there now, and people are promoting it without us doing that. (Psychologist).

Participants also highlighted how themselves benefit from being part of the pathway. This includes a sense of positive affect, motivation, confidence and accomplishment that extends both in the moment of delivering a check-in or then in general about being involved in the pathway.

> It's made me feel happier at work . . . I think not that I was unhappy at work, but I think I always enjoy doing it. Enjoy might be the wrong word because obviously that's a person who's struggling, but I get some well-being and I guess some pride from what I'm doing. (Peer Practitioner)

These benefits also present as transferable skills that support their professional development:

> I think it's made me better at my job, like I said, my day-to-day job is debriefing challenging scenarios, including some around violence and aggression and difficult communication. So, I think it's sort of added a slightly different perspective to the way I would do my normal job (Peer Practitioner)

However, the impact is not always positive. Both peer practitioners and psychologists interviewed referred to the pressure of not wanting to let others down, being concerned about not being able to support everyone who has asked for a check-in and the challenges of fitting this work alongside existing duties:

> The person that really needs our support probably falls through the net. That's how I feel anyway . . . I think I'm probably a bit sad that I've not had the opportunity to do many check-ins (Peer Practitioner)

Discussion

This study highlights the perspectives of peer practitioners and psychologists on the efficacy of a peer-based TSP in a major acute hospital. Benefits of the TSP include the positive reactions from those involved, its impact on staff well-being, increased awareness and the popularity of the service. Interviews suggest that this is accomplished by normalising stress reactions, the knowledge that support is available, more rapid and proactive support, offering reflective space, the importance of peer support and utilising resources better.

The increased awareness and the popularity of the service suggest that while the immediate user of the TSP is the individual who experienced a PTE, the programme has a wider impact on the culture of care within an organisation. The material and resources from the TSP provide reassurance to managers across the organisation of the support they can draw on or refer to, which dovetails with the needs for line managers feeling equipped with an organisation that supports mental health (Blake *et al.*, 2023). For peer practitioners, their contribution to the system extends beyond individuals referred to the TSP, as participants highlighted their better awareness around mental health, which allows them to be better managers and colleagues. This links in with findings from other peer support programmes for physicians, where only 25% of physicians had offered peer support through the programme, but more than 80% had used their training to support colleagues in other contexts (Fall *et al.*, 2024).

There are practical implications where programmes like the TSP serve as an important institutional means to support individual healthcare workers while simultaneously challenging the stigmatisation of mental health and help-seeking behaviours in general through increased awareness and resource signposting (Busch *et al.*, 2021). This needs to be embedded within existing organisational policies and activities to ensure its visibility and viability. It cannot be a standalone programme and has to complement a wider organisational approach to support employee health that recognises the roles and responsibilities of individual employees, teams and groups, line managers and the wider organisation (Nielsen *et al.*, 2021; Teoh *et al.*, 2023). In doing so, we also see that while there may be perceived benefits to the intervention programme, TSP stakeholders also report costs to them in terms of additional workload and demands from managing the programme, although the training costs are significantly less than contracting external facilitators. The scaling up of this programme draws on internal expertise and allows for better distribution of resources within the organisation, with the preventative approach likely leading to financial savings through reduced sickness and staffing costs (Teoh *et al.*, 2023). Regular evaluation of the programme is needed, with corresponding adjustments to process and resources allocation is needed to ensure the experience of parity of experience and not that one staff group is benefiting at the expense of others (Nielsen and Miraglia, 2017; Teoh *et al.*, 2023).

Our participants raised several challenges around being involved in the TSP programme. This echoes that from other interventions, namely the pressure placed on themselves to meet the needs of colleagues asking for help (Edrees *et al.*, 2016) and to try to balance this additional

responsibility alongside their primary work responsibilities (Busch *et al.*, 2021). From a practical perspective, this indicates the need to help peer practitioners manage expectations by being clear on their roles, acknowledging the difference they are making, and closing the loop in terms of what happened to individuals referred to (Ondrejková and Halamová, 2022; McGahern *et al.*, 2023). In addition, while the nature of healthcare work is busy and dynamic, formalising these tasks would help them be recognised as part of a peer practitioners' responsibility and get the support of their line managers, both of which are important steps in helping peer practitioners better manage their workload (Ramus, 2001; Grant, 2012).

The process factors identified here are congruent with the extant literature – particularly those on the importance of peers and early intervention. This not only reinforces the theoretical perspective but also provides the logic from which further evaluation of outcomes should then be measured, including behavioural (e.g. sickness absence), mental health (e.g. distress symptoms) and organisational outcomes (e.g. turnover rates) (Crandall *et al.*, 2022). The observed benefits and recognition of the underpinning factors help improve the acceptance of the programme, which is important for buy-in from stakeholders across the organisation to champion for improved visibility and for the required resources (Schwarz *et al.*, 2018). This is important given the challenge in sustaining initiatives and awareness of trauma in healthcare that grew during the pandemic (Connors *et al.*, 2023). Moreover, the TSP is reliant on peer practitioners to volunteer, and for many there has to be a belief that the programme brings anticipated benefits in order to recruit and retain them (Bryson, 2004; Grant, 2012). This is in addition to the personal benefits that many participants shared around improved confidence, skills and knowledge. How this is communicated matters, and organisations attempting similar programmes must consider tailoring the various messaging across multiple mediums to engage different stakeholder groups (e.g. potential volunteers, line managers, human resources and senior leaders) (Hubbart, 2023).

Limitations

The study is not without limitations. First, the perspective of the user of the TSP – individuals who may have experienced a PTE – is absent. The study therefore does not account for the experience of the primary beneficiaries of the programme. While the intention was for them to be included, the few that did respond to the participation call withdrew after reviewing the information sheet, which may reflect an unwillingness to revisit aspects of their PTE. Second, the sample size is small. Nevertheless, it is similar to other such studies (Agarwal *et al.*, 2020), with nearly all psychologists opting to take part. We also see the diversity in background and crucially the number of check-ins carried out, an indicator that there is appropriate representation, although there are few senior doctors that opt in, which has led to a need for more targeted training of this group. This is also important to understand the pathways' effectiveness in different healthcare settings (e.g. emergency vs intensive care). Similarly, culture does not feature in our study, a theoretical and practical limitation given the diversity of the healthcare workforce and what is known about the differences in the determinants and presentation of trauma across cultures and internationally (Benjamin *et al.*, 2025). Finally, quantitative studies, including randomised control trials and comparative studies against alternative support formats (e.g. structured trauma debriefing), are needed to evaluate the effectiveness of TSPs and to consider the long-term impact for both individuals and organisations.

Conclusions

This study explored the perspectives of peer practitioners and psychologists on the TSP, a peer-based initiative designed to support hospital-based healthcare workers exposed to potentially traumatic events. Participants highlighted how the TSP helped individuals' well-being by normalising stress reactions and providing a reflective space through timely peer support. The organisation also benefited through greater awareness of mental health, enhanced access to

resources, and a culture of care. The TSP also challenged mental health stigma and encouraged help-seeking behaviours. However, regular evaluations are necessary to refine processes, address resource demands and ensure equitable benefits for all stakeholders. To sustain the programme, clear role definitions, formal recognition and integration with organisational policies are essential. Additionally, tailored communication strategies are critical to maintaining stakeholder engagement and recruiting volunteers. All this supports the feasibility of a peer-based approach as part of a wider TSP, which may be particularly useful in low-resource settings alongside more specialised support offerings.

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