

***Trauma-Responsive Care: “What Happened To You?
and “What Will We Do About It?”***

Trauma-Responsive Approaches for Children with Adverse Childhood Experiences, including Youth Violence



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**the
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Front image generated with Google Gemini.

Prompt used:

Create an image with a tree with deep, tangled roots labelled "Trauma".

The tree should have strong new branches labelled in bold text, not italics: "Healing", "Resilience", "Connection", "Connectedness" and "Community".

Across the tree, write in italics:

"It Takes a Village".

Symbolism: Growth from a vibrant, hopeful, artistic style, soft lighting.

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1. Executive Summary

Reframing the Question: Learning from International Trauma-Informed Systems to Transform Outcomes for Children, Young People, and Communities in the United Kingdom

The United Kingdom is facing a quietly escalating crisis. A generation of children and young people are growing up in the shadow of unaddressed Adverse Childhood Experiences (ACEs), abuse, neglect, household dysfunction, poverty, and community violence, with insufficient systemic infrastructure to meet the complexity and scale of their needs. Youth violence, and knife crime in particular, has become a visceral and visible symptom of this deeper, largely invisible wound. Yet too often, our professional and institutional responses continue to ask the wrong question. We ask *"What is wrong with you?"*, locating the problem within the individual, rather than *"What happened to you?"* and, crucially, *"What are we going to do about it?"* This shift in question is not merely rhetorical. It represents a fundamental transformation in how systems are designed, how professionals are trained, how communities are engaged, and ultimately, how lives are changed.

This Churchill Fellowship was born from that conviction. Motivated by years of frontline leadership in young people's health and wellbeing services and galvanised by the preventable death of a young person already known to statutory systems, this Fellowship set out to learn from countries further along the journey of embedding trauma-informed care (TIC) as a whole-system philosophy. I selected the United States of America (USA) and Australia because both have made significant, system-level progress in embedding trauma-informed care across health, education, and youth justice sectors, offering mature models of training, policy, and practice. While their contexts differ from the UK, their approaches to workforce development, cross-sector collaboration, and culturally responsive care provide highly transferable insights that can be adapted to strengthen trauma-responsive systems for children and young people in the UK. Travelling across both countries, I engaged with trauma-informed systems operating across health, education, policing, social care, and community development, speaking with practitioners, system leaders, young people, families, and community organisations to understand what genuinely works, for whom, why and how.

What Trauma-Informed Care Means and Why It Matters

Trauma-informed care is a human-centred framework grounded in safety, trustworthiness, collaboration, empowerment, and cultural humility. It does not pathologise behaviour; it contextualises it. It recognises that what presents as aggression, disengagement, substance misuse, or risk-taking is frequently the language of unprocessed pain. The landmark Adverse Childhood Experiences study (Felitti et al., 1998) established with compelling evidence that early adversity creates a dose-response relationship with lifelong physical and mental health consequences. In England, at least

half of all adults report at least one ACE, with approximately nine per cent reporting four or more, a public health challenge of enormous proportions that demands a coordinated, compassionate, and structurally committed response.

For children and young people affected by knife crime and community violence, the stakes could not be higher. Every young person lost to violence represents not only a personal and family tragedy but a systemic failure, a moment where earlier, more courageous, more connected intervention might have altered the trajectory of a life, family and community. Trauma-informed care offers a framework for that earlier intervention, provided systems have the leadership, workforce capacity, and political will to embrace it fully.

International Insights: The United States of America (USA) and Australia

Both the USA and Australia offered rich, instructive, and at times humbling lessons in what whole-system trauma-informed transformation can achieve. Across both countries, the most effective models shared a set of consistent characteristics that transcended geography and cultural context.

Systems change through courageous leadership. In every high-functioning trauma-informed organisation encountered, leadership was the decisive variable. Where leaders, directors, and senior managers had personally committed to understanding trauma, not as a clinical specialism but as an organisational philosophy, the results were transformative. Trauma-informed principles were embedded not only in frontline practice but in human resources, supervision, policy, and governance. Leadership modelled the vulnerability, reflective practice, and psychological safety they expected of their teams.

Prevention and early intervention are non-negotiable. The most effective systems invested substantially upstream, in families, schools, and communities, long before crisis points were reached. Early childhood programmes, school-based trauma-sensitive practice, and community health worker models demonstrated that prevention is not only morally compelling but economically rational. The cost of inaction, measured in long-term health, justice, and social care expenditure, vastly exceeds the cost of early, relational investment.

Workforce development must prioritise staff wellbeing. A recurring and powerful finding across both countries was the recognition that traumatised workforces cannot deliver trauma-informed care. Organisations that invested in reflective supervision, restorative practice, peer support, and staff wellbeing saw measurable improvements in staff retention, organisational culture, and quality of care. Secondary traumatic stress and burnout are not individual failings; they are systemic responsibilities.

Community healing and co-production are essential, not optional. The most culturally resonant and sustainably effective programmes were those designed *with* communities rather than *for* them. People with lived experience of trauma, violence, and marginalisation were not merely consulted, they were centred, employed, empowered, and positioned as experts. This co-design and co-production model, built trust, dismantled stigma, and produced interventions of genuine cultural credibility.

Equity and cultural safety must be structurally embedded. Across both countries, the evidence was unambiguous: trauma-informed care that does not explicitly address racism, discrimination, and intergenerational trauma will fail the communities that need it most. Cultural safety is not an add-on to trauma-informed practice, it is its foundation. Systems serving Black, Indigenous, and racially marginalised communities must reckon honestly with how structural racism operates within their own institutions before they can offer authentic healing to those they serve.

Conclusions and Call to Action

This Fellowship concludes that trauma-responsive, culturally safe practice must become a national priority across every sector of UK public life, health, education, justice, social care, community organisations, and faith groups alike; everywhere a child may be seen. The evidence is clear, the international models are instructive, and the moral imperative is urgent. Rooted in the enduring wisdom that *it takes a village to raise a child*, the recommendations emerging from this Fellowship call for joined-up, equity-centred, and courageously led system transformation, ensuring that every child, regardless of background, postcode, or the adversity they have known, is met not with judgement, but with understanding, safety, and hope.

2. Acknowledgements

My deepest thanks to the *Churchill Fellowship* and the *Burdett Trust for Nursing* for believing in this work and enabling me to learn globally to act locally.

I am indebted to my hosts across the USA and Australia, leaders, practitioners, families, and young people, and community support organisations who opened their doors and hearts.

Organisations in the USA

Greater Richmond SCAN (Stop Child Abuse Now), Virginia's Trauma Informed Community Network (TICN), Richmond, Virginia

Richmond Police Department, Richmond, Virginia

East Bay Agency for Children, Oakland, California

Trauma Transformed based at East Bay Agency for Children, Oakland, California

San Francisco Department of Public Health, San Francisco, California

HOPE SF Resident Warriors, San Francisco, California

Alive and Free, Omega Boys Club, San Francisco, California

PACES Connection, Sacramento, California

ACE Interface, LLC, Peachtree City, Georgia

Health Federation of Philadelphia, Philadelphia, Pennsylvania

The Family Practice & Counselling Network, Philadelphia, Pennsylvania

Bureau of Maternal, Infant and Reproductive Health, New York City Department of Health and Mental Hygiene, New York City, New York

Organisations in Australia

Edith Cowan University, Perth, Western Australia

The Palm Island Community Company, Palm Island, Queensland

Lowitja Institute, Melbourne, Victoria

Positive Wellness Recovery Centre (PWRC), Shepparton, Victoria

Rumbalara Aboriginal Cooperative, Mooroopna, Victoria

The University of Sydney Susan Wakil School of Nursing and Midwifery, Sydney, New South Wales

Australian Childhood Foundation, Sydney, New South Wales

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Sue Buratti and Team (Stacey, Danielle, Sophie, Ilya, Claire, Jen and Luke), Australian Childhood Foundation

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Finally, to every young person, parent and support person who shared their story of youth violence: this report is for you.

In preparing this report, I made a conscious and values-driven decision not to include individual case studies. Throughout this work, individuals entrusted me with deeply personal stories, many of which were shaped by trauma, structural inequity, and profound vulnerability. That trust is something I hold with the utmost seriousness.

While case studies can powerfully illustrate key themes, they can also risk reducing complex human experiences to illustrative examples. Even when anonymised, there remains the possibility of re-identification, emotional re-exposure, or unintended harm. In keeping with trauma-informed principles, particularly safety, trustworthiness, and empowerment, I chose to privilege protection over publication.

The insights shared have informed the analysis, recommendations, and systems-level reflections within this report. However, the stories themselves remain safeguarded. My commitment is not only to amplify voices, but to do so ethically, ensuring that those who shared their experiences are not further burdened by the very systems we seek to transform.

This decision reflects a belief that impact does not require exposure, and that accountability and change can be driven without compromising the dignity of those who placed their trust in this work.

3. Introduction

3.1. Background: The Case for Trauma-Responsive Practice

Trauma-informed care (TIC) is a human-centred framework acknowledging the pervasive impact of trauma on individuals, communities, and systems. Grounded in principles of safety, trustworthiness, collaboration, empowerment, and cultural humility, TIC works actively to prevent re-traumatisation. It represents a philosophical shift from deficit-based thinking toward compassionate inquiry: from asking "What is wrong with you?" to asking "What happened to you?"; a reframe that restores humanity and creates the conditions for genuine healing.

3.2. The Evidence Base: Adverse Childhood Experiences (ACEs) and Lifelong Impact

The landmark ACE study (Felitti et al., 1998) demonstrated that childhood experiences of abuse, neglect, and household dysfunction significantly predispose individuals to chronic physical disease, mental illness, substance misuse, and high-risk behaviours in adulthood, with a clear dose-response relationship. In England, at least half of adults report one ACE, and approximately nine per cent report four or more (Public Health Wales, 2015). These are not statistics, they are lives shaped by unaddressed trauma, demanding a compassionate, systemic response.

3.3. Youth Violence: A Trauma Epidemic Hidden in Plain Sight

Youth violence in the United Kingdom is escalating. In 2017 alone, 46 young people aged 25 or under were fatally stabbed in London, almost double the previous year's figure (ONS, 2018). Behind each statistic lie bereaved families, fractured communities, and frontline professionals carrying vicarious trauma. Youth violence is not a criminal justice issue alone, it is a profound public health and trauma crisis requiring whole-system, compassionate responses that address root causes rather than symptoms.

London knife crime rises to four-year high

🕒 3 hours ago | London

🔗 Share





3.4. The Personal Catalyst

The devastating reality of youth violence is not always encountered through statistics. While leading the Lewisham Young People's Health and Wellbeing Service, I learned that a 15-year-old boy, already known to our partner agencies, had been fatally stabbed by other young people in the local community (Oshikanlu, 2019). He was not invisible to services. Yet the system's knowledge of his existence had not been enough to protect his life. His death galvanised a deeper commitment to understanding the root causes of youth violence and the urgent responsibility of healthcare and social systems to intervene earlier, more boldly, and more humanely. This was the rationale for this Fellowship. I am also a parent of a young Black teenager and imagined how it would feel to lose my son in such a violent way.

3.5. Purpose of the Fellowship

This Fellowship sought to learn from internationally recognised models of trauma-informed practice, identifying approaches translatable into the UK context – particularly for children, young people, and families living with ACEs and youth violence. Rooted in the principle that it takes a village to raise a child, the Fellowship prioritised joined-up, collaborative systems where professionals, communities, and institutions work in purposeful solidarity to deliver care that is equitable, compassionate, and transformative.

4. Aims and Objectives

The Fellowship was guided by five overarching aims and objectives:

Aim 1: To explore and critically evaluate trauma-informed systems of care operating within the USA and Australia, with particular focus on their effectiveness for marginalised young people and their families.

Objective: To conduct structured site visits, professional exchanges, and stakeholder interviews across key trauma-informed organisations and systems in both countries, documenting approaches that demonstrate measurable impact for communities disproportionately affected by structural inequality, racism, and adversity.

Aim 2: To identify and analyse replicable models for supporting children and families living with the compounding effects of Adverse Childhood Experiences and community violence.

Objective: To examine evidence-based and community-centred interventions that address ACEs holistically; evaluating their theoretical foundations, cultural responsiveness, trauma-informed principles, and outcomes for children, families, and the professionals who serve them.

Aim 3: To extract transferable lessons and best practice insights applicable to UK health, education, social care, and criminal justice systems.

Objective: To critically synthesise international learning into a practical, evidence-informed framework of recommendations; identifying what works, for whom, and under what conditions; ensuring findings are contextually relevant and actionable across multi-agency UK professional landscapes.

Aim 4: To explore how wider community networks, faith groups, and grassroots organisations can be meaningfully integrated into trauma-informed, whole-system responses for marginalised young people.

Objective: To document models where statutory services and community or faith-based organisations operate in genuine partnership; learning how trust, cultural safety, and shared accountability are built across organisational boundaries to reach those most often excluded from formal systems of support.

Aim 5: To champion a vision of equity-centred, culturally safe, and trauma-responsive practice that ensures no child or family is excluded or left behind.

Objective: To develop and disseminate a Fellowship report that translates international insights into a compelling call to action for UK policymakers, practitioners, and system leaders, advocating for the structural investment, professional development, and cross-sector collaboration necessary to build trauma-informed communities where every child, regardless of background, can truly thrive.

5. Methodology

This Fellowship employed a qualitative, experiential methodology combining structured site visits, professional observation, and stakeholder engagement across the USA and Australia. Data was gathered through in-depth conversations with practitioners, system leaders, community organisations, academics, policymakers, and people with lived experience of trauma and violence. Thematic analysis identified patterns, transferable models, and evidence-informed practices, critically evaluated for cultural relevance and applicability to the UK context.

This methodology prioritised learning with communities rather than about them, honouring the voices of those most affected.

Sites and Organisations Visited

In the USA: Richmond (Virginia), Oakland and San Francisco (California), Philadelphia (Pennsylvania), New York City (New York), and Washington State (virtually). In Australia: Palm Island (Queensland), Melbourne, Shepparton and Mooroopna (Victoria), and Sydney (New South Wales). Together, these sites offered a geographically and culturally varied evidence base from which to draw transferable lessons.

Organisations engaged spanned Trauma-Informed Community Networks, public health departments, schools, police departments, universities, justice programmes, and community-led healing projects, reflecting the core conviction that trauma-informed transformation requires whole-system, cross-sector commitment.

6. Key Findings: the United States of America

6.1. Overview

The landmark Adverse Childhood Experiences study (Felitti et al, 1998) ignited a nationwide movement that fundamentally reshaped how US institutions understand and respond to psychological trauma. Over the subsequent decades, federal agencies have translated this evidence base into structural policy and investment. The Substance Abuse and Mental Health Services Administration (SAMHSA) developed its seminal six-principle trauma-informed care framework, embedding these standards across federally funded programmes nationwide. Simultaneously, the Centers for Disease Control and Prevention (CDC) positioned ACEs as a critical public health priority, integrating trauma-informed principles into surveillance, prevention funding, and community health strategy, signalling an institutional commitment to addressing trauma not as an individual pathology, but as a collective, systemic responsibility (SAMHSA, 2014).

Richmond, Virginia

6.2. Trauma-Informed Community Network (TICN), Richmond, Virginia

The TICN, coordinated by Greater Richmond SCAN (GRSCAN), demonstrated how trauma-informed principles can be embedded across entire communities rather than individual organisations. Founded as a 12-person think-tank in 2012, it has grown into 26 networks across Virginia using SAMHSA's (2014) 4Rs framework (Realise, Recognise, Respond, Resist Re-traumatisation) and a collective impact model, recognising that sustainable community healing cannot be driven by institutions alone.



The 4Rs Framework: A Common Language for Change

SAMHSA's (2014) 4Rs framework: **Realise, Recognise, Respond, and Resist Re-traumatisation**, provides every participating agency with a shared language and a consistent set of principles for trauma-informed practice.

Realise calls on professionals and communities alike to understand the widespread prevalence and profound impact of trauma across individuals, families, and entire communities, reorienting the fundamental question from *"What is wrong with you?"* to *"What happened to you?"* This seemingly simple shift carries profound implications for how every interaction, policy, and system is designed and delivered.

Recognise equips practitioners across all sectors with the knowledge and awareness to identify the signs and symptoms of trauma, in behaviour, emotional response, and physical presentation, understanding that what often presents as aggression, disengagement, or non-compliance is frequently the visible language of invisible pain.

Respond moves from awareness into action, embedding trauma-informed principles into organisational policies, professional procedures, and everyday human interactions, ensuring that systems actively promote healing rather than inadvertently perpetuating harm.

Resist Re-traumatisation represents perhaps the most operationally challenging of the four principles, demanding that organisations and professionals consistently examine their own practices, environments, and power dynamics to eliminate triggers and conditions that could compound existing trauma for those they serve.

Community Health Workers and Behavioural Health Navigators serve as bridges between professional systems and residents. Free trauma training is provided to any community member. The central lesson: sustainable transformation requires a backbone organisation, shared language, and community ownership.

Contextualising Trauma Within Place and History

A powerful and unflinching feature of the TICN was its willingness to locate trauma within its historical and structural context. The TICN Coordinator spoke candidly about Richmond, Virginia's particular legacy, as the site of the largest enslaved people's auction in US history and the former capital of the Confederacy, acknowledging that institutional racism, concentrated poverty, and ongoing racial segregation are not incidental to the city's trauma landscape but foundational to it. This contextualisation was not merely historical; it was presented as essential professional knowledge, enabling practitioners to understand the intergenerational and racialised dimensions of the trauma they encounter daily. For a predominantly Black city still bearing the visible wounds of structural disinvestment, this honest reckoning with history was both courageous and clinically necessary.

Gun Violence as a Community Trauma Crisis

Gun violence in Richmond was presented as a defining public health and community trauma emergency, requiring a coordinated, cross-sector response. There were dedicated committees spanning schools, legal and court systems, judges, and juvenile probation services, all working under a shared trauma-informed framework. Notably, a senior police representative presented directly to the group on the devastating community impact of gun violence, modelling the kind of institutional transparency and vulnerability that trauma-informed leadership demands. This was not policing as enforcement; it was policing as community accountability.

6.3. Richmond Police Department (RPD), Virginia

The Richmond Police Department's trauma-informed journey, in which all 700 officers were trained, demonstrated that culture change within law enforcement is possible and necessary. Led by Lieutenant Anthony Jackson's Youth and Family Crimes Unit, the approach used a peer-led Train the Trainer model and hired a licensed clinical social worker for in-house counselling. Officer suicide and mental health were also addressed as systemic priorities.

A Homicide Team debrief protocol was established following critical incidents, alongside a Critical Incident Management Team providing structured peer support. Guiding messages (including: *Healthy Hire, Healthy Retire; Mental health: treat it like any other body part; It's okay to have feelings*) reframed officer wellbeing as operational imperative. The identified next step at the time of the visit was the development of **Trauma-Informed Supervision**, extending trauma-informed principles into the management and oversight of officers themselves, recognising that supervision is one of the most powerful levers for cultural change available to any organisation.



6.4. Trauma-Responsive Schools, Richmond

GRSCAN's partnership with schools in East End Richmond, Richmond's highest-need communities, combined professional development, parent engagement, and embedded clinical support as three non-negotiable strands. Licensed clinicians were placed within schools through the Child Savers model. Trauma leads in each school cascaded training to colleagues and modelled trauma-responsive practice. Training covered introduction to trauma and resilience, verbal de-escalation, and self-care for staff. Weekly training drew on Perry (2006), Burke Harris (2018), and SAMHSA's (2014) 4Rs framework. Honest reflection acknowledged that asking educators to adopt trauma-informed practice without reducing competing demands risks burnout and superficial compliance.

6.5. Child Advocacy Centre (CAC), Richmond

Established in 1991, the CAC demonstrated how a specialist child protection organisation can catalyse system-wide trauma-informed transformation. Services span forensic interviews, treatment programmes, and play and expressive therapies from age four. Using the National Child Traumatic Stress Network (NCTSN, 2014) principles of a trauma-informed juvenile system, 16 focus groups were convened to assess juvenile court readiness and provided a blueprint for justice reform.



Oakland and San Francisco, California

6.6. East Bay Agency for Children (EBAC), Oakland



MISSION

East Bay Agency for Children improves the well-being of children, youth and families by reducing the impact of trauma and social inequities.

VALUES

Equity
Humility
Collaboration
Innovation
Effectiveness

EBAC's core philosophical reframe, that communities are *mis-served, not under-served*, distinguishes it from deficit-oriented service models. Working in Oakland's highest-violence communities, EBAC integrates primary care, mental health, public health, juvenile justice, and child welfare within a Theory of Change that refuses to separate people's lives into professional silos.



Diagram created with ChatGPT (I used my notes from the conversation with Anh Ta to create a visual model which I instructed Chat GPT to create a diagram)

Creating a Movement, Not a Programme

A defining and transferable insight from this visit was the articulation of the difference between creating a movement and delivering a programme. Programmes have timelines, funding cycles, outputs, and exit strategies. Movements are cultural; they grow organically, sustain themselves through shared values and relational networks, and outlast the institutional structures that may have initially catalysed them. EBAC's work across seven Trauma-Informed Healing Networks, including connections to New York's TRIS (Trauma and Resilience Informed Systems) model, reflects this movement-building orientation, growing collective capacity through shared learning rather than competitive service delivery.

The organisation's use of non-violent communication as a relational and cultural framework was highlighted as particularly significant, grounded in the principle that conflict between individuals and communities rarely reflects incompatible needs, but rather incompatible strategies for meeting needs that are, at their core, entirely legitimate and universal.

Structural Trauma, Reckoning, and Reparations

The most philosophically challenging dimension of the visit was the unflinching engagement with the concepts of structural trauma, intergenerational ancestry, and reparations. Drawing on California's status as a politically progressive but deeply contradictory state, simultaneously pioneering social policy and perpetuating profound racial inequality, there is an argument that trauma-informed practice which refuses to name and address structural racism is fundamentally incomplete. Structural trauma operates simultaneously at the individual, community, and systemic level, and demands responses at all three levels simultaneously.

The framework of Reckoning, Reconciliation, and Reparations was presented not as a political slogan but as a practical sequence for community healing, drawing on analogies including Japan's Hiroshima Peace Memorial, which holds together the future of peace and the past of pain without requiring one to erase the other. Reparations, in this context, were framed not solely as financial restitution but as the broader work of repairing broken relationships between institutions, communities, and the individuals those institutions have historically harmed. The question posed: *why do we continue to ignore systemic racism?* was not rhetorical. It was a direct challenge to every professional and institution claiming commitment to trauma-informed practice whilst avoiding the structural reckoning that genuine healing demands.

How Culture Grows: the AND Culture

The concept of the AND culture is a framework for co-existence that resists the binary either/or thinking that typically characterises institutional responses to complexity.

Rather than forcing communities and professionals to choose between surviving and thriving, between individual healing and systemic change, between cultural identity and professional integration, the AND culture creates conditions for simultaneous, non-competing realities. Growing such a culture requires moving beyond a culture of surviving, endemic in communities shaped by chronic adversity, toward one that holds both the pain of the past and the possibility of the future, without requiring either to be diminished.



6.7. San Francisco Department of Public Health

The Department's Trauma-Informed Systems (TIS) Initiative offered a sophisticated whole-organisation transformation model. All 9,000 staff received 3.5-hour trauma training including dedicated content on cultural humility and structural racism. A six-month trust and leadership preparation phase preceded training delivery. Three-tier implementation: Leader, Catalyst (middle manager), and Champion, was central to embedding change. A Trauma-Informed Policy and Procedure Audit Tool provided a top-down and bottom-up mechanism for assessing where organisational policies and

practices were causing harm. The maxim that defined this work: *"In order to care for others, we need to care for ourselves. Trauma that is not transformed will be transmitted."*

6.8. Alive and Free, Omega Boys Club, San Francisco

Founded 33 years ago in direct response to gun violence among young Black men, Alive and Free positions violence as a social disease that can be diagnosed, treated, and prevented. Its Rules for Living provide an alternative moral framework: nothing is more valuable than life; respect comes from within; change begins with the individual; a true friend never leads you into danger. It has over 239 graduates, with 25–30% going on to graduate school. “Coachisms”, accessible, memorable philosophies, provide young people with cognitive reframes for interrupting self-destructive patterns. Professional training extends the disease-model framework to teachers and police officers.

6.9. HOPE SF, San Francisco

HOPE SF's Resident Warriors model, with residents from San Francisco's public housing trained in trauma-informed healing and positioned as community healers, demonstrated the power of self-determined, resident-led transformation. All 16 Resident Warriors worked through their own trauma first before supporting their communities. The HOPE SF Initiative centres racial equity and reparations explicitly, with a no-displacement commitment for original residents during urban regeneration. Community trust, built patiently over years, was identified as the non-negotiable foundation of all engagement in communities shaped by police violence and unresolved grief.

Philadelphia, Pennsylvania

6.10. Trauma-Informed Systems, Racing ACEs, and Community Resilience

Philadelphia Department of Public Health

This visit to the Philadelphia Department of Public Health offered a rich and multi-layered encounter with trauma-informed practice operating across public health, education, community development, and paediatric behavioural health. Philadelphia's approach is notable for its explicit integration of racial justice into ACEs frameworks insisting, with both intellectual rigour and moral clarity, that trauma-informed practice which fails to centre race is fundamentally incomplete.

Head Start and Early Years: Education Readiness and Family Support

The **Head Start** programme is a federally funded early childhood education and family support initiative targeting children from low-income families and those with disabilities. Integrating nursing, social work, parent education, and developmental support under one

framework, Head Start embodies the whole-family, multi-disciplinary approach that evidence consistently identifies as most effective for children carrying the earliest and most formative ACE burdens. The programme's explicit attachment to income and disability support reflects an understanding that educational readiness cannot be separated from economic security and family stability, a lesson with direct and urgent relevance for UK early years policy.

RYSE Centre, Richmond, California: Youth Power and Healing Justice

Although geographically located in Richmond, California, the **RYSE Centre** was referenced during this visit as a compelling model of youth-led, racially just, trauma-informed practice, and specifically for its development of a **modified ACEs Pyramid** that incorporates racial trauma, structural oppression, and community resilience as foundational dimensions of the ACEs framework. RYSE's core conviction: that young people possess the lived knowledge and expertise to identify, prioritise, and direct the activities and services necessary for their own thriving, represents a radical and evidence-supported departure from professionally designed, top-down youth provision.

Operating across four interconnected programme areas: **Education and Economic Justice, Health Justice, Media, Arts, and Culture**, and **Youth Power Building**, RYSE creates genuinely safe spaces for young people of colour aged 13 to 24, combining case management, college access, restorative justice, arts and dance, financial literacy, and community organising within a single, coherent, youth-centred framework. Its **Restorative Pathways Project (R2P2)** and **Richmond Youth Organising Team (RYOT)** exemplify the integration of personal healing with systemic advocacy, understanding that young people cannot heal in isolation from the structures that continue to harm them.

Racing ACEs: If It Is Not Racially Just, It Is Not Trauma-Informed

One of the most intellectually significant contributions of this visit was the engagement with **Racing ACEs**, a framework developed in part through the work of **Kanwarpal Dhaliwal**, which argues compellingly that the original ACEs study, whilst groundbreaking, was insufficient in its failure to account for the specific and disproportionate burden of racial trauma experienced by communities of colour, LGBTQ+ individuals, and people with disabilities.

Racing ACEs calls for a fundamental re-examination of how ACEs are defined, measured, and addressed, moving beyond a cumulative risk model and a deficit-based framework to incorporate racial justice, cultural humility, community resilience, and embodied and collective healing as non-negotiable dimensions of trauma-informed practice. The framework's central assertion: *if it is not racially just, it is not trauma-informed* should be understood not as a political statement but as a clinical and ethical one. Racism and discrimination are themselves significant risk factors for toxic stress, disrupting

biological systems and producing ACE-associated health conditions entirely independently of the ten original ACE categories. Any trauma-informed system that does not actively identify and dismantle racial injustice within its own structures will consistently re-traumatise the communities it claims to serve.

Philadelphia ACE Task Force and Southern New Jersey ACEs Initiative

Philadelphia's **ACE Task Force**, a network of over 100 professionals and community members committed to reducing ACEs incidence whilst building a resilient city, provides a powerful model of networked, cross-sector accountability for trauma-informed community development. Working in parallel, the **Southern New Jersey ACEs** initiative, coordinated through the **NJ ACEs Collaborative** as a public-private state-wide partnership, demonstrates how ACEs awareness and trauma-informed principles can be embedded across entire regional systems, with particular attention to the disproportionate burden carried by children of colour, those from low-income backgrounds, LGBTQ+ youth, and children in care.

Across both initiatives, the consistent emphasis on **creating trauma-informed communities** rather than merely trauma-informed services reflects the maturity of Philadelphia's systems thinking, recognising that sustainable change requires cultural transformation at population level, not just professional development at individual level.

6.11. Embedding Healing Within Education: A Whole-School Transformation Model (Trauma-Informed Schools, Philadelphia)

Philadelphia's trauma-informed schools initiative represents one of the most structurally coherent and outcome-evidenced models of whole-school transformation. By embedding dedicated support roles, ongoing professional development, and peer-led training within every school, Philadelphia has demonstrated that when educational institutions commit fully to trauma-informed principles, not as an add-on programme but as a governing philosophy, then measurable, sustained improvements in school culture, student behaviour, and community relationships follow.

Model Design: Roles, Relationships, and Cascading Culture

The Philadelphia model rests on three interlocking structural commitments that together create the conditions for genuine, sustainable cultural change within school communities.

Every school in the initiative has a dedicated **Parent Engagement Coordinator**, a role that recognises, with both practical and philosophical seriousness, that children's emotional and educational wellbeing cannot be separated from the health, trust, and active involvement of their families. Rather than treating parental engagement as a

supplementary activity, Philadelphia positions it as a clinical and educational priority, investing in the relational infrastructure that connects schools and families, particularly in communities where historical experiences of institutional systems have generated mistrust, disconnection, and disengagement.

Alongside this, every school has access to a **licensed therapist**, ensuring that children carrying the weight of trauma, adverse experiences, and mental health need are not referred into distant and inaccessible external services, but are met with skilled therapeutic support within the safety and familiarity of their own school environment. The co-location of therapy within educational settings removes the stigma, logistical, and financial barriers that routinely prevent the most vulnerable children from receiving the mental health support they urgently need.

Staff receive **ongoing coaching**, not one-time training events, but sustained, relational professional development that embeds trauma-informed thinking into everyday pedagogical practice, classroom culture, and staff-to-student interaction. Critically, designated **Trauma Leads** within each school are equipped and empowered to cascade this training to their peers, creating an internally driven, organically sustained model of professional development that builds institutional capacity rather than dependency on external expertise. These Trauma Leads become the go-to practitioners, coaches, and cultural anchors within their schools, modelling trauma-responsive practice and holding the relational and professional threads of the initiative together across the whole school community.

The results speak with authority. **Suspensions and exclusions have fallen markedly** across schools engaged in the initiative, one of the clearest and most consequential indicators that trauma-informed practice, when structurally embedded and consistently applied, transforms the way schools understand and respond to the behaviour of their most vulnerable children. Behaviour previously met with punishment is now met with curiosity, compassion, and skilled support, reflecting the fundamental reframe from *"What is wrong with you?"* to *"What happened to you?"*

Trauma-Informed Workplace and Secondary Traumatic Stress

A significant thread running through the Philadelphia visit was the recognition that workforce wellbeing is not peripheral to trauma-informed practice but central to it. Secondary traumatic stress and vicarious trauma were identified as serious occupational hazards for practitioners across health, education, and social care, requiring institutional responses that go beyond individual self-care advice to embed **cultures of wellness** through formal policies, protective protocols, and reflective practice structures. The principle of **leading with staff first** ensuring that the workforce is itself held within a trauma-informed organisational culture before being expected to deliver trauma-informed care was consistently affirmed as the foundational condition of sustainable service quality.

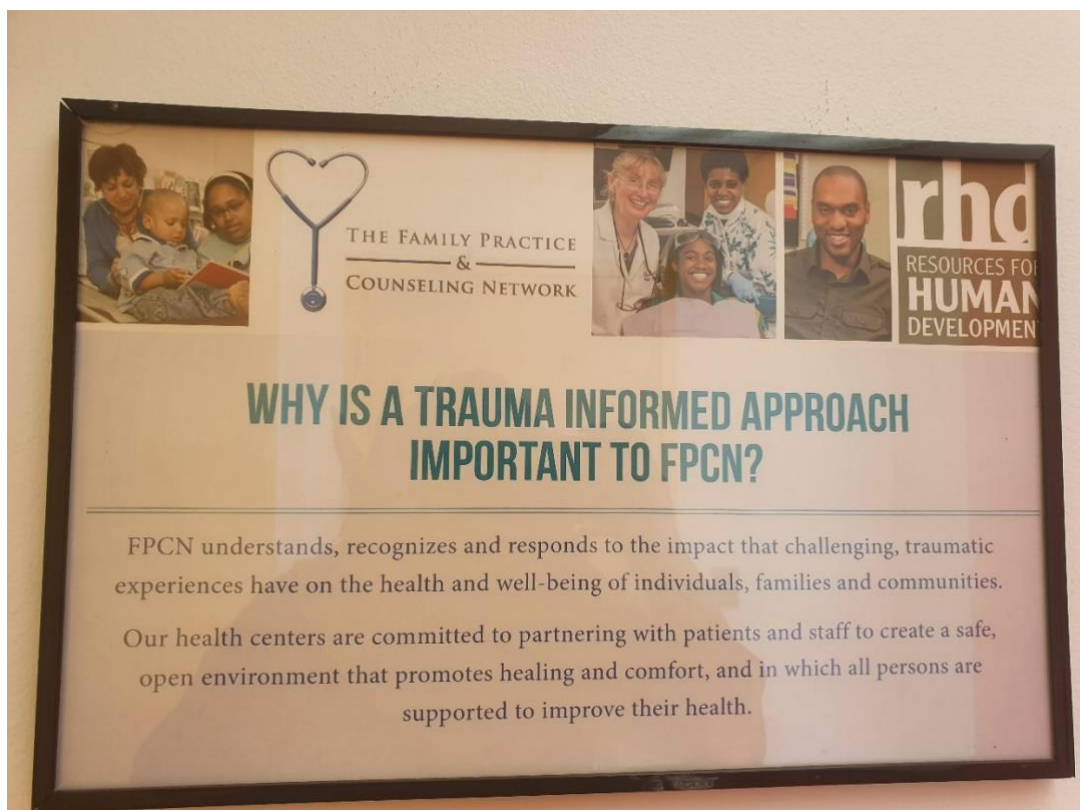
Paediatric Behavioural Health Consultation: Early Identification and Intervention

The visit included a particularly instructive encounter with a **Paediatric Behavioural Health Consultant** working with children aged 0 to 18, with a primary focus on the critical 0 to 5 age range. Working within a trauma-informed committee structure and holding a clinical social work background, this practitioner provides developmental milestone assessment, brief intervention, counselling, and staff education about trauma, supporting families affected by anxiety, depression, and domestic violence, and ensuring that children requiring early intervention are identified and referred at the earliest possible point. This model of embedded, multi-disciplinary paediatric behavioural health consultation, positioned within rather than alongside primary care, offers a directly transferable template for UK community health services.

6.12. Nurse-Managed, Trauma-Informed, Integrated Community Health: a Model for Equitable Care

The Family Practice and Counseling Network (FPCN), Philadelphia

FPCN operates as a programme of **Resources for Human Development**, receiving funding from the US Department of Health and Human Services through the Health Resources and Services Administration. Its local and national recognition as a best practice model of healthcare delivery reflects the depth and sustainability of its approach, one that offers profound lessons for UK community health systems navigating the twin challenges of health inequity and workforce transformation.



The Nurse-Managed Model: Advanced Practice at the Heart of Community Health

Perhaps the most striking and immediately transferable feature of FPCN's model is its positioning of **Nurse Practitioners** as the primary providers of comprehensive healthcare across the network. With advanced practice degrees, FPCN's Nurse Practitioners diagnose illness, prescribe medication, make specialist referrals, provide pre- and post-natal care, and deliver a wide range of primary health services, operating not as adjuncts to medical colleagues but as the central, authoritative, and highly skilled clinical leads of their communities' healthcare.

This model challenges the hierarchical assumptions that continue to constrain advanced nursing practice in the UK, demonstrating compellingly that nurse-led primary care, delivered with clinical rigour, interdisciplinary collaboration, and deep community embeddedness, produces outcomes of the highest quality for populations that mainstream healthcare systems have historically failed. FPCN's approach of metaphorically wrapping its arms around patients, attending to the full complexity of their lives rather than isolating presenting symptoms, embodies an integrated, psychosocial philosophy of care that is as ethically compelling as it is clinically effective.

Integrated, Whole-Person Care: Co-Located Services Under One Roof

FPCN's model of co-locating primary care, behavioural health, dental services, and preventive care within a single integrated centre removes the systemic barriers, geographical, financial, cultural, and psychological, that prevent the most vulnerable community members from accessing the full spectrum of support they need. This whole-person approach, attending explicitly to mind, body, and spirit, reflects a philosophy of care that extends well beyond the biomedical, acknowledging that human health is inseparable from social circumstances, emotional wellbeing, cultural identity, and spiritual life.

The network's founding principles deserve particular attention as a model of institutional values that are both aspirational and operationally binding. The commitment to culturally competent, trauma-informed, and compassionate care; the protection of patient confidentiality as a shared staff responsibility; the fostering of staff creativity, development, and engagement; and the maintenance of fiscally sound operations grounded in integrity and transparency – together these constitute a governance framework that any UK community health organisation would benefit from adopting as its own.

Paediatric Behavioural Health Consultation: Early Identification and Whole-Family Support

The visit included detailed engagement with FPCN's **Paediatric Behavioural Health Consultant**, a clinically trained social worker providing integrated behavioural health support for children aged 0 to 18, with particular emphasis on the critical 0 to 5 developmental window. Working as an active member of the organisation's **Trauma-Informed Committee**, this role encompasses developmental milestone assessment and referral for early intervention, brief therapeutic intervention and counselling, staff education about trauma and its impacts, and direct support for families navigating anxiety, depression, and domestic violence.

The integration of this role within FPCN's primary care structure, rather than as a separate referral pathway, is significant. It ensures that behavioural health support is normalised, accessible, and non-stigmatising; that children presenting with developmental concerns are identified and supported at the earliest possible point; and that the adults around them, both family members and staff, are themselves held within a trauma-informed framework of understanding and support.

A **Mind Body Practitioner** is embedded within the network to provide complementary support for both parents and staff, recognising that trauma is held in the body as well as the mind, and that healing modalities that address somatic as well as psychological dimensions of distress have an important role within integrated community health settings. FPCN was also at the time of the visit planning to open a **midwife-led birthing centre**, a significant development that would extend its integrated, nurse and midwife-managed model into the perinatal period, providing culturally safe, trauma-informed maternity care for a community whose birth outcomes and maternity experiences have historically been shaped by systemic inequity.

Health Education and Community Partnership: Empowerment as a Clinical Value

FPCN's foundational commitment to health education and self-management as tools of individual empowerment, alongside its insistence that the network works best when in genuine partnership with the community, reflects a model of care that refuses to position patients as passive recipients of professional expertise. This is not merely a values statement; it is an operational philosophy that shapes how appointments are structured, how information is communicated, how services are designed, and how the community is engaged as a co-producer of its own health. The explicit valuing and fostering of diversity and inclusion among both patients and staff in a safe and open environment further embeds equity as a non-negotiable organisational standard rather than an aspirational add-on.

New York City, New York

6.13. Breaking Cycles of Incarceration, Advancing Racial Justice, and Transforming Trauma (NYC Justice Network, New York City)

The NYC Justice Network in Northern Manhattan offered a politically clear-eyed and structurally ambitious encounter with trauma-informed practice; an organisation that refuses to separate youth justice from racial justice, individual healing from systemic transformation, or community recovery from institutional accountability. Founded on the unequivocal commitment that not a single young person should spend another night in jail, the NYC Justice Network operates at the intersection of criminal justice reform, public health, maternal health equity, and community-led healing, with a racially diverse team whose personal and professional credibility within the communities they serve is both their greatest asset and their most powerful intervention.



Youth Justice as Racial Justice: The Network's Core Philosophy

The NYC Justice Network's mission rests on a foundational and non-negotiable conviction: the fight for youth justice is inseparable from the fight for racial justice. The organisation does not merely seek to support individual young people navigate unjust systems, it actively works to dismantle those systems, promoting change not only in the

lives of its youth members but in the racist structures that led to their incarceration in the first place. This dual commitment to individual advocacy and systemic transformation simultaneously distinguishes the NYC Justice Network from services that address symptoms whilst leaving root causes undisturbed.

Operating through a three-year pilot project (at the time of visit), the Network pairs justice-involved young people with community health workers who have their own lived experience of the criminal justice system, providing the navigational support, relational trust, and experiential credibility that no professionally trained but personally inexperienced practitioner can replicate. Five community health workers, based within a community-based organisation in Northern Manhattan, deliver outreach presentations across shelters and communities, support young people with health, employment, and reintegration, and provide mental health crisis intervention, positioning public health as the primary framework for responding to justice involvement rather than punishment or incarceration.

Hospitals as Healing Hubs: Interrupting Violence at the Bedside

(New York City Community Violence Intervention)

New York City's Community Violence Intervention model recognises the hospital emergency department as a critical and time-sensitive point of intervention, a moment when individuals who have been stabbed or shot are uniquely open to support, reflection, and change. Through structured partnerships between hospitals and community-based violence-interruption teams, trained outreach workers, many with their own lived experience of violence and the justice system, provide bedside counselling, emotional support, and practical navigation for patients at their most vulnerable. These interventions connect individuals to community support networks, wraparound services, and long-term mentorship, interrupting the retaliatory cycles that so frequently transform victims into perpetrators, and perpetrators into victims, in an endless and devastating continuum. This model positions healthcare not merely as a site of physical repair, but as a gateway to community healing, one that the UK's hospital trusts, Violence Reduction Units, and community organisations are well placed to adopt and scale.

Public Health Detailing: An Innovative Outreach Model

A particularly innovative feature of the Network's approach is its Public Health Detailing Campaign, a model borrowed deliberately from pharmaceutical sales that deploys trained community health workers to conduct structured, evidence-based outreach to practitioners, organisations, and communities, disseminating trauma-informed and racially just practice in the same systematic, relationship-driven way that pharmaceutical representatives promote new medications. This model, combining professional credibility, community embeddedness, and consistent evidence-based

messaging, offers a creative and replicable template for scaling trauma-informed awareness across systems that formal training programmes struggle to penetrate.

The Network also supports Diversion Centres (Connection Centres) that provide an alternative to incarceration for young people at the point of crisis, alongside Health Education Alternatives for Teens (HEAT) and Co-Response initiatives that deploy trauma-informed, health-led responses to situations that would otherwise default to criminal justice involvement. A trauma-informed curriculum developed by the organisation equips first responders with the knowledge and skills to understand how children experience trauma when parents are arrested, a profoundly important and frequently overlooked dimension of ACEs that mainstream trauma-informed training rarely addresses.

6.14. Self-Healing Communities: Building Sustainable, Outcome-Driven ACEs Prevention at Scale (Washington State)

The meeting with Laura Porter, an expert in ACEs based in Washington State offered one of the Fellowship's most strategically sophisticated perspectives on how trauma-informed, ACE-focused work can be designed, measured, and sustained at genuine population scale. Having worked with the state for 17 years, serving as a liaison between the Governor's cabinet and 42 community groups, she brings a rare combination of political access, community credibility, and systems thinking to the challenge of preventing and reducing Adverse Childhood Experiences across entire populations. Her work is neither clinical nor purely activist; it occupies the critical and often neglected space where community capacity, government accountability, and outcome measurement converge.

Self-Healing Communities: A Living Systems Approach

The conceptual heart of Porter's work is the **Self-Healing Communities** model, a framework that draws on **Applied Living Systems theory**, using the metaphor of natural healing cycles, such as the self-regulating rhythms of the ocean, to understand how communities can develop their own internal capacity for recovery, resilience, and regeneration. Rather than positioning communities as passive recipients of professionally delivered interventions, this model treats communities as dynamic, self-organising systems capable of healing themselves when equipped with the right tools, knowledge, relationships, and structural support.

This philosophy has profound practical implications. Porter trained community members, lay people without professional qualifications, in qualitative interviewing and analysis, deliberately reducing the barriers to meaningful participation in community research and development. Quantitative data was collected alongside these qualitative insights, creating a rich, mixed-methods evidence base that could both attract funding

and demonstrate genuine learning and impact. The result was not a programme with a defined end point, but a **sustainable community infrastructure** oriented around continuous improvement and collective accountability.

Outcome Measurement and ACEs Integration

A particularly instructive dimension of Porter's work was her systematic approach to outcome measurement. An **Outcomes Matrix** was developed to attract funding, guide learning, and demonstrate measurable improvement against one or more major societal problems, providing the accountability framework that funders, policymakers, and communities all require. ACEs questions were formally added to **CDC survey questionnaires** in Washington State, enabling population-level tracking of ACEs scores over time. The results were striking: communities engaged in self-healing approaches recorded **lower ACEs scores**, providing powerful evidence that community-based, prevention-oriented investment produces measurable population health outcomes.

The work targeted five specific ACEs-related focus areas: child abuse and neglect, family violence, youth violence, youth substance abuse, and school dropout; recognising that these are not separate problems requiring separate solutions, but interconnected expressions of unaddressed trauma requiring an integrated, community-wide response.

Cultural Approaches to ACEs: Indigenous and Global Wisdom

Porter's work also drew attention to culturally grounded approaches to ACEs prevention and healing, particularly from Indigenous communities in Maui and Hawai'i, and from Māori frameworks in Aotearoa New Zealand. These perspectives offered a profound challenge to the dominant Western, clinically oriented trauma-informed paradigm, and carry significant implications for culturally responsive practice in the UK.

In **Hawai'i**, Native Hawaiian (Kānaka Maoli) healing approaches centre on the deep spiritual connection between people, land (*ʻāina*), and ocean (*moana*), positioning the natural environment not as backdrop but as ancestor, healer, and source of resilience. Strengths-based, family-focused programmes integrate cultural identity with trauma-informed care, recognising that strong Indigenous cultural identity actively protects against the intergenerational transmission of ACEs. Critically, standardised ACE questionnaires were identified as insufficient for capturing the specific trauma experiences of culturally distinct communities, pointing to an urgent need for culturally informed and adaptable assessment tools.

Māori healing frameworks centre on the concept of **mauri**, the vital life force flowing through all people, places, and living systems; and the practice of **Rongoā Māori**, a holistic healing system addressing mind, body, and spirit through plant-based remedies, massage (*mirimiri*), and spiritual healing through prayer (*karakia*). Healing, in this framework, means restoring balance and reconnecting individuals and families to their

culture, ancestors, land (*whenua*), and community, with identity, belonging, and ancestral connection understood as protective factors of the highest order.

The Māori concept of **Vā**, the sacred relational space between people, offers perhaps the most elegant articulation of what all trauma-informed practice ultimately seeks to cultivate: the quality of connection, care, and mutual regard that exists in the space between one human being and another. *Ia teu le vā*, to nurse, cherish, and care for that space, is both a cultural imperative and a clinical one, and its wisdom deserves serious engagement in UK trauma-informed frameworks.

7. Ten Key Lessons from the USA

- 1. Cross-sector collaboration is essential** Sustainable trauma-informed transformation requires health, education, justice, social care, and community organisations working under shared values and language – no single agency can achieve lasting change alone.
- 2. Community ownership sustains change** Programmes designed with communities, not for them; build the relational trust and collective investment that sustain transformation long after external funding has moved on.
- 3. Workforce wellbeing must be built in, not added on** Traumatized workforces transmit trauma. Staff wellbeing, reflective supervision, and cultures of wellness must be structurally embedded from the outset, not offered as afterthoughts when burnout has already taken hold.
- 4. Policy coherence amplifies impact** Trauma-informed practice achieves population-level impact only when policy frameworks, commissioning, funding, and accountability systems are aligned. Fragmented policy produces fragmented outcomes.
- 5. Racism must be explicitly named and addressed** Trauma-informed practice that does not centre racial justice is incomplete. Structural racism is itself a significant ACE and systems must actively dismantle it, not merely acknowledge it.
- 6. Lived experience is irreplaceable expertise** Community health workers, behavioural health navigators, and peer mentors with lived experience of trauma and injustice bring credibility, trust, and relational depth that no professional qualification can replicate.
- 7. Leadership commitment is the decisive variable** Every high-functioning trauma-informed system shared one feature: courageous, personally committed leadership that modelled vulnerability, prioritised culture, and held the organisation accountable to its values.
- 8. Early intervention delivers the greatest returns** Investment in the age 0–5 developmental window, through trauma-informed health visiting, paediatric behavioural health, and family support, produces the most profound and lasting outcomes for individuals and communities.
- 9. Movements outlast programmes** Creating shared values, networks, and community infrastructure, rather than time-limited programmes with exit strategies, builds sustainable cultural foundations within which trauma-informed transformation can genuinely take root.
- 10. Healing requires safe environments, not just skilled practitioners** Physical spaces, organisational cultures, and institutional relationships must themselves communicate safety, dignity, and belonging, because people can only heal in environments where they genuinely feel safe enough to do so.

8. Key Findings: Australia

8.1. Overview

Australia's trauma-informed movement is distinguished by its deep and principled grounding in cultural safety and Indigenous healing, offering a perspective that fundamentally enriches and challenges the predominantly Western clinical frameworks that dominate trauma-informed practice globally. The *Integrated Trauma-Informed Care Framework* (NSW, 2023) provides the strategic foundation for an approach, centring identity, connection, and community as the primary pathways to healing, recognising that for many Australians, particularly First Nations, Aboriginal and Torres Strait Islander peoples, trauma is not merely individual but collective, intergenerational, and inseparable from the historical wounds of colonisation, dispossession, and cultural erasure. Australia's experience offers the United Kingdom profound and transferable lessons in what genuinely culturally safe, community-centred trauma-informed practice looks like in practice.

8.2. Palm Island: Community-Led Healing and Cultural Sovereignty

Palm Island (Bwgcolman), a remote First Nations community off the coast of Queensland, established as a penal settlement in 1918 and shaped by decades of forced removal, colonial control, and systemic injustice, offered the Fellowship's most profoundly moving encounter with self-determined healing and cultural resurgence.

Services on Palm Island for marginalised young people focus on culturally safe and community-led initiatives, including mental health and well-being support.



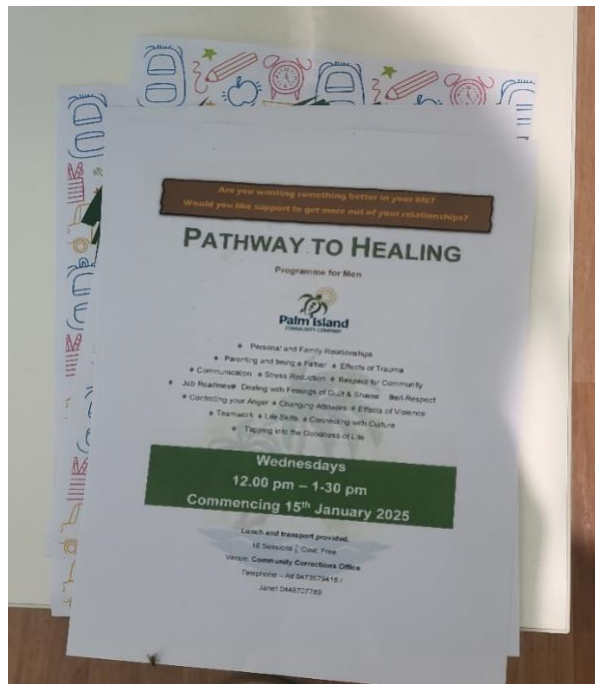
Focus on Cultural Safety and Community-Led Solutions

- **Cultural Safety:** Programmes are developed with local knowledge and understanding to ensure they are relevant and culturally safe for the Palm Island community.
- **Community Involvement:** The Palm Island Community Company, in collaboration with the community, develops programmes and aligns with priorities to close the gap in health and community services for Aboriginal and Torres Strait Islander people.
- **Youth Engagement:** Young people have been involved in the development and refinement of research tools and strategies, ensuring that community perspectives are central to the solutions being developed.

Organisations visited included the Palm Island Community Company (PICC), Selectability, Wakai Waian Healing (100% Indigenous-owned psychological and counselling service), Joyce Palmer Health Service, the Children and Family Centre, the Family Wellbeing Service, the Family Participation Programme, the Community Justice Group, and the Police Citizens Youth Club (PCYC) with its Yarning Circles.



PICC, a community-controlled not-for-profit delivering human services, capacity-building, and economic development, demonstrated how community control produces genuinely trusted, contextually appropriate provision. The Men's Gathering addressed mental health stigma in culturally safe ways. Yarning Circles, used for thousands of years by First Nations peoples for knowledge-sharing, conflict resolution, and community wellbeing, provided a model of culturally grounded dialogue that statutory services cannot replicate. Selectability conducted extensive community consultation before delivering a single service, ensuring provision was genuinely tailored, culturally accepted, and trusted from the outset.



8.3. Lowitja Institute, Melbourne

Australia's only Aboriginal and Torres Strait Islander community-controlled health research institute, established in 2010 and named in honour of the late Dr Lowitja O'Donoghue AC CBE DSG, the Lowitja Institute offered the Fellowship's most rigorous encounter with Indigenous-led health research. Running 30 active projects and funding the next generation of Aboriginal and Torres Strait Islander Masters and PhD researchers, the Institute's foundational contribution is its articulation of cultural determinants of health, positioning connection to culture, community, country, and identity as evidence-based protective factors rather than supplementary considerations. The Institute's Health Journey Mapping tools translate cultural safety principles into operational clinical instruments built on equity, safety, and partnership.



Conversations addressed gentrification displacing Aboriginal communities, colourism as a form of racialised trauma, the foster care system's replication of Stolen Generations logic, and the criminalisation of Aboriginal children as young as ten. The concept of consuming cultural load: the exhausting burden of navigating and resisting racism whilst sustaining cultural identity, resonated powerfully with the experiences of Black and Brown nurses and communities in the UK.

8.4. The Secretariat of National Aboriginal and Islander Child Care (SNAICC): National Voice for Aboriginal and Torres Strait Islander Children

SNAICC, governed entirely by Aboriginal and Torres Strait Islander community-controlled organisations, works across five areas: **Marulu** (every child is precious, worth nurturing); **Child and Family Safety** (addressing the devastating over-representation of Indigenous children in out-of-home care); **Culture and Identity** (as fundamental rights, not optional considerations); **Early Childhood Development** (community-controlled, not mainstream); and **Closing the Gap** (changing how Australian governments work with communities). SNAICC's advocacy that culturally appropriate, community-led approaches to child safety are inseparable from structural self-determination offers direct lessons for UK child protection reform.

8.5. Yoorrook Justice Commission, Melbourne

Victoria's and Australia's first formal truth-telling inquiry into historic and ongoing systemic injustices perpetrated against First Peoples, led by First Peoples, drawing on thousands of formal testimonies over four years, Yoorrook gave institutional form and legal weight to the generations-long call to have truths formally heard, acknowledged, and acted upon. Its reports are a roadmap for systemic change, demanding action from government, institutions, and all Victorians. Yoorrook's insistence that truth-telling is the necessary foundation for genuine healing, and that the strength, resilience, and solutions First Peoples carry are as central as the injustices, embodies the conviction that communities are not defined by what has been done to them, but by what they carry within them.

8.6. Positive Wellness Recovery Centre (PWRC), Melbourne

PWRC in Kalkallo offered a holistic, culturally centred community mental health service for African Australian and other marginalised communities.



Services span NDIS (National Disability Insurance Scheme) support, mental wellness counselling, refugee mental health, Wellness Recovery Action Plans, and natural and complementary therapies. The Drumming and Dancing for Life programme, grounded in thousands of years of therapeutic rhythm across cultures, addressed dimensions of wellbeing that conventional clinical settings neglect. The Fundi Homework Club supported children of African migrant backgrounds aged 5–18. Mental Health First Aid training built community-level mental health literacy. Project SUNRISE delivered culturally sensitive outreach aligned to the Victoria African Community Action Plan. The model demonstrates that effective mental health provision for racially marginalised communities cannot be limited to clinical intervention, it must attend to the whole person.

8.7. Rumbalara Aboriginal Cooperative, Shepparton

Rumbalara, whose name means *rainbow* or *at the end of the rainbow*, operates from the conviction that every person matters, offering culturally appropriate, community-controlled, whole-of-life support to one of regional Australia's largest Aboriginal and Torres Strait Islander populations. As a deliberate non-mainstream provider, Rumbalara attends to the full spectrum of health and wellbeing: illness prevention, harm reduction, chronic disease management, mental health, housing, and education, refusing the narrow, episodic model that characterises much of mainstream healthcare. Community governance ensures provision is genuinely personalised and trusted in ways externally designed services cannot achieve.



8.8. Australian Childhood Foundation (ACF), Melbourne

ACF, a 30-year-old national organisation with over 500 staff, offered the Fellowship's most neuroscientifically rigorous encounter with trauma-sensitive practice. The Australian Child Maltreatment Study (2023) found that 28.5% of Australians have experienced child sexual abuse (Mathews et al., 2023). Seventy per cent of children in the Australian out-of-home care system are Aboriginal. ACF's Neurosequential Modelling Therapy (NMT) framework, grounded in Bruce Perry's neuroscience, has moved the organisation away from Cognitive Behavioural Therapy (CBT) with children entirely, recognising that a developing prefrontal cortex cannot engage cognitive reframing when the limbic system is activated. The concept of relational betrayal, and the urgent imperative that "if the relationship is not repaired by eight, children will seek belonging elsewhere", illuminates the pathway from childhood trauma to gang involvement and justice system contact. ACF's deliberate choice to use trauma-sensitive rather than trauma-informed language, and to hold trauma-transformation as its aspirational horizon, reflects principled precision about what genuine healing requires.

8.9. University of Sydney: Nursing, Midwifery, and Cultural Safety

Nursing and midwifery academics at the University of Sydney are leading the decolonisation and Indigenisation of the Nurse Family Partnership for use with Aboriginal mothers and families, adapting the programme through cultural safety, Indigenous leadership, and Video Interactive Guidance. Cultural safety and anti-racism are embedded in professional codes of ethics and undergraduate training. The theory of historical trauma underpins an Applied Research Collaboration focused on de-problematising Aboriginal young people and centring culture and identity as protective

factors. The concept of survivance, the fusion of survival and resistance, rooted in knowing one's story, being present, and resisting erasure, emerged as a powerful framework for professional practice and community resilience. The adultification of Black children and the normalisation of casual racism within clinical settings were identified as urgent, unaddressed priorities.



8.10. Sydney: Trauma-Responsive Schools and Youth Violence Prevention

Sydney's most effective schools embed social-emotional learning as a core curriculum commitment, equipping teachers to interpret challenging behaviour through a trauma lens rather than a disciplinary one. Health and education teams share integrated plans for each child, whilst parents are actively positioned as co-educators. Community youth violence prevention programmes combine sport, mentoring, and cultural connection for young men, with police and community leaders co-chairing violence-prevention panels, modelling the cross-sector, trust-based collaboration that sustainable community safety demands.

9. Seven Key Lessons from Australia

- 1. Embed cultural safety in every service** Cultural safety must be structurally embedded within NHS codes of practice, professional standards, and undergraduate training, not treated as optional. Safety is determined by the patient, not the practitioner, and demands active anti-racist commitment at every level.
- 2. Address intergenerational trauma through community-led healing** Sustainable healing from intergenerational and colonial trauma requires community-owned, culturally grounded responses. Communities must be in the driving seat of their own recovery, with culture and identity recognised as evidence-based protective factors.
- 3. Pair policy with practice funding** Trauma-informed and culturally safe policy commitments without sustained, long-term funding produce performative rather than transformative change. The UK must match its equity rhetoric with the structural investment necessary to resource genuinely community-controlled services at scale.
- 4. Decolonise professional education and practice** Nursing, midwifery, social work, and education curricula must be actively decolonised, incorporating non-Western knowledge systems, Indigenous healing frameworks, and anti-racist pedagogy as foundational components, not peripheral additions.
- 5. Position culture and identity as public health protective factors** Connection to culture, language, community, and ancestral identity demonstrably reduces trauma, suicide risk, and youth violence. UK public health strategy must formally recognise and resource cultural connection, particularly for Black, Brown, and diaspora communities, as a clinical and preventive health intervention.
- 6. Centre community-controlled research and knowledge production** Establish UK equivalents of the Lowitja Institute, community-controlled research bodies led by and for racially marginalised communities, ensuring health research, policy, and practice is produced by the communities most affected, not merely conducted upon them.
- 7. Prioritise truth-telling, reckoning, and reparative justice** Modelled on Yoorrook, the UK urgently needs formal truth-telling processes that honestly reckon with the legacy of colonialism, the Windrush scandal, and institutional racism, recognising that genuine healing cannot begin without honest, courageous, institutionally accountable acknowledgement of historic and ongoing harm.

10. Cross-Cutting Insights: USA versus Australia

Theme	USA	Australia	Transferable Lessons for UK
Policy Drivers	Federal and state mandates post-ACE study	Integrated Trauma-Informed Care Framework and Indigenous strategy	National policy backing gives traction
Cultural Focus	Universal TIC language	Cultural safety and decolonisation	Marry universal and cultural approaches
Community Role	Grassroots networks (TICNs)	Elders and peer mentors	Co-design with lived experience
Workforce Support	Self-care embedded in training	Reflective practice supervision	Prioritise staff wellbeing
Evaluation	ACEs metrics and data dashboards	Qualitative story-based outcomes	Blend quantitative and qualitative measures

11. Implications for the United Kingdom

The United Kingdom stands at a critical juncture. Youth violence is rising. A generation of children and young people are carrying the unaddressed weight of Adverse Childhood Experiences. Workforces are exhausted. Communities are fractured. And the systems designed to help are too often replicating the very harm they were created to prevent.

This Fellowship demonstrates with compelling clarity that transformation is possible. The question is not whether we know enough to act. We do. The question is whether we have the authentic courage to do so.

Being trauma-informed is no longer sufficient. The United Kingdom must become trauma-responsive, embedding active, accountable, measurably effective responses to trauma across health, education, justice, social care, community organisations, and faith groups. Equity and cultural safety, not cultural competence, must be the standard. People with lived experience are not merely consulted voices: they are experts whose knowledge, co-design, and co-production must be structurally embedded within every service, policy, and research agenda that claims to serve them.

Six overarching implications for the UK emerge from this Fellowship:

- Trauma-responsive practice must become the standard across health, education, justice, and community services, moving from awareness to active, accountable response.
- Violence must be treated as preventable through a public health approach, not primarily a criminal justice problem.
- Lived experience must be centred, as those with experience of trauma and adversity are experts; co-design and co-production are non-negotiable.
- Joined-up leadership is essential, with a cross-government strategy for ACEs and trauma, aligned across all departments.
- Equity and cultural safety, not cultural competence, must ensure responses actively address systemic racism, discrimination, and intergenerational trauma.
- Data and research must build the UK evidence base, tracking trauma impact, demonstrating what works, and showcasing best practice.

12. Personal Reflection: Seeing the Child Behind the Statistic

Across every country visited during this Fellowship, one truth emerged with painful and consistent clarity: systemic and structural racism is not incidental to youth violence, it is foundational to it. When Black boys and girls are seen primarily as threats rather than children, as suspects rather than students, as problems to be managed rather than young people to be nurtured, the consequences are both predictable and devastating. The school-to-prison pipeline does not begin in adolescence, it begins in early childhood, in the moment a Black child is looked at differently, disciplined more harshly, excluded more readily, and protected less consistently than their white peers. Systems that were never designed with them in mind continue to fail them, not through isolated acts of individual prejudice, but through the accumulated, interlocking weight of race, gender, and social inequality operating simultaneously and relentlessly across every institution they encounter.

Trauma-informed practice asks: "*What happened to you?*" Trauma-responsive practice goes further: "*How can I work with you to make it better?*" And genuine systemic transformation asks the hardest question of all: "*Where do the patterns lie, and how do we, individually and collectively, prevent trauma from happening in the first place?*"

The answer demands the education of every stakeholder: practitioner, policymaker, community member, and leader alike. It demands a village approach, rooted in contextual safeguarding, that holds every child as precious and protected wherever they are: at home, at school, at college, in their community, in their place of worship, in their local restaurant, on their street corner, or in any other space they inhabit. Youth violence is not a problem that belongs to any single agency, profession, or community. It is everyone's responsibility. And everyone must be held accountable for playing their part in ending it.

13. Recommendations

The following ten recommendations are drawn from the full breadth of the Fellowship's learning and are intended for policymakers, commissioners, practitioners, community organisations, and system leaders across all sectors.

1. **Policy: Embed Trauma-Responsive Principles Across National Strategy**

Embed trauma-informed and trauma-responsive principles within national strategies for health, education, justice, and safeguarding, requiring every Integrated Care System, local authority, and government department to demonstrate implementation, accountability, and measurable outcomes. A cross-government ACEs and trauma strategy, led from the highest levels of political authority, is urgently needed to align fragmented departmental responses into a coherent, population-level commitment. Treat violence as a preventable public health issue, not a criminal justice problem alone.

2. **Practice: Train, Support, and Sustain the Workforce**

Fund mandatory, recurring trauma-responsive training for all frontline professionals across health, education, social care, justice, and community services, grounded in neuroscience, brain development, and the lived reality of ACEs. Incorporate reflective supervision, restorative practice, and vicarious trauma support as protected, non-negotiable components of every frontline role. Invest in train-the-trainer models that build internal organisational capacity. Equip practitioners with the resources, tools, and models encountered across this Fellowship to support immediate practice improvement.

3. **Community: Invest in Place-Based Prevention and Collective Action**

Invest in place-based, community-led prevention and resilience-building initiatives co-designed with families, young people, and communities, particularly in areas of highest ACEs prevalence and youth violence concentration. Fund Community Health Worker and Behavioural Health Navigator roles held by people with lived experience as trusted bridges between statutory systems and communities. Support collective action networks modelled on TICN and Self-Healing Communities frameworks, building community infrastructure that sustains healing beyond individual funding cycles.

4. **Child Advocacy and Protection: Centre the Child in Every System**

Establish Child Advocacy Centres across the UK providing coordinated, trauma-responsive, multi-disciplinary support for children who have experienced abuse, neglect, or violence, under one roof, with one trusted relationship. Prioritise the 0–5 developmental window through restored and expanded health visiting capacity, embedded paediatric behavioural health consultation, and universal trauma-

informed early years provision. Address the adultification of Black and Brown children within education, child protection, and justice systems as an urgent racial equity and child safeguarding priority.

5. Schools and Education: Make Every School Trauma-Responsive

Establish a national Trauma-Responsive Schools Programme embedding Parent Engagement Coordinators, licensed therapists, and designated Trauma Leads within every school serving communities with high ACEs prevalence. Equip teachers to interpret behaviour through a trauma and neuroscience lens, replacing punitive exclusion with curious, compassionate, skills-based intervention. Integrate health and education planning for each child, position parents as co-educators, and evaluate progress against exclusion rates, attendance, attainment, and staff wellbeing.

6. Police, Justice, and Law Enforcement: Transform the System's Response

Embed trauma-responsive training within all police induction programmes and ongoing professional development. Develop diversion centres as health-led alternatives to custody for young people in crisis. Pilot trauma-informed court models prioritising problem-solving, family support, and relational repair. Urgently raise the age of criminal responsibility and end the criminalisation of children, particularly Black and Brown children disproportionately funnelled into justice involvement through racialised school exclusion, adultification, and over-policing.

7. Family and Parent Engagement: Wrap Around Families, Not Just Children

Design and resource family-centred, trauma-responsive services engaging parents and carers as essential partners in children's healing, within culturally safe, accessible, community-embedded settings. Develop whole-family trauma assessment and support frameworks addressing the relational, intergenerational, and structural dimensions of family trauma. Ensure all child protection processes actively involve families as co-participants, not subjects.

8. Equity and Cultural Safety: Dismantle Racism Within Systems

Mandate cultural safety, not merely cultural competence, as a core standard across all UK public services, with particular urgency in health, education, and justice. Ensure trauma-responsive services for Black, Brown, and racially marginalised communities are co-designed with and led by those communities. Formally integrate racial trauma, structural racism, and intergenerational injustice into all ACEs frameworks, training, and research. Establish community-controlled research and advocacy infrastructure, modelled on the Lowitja Institute, to ensure that the knowledge base driving UK trauma policy is produced by the communities most affected.

9. Partnerships and Multi-Agency Collaboration: Build Joined-Up Leadership

Develop Regional Trauma-Responsive Community Networks across the UK, with backbone organisations providing strategic coordination, shared training infrastructure, and cross-sector accountability, modelled on Virginia's TICN and Philadelphia's ACE Task Force. Require genuine multi-agency collaboration with shared data, shared outcomes frameworks, and shared accountability as a condition of public funding for all services working with children, young people, and families affected by trauma and adversity.

10. Measurement, Research, and Evidence: Build the UK Evidence Base

Develop UK outcome frameworks for trauma-responsive practice capturing both individual healing and system-level change, measuring safety, belonging, relational repair, reduced exclusions, improved mental health, and community resilience. Commission a national UK ACEs prevalence study disaggregated by race, geography, disability, and other protected characteristics. Integrate ACEs questions into national population health surveys. Fund and showcase best practice through a dedicated national knowledge exchange platform, ensuring that the learning generated by this and future Fellowships reaches practitioners, leaders, and communities who need it most.

14. Conclusion

This Fellowship has been transformative. Across countries and contexts, I witnessed what becomes possible when trauma is met not with punishment, but with curiosity; not with exclusion, but with care. I saw services asking, "What has happened to you?" instead of "What is wrong with you?" I saw communities centring cultural safety and leaders courageous enough to confront structural inequities rather than ignore them.

The message was clear: trauma and violence are not inevitable. They are shaped by the systems we build. When systems respond with fear and control, harm deepens. When they respond with compassion, accountability, and partnership, cycles of harm can be interrupted.

"What will we do about it?"

I return to the UK convinced that it takes a village to heal trauma and prevent violence. Healing cannot sit within one service or sector. It takes educators, health professionals, youth workers, faith leaders, policymakers, families, and communities working together to create environments where children feel safe, seen, and valued.

Leadership rooted in love and curiosity is not soft; it is transformative. It shifts cultures from blame to understanding, from reaction to prevention.

Now is the moment to act. We must embed trauma-informed, culturally safe, and equity-driven approaches into policy, education, health, and justice systems; not as an initiative, but as infrastructure.

If we align our hearts with our systems, we can build villages that heal.

15. References

Burke Harris, N. (2018). *The Deepest Well: Healing the Long-Term Effects of Childhood Adversity*. Bluebird.

Felitti, V.J. et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. *American Journal of Preventive Medicine*, 14(4), 245–258.

Mathews, B. et al. (2023). The prevalence of child maltreatment in Australia: findings from a national survey. *Medical Journal of Australia*, 218 Suppl 6: S13–S18.

<https://doi.org/10.5694/mja2.51873>

National Child Traumatic Stress Network (NCTSN) (2014) *Essential elements of a trauma-informed juvenile justice system*. Los Angeles, CA and Durham, NC: National Center for Child Traumatic Stress.

https://www.nctsn.org/sites/default/files/resources//essential_elements_trauma_informed_juvenile_justice_system.pdf

NSW Health (2023). *Integrated Trauma-Informed Care Framework: My story, my health, my future*. NSW Health. Available at:

<https://www.health.nsw.gov.au/patients/trauma/Publications/itic-framework.pdf>

Office for National Statistics (2018). *Homicide in England and Wales: Year ending March 2017*. ONS.

Oshikanlu, R. (2019). My year out of health visiting: Lessons learned. *Journal of Health Visiting*. 7(8). <https://doi.org/10.12968/johv.2019.7.8.390>

Perry, B.D. & Szalavitz, M. (2006). *The Boy Who Was Raised as a Dog*. Basic Books.

Public Health Wales (2015). *Adverse Childhood Experiences and their impact on health-harming behaviours in the Welsh adult population*. Public Health Wales NHS Trust.

Substance Abuse and Mental Health Services Administration (2014). *SAMHSA's concept of trauma and guidance for a trauma-informed approach*. HHS Publication No. (SMA) 14-4884. SAMHSA.

Further Reading

Churchill Fellowship (2025). About us: Learning from the world, inspiring change in the UK. Available at: <https://www.churchillfellowship.org/about-us/>

Lowitja Institute (2024). *About us: Research, knowledge exchange and leadership for Aboriginal and Torres Strait Islander health*. Available at: www.lowitja.org.au

National Child Traumatic Stress Network (NCTSN): www.nctsn.org

Porter, L. (2016). *Self-Healing Communities: A Transformational Process Model for Improving Intergenerational Health*. Washington State Department of Social and Health Services. Available at: <https://criresilient.org/wp-content/uploads/2018/07/Self-healing-community-report.pdf>

Ramsden, I. (2002). *Cultural safety and nursing education in Aotearoa and Te Waipounamu*. Unpublished PhD thesis, Victoria University of Wellington.

16. Appendix A

The Continuum: From Trauma-Aware to Trauma-Responsive

Stage	What it Means
Trauma-Aware	Understanding that trauma is widespread and affects behaviour and health.
Trauma-Sensitive	Beginning to consider trauma in interactions and environments.
Trauma-Informed	Integrating knowledge of trauma into policies and practices.
Trauma-Responsive	Actively changing systems, services, and relationships to support healing.

17. Appendix B

Glossary

- **ACEs (Adverse Childhood Experiences):** stressful or traumatic events in childhood including abuse, neglect, and household dysfunction, shown to have dose-response relationships with adult health outcomes.
- **CDC (Centers for Disease Control and Prevention):** the United States' national public health agency. Although it is a US agency, the CDC collaborates worldwide with organisations such as the World Health Organization, ministries of health, and academic institutions to prevent and control global health threats.
- **Cultural Safety:** an approach that recognises power imbalances and structural inequities in health and social care; safety is defined by the patient/service user, not the practitioner.
- **Mauri:** a Māori concept of the vital life force flowing through all people, places, and living systems.
- **Secondary/Vicarious Trauma:** the cumulative emotional impact on practitioners of exposure to others' trauma experiences.
- **Survivance:** the combination of survival and resistance, used particularly in Indigenous contexts to describe the active, creative, ongoing presence and resilience of communities against colonial erasure.
- **TIC (Trauma-Informed Care):** a framework that recognises the widespread impact of trauma and integrates knowledge about trauma into policies, procedures, and practices.
- **TICN (Trauma Informed Community Network):** a collaborative system of organisations, professionals, and communities working together to embed trauma-informed principles into services, policies, and practice.
- **Trauma-Responsive Practice:** refers to the stage beyond trauma awareness and trauma-informed care where individuals, organisations, and systems actively adapt their behaviours, policies, and environments to respond effectively to trauma and promote healing. Rather than simply recognising that trauma exists, trauma-responsive systems **change what they do** to prevent re-traumatisation and support recovery.
- **Vā:** a Māori and Pacific concept of the sacred relational space between people. "Ia teu le vā" means to nurse, cherish, and care for that space.
- **Walla Walla** in Walla Walla, Washington, United States has become widely recognised as a **trauma-informed community**, where multiple sectors intentionally work together to respond to the impacts of trauma on individuals, families, and communities. The initiative is often referred to as **“Trauma-Informed Walla Walla”**.

18. About the Churchill Fellow

**Professor Ruth Oshikanlu MBE RN, RM, RSCPHN (HV)
QN, FRCN, FRSA, FRSPH, FAAN, FFNMRC SI, FiHV**

Ruth Oshikanlu is a nurse, midwife, health visitor, social entrepreneur, author and international advocate committed to improving outcomes for children, young people and families. With more than three decades of experience across the NHS, independent and voluntary sectors, her work has consistently focused on reducing health inequalities, supporting vulnerable populations and championing trauma-responsive approaches to care.

Ruth's professional journey has spanned clinical practice, leadership, education, policy influence and social entrepreneurship. She trained as a nurse, midwife and health visitor and has held a range of specialist roles including HIV Specialist Midwife, Family Nurse within one of England's early Family Nurse Partnership pilot sites, and Nurse Leader for a Young People's Health and Wellbeing Service. These experiences built upon years of frontline experience working with children, young people and families whose lives had been shaped by adversity, loss, poverty, discrimination and trauma. They also deepened her understanding of the complex social, emotional and environmental factors that shape health and life outcomes.

Ruth is widely recognised for her commitment to supporting children and families during the earliest stages of life. A passionate advocate for parenting and early intervention, she has spent much of her career helping parents build strong, nurturing relationships with their children. Her belief that supporting parents is one of the most effective ways to improve outcomes for children has informed her clinical work, writing, speaking and leadership.

Throughout her career, Ruth has remained committed to amplifying lived experience and ensuring that services are designed with people rather than for them. She is the author of *Tune In To Your Baby: Because Babies Don't Come With an Instruction Manual* and has become a respected voice in maternal and infant health, trauma-responsive care, health equity and leadership.

Ruth is the Executive Director at Abule CIC. She founded Abule CIC in response to a recurring challenge she observed throughout her professional career: many individuals and communities experiencing trauma, adversity and inequality were navigating fragmented systems that were not designed around their needs.

"Abule" is a Yoruba word meaning village or community, reflecting the African philosophy that collective wellbeing is achieved through connection, belonging and mutual support.

The organisation was established on the principle that lasting change happens when people, professionals and communities work together as equal partners. Drawing on her experience as a midwife, health visitor, Family Nurse, Churchill Fellow and social entrepreneur, Ruth created Abule CIC to address health inequities that worsened during the COVID-19 pandemic, using co-production, community engagement and trauma-responsive practice.

Under its guiding ethos, "It Takes a Village" and "Creating Connectedness Through Community", Abule CIC works alongside women, children, families, professionals, organisations and communities to improve outcomes and reduce inequalities. Its programmes focus on areas such as maternal and infant health, parenting, adverse childhood experiences, trauma-responsive care, leadership development, anti-racism, community wellbeing and health equity.

The lessons learned through Ruth's Churchill Fellowship continue to influence Abule's work today. The organisation's commitment to understanding the impact of adversity, strengthening protective factors and creating environments where people can heal, thrive and belong is rooted in the same principles that inspired this Fellowship journey: listening deeply, valuing lived experience and recognising that every child deserves the opportunity to flourish, regardless of the challenges they face.

Ruth is a Queen's Nurse (QN), and holds several prestigious fellowships including the Royal College of Nursing (FRCN), the American Academy of Nursing (FAAN), Faculty of Nursing and Midwifery Royal College of Surgeons Ireland (FFNMRC SI), the Institute of Health Visiting (FiHV), the Royal Society of Arts (FRSA), and the Royal Society for Public Health (FRSPH). She was appointed a Member of the Order of the British Empire (MBE) in 2019 for services to community nursing, children and families. Ruth is an honorary Visiting Professor at the School of Health and Medical Sciences, City St Georges, University of London.

19. Photo Gallery

United States of America

Richmond, Virginia



With the team at Greater Richmond SCAN





At the Richmond Police Department



Oakland and San Francisco, California



With the team at the East Bay Agency for Children (EBAC)





With Alive and Free, Omega Boys Club and HOPE SF, San Francisco

Visiting the Department of Public Health, San Francisco



New York City, New York



With the team at the New York City Health Department



Philadelphia, Pennsylvania



With the team at the Health Federation of Philadelphia



At the Family Practice and Counseling Network (FPCN)



Australia

Palm Island, Queensland



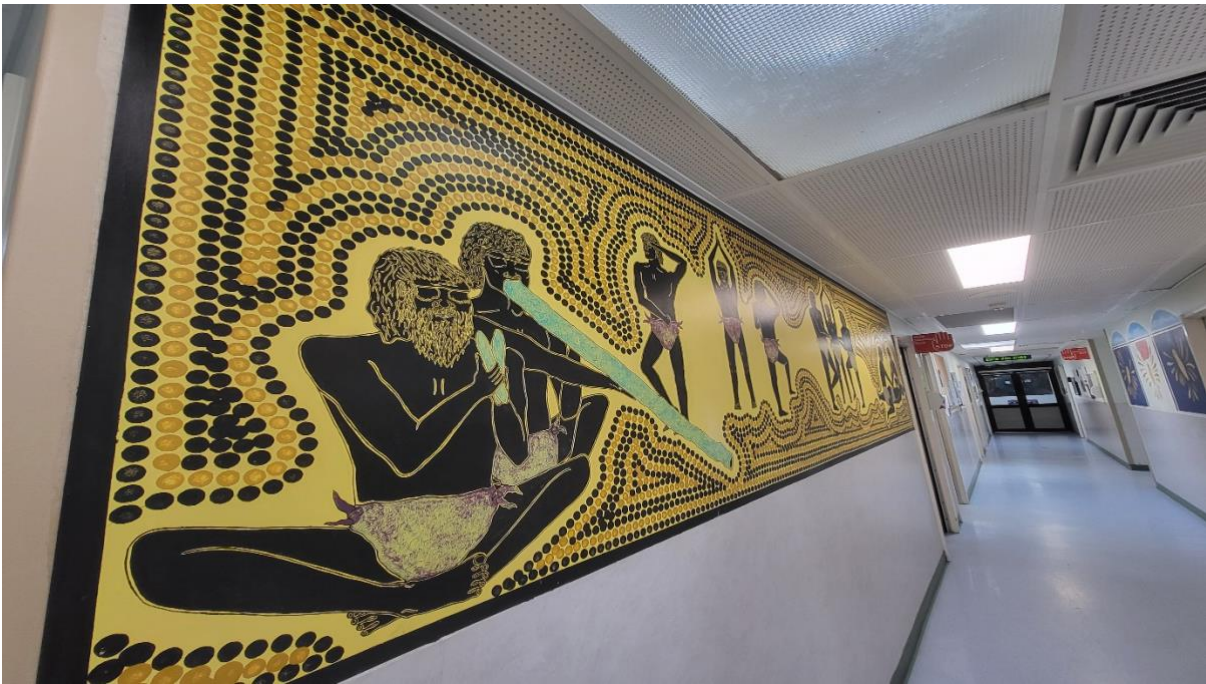
Travelling to Palm Island



Palm Island



Visiting the Palm Island Health Centre



With the Director of Nursing & Midwifery, Palm Island Health Centre



With Murri Watch



Lunch at the Beach to escape the 43°C heat



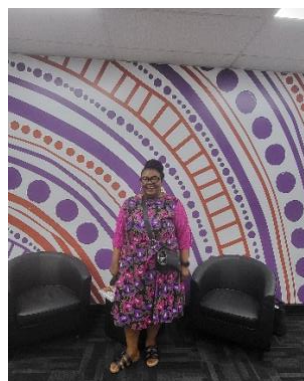
Melbourne, Victoria



Travelling from Townsville to Melbourne with Professor Lynore Geia



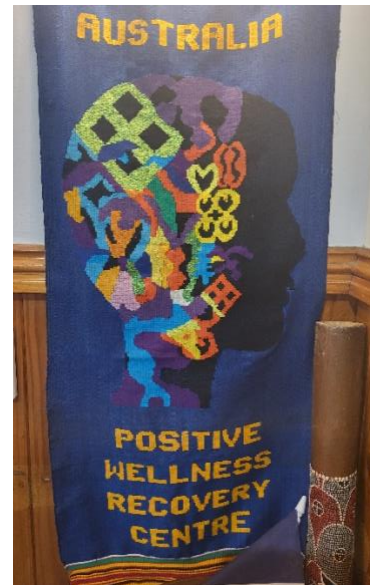
With Staff at the Lowitja Institute, Melbourne



Shepparton and Mooroopna, Victoria



With staff at the Positive Wellness Recovery Centre



With staff at the Rumbalara Aboriginal Cooperative

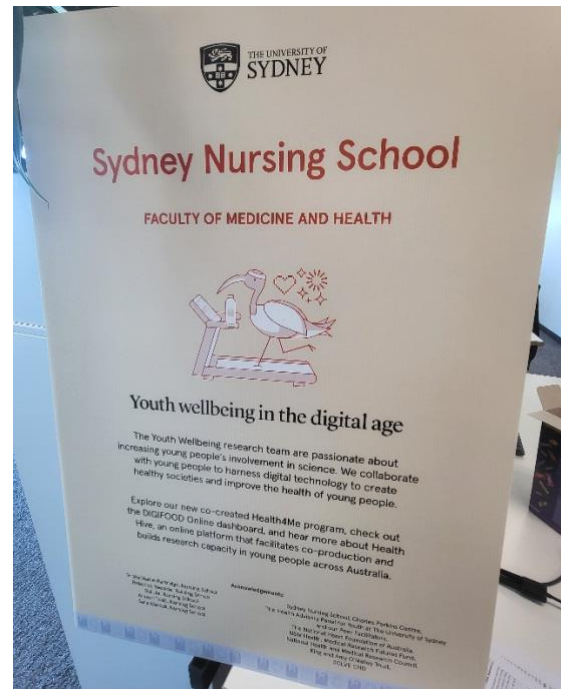


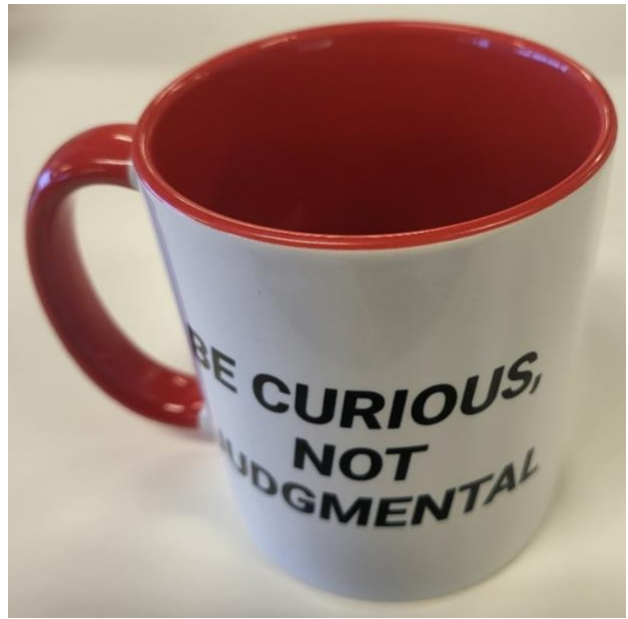
Sydney, New South Wales



With staff at the University of Sydney, Susan Wakil School of Nursing and Midwifery









With the team at the Australian Childhood Foundation



Down Time Exploration

