

115TH CONGRESS
1ST SESSION

H. R. 1757

To address the psychological, developmental, social, and emotional needs of children, youth, and families who have experienced trauma, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MARCH 28, 2017

Mr. DANNY K. DAVIS of Illinois (for himself, Ms. KELLY of Illinois, and Mrs. BUSTOS) introduced the following bill; which was referred to the Committee on Education and the Workforce, and in addition to the Committees on Energy and Commerce, Ways and Means, and the Judiciary, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To address the psychological, developmental, social, and emotional needs of children, youth, and families who have experienced trauma, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Trauma-Informed
5 Care for Children and Families Act of 2017”.

6 **SEC. 2. FINDINGS.**

7 Congress makes the following findings:

1 (1) The 2007 Great Smoky Mountains Study, a
2 representative longitudinal study of children, found
3 that by age 16, more than 67 percent of the children
4 had been exposed to 1 or more traumatic events,
5 such as child maltreatment, domestic violence, or
6 sexual assault.

7 (2) According to a 2009 Office of Juvenile Jus-
8 tice and Delinquency Prevention study of children
9 ages 0 through 17, more than 60 percent of the chil-
10 dren surveyed were exposed to violence within the
11 past year, either directly or indirectly.

12 (3) According to the Administration for Chil-
13 dren and Families, the rate of substantiated reports
14 of child maltreatment in fiscal year 2015 was 9.2
15 per 1,000 children ages 0 through 17, with children
16 under age 1 having the highest rate of 24.2 per
17 1,000 children.

18 (4) According to the Office of Juvenile Justice
19 and Delinquency Prevention, a longitudinal study of
20 youth detained at a juvenile detention center in Chi-
21 cago showed that 92.5 percent of youth had experi-
22 enced at least 1 trauma, and 84 percent had experi-
23 enced more than 1 trauma.

24 (5) The National Intimate Partner and Sexual
25 Violence Survey conducted by the Centers for Dis-

1 ease Control and Prevention revealed that nearly 1
2 in 5 women reported having been the victim of a
3 rape at some time during their lives. Seventy-eight
4 percent experienced their first rape before the age of
5 25.

6 (6) A 2017 study found that abuse and mal-
7 treatment suffered as a child was associated with
8 post-traumatic stress disorder and opioid-related
9 misuse as an adult, and recommended that trauma
10 history and post-traumatic stress disorder symptom
11 severity be addressed as part of opioid addiction
12 treatment.

13 (7) Findings from the Adverse Childhood Expe-
14 riences Study conducted by the Centers for Disease
15 Control and Prevention have shown that adverse
16 childhood experiences predispose children towards
17 negative trajectories from infancy through adoles-
18 cence. Followup representative studies have shown
19 the long-range impact of early trauma exposure on
20 adult health conditions, including heart disease,
21 asthma, and mental health.

22 (8) According to a subsequent study conducted
23 by the Centers for Disease Control and Prevention,
24 adults who had been exposed to multiple adverse
25 childhood experiences were significantly more likely

1 to be unemployed, to be living in poverty, and not
2 to have graduated high school than adults who had
3 zero adverse childhood experiences.

4 (9) According to a 2008 finding by the Na-
5 tional Child Traumatic Stress Network, educators
6 who work directly with traumatized children and
7 adolescents are particularly vulnerable to secondary
8 traumatic stress, experiencing burnout, fatigue, irri-
9 tability, and other symptoms, and can be supported
10 through early recognition of that stress, self-care,
11 and trauma-informed support systems.

12 (10) Findings from a 2012 study conducted by
13 the Centers for Disease Control and Prevention in-
14 cluded an estimate that the total lifetime burden of
15 child maltreatment cases that occur each year in the
16 United States, including medical, welfare, and crimi-
17 nal justice costs, is \$124,000,000,000.

18 (11) According to the Centers for Disease Con-
19 trol and Prevention's National Health and Nutrition
20 Examination Survey, only half of children ages 8
21 through 15 with a mental disorder had received
22 treatment for their disorder within the past year.
23 Children with anxiety disorders such as post-trau-
24 matic stress disorder were the least likely to be

1 treated, with only 32.2 percent having received
2 treatment for a mental disorder in the past year.

3 (12) According to a 2014 report of the Institute
4 of Medicine and National Research Council of the
5 National Academies entitled “New Directions in
6 Child Abuse and Neglect Research”, research has
7 shown that child abuse and neglect experiences re-
8 sulted in higher risk for behavioral health problems
9 (such as depression and substance use) throughout
10 life, but that with informed prevention approaches,
11 child abuse and neglect can be both preventable and
12 manageable.

13 (13) According to a 2017 finding by the Na-
14 tional Child Traumatic Stress Network, of the chil-
15 dren served by the Network with problems in the
16 clinical range when entering care, 83 percent showed
17 significant improvements in post-traumatic stress
18 disorder, behavioral problems, or traumatic stress
19 symptoms after receiving evidence-based treatments.

20 (14) According to a 2008 Washington State re-
21 port on prevention programs that assessed both cost
22 and effectiveness, evidence-based, two-generational
23 child trauma treatments such as Parent-Child Inter-
24 action Therapy return \$3.64 per dollar of cost.

1 **TITLE I—DEVELOPMENT OF**
2 **BEST PRACTICES**

3 **SEC. 101. TASK FORCE TO DEVELOP BEST PRACTICES FOR**
4 **TRAUMA-INFORMED IDENTIFICATION, RE-**
5 **FERRAL, AND SUPPORT.**

6 (a) ESTABLISHMENT OF TASK FORCE TO IDENTIFY,
7 EVALUATE, RECOMMEND, MAINTAIN, AND UPDATE BEST
8 PRACTICES.—

9 (1) ESTABLISHMENT.—There is established a
10 task force, to be known as the Interagency Task
11 Force on Trauma-Informed Care.

12 (2) MAIN DUTIES.—The task force shall—

13 (A) identify, evaluate, recommend, main-
14 tain, and update, as described in subsection (c)
15 and in accordance with subsection (d), a set of
16 best practices with respect to children and
17 youth, and their families as appropriate, who
18 have experienced or are at risk of experiencing
19 trauma; and

20 (B) carry out other duties as described in
21 subsection (c).

22 (b) TASK FORCE COMPOSITION.—

23 (1) COMPOSITION.—The task force shall be
24 composed of Federal employees, consisting of the
25 Assistant Secretary for Mental Health and Sub-

1 stance Use (referred to in this section as the “As-
2 sistant Secretary”, except where another Assistant
3 Secretary is specifically named) and 1 representative
4 of each of—

5 (A) the National Center for Injury Preven-
6 tion and Control of the Centers for Disease
7 Control and Prevention;

8 (B) the Center for Mental Health Services
9 of the Substance Abuse and Mental Health
10 Services Administration;

11 (C) the Center for Substance Abuse Pre-
12 vention of that Administration;

13 (D) the Center for Substance Abuse Treat-
14 ment of that Administration;

15 (E) the Center for Behavioral Health Sta-
16 tistics and Quality of that Administration;

17 (F) the Maternal and Child Health Bureau
18 of the Health Resources and Services Adminis-
19 tration;

20 (G) the Center for Medicaid and CHIP
21 Services;

22 (H) the National Institute of Mental
23 Health;

1 (I) the Eunice Kennedy Shriver National
2 Institute of Child Health and Human Develop-
3 ment;

4 (J) the National Institute on Drug Abuse;

5 (K) the National Institute on Alcohol
6 Abuse and Alcoholism;

7 (L) the Administration on Children, Youth
8 and Families of the Administration for Children
9 and Families;

10 (M) the Administration for Native Ameri-
11 cans of the Administration for Children and
12 Families;

13 (N) the Office of Child Care of the Admin-
14 istration for Children and Families;

15 (O) the Office of Head Start of the Admin-
16 istration for Children and Families;

17 (P) the Office of Refugee Resettlement of
18 the Administration for Children and Families;

19 (Q) the Indian Health Service of the De-
20 partment of Health and Human Services;

21 (R) the Office of Minority Health of the
22 Department of Health and Human Services;

23 (S) the Office of the Assistant Secretary
24 for Planning and Evaluation;

1 (T) the Office of Juvenile Justice and De-
2 linquency Prevention of the Department of Jus-
3 tice;

4 (U) the Office of Community Oriented Po-
5 licing Services of the Department of Justice;

6 (V) the Office on Violence Against Women
7 of the Department of Justice;

8 (W) the National Center for Education
9 Evaluation and Regional Assistance of the De-
10 partment of Education;

11 (X) the Office of Safe and Healthy Stu-
12 dents of the Department of Education;

13 (Y) the Office of Special Education and
14 Rehabilitative Services of the Department of
15 Education;

16 (Z) the Office of Indian Education of the
17 Department of Education;

18 (AA) the Bureau of Indian Affairs of the
19 Department of the Interior;

20 (BB) the Bureau of Indian Education of
21 the Department of the Interior;

22 (CC) the Veterans Health Administration
23 of the Department of Veterans Affairs;

1 (DD) the Office of Special Needs Assist-
2 ance Programs of the Department of Housing
3 and Urban Development; and

4 (EE) such other Federal agencies as—

5 (i) the Assistant Secretary rec-
6 ommends to the President; and

7 (ii) the President determines to be ap-
8 propriate.

9 (2) APPOINTMENT.—

10 (A) IN GENERAL.—Each member of the
11 task force, other than the Assistant Secretary,
12 shall be appointed by the Secretary or other
13 head of the entire Federal agency that contains
14 the office or other unit of government that the
15 member represents.

16 (B) DATE OF APPOINTMENTS.—The heads
17 of Federal agencies with appointing authority
18 under this paragraph shall appoint the cor-
19 responding members of the task force not later
20 than 6 months after the date of enactment of
21 this Act.

22 (3) CHAIRPERSON.—The task force shall be
23 chaired by the Assistant Secretary.

24 (c) TASK FORCE DUTIES.—The task force shall—

1 (1) not later than 1 year after the date of en-
2 actment of this Act, and not less often than annually
3 thereafter—

4 (A) identify and evaluate a set of evidence-
5 based, evidence-informed, and promising best
6 practices, which may include practices already
7 supported by offices of the Department of
8 Health and Human Services, including the Na-
9 tional Mental Health and Substance Use Policy
10 Laboratory, the Department of Justice, the De-
11 partment of Education, or another Federal
12 agency, with respect to—

13 (i) the early identification of children
14 and youth, and their families as appro-
15 priate, who have experienced or are at risk
16 of experiencing trauma;

17 (ii) the expeditious referral of such
18 children and youth, and their families as
19 appropriate, that require specialized serv-
20 ices to the appropriate trauma-informed
21 support (including treatment) services, in
22 accordance with applicable privacy laws;
23 and

24 (iii) the implementation of trauma-in-
25 formed approaches and interventions in

1 child and youth-serving schools, organiza-
2 tions, homes, and other settings to foster
3 safe, stable, and nurturing environments
4 and relationships that prevent and mitigate
5 the effects of trauma;

6 (B) recommend such set of best practices,
7 including disseminating the set, to the Depart-
8 ment of Health and Human Services, the De-
9 partment of Justice, the Department of Edu-
10 cation, other Federal agencies as appropriate,
11 State, tribal, and local government agencies, in-
12 cluding State, local, and tribal educational
13 agencies, and other entities (including recipients
14 of relevant Federal grants, professional associa-
15 tions, health professional organizations, na-
16 tional and State accreditation bodies, and
17 schools) that the Assistant Secretary deter-
18 mines to be appropriate, and to the general
19 public; and

20 (C) maintain and update, as appropriate,
21 the set of best practices recommended under
22 subparagraph (B);

23 (2) not later than 2 years after the date of en-
24 actment of this Act—

1 (A) prepare an integrated task force strat-
2 egy report concerning how the task force and
3 member agencies will collaborate, prioritize op-
4 tions for, and implement a coordinated ap-
5 proach to preventing trauma, and identifying
6 and ensuring the appropriate interventions and
7 supports for children, youth, and their families
8 as appropriate, who have experienced or are at
9 risk of experiencing trauma;

10 (B) submit the report to the appropriate
11 committees of Congress; and

12 (C) make the report publicly available; and

13 (3) not later than 1 year after the date of en-
14 actment of this Act, and as often as practicable but
15 not less often than annually thereafter, coordinate,
16 to the extent feasible, among the offices and other
17 units of government represented on the task force,
18 research, data collection, and evaluation regarding
19 models described in subsection (d)(1)(C), identify
20 gaps in or populations or settings not served by
21 models described in that subsection, solicit feedback
22 on the models, from the stakeholders described in
23 subsection (d)(1)(B), coordinate, among the offices
24 and other units of government represented on the
25 task force, the awarding of grants related to pre-

1 venting and mitigating trauma, and establish proce-
2 dures to enable the offices and units of government
3 to share technical expertise related to preventing and
4 mitigating trauma.

5 (d) BEST PRACTICES.—

6 (1) IN GENERAL.—In identifying, evaluating,
7 recommending, maintaining, and updating the set of
8 best practices under subsection (c), the task force
9 shall—

10 (A) consider findings from evidence-based,
11 evidence-informed, and promising practice-
12 based models, including from institutions of
13 higher education, community practice (including
14 tribal experience), recognized professional asso-
15 ciations, and programs of the Department of
16 Health and Human Services, the Department of
17 Justice, the Department of Education, and
18 other Federal agencies (including the National
19 Mental Health and Substance Use Policy Lab-
20 oratory and offices in such agencies that main-
21 tain registries and clearinghouses of relevant
22 models), that reflect the science of healthy
23 child, youth, and family development, and have
24 been developed, implemented, and evaluated to

1 demonstrate effectiveness or positive measur-
2 able outcomes;

3 (B) engage with, and solicit and receive
4 feedback from—

5 (i) faculty at institutions of higher
6 education, community practitioners associ-
7 ated with the community practice described
8 in subparagraph (A), and recognized pro-
9 fessional associations that represent the
10 experience and perspectives of individuals
11 who provide services in covered settings, to
12 obtain observations and practical rec-
13 ommendations on the best practices; and

14 (ii) the public, by—

15 (I) holding at least one public
16 meeting to solicit recommendations
17 and information relating to the best
18 practices; and

19 (II) providing notice of the meet-
20 ing in the Federal Register;

21 (C) recommend models for settings in
22 which individuals may come into contact with
23 children and youth, and their families as appro-
24 priate, who have experienced or are at risk of
25 experiencing trauma, including schools, hos-

1 pitals, settings where health care providers, in-
2 cluding primary care and pediatric providers,
3 provide services, preschool and early childhood
4 education and care settings, home visiting set-
5 tings, after-school program facilities, child wel-
6 fare agency facilities, public health agency fa-
7 cilities, mental health treatment facilities, sub-
8 stance abuse treatment facilities, faith-based in-
9 stitutions, domestic violence centers, homeless
10 services system facilities, refugee services sys-
11 tem facilities, juvenile justice system facilities,
12 and law enforcement agency facilities;

13 (D) recommend best practices that are evi-
14 dence-based, are evidence-informed, or are
15 promising and practice-based, and that include
16 guidelines for—

17 (i)(I) training of front-line service
18 providers, including teachers, providers
19 from child- or youth-serving organizations,
20 health care providers, individuals who are
21 mandatory reporters of child abuse or ne-
22 glect, and first responders, in under-
23 standing and identifying early signs and
24 risk factors of trauma in children and

1 youth, and their families as appropriate,
2 including through screening processes; and

3 (II) implementing appropriate re-
4 sponses;

5 (ii) procedures or systems that—

6 (I) are designed to quickly refer
7 children and youth, and their families
8 as appropriate, who have experienced
9 or are at risk of experiencing trauma
10 to, and ensure the children, youth,
11 and appropriate family members re-
12 ceive, the appropriate trauma-in-
13 formed screening and support, includ-
14 ing treatment; or

15 (II) use partnerships that—

16 (aa) include local social serv-
17 ices organizations or clinical
18 mental health or health care serv-
19 ice providers with expertise in
20 furnishing support services (in-
21 cluding trauma-informed treat-
22 ment) to prevent or mitigate the
23 effects of trauma;

24 (bb) may be partnerships
25 that co-locate or integrate serv-

1 ices, such as by providing serv-
2 ices at school-based health cen-
3 ters; and

4 (cc) are designed to make
5 such quick referrals, and ensure
6 the receipt of screening, support,
7 and treatment, described in sub-
8 clause (I);

9 (iii) educating children and youth
10 to—

11 (I) understand trauma;

12 (II) identify the signs, effects, or
13 symptoms of trauma; and

14 (III) build the resilience and cop-
15 ing skills to mitigate the effects of ex-
16 periencing trauma;

17 (iv) multi-generational interventions
18 to—

19 (I) support, including through
20 skills building, parents (with an ap-
21 propriate emphasis on fathers), foster
22 parents, adult caregivers, and front-
23 line service providers described in
24 clause (i)(I) in fostering safe, stable,
25 and nurturing environments and rela-

1 tionships that prevent and mitigate
2 the effects of trauma for children and
3 youth who have experienced or are at
4 risk of experiencing trauma;

5 (II) assist parents, foster par-
6 ents, and adult caregivers in learning
7 to access resources related to such
8 prevention and mitigation; and

9 (III) provide tools to prevent and
10 address caregiver or secondary trau-
11 ma, as appropriate;

12 (v) community interventions for un-
13 derserved areas that have faced trauma
14 through acute or long-term exposure to
15 substantial discrimination, historical or
16 cultural oppression, intergenerational pov-
17 erty, civil unrest, a high rate of violence, or
18 a high rate of drug overdose mortality;

19 (vi) assisting parents and guardians
20 in understanding eligibility for and obtain-
21 ing certain health benefits coverage, in-
22 cluding coverage under a State Medicaid
23 plan under title XIX of the Social Security
24 Act (42 U.S.C. 1396 et seq.) of screening
25 and treatment for children and youth, and

1 their families as appropriate, who have ex-
2 perience or are at risk of experiencing
3 trauma;

4 (vii) utilizing trained nonclinical pro-
5 viders (such as peers through peer support
6 models, mentors, clergy, and other commu-
7 nity figures), to—

8 (I) expeditiously link children
9 and youth, and their families as ap-
10 propriate, who have experienced or
11 are at risk of experiencing trauma, to
12 the appropriate trauma-informed
13 screening and support (including clin-
14 ical treatment) services; and

15 (II) provide ongoing care or case
16 management services;

17 (viii) collecting and utilizing data
18 from screenings, referrals, or the provision
19 of services and supports, conducted in the
20 covered settings, to evaluate and improve
21 processes for trauma-informed support and
22 outcomes;

23 (ix)(I) improving disciplinary practices
24 in early childhood education and care set-
25 tings and schools, including use of positive

1 disciplinary strategies that are effective at
2 reducing the incidence of punitive school
3 disciplinary actions, including school sus-
4 pensions and expulsions; and

5 (II) providing the training described
6 in clause (i) to child care providers and to
7 school personnel, including school resource
8 officers, teacher assistants, administrators,
9 and heads of charter schools; and

10 (x) incorporating trauma-informed
11 considerations into educational, preservice,
12 and continuing education opportunities, for
13 the use of health professional and edu-
14 cation organizations, national and State
15 accreditation bodies for health care and
16 education providers, health and education
17 professional schools or accredited graduate
18 schools, and other relevant training and
19 educational entities;

20 (E) recommend best practices that—

21 (i) include practices that are cul-
22 turally sensitive, linguistically appropriate,
23 age- and gender-relevant, and appropriate
24 for lesbian, gay, bisexual, transgender, and
25 queer populations;

1 (ii) can be applied across underserved
2 geographic areas; and

3 (iii) engage entire organizations in
4 training and skill building related to the
5 best practices; and

6 (F) recommend best practices that are de-
7 signed not to lead to unwarranted custody loss
8 or criminal penalties for parents or guardians
9 in connection with children and youth who have
10 experienced or are at risk of experiencing trau-
11 ma.

12 (e) AUTHORIZATION OF APPROPRIATIONS.—To carry
13 out this section, there are authorized to be appropriated
14 \$3,000,000 for fiscal year 2018 and \$1,000,000 for each
15 of fiscal years 2019 through 2022.

16 (f) DEFINITIONS.—In this section:

17 (1) COVERED RECIPIENT.—The term “covered
18 recipient” means a department or other entity de-
19 scribed in subsection (c)(1)(B).

20 (2) COVERED SETTING.—The term “covered
21 setting” means a setting described in subsection
22 (d)(1)(C).

1 **SEC. 102. DONALD J. COHEN NATIONAL CHILD TRAUMATIC**
2 **STRESS INITIATIVE.**

3 Section 582(f) of the Public Health Service Act (42
4 U.S.C. 290hh–1(f)) is amended—

5 (1) by striking “\$46,887,000” and inserting
6 “\$66,887,000”; and

7 (2) by adding at the end the following: “Of the
8 amounts appropriated under this subsection for each
9 of fiscal years 2018 through 2022, \$7,500,000 shall
10 be allocated to the operation of the coordinating cen-
11 ter of the National Child Traumatic Stress Initiative
12 for purposes of gathering and reporting data, evalu-
13 ating models, and providing technical assistance.”.

14 **TITLE II—DISSEMINATION AND**
15 **IMPLEMENTATION OF BEST**
16 **PRACTICES**

17 **SEC. 201. USE OF GRANT FUNDS FOR TRAINING IN BEST**
18 **PRACTICES RELATING TO CHILD AND YOUTH**
19 **TRAUMA AND COMMUNITY SUPPORT.**

20 (a) HEAD START ACT.—

21 (1) IN GENERAL.—Section 640(a) of the Head
22 Start Act (42 U.S.C. 9835(a)) is amended—

23 (A) by redesignating paragraph (7) as
24 paragraph (8); and

25 (B) by inserting after paragraph (6) the
26 following:

1 “(7) Any of the funds allocated under this sub-
2 section for Head Start programs (including Early
3 Head Start programs), for training and technical as-
4 sistance activities, or for collaboration grants may be
5 used to provide training for administrators and
6 other staff of Head Start agencies in the best prac-
7 tices developed under section 101 of the Trauma-In-
8 formed Care for Children and Families Act of
9 2017.”.

10 (2) CONFORMING AMENDMENTS.—

11 (A) Section 640(a)(2)(C)(i) of the Head
12 Start Act (42 U.S.C. 9835(a)(2)(C)(i)), in the
13 matter preceding subclause (I), by inserting
14 after “training and technical assistance activi-
15 ties” the following: “(such as training in the
16 best practices developed under section 101 of
17 the Trauma-Informed Care for Children and
18 Families Act of 2017)”.

19 (B) Sections 641A(h)(1)(B) and 645(d)(3)
20 of the Head Start Act (42 U.S.C.
21 9836a(h)(1)(B), 9840(d)(3)) are amended by
22 striking “640(a)(7)” and inserting “640(a)(8)”.

23 (C) Section 642B(a)(2)(B)(i) of the Head
24 Start Act (42 U.S.C. 9837b(a)(2)(B)(i)) is
25 amended by inserting before the semicolon the

1 following: “(such as by providing training for
2 administrators and other staff of those agencies
3 in the best practices developed under section
4 101 of the Trauma-Informed Care for Children
5 and Families Act of 2017)”.

6 (D) Section 648 of the Head Start Act (42
7 U.S.C. 9843) is amended—

8 (i) in subsection (a)(3)(B)(i), by in-
9 serting after “systems” the following:
10 “(such as systems that include training in
11 the best practices developed under section
12 101 of the Trauma-Informed Care for
13 Children and Families Act of 2017)”;

14 (ii) in subsection (b)(2)(C), by insert-
15 ing before the semicolon the following:
16 “(such as training in the best practices de-
17 veloped under section 101 of the Trauma-
18 Informed Care for Children and Families
19 Act of 2017)”;

20 (iii) in subsection (d)(1)(G), by insert-
21 ing after “staff training” the following
22 “(such as training in the best practices de-
23 veloped under section 101 of the Trauma-
24 Informed Care for Children and Families
25 Act of 2017)”.

1 (b) CHILD CARE AND DEVELOPMENT BLOCK
2 GRANT.—Section 658G(b)(1) of the Child Care and De-
3 velopment Block Grant Act of 1990 (42 U.S.C.
4 9858e(b)(1)) is amended—

5 (1) in subparagraph (G), by striking “; and”
6 and inserting a semicolon;

7 (2) in subparagraph (H), by striking the period
8 and inserting “; and”; and

9 (3) by adding at the end the following:

10 “(I) providing training in the best prac-
11 tices developed under section 101 of the Trau-
12 ma-Informed Care for Children and Families
13 Act of 2017 for administrators of child care
14 programs, and child care providers, that receive
15 assistance under this subchapter.”.

16 (c) SOCIAL SERVICES BLOCK GRANT.—Section
17 2002(a)(2)(B) of the Social Security Act (42 U.S.C.
18 1397a(a)(2)(B)) is amended—

19 (1) in clause (ii), by striking “and” after the
20 semicolon;

21 (2) in clause (iii), by striking the period at the
22 end and inserting “; and”; and

23 (3) by adding at the end the following new
24 clause:

1 “(iv) training for providers in the best
2 practices developed under section 101 of
3 the Trauma-Informed Care for Children
4 and Families Act of 2017.”.

5 (d) MATERNAL AND CHILD HEALTH SERVICES
6 BLOCK GRANT.—Section 504 of the Social Security Act
7 (42 U.S.C. 704) is amended by adding at the end the fol-
8 lowing new subsection:

9 “(e) A State may use a portion of the amounts de-
10 scribed in subsection (a) for the purpose of providing
11 training for licensed health care providers and public
12 health agencies in the best practices developed under sec-
13 tion 101 of the Trauma-Informed Care for Children and
14 Families Act of 2017.”.

15 (e) MATERNAL, INFANT, AND EARLY CHILDHOOD
16 HOME VISITING (MIECHV).—Section 511(i)(2) of the
17 Social Security Act (42 U.S.C. 711(i)(2)) is amended—

18 (1) by redesignating subparagraphs (D)
19 through (G) as subparagraphs (E) through (H), re-
20 spectively; and

21 (2) by inserting after subparagraph (C) the fol-
22 lowing new subparagraph:

23 “(D) Section 504(e) (relating to the use of
24 funds for training in the best practices devel-
25 oped under section 101 of the Trauma-In-

1 formed Care for Children and Families Act of
2 2017).”.

3 (f) CHILD WELFARE SERVICES.—Section
4 422(b)(4)(B) of the Social Security Act (42 U.S.C.
5 622(b)(4)(B)) is amended by inserting before the semi-
6 colon “(which may include training in the best practices
7 developed under section 101 of the Trauma-Informed Care
8 for Children and Families Act of 2017)”.

9 (g) FEDERAL PAYMENTS FOR FOSTER CARE AND
10 ADOPTION ASSISTANCE.—Section 474(a)(3)(A) of the So-
11 cial Security Act (42 U.S.C. 674(a)(3)(A)) is amended by
12 inserting “, and including training in the best practices
13 developed under section 101 of the Trauma-Informed Care
14 for Children and Families Act of 2017” after “enrolled
15 in such institutions”.

16 (h) HEALTHY START INITIATIVE.—Section 330H(e)
17 of the Public Health Service Act (42 U.S.C. 254c–8(e))
18 is amended by adding at the end the following:

19 “(3) TRAINING PROVIDERS IN BEST PRACTICES
20 RELATING TO TRAUMA.—Any of the funds appro-
21 priated under paragraph (1) may be used to provide
22 training for providers in the best practices developed
23 under section 101 of the Trauma-Informed Care for
24 Children and Families Act of 2017.”.

1 (i) BLOCK GRANTS FOR COMMUNITY MENTAL
2 HEALTH SERVICES.—Section 1920 of the Public Health
3 Service Act (42 U.S.C. 300x–9) is amended by adding at
4 the end the following:

5 “(d) TRAINING PROVIDERS IN BEST PRACTICES RE-
6 LATING TO TRAUMA.—Except as specified in subsection
7 (c), any of the funds appropriated under subsection (a)
8 may be used to provide training for providers in the best
9 practices developed under section 101 of the Trauma-In-
10 formed Care for Children and Families Act of 2017.”.

11 (j) BLOCK GRANTS FOR PREVENTION AND TREAT-
12 MENT OF SUBSTANCE ABUSE.—Section 1935 of the Pub-
13 lic Health Service Act (42 U.S.C. 300x–35) is amended
14 by adding at the end the following:

15 “(c) ALLOCATIONS FOR TRAINING PROVIDERS IN
16 BEST PRACTICES RELATING TO TRAUMA.—Any of the
17 funds appropriated under subsection (a) may be used to
18 provide training for providers in the best practices devel-
19 oped under section 101 of the Trauma-Informed Care for
20 Children and Families Act of 2017.”.

21 (k) USE OF GRANT FUNDS FOR TRAINING PRO-
22 VIDERS IN BEST PRACTICES RELATING TO TRAUMA.—

23 (1) SCHOOL-BASED HEALTH CENTERS.—Sec-
24 tion 399Z–1(l) of the Public Health Service Act (42
25 U.S.C. 280h–5(l)) is amended by adding “Any of

1 the funds appropriated under this subsection may be
2 used to provide training for providers in the best
3 practices developed under section 101 of the Trau-
4 ma-Informed Care for Children and Families Act of
5 2017.” after the first sentence.

6 (2) COMMUNITY HEALTH CENTERS.—Section
7 330(r) of the Public Health Service Act (42 U.S.C.
8 254b(r)) is amended by adding at the end the fol-
9 lowing:

10 “(5) TRAINING PROVIDERS IN BEST PRACTICES
11 RELATING TO TRAUMA.—Any of the funds appro-
12 priated under this subsection may be used to provide
13 training for providers in the best practices developed
14 under section 101 of the Trauma-Informed Care for
15 Children and Families Act of 2017.”.

16 (1) SUPPORTING EFFECTIVE INSTRUCTION; LOCAL
17 USE OF FUNDS.—Section 2103(b)(3) of the Elementary
18 and Secondary Education Act of 1965 (20 U.S.C.
19 6613(b)(3)) is amended—

20 (1) in subparagraph (O), by striking “and”
21 after the semicolon;

22 (2) by redesignating subparagraph (P) as sub-
23 paragraph (Q); and

24 (3) by inserting after subparagraph (O) the fol-
25 lowing:

1 “(P) providing training for school per-
2 sonnel, including teachers, principals, other
3 school leaders, specialized instructional support
4 personnel, and paraprofessionals, in the best
5 practices developed under section 101 of the
6 Trauma-Informed Care for Children and Fami-
7 lies Act of 2017; and”.

8 (m) STUDENT SUPPORT AND ACADEMIC ENRICH-
9 MENT.—

10 (1) STATE USE OF FUNDS.—Section 4104(b) of
11 the Elementary and Secondary Education Act of
12 1965 (20 U.S.C. 7114(b)) is amended—

13 (A) in paragraph (2), by striking “or” at
14 the end;

15 (B) in paragraph (3) by striking the period
16 at the end and inserting “; or”; and

17 (C) by adding at the end the following:

18 “(4) providing training for teachers, adminis-
19 trators, school counselors, mental health profes-
20 sionals, and other appropriate personnel in the best
21 practices developed under section 101 of the Trau-
22 ma-Informed Care for Children and Families Act of
23 2017.”.

1 (2) LOCAL USE OF FUNDS.—Paragraph (5) of
2 section 4108 of the Elementary and Secondary Edu-
3 cation Act of 1965 (20 U.S.C. 7118) is amended—

4 (A) in subparagraph (H), by striking “or”
5 at the end;

6 (B) in subparagraph (I), by striking the
7 period at the end and inserting “; or”; and

8 (C) by adding at the end the following:

9 “(J) providing training for teachers, ad-
10 ministrators, school counselors, mental health
11 professionals, and other appropriate personnel
12 in the best practices developed under section
13 101 of the Trauma-Informed Care for Children
14 and Families Act of 2017.”.

15 (n) 21ST CENTURY COMMUNITY LEARNING CEN-
16 TERS.—

17 (1) STATE USE OF FUNDS.—Section 4202(c)(3)
18 of the Elementary and Secondary Education Act of
19 1965 (20 U.S.C. 7172(c)(3)) is amended—

20 (A) by redesignating subparagraphs (H),
21 (I), and (G), as subparagraphs (G), (H), and
22 (I), respectively; and

23 (B) by adding at the end the following:

24 “(J) Providing training for teachers, ad-
25 ministrators, school counselors, mental health

1 professionals, and other appropriate personnel
2 (including appropriate personnel involved with
3 programs and activities that advance student
4 academic achievement and support student suc-
5 cess during nonschool hours) in the best prac-
6 tices developed under section 101 of the Trau-
7 ma-Informed Care for Children and Families
8 Act of 2017.”.

9 (2) LOCAL USE OF FUNDS.—Section 4205(a) of
10 the Elementary and Secondary Education Act of
11 1965 (20 U.S.C. 7175(a)) is amended—

12 (A) in paragraph (13), by striking “and”
13 at the end;

14 (B) in paragraph (14), by striking the pe-
15 riod at the end and inserting “; and”; and

16 (C) by adding at the end the following:

17 “(15) training for teachers, administrators,
18 school counselors, mental health professionals, and
19 other appropriate personnel in the best practices de-
20 veloped under section 101 of the Trauma-Informed
21 Care for Children and Families Act of 2017.”.

22 (o) FULL-SERVICE COMMUNITY SCHOOLS.—Section
23 4625(e) of the Elementary and Secondary Education Act
24 of 1965 (20 U.S.C. 7275(e)) is amended—

1 (1) in paragraph (2), by striking “and” after
2 the semicolon;

3 (2) by redesignating paragraph (3) as para-
4 graph (4); and

5 (3) by inserting after paragraph (2) the fol-
6 lowing:

7 “(3) provide training for teachers, administra-
8 tors, school counselors, mental health professionals,
9 and other appropriate personnel (including appro-
10 pate personnel involved with the full-service com-
11 munity school) in the best practices developed under
12 section 101 of the Trauma-Informed Care for Chil-
13 dren and Families Act of 2017; and”.

14 (p) NATIONAL ACTIVITIES FOR SCHOOLS.—Section
15 4631(a)(1)(B) of the Elementary and Secondary Edu-
16 cation Act of 1965 (20 U.S.C. 7281(a)(1)(B)) is amended
17 by striking “or conducting a national evaluation.” and in-
18 serting “, conducting a national evaluation, or providing
19 training for teachers, administrators, school counselors,
20 mental health professionals, and other appropriate per-
21 sonnel in the best practices developed under section 101
22 of the Trauma-Informed Care for Children and Families
23 Act of 2017.”.

24 (q) IDEA.—Section 638 of the Individuals with Dis-
25 abilities Education Act (20 U.S.C. 1438) is amended—

1 (1) in paragraph (4), by striking “and” after
2 the semicolon;

3 (2) in paragraph (5), by striking the period at
4 the end and inserting “; and”; and

5 (3) by adding at the end the following:

6 “(6) to provide training for appropriate per-
7 sonnel who provide direct early intervention services
8 for infants and toddlers with disabilities in the best
9 practices developed under section 101 of the Trau-
10 ma-Informed Care for Children and Families Act of
11 2017.”.

12 (f) SPECIAL SUPPLEMENTAL NUTRITION PROGRAM
13 FOR WOMEN, INFANTS, AND CHILDREN.—Section 17(f)
14 of the Child Nutrition Act of 1966 (42 U.S.C. 1786(f))
15 is amended by adding at the end the following:

16 “(27) BEST PRACTICES.—A State agency may
17 use a portion of the amounts made available to the
18 State agency under this section for the purpose of
19 providing training for local agencies in the best prac-
20 tices developed under section 101 of the Trauma-In-
21 formed Care for Children and Families Act of
22 2017.”.

23 (s) COMMUNITY SERVICES BLOCK GRANT ACT.—

24 (1) STATE ACTIVITIES.—Section 675C(b)(1)(A)
25 of the Community Services Block Grant Act (42

1 U.S.C. 9907(b)(1)(A)) is amended by inserting after
2 “providing training” the following: “(which may in-
3 clude providing training, to the entities that are pro-
4 viders of services to children and youth, in the best
5 practices developed under section 101 of the Trau-
6 ma-Informed Care for Children and Families Act of
7 2017)”.

8 (2) NATIONAL ACTIVITIES.—Section
9 678A(a)(1)(A) of the Community Services Block
10 Grant Act (42 U.S.C. 9913(a)(1)(A)) is amended by
11 inserting after “training” the following: “(which may
12 include providing training, to the entities that are
13 providers of services to children and youth, in the
14 best practices developed under section 101 of the
15 Trauma-Informed Care for Children and Families
16 Act of 2017)”.

17 (t) RUNAWAY AND HOMELESS YOUTH ACT.—Section
18 342 of the Runaway and Homeless Youth Act (42 U.S.C.
19 5714–22) is amended by inserting after “technical assist-
20 ance and training” the following: “(which may include
21 providing training, to providers of services under this title,
22 in the best practices developed under section 101 of the
23 Trauma-Informed Care for Children and Families Act of
24 2017)”.

1 (u) PROGRAMS OF THE OFFICE OF REFUGEE RESET-
2 TLEMENT.—Section 462(b)(1) of the Homeland Security
3 Act of 2002 (6 U.S.C. 279(b)(1)) is amended—

4 (1) in subparagraph (K), by striking “and” at
5 the end;

6 (2) in subparagraph (L), by striking the period
7 and inserting “; and”; and

8 (3) by adding at the end the following:

9 “(M) at the election of the Director, pro-
10 viding training, to providers responsible for the
11 care of the unaccompanied alien children, in the
12 best practices developed under section 101 of
13 the Trauma-Informed Care for Children and
14 Families Act of 2017.”.

15 (v) CHILD ABUSE PREVENTION AND TREATMENT.—

16 (1) NATIONAL CLEARINGHOUSE.—Section
17 103(b) of the Child Abuse Prevention and Treat-
18 ment Act (42 U.S.C. 5104) is amended—

19 (A) in paragraph (8), by striking “and” at
20 the end;

21 (B) in paragraph (9), by striking the pe-
22 riod and inserting “; and”; and

23 (C) by adding at the end the following:

24 “(10) disseminate information regarding the
25 best practices developed under section 101 of the

1 Trauma-Informed Care for Children and Families
2 Act of 2017 for individuals and officials described in
3 paragraph (8).”.

4 (2) RESEARCH AND ASSISTANCE ACTIVITIES.—
5 Section 104(b)(1) of that Act (42 U.S.C.
6 5105(b)(1)) is amended by adding at the end the
7 following: “Such assistance may include technical as-
8 sistance regarding the best practices developed
9 under section 101 of the Trauma-Informed Care for
10 Children and Families Act of 2017.”.

11 (3) TRAINING.—Section 105(a)(1) of that Act
12 (42 U.S.C. 5106(a)(1)) is amended—

13 (A) in subparagraph (L), by striking
14 “and” at the end;

15 (B) in subparagraph (M), by striking the
16 period and inserting “; and”; and

17 (C) by adding at the end the following:

18 “(D) for providing training in the best
19 practices developed under section 101 of the
20 Trauma-Informed Care for Children and Fami-
21 lies Act of 2017 to individuals and entities de-
22 scribed in this paragraph.”.

23 (4) STATE CHILD ABUSE OR NEGLECT PREVEN-
24 TION AND TREATMENT PROGRAMS.—Section 106(a)
25 of that Act (42 U.S.C. 5106a(a)) is amended—

1 (A) in paragraph (13), by striking “or” at
2 the end;

3 (B) in paragraph (14), by striking the pe-
4 riod and inserting “; or”; and

5 (C) by adding at the end the following:

6 “(15) providing training in the best practices
7 developed under section 101 of the Trauma-In-
8 formed Care for Children and Families Act of 2017
9 for employees of agencies or systems described in
10 paragraph (12), (13), or (14).”.

11 (5) COMMUNITY-BASED GRANTS FOR THE PRE-
12 VENTION OF CHILD ABUSE AND NEGLECT.—Section
13 205(b) of that Act (42 U.S.C. 5116e(b)) is amend-
14 ed—

15 (A) in paragraph (5), by striking “and” at
16 the end;

17 (B) in paragraph (6), by striking the pe-
18 riod and inserting “; and”; and

19 (C) by adding at the end the following:

20 “(7) provide training in the best practices devel-
21 oped under section 101 of the Trauma-Informed
22 Care for Children and Families Act of 2017 for pro-
23 viders of programs, activities, or services described
24 in this subsection.”.

1 (w) GRANTS FOR JUVENILE AND FAMILY COURT
2 PERSONNEL.—Section 222(1) of the Victims of Child
3 Abuse Act of 1990 (42 U.S.C. 13022(1)) is amended by
4 inserting “(which may include providing training, to the
5 entities that are providers of services to children and
6 youth, in the best practices developed under section 101
7 of the Trauma-Informed Care for Children and Families
8 Act of 2017)” after “technical assistance and training”.

9 (x) GRANTS TO SUPPORT FAMILIES IN THE JUSTICE
10 SYSTEM.—Section 1301(e) of the Victims of Trafficking
11 and Violence Protection Act of 2000 (42 U.S.C. 10420(e))
12 is amended by adding at the end the following:

13 “(3) BEST PRACTICES FOR TRAUMA-INFORMED
14 CARE FOR CHILDREN AND FAMILIES.—In making
15 grants under subsection (b), the Attorney General
16 shall take into account the extent to which the appli-
17 cant is using the best practices developed under sec-
18 tion 101 of the Trauma-Informed Care for Children
19 and Families Act of 2017.”.

20 **SEC. 202. ESTABLISHMENT OF LAW ENFORCEMENT CHILD**
21 **AND YOUTH TRAUMA COORDINATING CEN-**
22 **TER.**

23 (a) ESTABLISHMENT OF CENTER.—

24 (1) IN GENERAL.—The Attorney General shall
25 establish a National Law Enforcement Child and

1 Youth Trauma Coordinating Center (referred to in
2 this section as the “Center”) to provide assistance to
3 State, local, and tribal law enforcement agencies in
4 interacting with children and youth who have been
5 exposed to violence or other trauma, and their fami-
6 lies as appropriate.

7 (2) AGE RANGE.—The Center shall determine
8 the age range of children and youth to be covered
9 by the activities of the Center.

10 (b) DUTIES.—The Center shall provide assistance to
11 State, local, and tribal law enforcement agencies by—

12 (1) disseminating information on the best prac-
13 tices for law enforcement officers developed under
14 section 101, which may include best practices based
15 on evidence-based and evidence-informed models
16 from programs of the Department of Justice and the
17 Office of Justice Services of the Bureau of Indian
18 Affairs, such as—

19 (A) models developed in partnership with
20 national law enforcement organizations, Indian
21 tribes, or clinical researchers; and

22 (B) models that include—

23 (i) trauma-informed approaches to
24 conflict resolution, de-escalation, and crisis
25 intervention training;

1 (ii) early interventions that link child
2 and youth witnesses and victims, and their
3 families as appropriate, to appropriate
4 trauma-informed services; and

5 (iii) supporting officers who experi-
6 ence secondary trauma;

7 (2) providing professional training and technical
8 assistance; and

9 (3) awarding grants under subsection (c).

10 (c) GRANT PROGRAM.—

11 (1) IN GENERAL.—The Attorney General, act-
12 ing through the Center, may award grants to State,
13 local, and tribal law enforcement agencies or to
14 multi-disciplinary consortia to—

15 (A) enhance the awareness of best prac-
16 tices developed under section 101 for trauma-
17 informed responses to children and youth who
18 have been exposed to violence or other trauma,
19 and their families as appropriate; and

20 (B) provide professional training and tech-
21 nical assistance in implementing the best prac-
22 tices described in subparagraph (A).

23 (2) APPLICATION.—Any State, local, or tribal
24 law enforcement agency seeking a grant under this
25 subsection shall submit an application to the Attor-

1 ney General at such time, in such manner, and con-
2 taining such information as the Attorney General
3 may require.

4 (3) USE OF FUNDS.—A grant awarded under
5 this subsection may be used to—

6 (A) provide training to law enforcement of-
7 ficers on the best practices developed under sec-
8 tion 101, including how to identify early signs
9 of trauma and violence exposure when inter-
10 acting with children and youth; and

11 (B) establish, operate, and evaluate a re-
12 ferral and partnership program with trauma-in-
13 formed clinical mental health, substance use,
14 health care, or social service professionals in the
15 community in which the law enforcement agen-
16 cy serves.

17 (d) AUTHORIZATION OF APPROPRIATIONS.—There
18 are authorized to be appropriated to the Attorney Gen-
19 eral—

20 (1) \$15,000,000 for each of fiscal years 2018
21 through 2022 to award grants under subsection (c);
22 and

23 (2) \$2,000,000 for each of fiscal years 2018
24 through 2022 for other activities of the Center.

1 **SEC. 203. ESTABLISHMENT OF NATIVE AMERICAN TECH-**
2 **NICAL ASSISTANCE RESOURCE CENTER.**

3 (a) DEFINITIONS.—In this section:

4 (1) INDIAN TRIBE; TRIBAL ORGANIZATION.—
5 The terms “Indian tribe” and “tribal organization”
6 have the meanings given the terms in section 4 of
7 the Indian Self-Determination and Education Assist-
8 ance Act (25 U.S.C. 5304).

9 (2) INSTITUTION OF HIGHER EDUCATION.—The
10 term “institution of higher education” has the
11 meaning given the term in section 101 of the Higher
12 Education Act of 1965 (20 U.S.C. 1001).

13 (3) SECRETARY.—The term “Secretary” means
14 the Secretary of Health and Human Services, act-
15 ing—

16 (A) through the Assistant Secretary for
17 Mental Health and Substance Use; and

18 (B) after consultation with—

19 (i) the Director of the Bureau of In-
20 dian Education of the Department of the
21 Interior; and

22 (ii) the Director of the Indian Health
23 Service.

24 (b) ESTABLISHMENT OF CENTER.—The Secretary
25 shall establish and operate a Native American Technical

1 Assistance Resource Center (referred to in this section as
2 the “Center”) to provide assistance to Indian tribes.

3 (c) DUTIES.—The Center shall provide assistance to
4 the Indian tribes by—

5 (1) providing trauma-informed technical assist-
6 ance to tribal organizations in implementing the best
7 practices developed under section 101; and

8 (2) disseminating the best practices to the trib-
9 al organizations, to schools that serve students from
10 the Indian tribes, to health care entities that serve
11 the Indian tribes, to child welfare systems that serve
12 children and youth from the Indian tribes, to law en-
13 forcement agencies that serve the Indian tribes, to
14 criminal justice and court systems that serve the In-
15 dian tribes, and other relevant entities.

16 (d) GRANT PROGRAM.—

17 (1) IN GENERAL.—The Secretary may award
18 grants to nonprofit organizations or institutions of
19 higher education, to operate the Center.

20 (2) APPLICATION.—An organization or institu-
21 tion seeking a grant under this subsection shall sub-
22 mit an application to the Secretary at such time, in
23 such manner, and containing such information as
24 the Secretary may require.

1 (e) AUTHORIZATION OF APPROPRIATIONS.—There is
2 authorized to be appropriated to the Secretary, to carry
3 out this section, \$2,000,000 for each of fiscal years 2018
4 through 2021.

5 **SEC. 204. GRANTS TO IMPROVE TRAUMA SUPPORT SERV-**
6 **ICES AND MENTAL HEALTH CARE FOR CHIL-**
7 **DREN AND YOUTH IN EDUCATIONAL SET-**
8 **TINGS.**

9 Part A of title IV of the Elementary and Secondary
10 Education Act of 1965 (20 U.S.C. 7101 et seq.) is amend-
11 ed by adding at the end the following:

12 **“Subpart 3—Grants To Improve Trauma Support**
13 **Services and Mental Health Care for Children**
14 **and Youth in Educational Settings**

15 **“SEC. 4131. GRANTS TO IMPROVE TRAUMA SUPPORT SERV-**
16 **ICES AND MENTAL HEALTH CARE FOR CHIL-**
17 **DREN AND YOUTH IN EDUCATIONAL SET-**
18 **TINGS.**

19 “(a) GRANTS, CONTRACTS, AND COOPERATIVE
20 AGREEMENTS AUTHORIZED.—The Secretary is authorized
21 to award grants to, or enter into contracts or cooperative
22 agreements with, State educational agencies, local edu-
23 cational agencies, Indian tribes or their tribal educational
24 agencies, a school operated by the Bureau of Indian Edu-
25 cation, or a Regional Corporation (as defined in section

1 3 of the Alaska Native Claims Settlement Act (43 U.S.C.
2 1602)) for the purpose of increasing student access to
3 quality trauma support services and mental health care
4 by developing innovative programs to link local school sys-
5 tems with local trauma-informed support and mental
6 health systems, including those under the Indian Health
7 Service.

8 “(b) DURATION.—With respect to a grant, contract,
9 or cooperative agreement awarded or entered into under
10 this section, the period during which payments under such
11 grant, contract or agreement are made to the recipient
12 may not exceed 5 years.

13 “(c) USE OF FUNDS.—An entity that receives a
14 grant, contract, or cooperative agreement under this sec-
15 tion shall use amounts made available through such grant,
16 contract, or cooperative agreement for any of the fol-
17 lowing:

18 “(1) To enhance, improve, or develop collabo-
19 rative efforts between school-based service systems
20 and trauma-informed support and mental health
21 service systems to provide, enhance, or improve pre-
22 vention, screening, referral, and treatment services
23 to students.

24 “(2) To enhance the availability of trauma sup-
25 port services and school-based counseling programs,

1 and provide appropriate referrals and interventions
2 for students potentially in need of mental health
3 services.

4 “(3) To provide universal trauma screenings to
5 identify students in need of specialized support.

6 “(4) To implement multi-tiered positive behav-
7 ioral interventions and supports, or other trauma-in-
8 formed models of support.

9 “(5) To provide training to teachers, teacher
10 assistants, specialized instructional support per-
11 sonnel, and mental health professionals to—

12 “(A) develop safe, stable, and nurturing
13 learning environments that prevent and miti-
14 gate the effects of trauma, including through
15 social and emotional learning; or

16 “(B) improve school capacity to identify,
17 refer, and provide services, as appropriate, to
18 students in need of trauma support or behav-
19 ioral health services.

20 “(6) To provide technical assistance and con-
21 sultation to school systems and mental health agen-
22 cies as well as to families participating in the pro-
23 gram carried out under this section.

24 “(7) To provide linguistically appropriate and
25 culturally competent services.

1 “(8) To evaluate the effectiveness of the pro-
2 gram carried out under this section in increasing
3 student access to quality trauma support services
4 and mental health care, and make recommendations
5 to the Secretary about the sustainability of the pro-
6 gram.

7 “(9) To engage and utilize expertise provided
8 by institutions of higher education, such as a Tribal
9 College or University, as defined in section 316(b) of
10 the Higher Education Act of 1965.

11 “(10) To provide trainings and implement pro-
12 cedures pursuant to the relevant best practices de-
13 veloped under section 101 of the Trauma-Informed
14 Care for Children and Families Act of 2017.

15 “(d) APPLICATIONS.—To be eligible to receive a
16 grant, contract, or cooperative agreement under this sec-
17 tion, an entity described in subsection (a) shall submit an
18 application to the Secretary at such time, in such manner,
19 and containing such information as the Secretary may rea-
20 sonably require, such as the following:

21 “(1) A description of the program to be funded
22 under the grant, contract, or cooperative agreement.

23 “(2) A description of how such program will in-
24 crease access to quality trauma support services and
25 mental health care for students.

1 “(3) A description of how the applicant will es-
2 tablish trauma support services or a school-based
3 counseling program, or both, that provide immediate
4 prevention and mental health services to the school
5 community as necessary.

6 “(4) An assurance that—

7 “(A) persons providing services under the
8 grant, contract, or cooperative agreement are
9 adequately trained to provide such services;

10 “(B) the services will be provided in ac-
11 cordance with subsection (c);

12 “(C) teachers, administrators, specialized
13 instructional support personnel, parents or
14 guardians, representatives of local Indian tribes,
15 and other school personnel are aware of the
16 program; and

17 “(D) parents or guardians of students par-
18 ticipating in services under this section will be
19 engaged and involved in the design and imple-
20 mentation of the services.

21 “(5) An assurance that the applicant will sup-
22 port and integrate existing school-based services
23 with the program in order to provide appropriate
24 mental health services for students.

1 “(6) An assurance that the applicant will estab-
2 lish a program that will support students and the
3 school in improving the school climate in order to
4 support an environment conducive to learning.

5 “(e) INTERAGENCY AGREEMENTS.—

6 “(1) DESIGNATION OF LEAD AGENCY.—A re-
7 cipient of a grant, contract, or cooperative agree-
8 ment under this section shall designate a lead agen-
9 cy to direct the establishment of an interagency
10 agreement among local educational agencies, juvenile
11 justice authorities, mental health agencies, and other
12 relevant entities in the State, in collaboration with
13 local entities, such as Indian tribes.

14 “(2) CONTENTS.—The interagency agreement
15 shall ensure the provision of the services described
16 in subsection (c), specifying with respect to each
17 agency, authority, or entity—

18 “(A) the financial responsibility for the
19 services;

20 “(B) the conditions and terms of responsi-
21 bility for the services, including quality, ac-
22 countability, and coordination of the services;
23 and

24 “(C) the conditions and terms of reim-
25 bursement among the agencies, authorities, or

1 entities that are parties to the interagency
2 agreement, including procedures for dispute
3 resolution.

4 “(f) EVALUATION.—The Secretary shall evaluate
5 each program carried out under this section and shall dis-
6 seminate the findings with respect to each such evaluation
7 to appropriate public, tribal, and private entities.

8 “(g) DISTRIBUTION OF AWARDS.—The Secretary
9 may ensure that grants, contracts, and cooperative agree-
10 ments awarded or entered into under this section are equi-
11 tably distributed among the geographical regions of the
12 United States and among tribal, urban, suburban, and
13 rural populations.

14 “(h) RULE OF CONSTRUCTION.—Nothing in this sec-
15 tion shall be construed—

16 “(1) to prohibit an entity involved with a pro-
17 gram carried out under this section from reporting
18 a crime that is committed by a student to appro-
19 priate authorities; or

20 “(2) to prevent State and tribal law enforce-
21 ment and judicial authorities from exercising their
22 responsibilities with regard to the application of
23 Federal, tribal, and State law to crimes committed
24 by a student.

1 “(i) SUPPLEMENT, NOT SUPPLANT.—Any services
2 provided through programs carried out under this section
3 shall supplement, and not supplant, existing mental health
4 services, including any services required to be provided
5 under the Individuals with Disabilities Education Act.

6 “(j) CONSULTATION WITH INDIAN TRIBES.—In car-
7 rying out subsection (a), the Secretary shall, in a timely
8 manner, meaningfully consult, engage, and cooperate with
9 Indian tribes and their representatives to ensure notice of
10 eligibility.

11 “(k) AUTHORIZATION OF APPROPRIATIONS.—There
12 is authorized to be appropriated to carry out this section
13 \$6,000,000 for the period of fiscal years 2018 through
14 2023.”.

15 **TITLE III—UNDERSTANDING**
16 **THE SCOPE OF TRAUMA EX-**
17 **POSURE**

18 **SEC. 301. CDC SURVEILLANCE AND DATA COLLECTION FOR**
19 **CHILD, YOUTH, AND ADULT TRAUMA.**

20 (a) DATA COLLECTION.—The Director of the Centers
21 for Disease Control and Prevention (referred to in this
22 section as the “Director”) shall authorize and encourage
23 States to collect and report data on adverse childhood ex-
24 periences through the Behavioral Risk Factor Surveillance
25 System and the Youth Risk Behavior Surveillance System.

1 In collecting and reporting such data, States shall use the
2 appropriate modules developed under section 302(2)(B),
3 in addition to other appropriate modules.

4 (b) TIMING.—The collection of data authorized under
5 subsection (a) may occur in fiscal year 2019 and every
6 2 years thereafter.

7 (c) DATA FROM TRIBAL AND RURAL AREAS.—The
8 Director shall require that each State, in collecting data
9 in accordance with subsection (a), ensure that, as appro-
10 priate, data from tribal and rural areas within such State
11 is included by oversampling from such areas.

12 (d) AUTHORIZATION OF APPROPRIATIONS.—To carry
13 out this section, there are authorized to be appropriated
14 \$64,000,000 for the period of fiscal years 2019 through
15 2021.

16 **SEC. 302. CDC ANALYSIS OF CHILD, YOUTH, AND ADULT**
17 **TRAUMA.**

18 The Secretary of Health and Human Services, acting
19 through the Director of the Centers for Disease Control
20 and Prevention, shall—

21 (1) conduct an analysis of—

22 (A) the prevalence of child, youth, and
23 adult trauma experienced in the United States,
24 including assessments of the types of the most
25 prominent adverse childhood experiences, and

1 disparities by race and ethnicity, by geographic
2 distribution, and by socioeconomic status;

3 (B) the public health impact of adverse
4 childhood experiences, including the correlation
5 of such experiences with trends in life expect-
6 ancy and whether the scope of such experiences
7 constitutes a public health epidemic;

8 (C) modules that measure and assess ad-
9 verse childhood experiences, for development
10 and ultimate inclusion in the Youth Risk Be-
11 havior Surveillance System; and

12 (D) outcomes modules that measure and
13 evaluate the utilization and efficacy of trauma-
14 informed interventions, such as mental health
15 services or other clinical or sub-clinical care, for
16 ultimate inclusion in the Youth Risk Behavior
17 Surveillance System and the Behavioral Risk
18 Factor Surveillance System; and

19 (2) not later than 1 year after the date of en-
20 actment of this Act, submit to Congress a report on
21 the analysis under paragraph (1) that includes rec-
22 ommendations on—

23 (A) what communities can do to mitigate
24 the impact of adverse childhood experiences and
25 how Indian tribes, social service providers, law

1 enforcement, health care practitioners, public
2 health agencies, educational institutions, and
3 other community stakeholders may collaborate
4 to improve efforts to identify, connect to appro-
5 priate services, and provide treatment and sup-
6 port for children and youth, and their families
7 as appropriate, who have experienced or are at
8 risk of experiencing trauma;

9 (B) modules for inclusion in the appro-
10 priate surveillance systems, as described in sub-
11 paragraphs (C) and (D) of paragraph (1); and

12 (C) how the Centers for Disease Control
13 and Prevention can utilize data collected
14 through surveillance systems to target specific
15 populations or geographic locations with a high
16 incidence of measured Adverse Childhood Expe-
17 riences, including by considering such data
18 when awarding grants and contracts to entities
19 serving such populations or locations.

20 **SEC. 303. GOVERNMENT ACCOUNTABILITY STUDY ON BAR-**
21 **RIERS TO AND OPPORTUNITIES FOR TRAU-**
22 **MA-INFORMED IDENTIFICATION AND TREAT-**
23 **MENT.**

24 (a) STUDY.—

1 (1) IN GENERAL.—The Comptroller General
2 shall conduct a study of the barriers to, and the op-
3 portunities for increasing, the early identification
4 and treatment of children and youth, and their fami-
5 lies as appropriate, who have experienced or are at
6 risk of experiencing trauma.

7 (2) CONTENTS.—In conducting the study, the
8 Comptroller General shall examine—

9 (A) ways in which such identification and
10 treatment could be facilitated in early childhood
11 education and care settings and elementary and
12 secondary schools, such as through improved
13 teacher preparation, professional development,
14 and curriculum design, and the development of
15 the cognitive and social-emotional skills of stu-
16 dents;

17 (B)(i) the extent to which State Medicaid
18 plans use early and periodic screening, diag-
19 nostic, and treatment services (as defined in
20 section 1905(r) of the Social Security Act (42
21 U.S.C. 1396d(r)) that are provided in accord-
22 ance with the requirements of section
23 1902(a)(43) of such Act (42 U.S.C.
24 1396a(a)(43))) to provide trauma-informed
25 services to children and youth, and their fami-

1 lies as appropriate, who have experienced or are
2 at risk of experiencing trauma;

3 (ii) barriers to increased utilization of such
4 screening, diagnostic, and treatment services;
5 and

6 (iii) the impact of State Medicaid plan de-
7 sign and State regulatory decisions on the pro-
8 vision of such services;

9 (C) the feasibility of, State experiences
10 with, and considerations regarding, systematic
11 collection and sharing of data that—

12 (i) is carried out by health care pro-
13 viders, State, local, and tribal educational
14 agencies, social service providers, law en-
15 forcement, and any other entity providing
16 services in a covered setting (as defined in
17 section 101(f));

18 (ii) relies on common data measures,
19 fosters communication and coordination
20 across covered settings (as so defined), and
21 promotes shared accountability for the
22 data; and

23 (iii) relates to the screening, referral,
24 and support of children and youth, and
25 their families as appropriate, who have ex-

1 perienced or are at risk of experiencing
2 trauma;

3 (D) privacy and consent issues affecting
4 identification and treatment of children and
5 youth who have experienced or are at risk of ex-
6 periencing trauma, including considerations re-
7 garding information collected and reported by
8 providers and regarding parental consent;

9 (E)(i) the comprehensive, coordinated, and
10 multisector process through which State, local,
11 and tribal educational agencies locate, identify,
12 and screen infants and toddlers with disabil-
13 ities, and children with disabilities (including
14 such children who are youth), under the Indi-
15 viduals with Disabilities Education Act (20
16 U.S.C. 1400 et seq.); and

17 (ii) considerations, strategies, alignment
18 opportunities, and applicability for trauma-in-
19 formed models for conducting such location,
20 identification, and screening;

21 (F)(i) clinical child and adolescent mental
22 health and child- and youth-serving social serv-
23 ice workforce capacity, including analyzing that
24 capacity by setting, geographic distribution, and
25 population served; and

1 (ii) barriers that contribute to any short-
2 ages in professionals in that workforce; and

3 (G) the cost-effectiveness and success of
4 providing services through school-based health
5 centers as a method of—

6 (i) addressing the needs of students
7 who have experienced or are at risk of ex-
8 perencing trauma; and

9 (ii) improving their academic achieve-
10 ment.

11 (b) REPORT.—The Comptroller General shall submit
12 a report containing the results of the study to—

13 (1) the Committee on Appropriations, the Com-
14 mittee on Health, Education, Labor, and Pensions,
15 the Committee on Finance, the Committee on Indian
16 Affairs, and the Committee on the Judiciary of the
17 Senate; and

18 (2) the Committee on Appropriations, the Com-
19 mittee on Energy and Commerce, the Committee on
20 Education and the Workforce, the Committee on
21 Ways and Means, the Committee on Natural Re-
22 sources, and the Committee on the Judiciary of the
23 House of Representatives.

24 (c) DEFINITIONS.—In this section:

1 (1) CHILD WITH A DISABILITY.—The term
2 “child with a disability” has the meaning given the
3 term in section 602 of the Individuals with Disabil-
4 ities Education Act (20 U.S.C. 1401).

5 (2) INFANT OR TODDLER WITH A DIS-
6 ABILITY.—The term “infant or toddler with a dis-
7 ability” has the meaning given the term in section
8 632 of the Individuals with Disabilities Education
9 Act (20 U.S.C. 1432).

10 **SEC. 304. NIH REPORT ON TRAUMA.**

11 The Director of the National Institutes of Health, not
12 later than 1 year after the date of enactment of this Act,
13 shall submit to Congress a report on the activities of the
14 National Institutes of Health with respect to trauma (in-
15 cluding trauma that stems from child abuse, exposure to
16 violence, and toxic stress) and the implications of trauma
17 for children, youth, and adults. Such report shall in-
18 clude—

19 (1) the comprehensive research agenda of the
20 National Institutes of Health with respect to trau-
21 ma;

22 (2) the capacity, expertise, and review mecha-
23 nisms of the National Institutes of Health with re-
24 spect to the evaluation and examination of research

1 proposals related to child trauma, including coordi-
2 nation across institutes and centers;

3 (3) the relevance of trauma to other diseases,
4 outcomes, and domains;

5 (4) strategies to link and analyze data from
6 multiple independent sources, including child wel-
7 fare, health care (including mental health care), law
8 enforcement, and education systems, to enhance re-
9 search efforts and improve health outcomes;

10 (5) the efficacy of existing interventions, includ-
11 ing clinical treatment methods, child- and family-fo-
12 cused prevention models, and community-based ap-
13 proaches, in mitigating the effects of experiencing
14 trauma and improving health and societal outcomes;
15 and

16 (6) identification of gaps in understanding in
17 the field of trauma and areas of greatest need for
18 further research related to trauma.

1 **TITLE IV—EVALUATION OF NEW**
2 **INTERVENTIONS AND IM-**
3 **PROVING SERVICE DELIVERY**

4 **SEC. 401. CLARIFICATION OF DEFINITION OF MEDICAID**
5 **EPSDT SERVICES; DEMONSTRATION**
6 **PROJECT TO TEST TRAUMA-INFORMED DE-**
7 **LIVERY OF EPSDT SERVICES.**

8 (a) CLARIFICATION OF DEFINITION OF EPSDT
9 SERVICES.—Section 1905(r) of the Social Security Act
10 (42 U.S.C. 1396d(r)) is amended—

11 (1) in paragraph (1)—

12 (A) in subparagraph (A)(ii), by inserting
13 “(including in the immediate aftermath of expo-
14 sure to a traumatic event)” after “medically
15 necessary”; and

16 (B) in subparagraph (B)(i), by inserting
17 “and any past exposure to traumatic events”
18 after “health development”; and

19 (2) in paragraph (5), by inserting “including
20 any defects, illnesses, and conditions (including
21 symptoms of a possible mental health disorder that
22 are not sufficiently acute for a diagnosis of a clinical
23 mental health disorder) stemming from exposure to
24 traumatic events,” after “screening services,”.

1 (b) TRAUMA-INFORMED DELIVERY OF EPSDT
2 SERVICES DEMONSTRATION PROJECT.—

3 (1) IN GENERAL.—The Secretary shall make
4 grants to States to conduct demonstration projects
5 under title XIX of the Social Security Act (42
6 U.S.C. 1396 et seq.) to test innovative, trauma-in-
7 formed approaches for delivering early and periodic
8 screening, diagnostic, and treatment services (as de-
9 fined in section 1905(r) of the Social Security Act
10 (42 U.S.C. 1396d(r))) to eligible children.

11 (2) SCOPE AND DURATION.—

12 (A) SCOPE.—The Secretary shall select 10
13 States to participate in the demonstration
14 project.

15 (B) SELECTION.—

16 (i) DIVERSITY.—In selecting States to
17 participate in the demonstration project,
18 the Secretary shall—

19 (I) ensure that geographically di-
20 verse areas, including rural and un-
21 derserved areas, are included; and

22 (II) include at least 2 States in
23 which Indian tribes or tribal organiza-
24 tions (as defined in section 4 of the

1 Indian Health Care Improvement Act
2 (25 U.S.C. 1603)) are located.

3 (ii) PRIORITY.—In selecting States to
4 participate in the demonstration project,
5 the Secretary shall give priority to States
6 that—

7 (I) use a value-based payment
8 methodology for paying providers for
9 services provided under the State
10 Medicaid program, including services
11 related to healthy child development;

12 (II) use an alternative payment
13 model under the State Medicaid pro-
14 gram that enables cross-sector col-
15 laboration, provision of trauma-in-
16 formed services, and supports for
17 healthy child development; or

18 (III) integrate information tech-
19 nology between child- and youth-serv-
20 ing sectors to improve coordination
21 and outcomes.

22 (C) DURATION.—The demonstration
23 project shall begin not later than 1 year after
24 the date of the enactment of this Act, and shall
25 be conducted for a period of 4 years.

1 (3) REQUIREMENTS.—To be eligible for a grant
2 under this subsection, a State that is participating
3 in the demonstration project shall demonstrate that
4 it has implemented the following measures with re-
5 spect to the State Medicaid program:

6 (A) The State Medicaid program allows for
7 the provision of early and periodic screening, di-
8 agnostic, and treatment services—

9 (i) in a diverse set of settings, includ-
10 ing schools, hospitals, primary care set-
11 tings, Federally-qualified health centers (as
12 defined in section 1905(l)(2)(B) of the So-
13 cial Security Act (42 U.S.C.
14 1396d(l)(2)(B))), and tribally-operated
15 health facilities, without undue restrictions
16 on the settings in which providers are per-
17 mitted to furnish such services; and

18 (ii) by the full scope of providers that
19 are licensed or otherwise authorized under
20 State law to provide the services, including
21 trained peers through eligible peer support
22 services, community health workers, or
23 subclinical case managers.

24 (B) Where necessary to improve or pro-
25 mote the health of an eligible child, the State

1 Medicaid program provides for payment for
2 services provided to the parent of the child.

3 (C) The State Medicaid program has pro-
4 cedures in place to coordinate across settings,
5 which may include coordinating with law en-
6 forcement, juvenile justice agencies, schools (in-
7 cluding preschools and after-school programs),
8 hospitals, primary care providers, tribally-oper-
9 ated health facilities, mental health and sub-
10 stance use treatment facilities, and child welfare
11 providers, to ensure that eligible children who
12 experience trauma receive the appropriate serv-
13 ices.

14 (D) Where appropriate, the State Medicaid
15 program coordinates with facilities of the In-
16 dian Health Service (including a hospital, nurs-
17 ing facility, or any other type of facility which
18 provides services of a type otherwise covered
19 under the program) and other tribally-operated
20 health facilities to ensure eligible children have
21 access to adequate qualified providers that are
22 licensed or otherwise authorized under State
23 law to furnish the services.

24 (4) FUNDING.—Out of any funds in the Treas-
25 ury not otherwise appropriated, there is appro-

1 priated \$75,000,000 for the period of fiscal years
2 2017 through 2021 to carry out this subsection.

3 (5) DEFINITIONS.—In this subsection:

4 (A) DEMONSTRATION PROJECT.—The term
5 “demonstration project” means the demonstra-
6 tion project established under this subsection.

7 (B) ELIGIBLE CHILD.—The term “eligible
8 child” means an individual who is under age 21
9 and who is enrolled in a State plan under title
10 XIX of the Social Security Act (42 U.S.C. 1396
11 et seq.).

12 (C) SECRETARY.—The term “Secretary”
13 means the Secretary of Health and Human
14 Services.

15 (D) STATE MEDICAID PROGRAM.—The
16 term “State Medicaid program” means a State
17 plan or waiver under title XIX of the Social Se-
18 curity Act (42 U.S.C. 1396 et seq.).

19 **SEC. 402. HEALTH PROFESSIONAL SHORTAGE AREAS.**

20 Section 332(a) of the Public Health Service Act (42
21 U.S.C. 254e(a)) is amended—

22 (1) in paragraph (2)(A), by inserting “(includ-
23 ing a community health center operated in an ele-
24 mentary or secondary school)” after “community
25 health center”; and

1 (2) in paragraph (3)—

2 (A) by striking “, and residents” and in-
3 serting “, residents”; and

4 (B) by inserting “, and a population group
5 that the Secretary determines has experienced
6 trauma (such as through acute or long-term ex-
7 posure to substantial discrimination, historical
8 or cultural oppression, intergenerational pov-
9 erty, civil unrest, a high rate of violence, or a
10 high rate of drug overdose mortality)” before
11 “may be”.

12 **SEC. 403. TRAINING AND CERTIFICATION GUIDELINES FOR**
13 **COMMUNITY FIGURES.**

14 The Secretary of Health and Human Services, acting
15 through the Administrator of the Agency for Healthcare
16 Research and Quality, shall conduct a study on, and estab-
17 lish guidelines for States to consider with respect to, the
18 training and certification of community figures, including
19 community mentors, peers with lived experiences, and
20 faith-based leaders, to build awareness of trauma and pro-
21 mote linkages to community services, provide case man-
22 agement services, and conduct appropriate trauma-in-
23 formed screening for individuals who have experienced or
24 are at risk of experiencing trauma. Such training and cer-
25 tification guidelines shall include recommendations for ex-

1 perience, education, and supervision requirements for, and
2 partnerships between, such trained and certified commu-
3 nity figures and other health care providers such that the
4 trained and certified community figures may be reim-
5 bursed through the State Medicaid plan under title XIX
6 of the Social Security Act (42 U.S.C. 1396 et seq.) for
7 furnishing services to individuals enrolled in such plan.

8 **SEC. 404. TRAINING FOR HEALTH CARE WORKFORCE.**

9 (a) **MENTAL AND BEHAVIORAL HEALTH EDUCATION**
10 **AND TRAINING PROGRAM.**—Section 756 of the Public
11 Health Service Act (42 U.S.C. 294e–1) is amended—

12 (1) in subsection (a)—

13 (A) in paragraph (1), by inserting “, trau-
14 ma,” after “focus on child and adolescent men-
15 tal health”; and

16 (B) in paragraphs (2) and (3), by inserting
17 “trauma-informed care and” before “substance
18 use disorder prevention and treatment serv-
19 ices”; and

20 (2) in subsection (d)—

21 (A) in paragraph (1), by striking “and” at
22 the end;

23 (B) in paragraph (2), by striking the pe-
24 riod and inserting “; and”; and

25 (C) by adding at the end the following:

1 “(3) programs with academic study and com-
2 munity practice related to trauma, its impact on
3 mental and behavioral health outcomes, and appro-
4 priate interventions, which may include best prac-
5 tices developed under section 101 of the Trauma-In-
6 formed Care for Children and Families Act of
7 2017.”.

8 (b) TRAINING DEMONSTRATION PROGRAM.—Section
9 760 of such Act (42 U.S.C. 294k) is amended—

10 (1) in subsection (a)—

11 (A) in paragraphs (1) and (2), by inserting
12 “trauma-informed” after “integrate”; and

13 (B) in paragraph (3)(A), by inserting “,
14 and recognize and address the impacts of expe-
15 riencing trauma on children, youth, and fami-
16 lies” before the semicolon;

17 (2) in subsection (b)—

18 (A) in paragraph (1)(A)—

19 (i) in clause (i)(II), by inserting
20 “trauma-informed” after “integrated”; and

21 (ii) in clause (ii)(III), by inserting
22 “trauma-informed” before “treatment”;

23 and

24 (B) in paragraph (2)(A), by inserting
25 “trauma-informed” after “integrate”;

1 (3) in subsection (c)(1)(B), by inserting “trau-
2 ma-informed” after “integrate”; and

3 (4) in subsection (d)—

4 (A) in paragraph (1)—

5 (i) in subparagraph (C), by striking
6 “or” at the end;

7 (ii) in subparagraph (D), by striking
8 the period and inserting “; or”; and

9 (iii) by adding at the end the fol-
10 lowing:

11 “(E) provide training with academic study
12 and community practice related to trauma, its
13 impact on mental health outcomes, and appro-
14 priate interventions, which may include best
15 practices developed under section 101 of the
16 Trauma-Informed Care for Children and Fami-
17 lies Act of 2017.”; and

18 (B) in paragraph (2)—

19 (i) in subparagraph (D), by striking
20 “or” at the end;

21 (ii) in subparagraph (E), by striking
22 the period and inserting “; or”; and

23 (iii) by adding at the end the fol-
24 lowing:

1 “(F) provide training with academic study
2 and community practice related to trauma, its
3 impact on mental health outcomes, and appro-
4 priate interventions, which may include best
5 practices developed under section 101 of the
6 Trauma-Informed Care for Children and Fami-
7 lies Act of 2017.”.

8 **SEC. 405. TRAUMA-RELATED COORDINATING BODIES.**

9 Part G of title V of the Public Health Service Act
10 (42 U.S.C. 290hh et seq.) is amended by adding at the
11 end the following:

12 **“SEC. 583. TRAUMA-RELATED COORDINATING BODIES.**

13 “(a) GRANTS.—

14 “(1) IN GENERAL.—The Secretary, acting
15 through the Administrator, shall make not more
16 than 20 grants for demonstration projects to State,
17 local, or tribal eligible entities to act as trauma-re-
18 lated coordinating bodies.

19 “(2) AMOUNT.—The Secretary shall make such
20 a grant in an amount of not more than \$4,000,000.

21 “(3) DURATION.—The Secretary shall make
22 such a grant for a period of 4 years.

23 “(b) ELIGIBLE ENTITIES.—

24 “(1) IN GENERAL.—To be eligible to receive a
25 grant under this section, an entity shall include 1 or

1 more representatives of each of the categories de-
2 scribed in paragraph (2).

3 “(2) COMPOSITION.—The categories referred to
4 in paragraph (1) are—

5 “(A) agencies, such as public health or
6 child welfare agencies, that provide services to
7 prevent the impact of trauma among, identify,
8 refer for services, or support (including pro-
9 viding treatment for) children and youth, and
10 their families as appropriate, that have experi-
11 enced or are at risk of experiencing trauma;

12 “(B) faculty at an institution of higher
13 education, or researchers or experts, in an area
14 related to prevention of the impact of, identi-
15 fication of, referral for services for, or support
16 (including treatment) for child and youth trau-
17 ma;

18 “(C) hospitals or other health care institu-
19 tions, such as mental health and substance use
20 treatment facilities;

21 “(D) law enforcement;

22 “(E) elementary or secondary schools, or
23 early childhood education or care programs;

24 “(F) community-based faith, human serv-
25 ices, or social services organizations, including

1 providers of after-school programs, home vis-
2 iting programs, or programs to prevent or ad-
3 dress the impact of violence; and

4 “(G) the general public, including individ-
5 uals who have experienced trauma.

6 “(3) QUALIFICATIONS.—In order for an entity
7 to be eligible to receive the grant, the representatives
8 included in the entity shall, collectively, have profes-
9 sional training and expertise concerning a broad
10 range of adverse childhood experiences.

11 “(c) APPLICATION.—To be eligible to receive a grant
12 under this section, an entity shall submit an application
13 to the Secretary at such time, in such manner, and con-
14 taining such information as the Secretary may require, in-
15 cluding information describing how the coordinating body
16 will continue its activities after the end of the grant pe-
17 riod.

18 “(d) PRIORITY.—In making grants under this sec-
19 tion, the Secretary shall give priority to entities proposing
20 to serve communities that have faced trauma due to sub-
21 stantial discrimination, historical or cultural oppression,
22 intergenerational poverty, civil unrest, a high rate of vio-
23 lence, or a high rate of drug overdose mortality.

1 “(e) USE OF FUNDS.—An entity that receives a grant
2 under this section to act as a coordinating body shall use
3 the grant funds—

4 “(1) to bring together stakeholders who provide
5 or use services in, or have expertise concerning, cov-
6 ered settings to identify community needs and re-
7 sources related to services to prevent or address the
8 impact of trauma, and to build on any needs assess-
9 ments conducted by organizations or groups rep-
10 resented on the coordinating body;

11 “(2)(A) to collect data, on indicators specified
12 by the Secretary, that covers multiple covered set-
13 tings; and

14 “(B) to use the data to identify unique commu-
15 nity challenges, gaps in services, and high-need
16 areas, related to services to prevent or address the
17 impact of trauma;

18 “(3) to build awareness, skills, and leadership
19 (including through trauma-informed training and
20 public outreach campaigns) related to implementing
21 the best practices developed under section 101 of the
22 Trauma-Informed Care for Children and Families
23 Act of 2017 (referred to in this subsection as the
24 ‘developed best practices’);

1 “(4) to pool resources of the members of the or-
2 ganizations and groups represented on the coordi-
3 nating body, related to implementing the developed
4 best practices; and

5 “(5) to develop a strategic plan that identi-
6 fies—

7 “(A) barriers to and gaps in the provision
8 of services to prevent or address the impact of
9 trauma; and

10 “(B) policy goals and coordination oppor-
11 tunities (including coordination in applying for
12 grants) relating to implementing the developed
13 best practices.

14 “(f) SUPPLEMENT NOT SUPPLANT.—Amounts made
15 available under this section shall be used to supplement
16 and not supplant other Federal, State, and local public
17 funds and private funds expended to provide trauma-re-
18 lated coordination activities.

19 “(g) EVALUATION.—At the end of the period for
20 which grants are made under this section, the Secretary
21 shall conduct an evaluation of the activities carried out
22 under each grant under this section. In conducting the
23 evaluation, the Secretary shall assess the outcomes of the
24 grant activities carried out by each grant recipient.

1 “(h) AUTHORIZATION OF APPROPRIATIONS.—There
2 is authorized to be appropriated to carry out this section
3 \$80,000,000 for the period of fiscal years 2018 through
4 2021.

5 “(i) DEFINITION.—In this section, the term ‘covered
6 setting’ has the meaning given the term in section 101(f)
7 of the Trauma-Informed Care for Children and Families
8 Act of 2017.”.

9 **SEC. 406. EXPANSION OF PERFORMANCE PARTNERSHIP**
10 **PILOT FOR CHILDREN WHO HAVE EXPERI-**
11 **ENCED OR ARE AT RISK OF EXPERIENCING**
12 **TRAUMA.**

13 Section 526 of the Departments of Labor, Health and
14 Human Services, and Education, and Related Agencies
15 Appropriations Act, 2014 (42 U.S.C. 12301 note) is
16 amended—

17 (1) in subsection (a), by adding at the end the
18 following:

19 “(4) ‘To improve outcomes for children and
20 youth, and their families as appropriate, who have
21 experienced or are at risk of experiencing trauma’
22 means to increase the rate at which individuals who
23 have experienced or are at risk of experiencing trau-
24 ma, including those who are low-income, homeless,
25 in foster care, involved in the juvenile justice system,

1 unemployed, or not enrolled in or at risk of dropping
2 out of an educational institution and live in a com-
3 munity that has faced acute or long-term exposure
4 to substantial discrimination, historical oppression,
5 intergenerational poverty, civil unrest, or a high rate
6 of violence, achieve success in meeting educational,
7 employment, health, developmental, community re-
8 entry, or other key goals.”;

9 (2) in subsection (b)—

10 (A) in the subsection heading, by striking
11 “FISCAL YEAR 2014” and inserting “FISCAL
12 YEARS 2018 THROUGH 2022”;

13 (B) by redesignating paragraphs (1) and
14 (2) as subparagraphs (A) and (B), respectively,
15 and by moving such subparagraphs, as so re-
16 designated, 2 ems to the right;

17 (C) by striking “Federal agencies” and in-
18 serting the following:

19 “(1) DISCONNECTED YOUTH PILOTS.—Federal
20 agencies”; and

21 (D) by adding at the end the following:

22 “(2) TRAUMA-INFORMED CARE PILOTS.—Fed-
23 eral agencies may use Federal discretionary funds
24 that are made available in this Act or any Act ap-
25 propriating funds for any of fiscal years 2018

1 through 2022 to carry out up to 10 Performance
2 Partnership Pilots. Such Pilots shall—

3 “(A) be designed to improve outcomes for
4 children and youth, and their families as appro-
5 priate, who have experienced or are at risk of
6 experiencing trauma; and

7 “(B) involve Federal programs targeted on
8 children and youth, and their families as appro-
9 priate, who have experienced or are at risk of
10 experiencing trauma.”;

11 (3) in subsection (c)(2)(A), by striking “2018”
12 and inserting “2022”; and

13 (4) in subsection (e), by striking “2018” and
14 inserting “2022”.

15 **SEC. 407. TRAUMA-INFORMED TEACHING.**

16 (a) PARTNERSHIP GRANTS.—Section 202 of the
17 Higher Education Act of 1965 (20 U.S.C. 1022a) is
18 amended—

19 (1) in subsection (b)(6)—

20 (A) by redesignating subparagraphs (H)
21 through (K) as subparagraphs (I) through (L),
22 respectively; and

23 (B) by inserting after subparagraph (G)
24 the following:

1 “(H) how the partnership will prepare gen-
2 eral education and special education teachers to
3 work with students who have experienced trau-
4 ma (including students who are involved in the
5 foster care or juvenile justice systems or run-
6 away or homeless youth) and in alternative edu-
7 cation settings in which high populations of
8 youth with trauma exposure may learn (includ-
9 ing settings for correctional education, juvenile
10 justice, pregnant and parenting students, or
11 youth who have re-entered school after a period
12 of absence due to dropping out);”;

13 (2) in subsection (d)(1)(A)(i)—

14 (A) in subclause (II), by striking “and” at
15 the end;

16 (B) by redesignating subclause (III) as
17 subclause (IV); and

18 (C) by inserting after subclause (II) the
19 following:

20 “(III) such teachers to adopt evi-
21 dence-based approaches for improving
22 behavior (such as positive behavior
23 interventions and supports and restor-
24 ative justice), supporting social and
25 emotional learning, mitigating the ef-

1 fects of trauma, improving the learn-
2 ing environment in the school, and for
3 reducing the need for suspensions, ex-
4 pulsions, corporal punishment, refer-
5 rals to law enforcement, and other ac-
6 tions that remove students from in-
7 struction; and”;

8 (3) in subsection (d), by adding at the end the
9 following:

10 “(7) TRAUMA-INFORMED PRACTICE AND WORK
11 IN ALTERNATIVE EDUCATION SETTINGS.—Devel-
12 oping the teaching skills of prospective and, as appli-
13 cable, new elementary school and secondary school
14 teachers to adopt evidence-based trauma-informed
15 teaching strategies—

16 “(A) to—

17 “(i) recognize the signs of trauma and
18 its impact on learning;

19 “(ii) maximize student engagement;
20 and

21 “(iii) minimize suspension and expul-
22 sion; and

23 “(B) including programs training teachers
24 to work with students with exposure to trau-
25 matic events (including students involved in the

1 foster care or juvenile justice systems) and in
2 alternative academic settings for youth unable
3 to participate in a traditional public school pro-
4 gram in which high populations of students
5 with trauma exposure may learn (such as stu-
6 dents involved in the foster care or juvenile jus-
7 tice systems, pregnant and parenting students,
8 runaway and homeless students, and other
9 youth who have re-entered school after a period
10 of absence due to dropping out).”.

11 (b) ADMINISTRATIVE PROVISIONS.—Section
12 203(b)(2) of the Higher Education Act of 1965 (20
13 U.S.C. 1022b(b)(2)) is amended—

14 (1) in subparagraph (A), by striking “and” at
15 the end;

16 (2) in subparagraph (B), by striking the period
17 at the end and inserting “; and”; and

18 (3) by adding at the end the following:

19 “(C) to eligible partnerships that have a
20 high-quality proposal for trauma training pro-
21 grams for general education and special edu-
22 cation teachers.”.

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