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February 26, 2018

SENATE BILL NO. 1517

By: Griffin of the Senate

and

Bush of the House

An Act relating to trauma-informed care; creating the Task Force on Trauma-Informed Care to study and make recommendations to the Legislature on best practices with respect to children and youth who have experienced trauma; setting forth Task Force duties; providing for membership; specifying areas to be examined and time lines; specifying nature of recommendations; providing that Task Force meetings are subject to Oklahoma Open Meeting Act; providing that Task Force members shall not receive reimbursement; providing for noncodification; and providing an effective date.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. NEW LAW A new section of law not to be
codified in the Oklahoma Statutes reads as follows:

A. There is hereby created until three (3) years after the effective date of this act, a task force to be known as the Task Force on Trauma-Informed Care. The Task Force shall:

1. Identify, evaluate, recommend, maintain and update as described in subsection D of this section and in accordance with subsection E of this section, a set of best practices with respect

1 to children and youth, and their families as appropriate, who have
2 experienced or are at risk of experiencing trauma, especially
3 adverse childhood experiences (ACEs); and

4 2. Carry out other duties as described in subsection C of this
5 section.

6 B. The Task Force shall be comprised of seventeen (17) members,
7 each appointed by his or her respective agency:

8 1. One member who is an employee or designee of the State
9 Department of Health;

10 2. One member who is an employee or designee of the Department
11 of Mental Health and Substance Abuse Services;

12 3. One member who is an employee or designee of the Department
13 of Human Services;

14 4. One member who is an employee or designee of the SoonerStart
15 division of the State Department of Education;

16 5. One member who is an employee or designee of the State
17 Department of Education, other than an employee or designee of the
18 SoonerStart division;

19 6. One member who is an employee or designee of the Office of
20 Juvenile Affairs;

21 7. One member who is an employee or designee of the Council on
22 Law Enforcement Education and Training;

23 8. One member who is an employee or designee of the Oklahoma
24 Commission on Children and Youth;

1 9. One member who is an employee or designee of Indian Health
2 Services;

3 10. One member who is an employee or designee of the Oklahoma
4 Health Care Authority;

5 11. One member who is an employee or designee of the Office of
6 the Attorney General;

7 12. One member who is an employee or designee of the Center for
8 Integrative Research on Childhood Adversity at Oklahoma State
9 University;

10 13. One member who is an employee or designee of the Oklahoma
11 chapter of a professional association of pediatricians;

12 14. One member who is an employee or designee of an association
13 of Oklahoma physicians;

14 15. One member who is an employee or designee of the University
15 of Oklahoma Health Sciences Center's Department of Pediatrics;

16 16. One member who is an employee or designee of an Oklahoma
17 organization that advocates on behalf of children; and

18 17. One member who is an employee or designee of the Institute
19 for Building Early Relationships at Oklahoma State University.

20 The members of the Task Force shall elect a chair from among the
21 Task Force's membership.

22 C. Appointments to the Task Force shall be made within thirty
23 (30) days after the effective date of this act.

24 D. The Task Force shall:

1 1. Not later than one year after the effective date of this
2 act, and not less often than annually thereafter:

3 a. identify and evaluate a set of evidence-based,
4 evidence-informed and promising best practices, which
5 may include practices already supported by the State
6 Department of Health, the Department of Human
7 Services, the Office of Attorney General, the State
8 Department of Education or another state agency,

9 b. recommend such set of best practices, including
10 disseminating the set to:

11 (1) the State Department of Health, the
12 Department of Human Services, the Office of
13 Attorney General, the State Department of
14 Education and other state agencies as
15 appropriate,

16 (2) state, tribal and local government agencies,
17 including State, local and tribal
18 educational agencies,

19 (3) other entities, including but not limited to
20 recipients of relevant state grants,
21 professional associations, health
22 professional organizations, state
23 accreditation bodies and schools, and

24 (4) to the general public, and

1 c. maintain and update, as appropriate, the set of best
2 practices pursuant to this paragraph;

3 2. Not later than two (2) years after the effective date of
4 this act:

5 a. prepare an integrated task force strategy
6 report concerning how the Task Force and
7 member agencies will collaborate, prioritize
8 options for and implement a coordinated
9 approach to preventing trauma, especially
10 ACEs, and identifying and ensuring the
11 appropriate interventions and supports for
12 children, youth and their families as
13 appropriate, who have experienced or are at
14 risk of experiencing trauma,

15 b. submit the report to the chair of the Senate
16 Health and Human Services Committee and the
17 chair of the House of Representatives
18 Children, Youth and Family Services
19 Committee, and

20 c. make the report publicly available; and

21 3. Not later than one year after the effective date of this
22 act, and as often as practicable, but not less often than annually
23 thereafter:
24

1 a. coordinate, to the extent feasible, among the offices
2 and other units of government represented on the Task
3 Force, research, data collection and evaluation
4 regarding models described in subsection E of this
5 section,

6 b. identify gaps in or populations or settings not served
7 by models described in subsection E of this section,
8 solicit feedback on the models from the stakeholders
9 described in subsection E of this section,

10 c. coordinate, among the offices and other units of
11 government represented on the Task Force, the
12 preventing and mitigating trauma, and

13 d. establish procedures to enable the offices and units
14 of government to share technical expertise related to
15 preventing and mitigating of trauma.

16 E. In identifying, evaluating, recommending, maintaining and
17 updating the set of best practices under subsection D of this
18 section, the Task Force shall:

19 1. Consider findings from evidence-based, evidence-informed and
20 promising practice-based models, including from institutions of
21 higher education, community practice, recognized professional
22 associations and programs of the State Department of Health, the
23 Department of Human Services, the Office of Attorney General, the
24 State Department of Education and other agencies that reflect the

1 science of healthy child, youth and family development, and have
2 been developed, implemented and evaluated to demonstrate
3 effectiveness or positive measurable outcomes;

4 2. Engage with and solicit feedback from:

- 5 a. faculty at institutions of higher education including,
6 but not limited to, the Center for Integrative
7 Research on Childhood Adversity (CIRCA),
- 8 b. community practitioners associated with the community
9 practice described in paragraph 1 of this subsection,
- 10 c. recognized professional associations that represent
11 the experience and perspectives of individuals who
12 provide services in covered settings in order to
13 obtain observations and practical recommendations on
14 best practices, and
- 15 d. the public, by holding at least one public meeting to
16 solicit recommendations and information relating to
17 best practices;

18 3. Recommend models for settings in which individuals may come
19 into contact with children and youth, and their families as
20 appropriate, who have experienced or are at risk of experiencing
21 trauma, including schools, hospitals and settings where health care
22 providers, including primary care and pediatric providers, provide
23 services, preschool and early childhood education and care settings,
24 home visiting settings, after-school program facilities, child

1 welfare agency facilities, public health agency facilities, mental
2 health treatment facilities, substance abuse treatment facilities,
3 faith-based institutions, domestic violence centers, homeless
4 services system facilities, juvenile justice system facilities and
5 law enforcement agency facilities; and

6 4. Recommend best practices that are evidence-based, are
7 evidence-informed or are promising and practice-based, and that
8 include guidelines for:

- 9 a. training of front-line service providers including
10 teachers, providers from child-serving or youth-
11 serving organizations, health care providers,
12 individuals who are mandatory reporters of child abuse
13 or neglect and first responders, in understanding and
14 identifying early signs and risk factors of trauma in
15 children and youth, and their families as appropriate,
16 including through screening processes,
- 17 b. implementing appropriate responses,
- 18 c. implementing procedures or systems that:
 - 19 (1) are designed to quickly refer children and youth
20 and their families, as appropriate, who have
21 experienced or are at risk of experiencing
22 trauma, and ensure the children, youth and
23 appropriate family members receive the
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appropriate trauma-informed screening and support, including treatment,

(2) use partnerships that include local social services organizations or clinical mental health or health care service providers with expertise in furnishing support services including, but not limited to, trauma-informed treatment to prevent or mitigate the effects of trauma,

(3) use partnerships which co-locate or integrate services, such as by providing services at school-based health centers, and

(4) use partnerships designed to make such quick referrals, and ensure the receipt of screening, support and treatment, described in division (1) of this subparagraph,

d. educating children and youth to:

(1) understand trauma,

(2) identify signs, effects or symptoms of trauma, and

(3) build the resilience and coping skills to mitigate the effects of experiencing trauma,

e. multi-generational interventions to:

(1) support, including through skills building, parents, foster parents, adult caregivers and

1 front-line service providers described in
2 subparagraph a of this paragraph in fostering
3 safe, stable and nurturing environments and
4 relationships that prevent and mitigate the
5 effects of trauma for children and youth who have
6 experienced or are at risk of experiencing
7 trauma,

8 (2) assist parents, foster parents and adult
9 caregivers in learning to access resources
10 related to such prevention and mitigation, and

11 (3) provide tools to prevent and address caregiver or
12 secondary trauma, as appropriate,

13 f. community interventions for underserved areas that
14 have faced trauma through acute or long-term exposure
15 to substantial discrimination, historical or cultural
16 oppression, intergenerational poverty, civil unrest, a
17 high rate of violence or a high rate of drug overdose
18 mortality,

19 g. assisting parents and guardians in understanding
20 eligibility for and obtaining certain health benefits
21 coverage, including coverage under a State Medicaid
22 plan under Title XIX of the Social Security Act of
23 screening and treatment for children and youth, and
24

- 1 their families as appropriate, who have experienced or
2 are at risk of experiencing trauma,
- 3 h. utilizing trained nonclinical providers such as peers
4 through peer support models, mentors, clergy and other
5 community figures, to:
- 6 (1) expeditiously link children and youth, and their
7 families as appropriate, who have experienced or
8 are at risk of experiencing trauma, to the
9 appropriate trauma-informed screening and support
10 including, but not limited to, clinical treatment
11 services, and
- 12 (2) provide ongoing care or case management services,
- 13 i. collecting and utilizing data from screenings,
14 referrals or the provision of services and supports,
15 conducted in the covered settings, to evaluate and
16 improve processes for trauma-informed support and
17 outcomes,
- 18 j. improving disciplinary practices in early childhood
19 education and care settings and schools, including but
20 not limited to use of positive disciplinary strategies
21 that are effective at reducing the incidence of
22 punitive school disciplinary actions, including but
23 not limited to school suspensions and expulsions,
- 24

- 1 k. providing the training described in subparagraph a of
2 this paragraph to child care providers and to school
3 personnel, including school resource officers, teacher
4 assistants, administrators and heads of charter
5 schools, and
- 6 l. incorporating trauma-informed considerations into
7 educational, pre-service and continuing education
8 opportunities, for the use of health professional and
9 education organizations, national and state
10 accreditation bodies for health care and education
11 providers, health and education professional schools
12 or accredited graduate schools and other relevant
13 training and educational entities.

14 F. The Task Force may meet as often as may be required in order
15 to perform the duties imposed upon it. Meetings of the Task Force
16 shall be subject to the Oklahoma Open Meeting Act.

17 G. Members of the Task Force shall receive no compensation or
18 travel reimbursement.

19 SECTION 2. This act shall become effective November 1, 2018.

20 COMMITTEE REPORT BY: COMMITTEE ON HEALTH AND HUMAN SERVICES
21 February 26, 2018 - DO PASS
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