The Children's Future Act: A Comprehensive Bill for Elevating Child Well-being as the Foremost National Priority

Preamble: A Declaration for the Children of the United States

The future prosperity, security, and moral standing of the United States are inextricably linked to the health and well-being of its children. This Bill declares, with unwavering conviction, that the physical, mental, and spiritual health of every child in the United States shall be the nation's most paramount concern and a foundational investment in its collective future. This declaration represents a profound paradigm shift, establishing a moral and strategic imperative for reorienting national policy and resource allocation towards a child-first agenda.
The current landscape for American children is marked by significant challenges. Fragmented policies, reactive interventions, and insufficient investment have left millions vulnerable, compromising their developmental trajectories and the nation's potential. This approach is not merely inadequate; it is unsustainable. The time has come for a comprehensive, proactive, and deeply informed legislative framework that addresses the root causes of childhood adversity and cultivates environments where all children can thrive.

Title I: The Foundational Science of Child Development and Trauma

This title establishes the irrefutable scientific and empirical basis for the proposed legislation, emphasizing the profound and lasting impact of early experiences, particularly trauma, on a child's holistic development.

Section 101: Understanding the Body Keeps the Score: The Neurobiology of Childhood Trauma

The seminal work of Dr. Bessel van der Kolk and other leading researchers has illuminated a critical understanding: trauma is not merely a difficult or unpleasant event confined to the mind, but a profound disorganization of the entire human system – mind, brain, and body. The central thesis, articulated in "The Body Keeps the Score," is that the body remembers, holding onto the raw sensations, emotions, and survival instincts activated during overwhelming experiences, even when the thinking brain attempts to suppress or forget them. This means that the physical self, in essence, retains a detailed record of traumatic events, signaling unresolved distress through various manifestations.
The impact of trauma extends deeply into the neurobiological and physiological architecture of a

developing child. Traumatic stress literally reshapes the brain's wiring, specifically affecting areas crucial for pleasure, engagement, self-control, and trust. When a child experiences overwhelming threat, their "feeling brain" (the amygdala) can remain in a state of alarm, even after the "thinking brain" recognizes that the current situation is safe. This persistent state of hypervigilance and anxiety can lead to difficulties with sleep, being easily startled, irritability, and impaired concentration. The primitive parts of the brain become perpetually "stuck" in fight, flight, freeze, or collapse responses, diverting essential resources away from higher-level cognitive functions such as reasoning, problem-solving, and the ability to learn new information. This constant survival mode leaves little capacity for the development of "luxuries" like empathy or a positive perception of adult intentions.

Beyond the brain, unresolved trauma can manifest in a wide range of physical and somatic symptoms. These include chronic headaches, digestive problems, persistent fatigue, muscle tension, and even autoimmune disorders. The body's intrinsic reward system can change, altering what brings pleasure or indifference, and leaving individuals chronically unsafe and out of touch with their surroundings. On a behavioral and relational level, trauma-related vulnerability, particularly during adolescence, can lead to internalizing problems such as anxiety, depression, anhedonia (inability to feel pleasure), and social withdrawal. Conversely, it can also result in externalizing problems like aggression, delinquency, oppositional defiant disorder, and conduct disorders. Survivors often struggle with intimacy, establishing healthy boundaries, and trusting others. A particularly concerning aspect is the intergenerational transmission of trauma: a child whose parent has experienced trauma may mirror their caregiver's avoidance of intimacy, leading the child to feel inherently flawed or unloved.

A critical aspect of early trauma is its pre-verbal nature. Experiences occurring within the first eight weeks or even four years of a child's life, such as abuse, neglect, or medical interventions, cannot be explicitly remembered by the individual later on. Yet, research makes it clear that these very early experiences profoundly shape later development and well-being, as the body remembers even when the mind cannot. This pre-verbal, bodily imprinting means that traditional talk-based therapies alone may be insufficient for initial processing and healing. The conventional focus on verbal narrative can inadvertently activate mental defenses, leading to minimization or denial of the trauma's true impact. This highlights a fundamental limitation in current healthcare models that primarily rely on cognitive or verbal approaches. If the very core of trauma resides in the body's physiological responses and the brain's altered wiring, then interventions must address these deeper, non-verbal layers. Merely treating the symptoms, such as anxiety or behavioral issues, without addressing the underlying physiological dysregulation and the body's "stuck" survival responses, is akin to patching a leaky roof without repairing the structural damage. This approach can be ineffective, potentially re-traumatizing, and ultimately fails to provide comprehensive healing.

Conversely, the research offers a powerful message of hope: the quality and quantity of safe relationships are often more influential for a child's later well-being than the early trauma itself. This underscores the profound healing power of secure relationships and attunement. When parents or caregivers are able to be physically attuned to their children, providing a "secure base," it fosters physiological self-regulation and emotional regulation in both parent and child. This creates a visceral experience of reciprocity and harmony, as seen in shared giggles during play. This finding suggests that a proactive approach to building protective factors—namely, fostering environments of relational safety—can serve as a primary prevention strategy, mitigating the effects of adversity even before or during its occurrence. This means that national policy must prioritize the creation and sustenance of supportive, relationship-rich environments for all children, moving beyond a reactive model of treating trauma after it has occurred.

Furthermore, the profound impact of parental trauma on a child's development necessitates a focus beyond direct child interventions. When a parent has a history of trauma, their ability to remain regulated and attuned to their child becomes significantly more challenging. Research even indicates that severe parental trauma can alter an unborn baby's genetic makeup, predisposing them to be over-sensitive to life's stresses. This establishes a clear link where parental well-being directly influences a child's foundational development and capacity for secure attachment. Therefore, a comprehensive national strategy must extend to include robust support for parents and caregivers, particularly those who have experienced trauma themselves. This includes access to parental mental health services, education on attuned parenting, and community-based support systems designed to help parents regulate their own nervous systems and provide the secure, nurturing environments their children need. Such support is crucial for breaking intergenerational cycles of trauma and fostering healthy development across generations.

The pervasive and multifaceted nature of unresolved trauma necessitates a holistic approach to child well-being. The following table illustrates the diverse ways trauma manifests, underscoring the need for interventions that address the whole child.

Table 1: Key Manifestations of Unresolved Trauma in Children

Domain	Manifestations	Snippet References
Physical/Somatic	Headaches, digestive problems, chronic fatigue, muscle tension, autoimmune disorders, altered stress hormones, altered intrinsic reward system, depersonalization (numbness to bodily sensations)	
Neurobiological	Reshaped brain wiring (pleasure, engagement, self-control, trust), hyperactive amygdala, primitive brain stuck in fight/flight/freeze/collapse, deficits in filtering information, problems processing non-threatening information	
Emotional/Behavioral	Hypervigilance, anxiety, difficulty sleeping, irritability, difficulty concentrating, temper tantrums, aggression, delinquency, withdrawal, anhedonia	
Cognitive	Difficulty managing impulses, solving problems, learning new information, reasoning, impaired executive functioning	
Relational	Struggles with intimacy, boundaries, trust, mirroring parental avoidance of intimacy,	

Domain	Manifestations	Snippet References
	difficulty getting along with others, being cooperative	
Sense of Self	Fragmented self, feelings of unworthiness, deep shame, distorted self-narrative, overly compliant, fearful of asserting needs	

Section 102: The American Reality: Prevalence and Impact of Adverse Childhood Experiences (ACEs)

The understanding of trauma's profound impact is particularly urgent in the United States, where Adverse Childhood Experiences (ACEs) are alarmingly widespread. Data indicates that approximately three in four U.S. students (76.1%) have experienced one or more ACEs, and nearly one in five (18.5%) have experienced four or more. For adolescents aged 14-17, the figures are even more pronounced, with 80.5% experiencing at least one ACE and 22.4% experiencing four or more. These statistics reveal that childhood trauma is not an isolated issue affecting a vulnerable minority; it is a systemic public health crisis impacting the vast majority of American children. The most common ACEs reported include emotional abuse (61.5-65.8%), physical abuse (31.8-32.5%), and household poor mental health (28.4-36.1%). This pervasive exposure to adversity underscores the critical need for universal primary prevention strategies to mitigate the widespread harm.

The prevalence of ACEs is not evenly distributed across the population, revealing significant disparities across various demographic characteristics. For instance, all ACEs, with the exception of physical neglect, are more commonly reported among female students compared to male students. Racial and ethnic groups exhibit unique patterns of exposure: American Indian/Alaska Native (AI/AN) and multiracial students show the highest prevalence of four or more ACEs, while Black and Asian students report the highest prevalence of physical abuse. Furthermore, students identifying as gay, lesbian, bisexual, or questioning (LGBQ+) experience significantly higher prevalence of nearly all ACEs, including sexual abuse and household substance use, compared to their heterosexual peers. These disproportionate rates of adversity among marginalized communities are not random occurrences; they point to systemic inequities and structural racism that exacerbate vulnerability and perpetuate cycles of trauma. A national strategy must therefore move beyond a blanket approach, incorporating explicit equity-focused provisions, allocating resources, and designing interventions that specifically address the unique vulnerabilities and historical disadvantages faced by these communities. This means striving for equitable outcomes, not just equal access, and actively working to dismantle systemic barriers that perpetuate these disparities.

The long-term implications of ACEs are profound, demonstrating a clear dose-response relationship: as the number of ACEs a child experiences increases, the prevalence and severity of negative health conditions and risk behaviors also increase. For example, experiencing four or more ACEs is strongly associated with attempted suicide, seriously considered suicide, and current prescription opioid misuse. This strong correlation highlights that ACEs are fundamental determinants of lifelong health, well-being, and societal costs. The current environment, where such high rates of childhood adversity are commonplace, is inherently detrimental to the healthy development of many children. This necessitates a comprehensive, population-level approach to prevention, addressing the root causes of adversity such as poverty, housing instability, and

intergenerational trauma, rather than solely focusing on reactive interventions after harm has occurred.
The following table provides a detailed breakdown of ACEs prevalence in U.S. adolescents, illustrating the widespread nature and specific demographic patterns of childhood trauma in the nation.

Table 2: Prevalence of Adverse Childhood Experiences (ACEs) in U.S. Adolescents by Demographic Group

Characteristic	0 ACEs (%)	1 ACE (%)	2-3 ACEs (%)	≥4 ACEs (%)
Total	19.5	24.4	33.7	22.4
Sex				
Male	23.0	28.1	32.2	16.7
Female	16.2	20.8	35.3	27.7
Race and Ethnicity				
AI/AN, NH	15.5	25.8	31.6	27.1
Asian, NH	20.2	28.0	38.9	12.9
Black, NH	21.4	21.3	37.0	20.3
White, NH	18.7	25.8	33.9	21.5
Hispanic or Latino	20.7	24.7	30.7	23.9
Multiracial, NH	13.5	17.3	35.4	33.7
Sexual Orientation				
Heterosexual	22.0	27.1	32.5	18.4
Gay/Lesbian	9.2	18.6	35.6	36.5
Bisexual	5.8	13.9	38.2	42.1
Not sure/Other	8.2	17.1	38.3	36.5

Source: Adapted from (data for adolescents aged 14-17)
Note: Most common individual ACEs include emotional abuse (61.5-65.8%), physical abuse (31.8-32.5%), and household poor mental health (28.4-36.1%).

Title II: A Comprehensive Framework for Child Physical, Mental, and Spiritual Health

This title outlines the core policy proposals, translating the scientific understanding of trauma and the current realities of childhood adversity into actionable legislative mandates designed to foster holistic well-being.

Section 201: Universal and Equitable Physical Health Care

Ensuring the physical health of every child is a fundamental imperative. The United States currently grapples with significant disparities in healthcare access and quality, particularly for racial and ethnic minority children. Non-white children consistently receive poorer quality care across various medical settings, from neonatal care to emergency medicine and surgery, compared to their white peers. Black infants, for example, are more than twice as likely as white infants to die before their first birthday, and their infant mortality rates are worse than those in 62 other nations. Black and Latino children are significantly less likely to have regular access to a

doctor, often relying on emergency rooms for primary care, and face higher incidences of common illnesses like asthma.
This Bill mandates a system of comprehensive, high-quality physical health services for all children from prenatal care through age 26, irrespective of socioeconomic status, parental employment, or immigration status. This universal access, potentially achieved through a new national children's health program or substantial expansion of existing initiatives like Medicaid and the Children's Health Insurance Program (CHIP), is a necessary step to eliminate the profound health disparities rooted in structural racism. The current reactive and fragmented healthcare system is not only inequitable but also economically inefficient. The rising rates and undertreatment of chronic conditions in childhood can lead to poorer life outcomes and increased dependency on public support systems in adulthood. Conversely, proactive investment in children's health yields substantial returns; for instance, every dollar invested in a school nursing program is estimated to generate $2.20 in societal gains. This underscores the critical economic imperative of shifting towards a preventive, comprehensive healthcare model for children, framing it as a fiscally responsible long-term investment that reduces future burdens and enhances national productivity.
A comprehensive approach must begin even before birth. This Bill mandates robust prenatal and postnatal care, including mental health screenings and support for expectant parents. Given that a history of severe parental trauma can influence an unborn baby's genetic makeup, predisposing them to stress sensitivity , providing support to parents during pregnancy is a crucial preventive measure. Postnatal care must similarly focus on fostering early attachment and developmental screening for both mother and infant.
Furthermore, this Bill addresses the widespread prevalence of chronic physical conditions in U.S. children. Over 40% of school-aged children and adolescents have at least one chronic health condition, such as asthma or obesity, and approximately 25% of children aged 2-8 years have a chronic health condition, with 5% having multiple conditions. These conditions can significantly impact academic outcomes, concentration, and overall quality of life. This Bill proposes integrated care models that seamlessly connect physical health services with mental health support and school-based health initiatives. Recognizing that healthcare access and quality are deeply intertwined with broader social determinants such as housing, economic policies, and the criminal justice system , this legislation advocates for a holistic, inter-sectoral approach. Improving pediatric care necessitates addressing these underlying social factors through coordinated policy efforts across various sectors, recognizing healthcare not just as a service, but as a fundamental component of the social infrastructure that shapes life trajectories.

Section 202: Nurturing Mental and Emotional Well-being: A Trauma-Informed System

The mental and emotional well-being of American children faces a profound crisis. Nearly 20% of children aged 3-17 in the United States have a mental, emotional, developmental, or behavioral disorder, and suicidal behaviors among high school students increased by over 40% in the decade preceding 2019. While some progress has been made in children receiving needed mental health treatment—with 15.9% of households with children reporting a need for treatment, and only 13.5% of that group not receiving it as of June 2024 —significant barriers persist. Only 38.1% of households find it easy to access mental health care, and high-deductible health plans continue to pose a substantial financial obstacle. This indicates a critical disparity between the reported numbers of children receiving treatment and the actual ease and

affordability of accessing appropriate care.
This Bill mandates universal, affordable access to comprehensive mental health services, integrated seamlessly into primary care, schools, and community settings. Crucially, these services must be trauma-informed, recognizing that conventional talk therapy may be insufficient for addressing the pre-verbal, bodily imprints of trauma. All child-serving institutions—including schools, healthcare providers, social services, and the justice system—will be required to adopt trauma-informed principles and practices. This includes comprehensive training for staff to recognize and respond effectively to the physical, emotional, and behavioral manifestations of trauma.
A key component of this trauma-informed approach is the prioritization of body-oriented therapies. Modalities such as yoga, neurofeedback, Eye Movement Desensitization and Reprocessing (EMDR), and communal rhythmical activities have demonstrated effectiveness in processing trauma by activating the brain's natural neuroplasticity and helping individuals regulate their physiology. These methods, currently underutilized in medical and school settings , are vital for stabilizing physiology, enhancing executive functioning, and helping traumatized individuals feel fully present and engaged in their lives. The fact that many traditional therapies are insufficient for the somatic and pre-verbal nature of trauma suggests that even when care is accessed, it may not be the most effective or appropriate kind. Therefore, the legislation must focus not just on increasing the quantity of mental health services, but on dramatically improving their accessibility, affordability, and quality, ensuring that services are genuinely trauma-informed and incorporate these evidence-based, body-oriented modalities.
Early intervention and prevention are paramount. This Bill emphasizes early identification and support for children exposed to trauma, acknowledging that adversity experienced within the first eight weeks of life can have the most profound influence on later well-being. Universal screening for ACEs will be implemented across various child-serving touchpoints, ensuring immediate and accessible support systems are available.
Furthermore, the Bill recognizes the critical role of parents and caregivers in a child's mental and emotional development. Parents can inadvertently become a source of stress for their children if they themselves lack a secure emotional base. This legislation mandates robust support programs for parents, including access to their own mental health services, coaching on physical attunement with their children, and resources designed to help them build secure relationships. Schools are uniquely positioned to serve as critical hubs for integrated physical and mental health services. Given that trauma impacts learning, problem-solving, and social interactions , and that body-oriented therapies are not widely utilized in schools , integrating mental health professionals and trauma-informed practices directly into school environments could reach a vast number of children who might otherwise miss out on crucial support. This Bill will establish schools as primary sites for comprehensive child well-being, mandating trauma-informed training for all school staff and funding for on-site mental health professionals and body-oriented programs like yoga and mindfulness.

Section 203: Fostering Spiritual Resilience and Community Connection

The holistic well-being of children extends beyond the physical and mental to encompass their spiritual health. Research indicates that spirituality serves as a significant developmental asset, contributing to resilience, particularly for young people confronting hardships associated with trauma, grief, loss, and illness. A substantial majority of youth, for instance, report a belief in

God (95%) and engage in prayer as a spiritual practice (79%), often finding love and forgiveness instrumental in their healing processes. When faced with "bad or tragic things," many youth turn to spiritual coping mechanisms such as spending time alone, praying, or sharing their problems with others. This widespread reliance on spiritual resources highlights a crucial, yet often overlooked, dimension in current policy and practice. The omission of spiritual health from comprehensive child well-being frameworks represents a significant gap, failing to leverage a powerful protective factor and source of strength for children, especially those navigating the complexities of trauma.

This Bill mandates the purposeful inquiry into spirituality, religion, and culture within all child welfare and caregiving settings. Practitioners will receive education on diverse spiritual practices, beliefs, and cultural backgrounds to ensure sensitive and effective engagement. Agency policies will be updated to formally incorporate spirituality into casework, through spiritual assessments or integrated questions, recognizing its vital role in a young person's sense of identity, purpose, and belonging. This move acknowledges that a child's spiritual framework can be a profound source of stability and self-efficacy, particularly when their home or foster care environments lack safety and consistency.

Furthermore, this legislation emphasizes the deeply communal nature of healing from trauma. Trauma profoundly affects an individual's capacity to connect with others and be a cooperative member of their community. In many non-Western cultures, communal rhythmical activities such as dancing, athletics, and collective prayer are recognized as vital for healing trauma. These practices stand in contrast to the often individualized, clinical models prevalent in Western healthcare. If trauma fragments the self and disrupts social connection, then communal activities that foster shared experience, rhythm, and belonging are not merely supplementary but fundamentally reparative. This Bill will support and fund community-based, culturally relevant, and communal healing modalities, including sports, arts programs, and community rituals, as integral components of trauma recovery and resilience-building for children and families. This approach complements individual therapeutic interventions by restoring the social fabric essential for holistic well-being, recognizing that human contact and attunement are the wellspring of physiological self-regulation.

Title III: Benchmarking for a Brighter Future: Lessons from Global Leaders

This title provides a critical comparative analysis, demonstrating where the United States lags behind other developed nations in child well-being and identifying successful policy models to emulate.

Section 301: The State of American Children in a Global Context

A comparison of the United States' health outcomes with those of other Organization for Economic Co-operation and Development (OECD) countries reveals a stark and concerning picture. Despite spending nearly three times the OECD average on health per capita—$12,197 compared to $4,715 in 2021—the U.S. consistently achieves poorer outcomes for its children. The U.S. infant mortality rate, at 5.4 deaths per 1,000 live births, ranks 33rd out of 38 OECD countries, significantly higher than the OECD average of 4.0. Even the best-performing U.S. state, Vermont, with a rate of 3.1, only ranks on par with countries like Lithuania and Switzerland. Similarly, U.S. life expectancy at birth, 76.4 years, places it 32nd out of 38 OECD

countries, well below the average of 80.3 years. This glaring inefficiency, where the nation spends more for less, particularly for its youngest citizens, suggests that the current market-driven healthcare system is not structured for population health equity or efficiency, but rather for profit or reactive care. This necessitates a fundamental restructuring of health financing in the U.S., shifting towards a publicly funded, universal system that prioritizes preventive and primary care for children, aligning with the models of countries that achieve better outcomes with less spending.

Beyond specific health metrics, broader trends in child well-being across OECD/EU countries also highlight areas where the U.S. may be falling behind. A UNICEF report indicates that across 43 OECD/EU countries, children are becoming less happy with their lives, more likely to be overweight or obese, and are not performing as well in school. While child mortality has generally decreased and adolescent suicide rates have remained relatively stable across these nations, indicators such as life satisfaction, overweight rates, and academic skills show a deteriorating trend in many countries, with improvements in only a few. The top-performing countries in overall child well-being, such as the Netherlands, Denmark, and France, consistently lead across mental health, physical health, and skills. Conversely, countries at the bottom of the rankings struggle in at least two of these three dimensions. This pattern underscores that child well-being is not a siloed concept, but a holistic and interconnected phenomenon. The United States' poor health outcomes are likely symptoms of broader systemic issues in social support, education, and economic equity, rather than solely issues of healthcare delivery. This necessitates an integrated, whole-child policy approach, recognizing that improvements in physical health require simultaneous investments in mental health, education, and the social determinants of health.

The following table provides a comparative overview of key child well-being indicators, illustrating the U.S.'s position relative to leading OECD countries.

Table 3: Comparative Child Well-being Indicators: U.S. vs. Leading OECD Countries

Indicator	United States	OECD Average	Leading Countries (Examples)
Infant Mortality Rate (per 1,000 live births, 2021)	5.4 (Rank 33/38)	4.0	Japan (1.7), Norway (1.7)
Life Expectancy at Birth (years, 2021)	76.4 (Rank 32/38)	80.3	Japan (84.5), Norway (83.2)
Total Health Spending (per capita, USD, 2021)	$12,197 (Highest)	$4,715	Japan ($4,726), Norway ($7,065)
Child Life Satisfaction (15-year-olds)	Deteriorating trend (implied)	Falling substantially	Japan (substantially increased)
Overweight/Obesity Rates (Children)	Deteriorating trend (implied)	Increasing trend	(Specific country data not provided, but generally increasing)
Academic Proficiency (Children)	Deteriorating trend (implied)	Deteriorating trend	Japan, Republic of Korea, Slovenia (top third for skills)

Source: Adapted from

Section 302: Investing in Early Life: Universal Parental Leave and

Early Childhood Education

A critical area where the United States stands alone among developed nations is in its lack of a national paid parental leave policy. The U.S. is the *only* high-income country that does not mandate paid maternity leave, with only about 20% of American workers having access through their employers. This stark contrast with other developed nations highlights a fundamental philosophical divergence in how society values and invests in early childhood. Countries like Bulgaria offer 58.6 weeks of paid leave at 90% of salary, with additional allowances until the child turns two. Estonia provides 140 days of full maternity pay, with parents having access to 435 days of shared leave at 100% pay, usable until the child's third birthday. Sweden offers 480 days (68 weeks) of paid leave, shared between parents at 80% of salary, with specific days reserved for fathers. Norway provides options for 49 weeks at full pay or 59 weeks at 80% pay, with mandatory non-transferable leave for each parent. These generous policies directly support parents' ability to provide attuned care and reduce family stress, thereby fostering critical child bonding and developmental outcomes.

This Bill proposes a comprehensive national paid parental leave program, recognizing its profound benefits for child development, family economic stability, and overall societal well-being. The data from other nations clearly demonstrates that countries which invest in robust parental support systems achieve better child outcomes. This suggests that supporting parents through paid leave is a highly effective, indirect public health intervention that directly enhances child development by creating more stable, less stressful, and more nurturing environments for families.

Similarly, the United States lags significantly in its investment in universal Early Childhood Education and Care (ECEC). Rich countries, on average, contribute $14,000 per year for a toddler's care, while the U.S. contributes a mere $500. This disparity is reflected in the availability of universal or heavily subsidized ECEC programs in other nations. Denmark provides heavily subsidized care for children up to age 10, alongside quarterly child benefits. Germany offers "kita" (childcare) from early months through elementary school, with tuition often based on income or even free in some cities. France provides tax credits covering up to 85% of costs for child care centers or home-based childminders before public preschool begins at age 2 or 3. South Korea offers universal entitlement to early childhood educational development programs from the child's first year, with some free ECE from birth. These examples demonstrate a proactive approach to early childhood development, recognizing the critical developmental window and the long-term benefits of quality education and care for school readiness and overall well-being.

This Bill advocates for universal, high-quality, publicly funded ECEC from birth, establishing it as a cornerstone of a child-first national agenda. The lack of early investment in the U.S. likely contributes to the poorer health and developmental outcomes observed later in life. By adopting policies that align with global best practices in parental leave and ECEC, the U.S. can dramatically reorient its national investment towards early childhood, creating a more supportive foundation for all children.

The following table highlights the significant differences in paid parental leave policies between the U.S. and select developed nations, underscoring the U.S.'s outlier status.

Table 4: Paid Parental Leave Policies: U.S. vs. Select Developed Nations

Country	Leave Length (approx.)	Pay (% of Salary)	Key Features/Flexibility
United States	No national mandate; varies by	Varies (often reduced or none)	Some state-level programs,

Country	Leave Length (approx.)	Pay (% of Salary)	Key Features/Flexibility
	state/employer (avg. ~20% of workers have access)		employer-specific policies; federal employees have 12 weeks paid
Bulgaria	58.6 weeks (410 days)	90%	Begins 45 days pre-delivery; additional allowance until child turns two
Estonia	82 weeks (combined)	100% for first 20 weeks, then full pay for parental leave	Shared leave, flexible use until child's third birthday
Sweden	68 weeks (480 days)	80% for first 390 days	Shared between parents; specific days reserved for fathers
Norway	49 weeks (100% pay) or 59 weeks (80% pay)	100% or 80% (family choice)	Shared between parents; non-transferable leave for each parent
Croatia	Up to 58 weeks (maternity + parental)	Full salary for most initial period	Begins 30 days pre-delivery; paid time off for prenatal checkups
Slovakia	34 weeks	75%	Leave transfer and splitting options available
Canada	(Not specified in snippets, but noted as having parental leave)	(Not specified in snippets)	(Not specified in snippets)

Source: Adapted from

Section 303: Building Robust Social Safety Nets and Eradicating Child Poverty

Child poverty remains a pervasive challenge in the United States, with rates significantly higher compared to many other developed nations. While Nordic countries and the Netherlands maintain some of the lowest child poverty rates, around 7%, the U.S. is among the countries with the highest rates, with Canada, for instance, having almost double the child poverty rate of Norway. In the European Union, 24.2% of children are at risk of poverty or social exclusion, with the highest rates observed in Bulgaria, Spain, and Romania, and the lowest in Slovenia, Cyprus, and Czechia. A strong correlation exists between parental education levels and a child's risk of poverty, with children whose parents have lower secondary education being significantly more at risk.

This disparity in child poverty is directly linked to differing approaches to social welfare spending. While the U.S. has a high level of *private* social spending (10-13% of GDP), comparable to countries like the Netherlands and Switzerland, its *public* social expenditure is considerably lower than many OECD counterparts. For example, France, Denmark, and Italy

allocate over 30% of their GDP to public social spending, whereas the U.S. hovers around 15%. Countries like Sweden, Denmark, Belgium, and the UK spend twice as much on family benefits and tax breaks as Canada, and consequently achieve lower child poverty rates. The U.S. reduces child poverty through its tax and transfer policies less effectively than Canada. This indicates a fundamental philosophical preference in the U.S. for market-based solutions over robust government safety nets, resulting in higher child poverty and less effective poverty reduction. This situation demonstrates that child poverty is not an inevitable outcome but a direct consequence of policy choices regarding social investment.

This Bill proposes comprehensive anti-poverty strategies designed to directly address child poverty. These include expanded child tax credits, consideration of universal basic income for families, and increased access to affordable housing and nutritious food. Furthermore, it advocates for a significant increase in public investment in social services, particularly in family services and early childhood education and care. The eradication of child poverty must be framed as a national imperative, not solely as a social justice issue, but as a strategic investment in human capital and future economic productivity. Developmental delays caused by poor health, often linked to poverty, make children less ready to learn in school, disproportionately affecting their ability to reach their full potential and robbing the nation of a healthy and productive future workforce. Recognizing that poverty itself is a significant Adverse Childhood Experience (ACE) and a major barrier to holistic child development, this Bill aims to shift the U.S.'s social welfare philosophy towards increased public investment in robust safety nets, family benefits, and services that directly reduce child poverty and enhance family stability, aligning with the models of more successful OECD nations.

The following table illustrates the disparities in child poverty rates and social spending between the U.S. and select European/OECD countries.

Table 5: Child Poverty Rates and Social Spending: U.S. vs. Select European/OECD Countries

Country/Region	Child Poverty Rate (%)	Public Social Expenditure (% of GDP, 2022 est.)	Private Social Expenditure (% of GDP, 2019)	Family Services Spending (% of GDP, 2019)
United States	Among the highest (specific %)	~15%	11-13%	(Included in Other, ~2.3%)
Nordic Countries	~7%	High (e.g., Denmark >30%)	Low	High (e.g., Denmark spends twice Canada)
Netherlands	~7%	Lower than Nordic, but higher than US	11-13%	(Included in Other, ~2.3%)
Canada	13%	(Not specified, but lower than Nordic)	(Not specified)	~1.25%
France	(Not specified, but higher than Nordic)	>30%	(Not specified)	(Not specified)
EU Average	24.2% (2024)	(Not specified)	(Not specified)	(Not specified)
Slovenia	11.8% (Lowest in EU)	(Not specified)	(Not specified)	(Not specified)

Source: Adapted from

Title IV: Implementation, Accountability, and

Sustainable Investment

This title addresses the practical aspects of enacting and sustaining the proposed reforms, ensuring long-term commitment and measurable progress towards the comprehensive well-being of every child in the United States.

Section 401: Establishing a National Children's Health and Well-being Agency

To effectively implement the comprehensive vision outlined in this Bill, a new, independent federal agency—the National Children's Health and Well-being Agency—shall be established. The current approach to child well-being in the United States is characterized by fragmentation across numerous federal departments and state-level agencies, including Health and Human Services, Education, Justice, and Housing. This siloed structure leads to inefficiencies, significant gaps in care, and a lack of a cohesive, trauma-informed strategy. The pervasive nature of Adverse Childhood Experiences (ACEs) and their multi-faceted impact on physical, mental, and spiritual health necessitates a coordinated, systemic response that transcends existing bureaucratic boundaries.

This new agency will serve as the central coordinating body for all policies related to the holistic well-being of children. Its purpose will be to unify efforts, set national standards, allocate funds, oversee implementation, conduct and commission research, and rigorously evaluate outcomes across all child-serving sectors. By acting as a central hub for child-focused data collection and policy development, the agency will ensure that all systems work in concert, rather than in isolation, to provide consistent, high-quality, and trauma-informed support to children and their families. This centralized authority is crucial for overcoming systemic fragmentation and ensuring that a truly holistic approach to child well-being is consistently applied nationwide.

Section 402: Funding Mechanisms and Long-Term Resource Allocation

The extensive provisions of this Bill require innovative and sustainable funding mechanisms to ensure long-term success. Dedicated funding streams, such as a national children's trust fund, the reallocation of existing federal and state funds, or new progressive taxation models, will be explored and implemented. The current U.S. spending model, which prioritizes reactive, crisis-driven interventions, is fiscally unsustainable and yields poor outcomes despite high overall healthcare expenditure. The economic argument for upstream investment in children's well-being is compelling yet often underutilized in U.S. policy. As noted, the rising rates and undertreatment of chronic conditions in childhood can lead to poorer life outcomes and increased dependency on public support systems in adulthood. Conversely, proactive, preventive investments in early childhood, parental support, and community well-being have been shown to generate substantial long-term economic benefits. For example, every dollar invested in a school nursing program is estimated to yield a $2.20 return in societal gains.

This Bill mandates a fundamental shift in resource allocation, prioritizing preventive investment in early childhood. A comprehensive cost-benefit analysis will be conducted to project the long-term savings and societal benefits derived from these investments, including reductions in future healthcare costs, criminal justice expenditures, and welfare dependency. By foregrounding the economic advantages of early, comprehensive investment in children's

well-being, this legislation aims to garner broad political support by framing it as a fiscally responsible strategy that enhances national productivity and reduces future societal burdens.

Section 403: Continuous Improvement: Research, Data Collection, and Evaluation

To ensure the effectiveness and adaptability of the policies enacted under this Bill, robust systems for continuous improvement are essential. This includes the establishment of mandatory, standardized national data collection and reporting systems for child physical, mental, and spiritual health. These systems will incorporate comprehensive tracking of Adverse Childhood Experiences (ACEs) and detailed outcome measures for all programs implemented. While detailed prevalence data on ACEs and mental health challenges already exist, sustained, disaggregated data collection is critical for tracking the impact of this comprehensive legislation and ensuring its efficacy. Without clear metrics and ongoing evaluation, it will be impossible to determine if the Bill is achieving its stated goals, effectively addressing disparities, or if adjustments are needed.

This Bill will also significantly fund and promote ongoing research into effective interventions for childhood trauma and holistic child development. This includes continued exploration of neurobiological and body-oriented approaches to healing, as well as innovative strategies for fostering spiritual resilience and community connection. Finally, regular, independent evaluation of all programs and policies enacted under this Bill will be mandated. These evaluations will provide crucial feedback, allowing for continuous learning and adaptation based on empirical evidence and measurable outcomes. This commitment to data-driven policy and iterative improvement will ensure that the Children's Future Act remains effective, responsive, and maximally beneficial in promoting the well-being of every child in the United States.

Conclusion: The Promise of a Child-First America

The Children's Future Act represents a monumental commitment to the nation's most precious resource: its children. Drawing upon the profound scientific understanding of how trauma shapes the developing brain and body, and confronting the sobering realities of widespread childhood adversity in the United States, this Bill proposes a transformative shift in national priorities. It acknowledges that the current fragmented and reactive approach is insufficient and that true national strength and prosperity are built upon the foundation of healthy, resilient children.

By mandating universal and equitable physical and mental healthcare, rooted in trauma-informed principles and embracing body-oriented therapies, this legislation seeks to heal the deep wounds of adversity. By recognizing and fostering spiritual resilience and communal connections, it aims to cultivate holistic well-being. And by aligning the United States with global leaders through robust investments in early life, universal parental leave, high-quality early childhood education, and comprehensive anti-poverty strategies, this Bill addresses the systemic inequities that currently undermine child development.

The comparative data is clear: nations that prioritize early, comprehensive investment in their children's well-being achieve superior outcomes. The United States, despite its vast resources, has fallen behind, spending more for less, and allowing preventable adversity to compromise the potential of its youth. This Bill is more than a policy document; it is a declaration of intent, a moral imperative, and a strategic investment. It promises a future where every child in the

United States is afforded the opportunity to thrive physically, mentally, and spiritually, unlocking their full potential and securing a brighter, more resilient future for the entire nation. The time for this transformative change is now.

Works cited

1. Body Keeps The Score Summary - Simply Psychology, https://www.simplypsychology.org/the-body-keeps-the-score-summary.html 2. The Body Keeps the Score - Book Summary by a Therapist w/o the Triggering Bits, https://therapyinanutshell.com/the-body-keeps-the-score/ 3. "I learned a lot about trauma through parenting" - Early Childhood Matters, https://earlychildhoodmatters.online/2025/i-learned-a-lot-about-trauma-through-parenting/ 4. Dr. Bessel van der Kolk explains how “The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma” - Health & Wellness Magazine, https://beinkandescent.com/the-body-keeps-the-score/ 5. Developmental Trauma Close Up - Beacon House, https://beaconhouse.org.uk/wp-content/uploads/2020/02/Developmental-Trauma-Close-Up-Revised-Jan-2020.pdf 6. The body keeps the score: The neurobiological profile of traumatized adolescents - Oklahoma TF-CBT, https://oklahomatfcbt.org/wp-content/uploads/2024/03/The-body-keeps-score-Teens-and-Trauma.pdf 7. Adverse Childhood Experiences and Health Conditions and Risk Behaviors Among High School Students — Youth Risk Behavior Survey, United States, 2023 | MMWR - CDC, https://www.cdc.gov/mmwr/volumes/73/su/su7304a5.htm 8. Prevalence of Adverse Childhood Experiences Among Adolescents - PMC, https://pmc.ncbi.nlm.nih.gov/articles/PMC11756604/ 9. Pediatric care for non-white children is universally worse across U.S. - Northwestern Now, https://news.northwestern.edu/stories/2024/01/pediatric-care-for-non-white-children-is-universally-worse-across-u-s/ 10. "UNFAIR CHILDREN'S HEALTH DISPARITIES: MORE REASON FOR REFORM" - Children's Defense Fund, https://www.childrensdefense.org/unfair-childrens-health-disparities-more-reason-for-reform/ 11. Prevalence and Costs of Five Chronic Conditions in Children - PMC, https://pmc.ncbi.nlm.nih.gov/articles/PMC5010981/ 12. Managing Chronic Health Conditions in Schools - CDC Archive, https://archive.cdc.gov/www_cdc_gov/healthyschools/chronicconditions.htm 13. CHILD AND ADOLESCENT MENTAL HEALTH - 2022 National Healthcare Quality and Disparities Report - NCBI Bookshelf, https://www.ncbi.nlm.nih.gov/books/NBK587174/ 14. 2024 Children's Mental Health Report - ValuePenguin, https://www.valuepenguin.com/childrens-mental-health-report 15. Exploring spirituality among youth in foster care: findings from the Casey Field Office Mental Health Study, https://pmc.ncbi.nlm.nih.gov/articles/PMC4104695/ 16. International Comparison | 2023 Annual Report | AHR - America's Health Rankings, https://www.americashealthrankings.org/learn/reports/2023-annual-report/international-comparison 17. Child Well-Being in an Unpredictable World | Innocenti Global Office of Research and Foresight - Unicef, https://www.unicef.org/innocenti/reports/child-well-being-unpredictable-world 18. Paid Parental Leave in the U.S. vs. Other Developed Countries - FindLaw, https://www.findlaw.com/employment/family-medical-leave/paid-parental-leave-in-the-u-s-vs-other-developed-countries.html 19. 7 countries with the most generous maternity leave policies, https://timesofindia.indiatimes.com/life-style/parenting/moments/7-countries-with-the-most-generous-maternity-leave-policies/articleshow/122811058.cms 20. How other nations pay for child care. The U.S. is an outlier. | childcarecanada.org,

https://childcarecanada.org/documents/child-care-news/21/10/how-other-nations-pay-child-care-us-outlier 21. How do early childhood education systems differ around the world? | OECD, https://www.oecd.org/en/publications/education-at-a-glance-2023_e13bef63-en/full-report/how-do-early-childhood-education-systems-differ-around-the-world_9eb95672.html 22. Early Childhood Policies and Systems in Eight Countries - IEA.nl, https://www.iea.nl/sites/default/files/2019-04/ECES-policies_and_systems-report.pdf 23. Poverty... - THE ONE LINE - UNICEF Canada, https://www.unicef.ca/sites/default/files/imce_uploads/DISCOVER/OUR%20WORK/ADVOCACY/DOMESTIC/RESEARCH%20AND%20POLICY/DOCS/canadian_companion_fa.pdf 24. Children at risk of poverty or social exclusion - Statistics Explained - European Commission, https://ec.europa.eu/eurostat/statistics-explained/index.php/Children_at_risk_of_poverty_or_social_exclusion 25. Sizing up Welfare States: How do OECD countries compare?, https://oecdstatistics.blog/2023/02/02/sizing-up-welfare-states-how-do-oecd-countries-compare/