

REIMAGINING CHILD WELFARE IN ALASKA

Strategies for building an effective prevention program network.



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Alaska Office of
Children's Services

Alaska's Child Welfare
Leaders and Practitioners



*It is easier to build strong children
than repair broken men.*

– Fredrick Douglass

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REPORT OVERVIEW

The purpose of this report is two-fold. It aims to provide a general overview of current obstacles in creating a statewide child welfare prevention network and present possible solutions to those obstacles.

Social system change happens through small, strategic steps made by those with the ability and influence to disrupt what has become normalized system disfunction. A sense of urgency and desperation is the first catalyst for acting. We are there.

In 2020, 4,293 children were in the custody of the State of Alaska at some point. Only 1,266 children were removed from their parents in 2020, meaning 3,027 children were in OCS custody before 2020 (2021). Two out of every 100 youth under 18 are child welfare involved in Alaska (2021).

Although foster care is at times necessary, it is far from ideal. National studies reveal that 50% of children in foster care will not graduate high school by age 18, and 25% will experience PTSD comparable to that of a veteran (Casey Family Programs, 2021) (2021). We must do our best to reduce the number of children in foster care.

Efforts to reduce the number of Alaskan children in foster care over the past ten years have been mainly unsuccessful. The increasing number of children in care is costing millions and harming children and families.

Everyone agrees that child welfare prevention efforts should begin with family health, educating parents, building resiliency, and engaging community supports. These effective preventions are not solely the responsibility of a state agency tasked with child safety. Prevention is a community mindset to be embraced and implemented by those closest to children and families.

Clear identification of existing barriers and their potential solutions within Alaska's child welfare system will provide leaders the knowledge to address ineffective systems and practices with a thoughtful and data-driven approach. As prevention has become a focal point for child welfare systems globally, Alaska can utilize new research and associations with prevention innovators to create a program network that will be effective and sustainable in this great land.

Alaska needs a fresh, collective approach to child welfare prevention. We would do well to reimagine child welfare in Alaska. Let us come together and build a beautiful future for Alaska's children and families.



ISSUES AT HAND

The Issues at Hand in this report highlight realities that the State, Tribes, and child welfare professionals have been wrestling with for years. The purpose of highlighting these issues is to acknowledge and identify the complexities in building an effective and sustainable child welfare prevention network in Alaska. That said, this report does not end with a simple re-hashing of our struggles. Each section contains potential solutions to our system inadequacies and provides hopeful examples of what others are doing to address similar issues. These solutions are in no way an exhaustive list of how issues can be addressed but are a starting point for conversation and strategic collaboration.

A sense of urgency and desperation is the first catalyst for acting.

FAMILY FIRST PREVENTION SERVICES ACT (FFPSA)



ISSUES

President Trump signed the Family First Prevention Services Act (FFPSA) (H.R. 253) as part of The Bipartisan Budget Act of 2018 (P.L. 115-123). FFPSA is the most comprehensive effort in decades aimed at preventing children from being placed into foster care. FFPSA allows partial federal reimbursement for foster care prevention and shifts funding away from institutions and group homes that child advocates and child welfare professionals have long criticized. The Act also reauthorized several existing child welfare funding streams. This report focuses primarily on the prevention aspects of the FFPSA.

FFPSA is a significant shift in federal child welfare policy as it requires federal matching funds to be tied to prevention programs that utilize evidence-based practice models. The goal of connecting funding to established and proven prevention methods is to uphold practice standards that produce improved outcomes for children and vulnerable families.

With an approved five-year FFPSA Prevention plan, State Title IV-E agencies, and Title IV-E AI/AN Tribes can now get Federal reimbursement for 50% of eligible prevention services expenditures for children, ages 0-21, who are “candidates for foster care” and youth in foster care who are pregnant or parenting. A candidate for foster care is a child identified by a Title IV-E agency assessment to be at imminent risk of entering foster care but can remain at home or in kinship placement safely with adequate prevention supports and services.

Under FFPSA, prevention programs fall under four categories:

1. mental health services from qualified clinicians
2. substance abuse prevention and treatment services administered by qualified clinicians
3. parent skill-based programs to include parenting skills training and education as well as individual and family counseling
4. kinship navigator programs

There are no income requirements for the services, and they can be used up to 12 months from the date a child is identified as a candidate for foster care or is a pregnant or parenting child in foster care in need of prevention. Services can continue for contiguous 12-month cycles on an approved case-by-case basis. There is no lifetime limit in accessing prevention services.

Prevention services eligible for Federal reimbursement must be evidence-based and trauma-informed. Evidence-based practices in child welfare are defined as using the best research evidence, best clinical experience and are consistent with family/client values (2021). "Trauma-Informed Care (TIC) understands and considers the pervasive nature of trauma and promotes environments of healing and recovery rather than practices and services that may inadvertently re-traumatize (University at Buffalo, Buffalo Center for Social Research, 2021)."



Prevention services eligible for Federal reimbursement must be evidence-based and trauma-informed.

To establish national continuity with the evidence-based practice requirements built into the new law, the Title IV-E Prevention Services Clearinghouse is used as the information source, program assessor, and registrar for all FFPSA evidence-based programs (2021). The Clearinghouse has divided up evidence-based practices into the following three categories of proof: promising, supported, and well-supported. Practices are rated as "promising" if they were created from a study that "achieves a rating of moderate or high on study design and execution and demonstrates a favorable effect on a target outcome" (2021). Practices are "supported" once they have sustained success for a minimum of six months after treatment and were "carried out in a usual care or practice setting that achieves a rating of moderate or high on design and execution" (2021). "Well-supported" programs must have at "least two contrasts with non-overlapping samples in studies carried out in usual care and practice settings that achieve a rating of moderate or high on design and execution and demonstrate favorable effects in a target outcome domain. At least one of the contrasts must demonstrate a sustained favorable effect of at least 12 months beyond the end of treatment on at least one target outcome (2021)."

Until 2024, a prerequisite for Alaska's Office of Children's Services to draw down prevention dollars for services available because of FFPSA, 50% of all expenditures for the State's prevention program must be for services deemed by the Clearinghouse to be supported or well-supported. Beyond 2024, 50% of the State's reimbursable prevention programs must be well-supported.

Tribal entities with a direct IV-E agreement with the federal government are exempt from these criteria, however, the only Tribe with this agreement is the Aleut Community of St. Paul Island. All other Tribes are currently under a Title IV-E Administrative Agreement with the State and work within the State's plan requirements. This is unfortunate because there are currently no programs designed with culturally appropriate services meeting the supported or well-supported criteria. Family Spirit is one culturally tailored home visiting program that is rated as promising.

The Clearinghouse has not yet evaluated many prevention programs. States can use these services if they believe that they will meet the criteria and if other States have applied to have them evaluated and incorporated into their plan. These programs under review can be reimbursed as a "transitional" payment if the state's plan is submitted and accepted by October 1, 2021.

In addition to 50% reimbursement for prevention programs and services, Title IV-E agencies may receive funding for administrative and case management activity costs related to administering these preventative programs.

Part of the FFPSA requires that states meet a Maintenance of Effort (MOE) standard of spending on prevention services. New prevention spending must exceed prior spending on FFPSA services. Because OCS has not funded any of the services listed in the Clearinghouse, the baseline for Alaska's MOE is \$0, and future spending is eligible for partial federal reimbursement with an approved FFPSA Plan.

Approval of an FFPSA five-year prevention plan requires:

- 1 Operational prevention programs that are evaluated, monitored for fidelity to their models, and reported to the State in compliance with all guidelines. 50% of these prevention programs must qualify as supported or well-supported.
- 2 In addition to a list of eligible programs, OCS must submit details of the program, how they were selected, a defined target population, assurance that the program is trauma-informed, and a detailed plan of how each program is expecting to improve outcomes for children and families.
- 3 A description of how OCS will monitor and oversee the prevention programs to ensure the safety of the children served. This oversight and evaluation is extensive and will require analysis and assistance to develop processes and increased administration to maintain.
- 4 The creation of a coordinated administration plan after consulting with other State health and child and family services funded through Title IV-B.
- 5 A child welfare workforce training and support program guaranteeing adequate support and training for all child welfare workers along with a plan for how reasonable prevention caseloads will be determined, managed, and overseen.

The Status of Alaska's Family First Prevention Services Act Plan

Alaska's Office of Children's Services submitted their first Title IV-E Prevention Program 5 Year Plan on January 10, 2020. The plan was evaluated by the Children's Bureau and returned to OCS for further clarification and revision in March of 2020. OCS sent a revised plan back on October 2, 2020. On November 12, 2020, the Children's Bureau returned the plan with further revision requests. At this point, there have been no additional revisions submitted. According to Brooke Katasse of OCS, other submissions were halted by mutual agreement of OCS and Tribal partners. This pause was to provide time to evaluate the feasibility of operating an FFPSA prevention plan instead of a general fund prevention plan. An in-depth analysis must be done on the availability of services, how to evaluate services provided, and how to design a culturally appropriate network. It is possible that for several reasons, implementing an FFPSA Plan may cost more than the federal dollars reimbursed. A fiscal analysis must be completed prior to moving forward.

States do not have to apply for FFPSA prevention funding. Some states will find that compliance is too costly and laborious. Alaska is not the only state still working on the process of implementing the 5-year Plan. As of May 2021, 64 Title IV-E State and Tribal agencies are eligible to submit an FFPSA 5-yr. Plan. Twenty-six agencies have submitted their Plan to the Children’s Bureau, and only 13 have been approved (Administration for Children & Families Children’s Bureau, 2021).



20% of States and Tribes have an approved FFPSA plan

The Status of Eligible Evidence-Based Practice Models

Alaska’s 5-year prevention plan identifies 20 prevention programs operating in Alaska. Of the 20 prevention programs listed, five are well-supported. These include:



Parent Child Interaction Therapy



Nurse Family Partnership



Motivational Interviewing



Multisystemic Therapy



Parents as Teachers

Parenting with Love and Limits is a supported practice that is listed in the Plan. Utilizing well-supported programs is of extreme benefit in that they do not require the same evaluation by OCS, and at least 50% of the overall IV-E claim must have this rating.

Although Alaska’s agencies are implementing some supported and well-supported evidence-based practices, documentation of curriculum, evaluation, and outcome must be provided to the Children’s Bureau to prove that the agency operates with fidelity to the model. This is no small endeavor, and many organizations have modified their practices for several reasons, which may now deem the program to be operating outside of fidelity.

What It Will Take to Get Alaska’s Title IV-E Prevention Program 5 Year Plan Approved

OCS does not currently have the workforce to complete the required elements of the 5-year Plan necessary for Federal approval.

A third party should do a comprehensive statewide scan of all child welfare prevention programs. This scan must include all components required for evaluation, such as curriculum used, staff criteria and workloads, targeted population identification and methods of outreach, data collection, organizational management, evaluation, and reporting.

Agencies administering prevention programs should collaborate with other agencies offering the same program and with OCS and Tribes to ensure fidelity to the model and acceptable reporting.

A prevention and FFPSA implementation team will need to be established within OCS to ensure progress toward Plan approval. Once approved, the Plan will require ongoing assessment, communication with agency partners, evaluation, and reporting.

Getting Alaska’s Title IV-E Prevention Program 5 Year Plan approved is not an impossibility and could be a reality in coming years with a dedicated team in place. Building operational capacity to administer the FFPSA Plan will prove the most challenging. The State must spend money on prevention before the Federal government can reimburse it. As preventions prove effective in reducing the number of children in care, the State of Alaska must commit to re-allocating a portion of the OCS budget to fund child welfare prevention services.



SOLUTIONS

A survey of the Title IV-E Prevention Services Clearinghouse was conducted in June 2021 for eligible prevention programs rated as supported or well-supported. Under FFPSA, four service areas can be funded with prevention dollars. They are 1) mental health, 2) substance abuse, 3) in-home parent skill-based, and 4) kinship navigator services. As of this writing, there are no FFPSA approved evidence-based kinship navigator programs; however, some have been recommended and are under review.

Evidence-Based Practice	Prevention Service	Target Population	Program Rating	Program Summary	Workforce
Brief Strategic Family Therapy	Mental Health, Substance Abuse, In-Home Parent Skill-based	Families with children 6 to 17	Well-supported	Professional counseling program promoting effective and adaptive family interactions	Trained Therapists
Child First	Mental Health, In-Home Parent Skill-Based	Families with young children 0-5	Supported	Home based psychotherapy and care coordination	Mental Health Clinician and Care Coordinator
Families Facing the Future	Substance Abuse	Families with a parent receiving methadone treatment who have children	Supported	Parenting and relapse prevention in group settings	Chemical Dependency Case Managers with a master’s degree
Family Check-Up	Mental Health, In-Home Parent Skill-Based	Families with children 2-17	Well-supported	Parenting and family management strengths-based intervention	Family Check-Up Provider (non-clinical)
Functional Family Therapy	Mental Health	Children 11-18	Well-supported	Therapy for youth referred for behavioral or emotional problems	Trained Therapists
Healthy Families America	In-Home Parent Skill-Based	New or expectant families	Well-supported	Home visitation to cultivate and strengthen parent-child relationships for those at risk for maltreatment or adverse childhood experiences.	Visiting Staff, Supervisors, and Program Managers (non-clinical)
Homebuilders	In-Home Parent Skill-Based	Families with children 0-18 at imminent risk for out-of-home placement or being reunified	Well-supported	Intensive counseling and skill building	Practitioners with a minimum of bachelor’s degree in psychology, social work, or counseling
Intercept	In-Home Parent Skill-Based	Children 0-18 at risk of entry or re-entry to out-of-home placement	Supported	Intensive reunification supports	Practitioners with a minimum of bachelor’s degree in psychology, social work, or counseling

Evidence-Based Practice	Prevention Service	Target Population	Program Rating	Program Summary	Workforce
Interpersonal Psychotherapy	Mental Health	Adults	Supported	Therapy addressing depression	Trained Therapist
Motivational Interviewing	Substance Abuse	Range of target populations	Well-supported	Counseling method to promote behavior change	Trained Providers (can be non-clinical)
Multidimensional Family Therapy	Mental Health, Substance Abuse, In-Home Parent Skill-based	Children and young adults 9-26 (Parent must participate)	Supported	Therapy addressing substance use, delinquency, mental health, and emotional problems	Trained Therapist
Multisystemic Therapy	Mental Health, Substance Abuse	Children 12-17 and their families	Well-supported	Therapy promoting pro-social behavior and reducing negative activity	Trained Therapist
Nurse-Family Partnership	In-Home Parent Skill-Based	Young, first-time, low-income mothers	Well-supported	One-on-one home visits to improve health, relationships, and economic well-being	Registered Nurse
Parent-Child Interaction Therapy	Mental Health	Families with children 2-7	Well-supported	Therapy addressing behavior-management and relationship skills	Trained Therapist
Parents as Teachers	In-Home Parent Skill-Based	New and expectant parents	Well-supported	Parenting skills education	Parent Educators (non-clinical)
Prolonged Exposure Therapy for Adolescents with PTSD	Mental Health	Children 13-18	Supported	Therapy for youth diagnosed with PTSD or manifesting trauma-related symptoms	Mental Health Clinician
SafeCare	In-Home Parent Skill-Based	Families with children 0-5	Supported	Parenting skills to promote positive parent-child interactions and reduce risk of maltreatment	Providers and Coaches (non-clinical)
Triple P - Positive Parenting Program	Mental Health	Families with children 0-12	Supported	Parent training for managing behavior problems	Web-based intervention without practitioner

As Alaska works toward standing up a program network that has the potential to qualify for FFPSA, a focused team of experts in each of the four prevention disciplines should focus on one or two appropriate programs for consideration. They will need to determine the feasibility for and status of:

- Community demand and ownership
- Culturally appropriate programming
- Existing local agency capacity
- Possible agency partnerships for service delivery or administration
- Workforce availability
- Program delivery within the target community and population
- Training requirements
- Program costs and national supports
- Outreach or marketing needed for community awareness
- Implementation timeline
- Scalability within the State
- Funding

Narrowing potential programs for utilization in Alaska is necessary for efficiency in training, evaluation, and overall cost-sharing between implementing agencies. It is also critical that programs chosen for implementation are committed to for the long term as to build a stable network of prevention tactics across the state.

OCS will need to establish or contract out an evaluation department responsible for tracking and reporting program status and effectiveness. If prevention programs used are not rated as well-supported, an ongoing manual evaluation process must be created and adhered to for compliance with federal requirements.



FFPSA has the potential to provide Alaska with partial federal reimbursement for prevention spending. Still, it has yet to be determined if the requirements and constraints of the new law will outweigh the costs and benefits of this federal funding. Extensive feasibility analysis needs to begin so that this can be determined, and Alaska's providers can proceed accordingly. Removing the requirements for supported and well-supported evidence-based practices dramatically changes the programming and administration of a prevention network. Despite the outcome of an FFPSA feasibility analysis, it is crucial that Alaska's providers and OCS strive for data-driven methods and build-in evaluation mechanisms to increase prevention system effectiveness.

Although there are currently no supported or well-supported programs listed in the Clearinghouse designed for AI/AN cultures, Alaska's Tribes have tremendous expertise to contribute. Alaska can be a much-needed advocate by recommending to the Clearinghouse successful Tribal programs for evaluation. These contributions would add to a foundation of culturally sensitive programming for national utilization.

Each state is struggling with FFPSA implementation for various reasons. Alaska is not alone in its efforts to shift from child welfare involvement to prevention. The current barriers will not be barriers forever if we continue to move forward together.



FEDERAL AND STATE FUNDING



ISSUES

Most of the funding for foster care in America comes from individual state budgets. States are tasked with ensuring the well-being of children and families. The federal government oversees state child welfare systems under the Children's Bureau, a division of the U.S. Department of Health and Social Services. Of the \$30 billion spent on child welfare in the U.S., roughly 56% comes from state budgets, and the rest is paid for by the federal government (FamilyFirstAct, 2020). The allotment for direct foster care funding by the federal government comes from Title IV-E and Title IV-B of the Social Security Act (P.L. 115-123) as well as the Child Abuse Prevention and Treatment Act (CAPTA) (P.L. 115-424).

\$30B
is spent on child welfare in the U.S.

56%
comes from state budgets

Title IV-E

The largest source of federal funds comes through Title IV-E payments. Title IV-E funds are uncapped and guaranteed funds that pay for the administrative, training, and physical costs of keeping a child in foster care. It also pays for the Adoption Assistance Program, Guardianship Assistance Program, and the Chafee Foster Care Program for Successful Transition to Adulthood/Education and Training Vouchers.

State of Alaska
Fiscal Year (SFY)

2018

OSC spending was **\$160,153,202** (Child Trends, 2021)

\$97,417,400
were State dollars, with
the rest being federal.

Of the **\$59,367,489** federal dollars used
in Alaska, **80%** of these expenditures were IV-E.

Title IV-B

Title IV-B of the Social Security Act (P.L. 115-123) funds are drawn down for child welfare professional training, prevention, family preservation and reunification, and services for adopted children. In the 2018 SFY, OCS spent \$731,192 in Title IV-B funds (Child Trends, 2021).



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CAPTA

The Child Abuse Prevention and Treatment Act (CAPTA) (42 U.S.C. § 5101) provides four funding streams: state grants, child abuse discretionary activities, Children’s Justice Act Grants, and Community-Based Child Abuse Prevention Grants (CBCAP) (Casey Family Programs, 2021). CAPTA provides support for investigation, prosecution, treatment, prevention, and assessment. The CBCAP grant program within CAPTA is designated for community-based child abuse prevention services.

Alaska submits a state plan each year for CAPTA funding and follows up with data reports annually. Unlike many other Federal funding streams, CAPTA funds require no state match. These CAPTA funds are allocated on a formula basis and are small in relation to foster care and permanency federal funding.

TANF

Temporary Assistance for Needy Families (TANF) (45 CFR § 260.20) transferred \$3,973,956 to OCS in the 2018 SFY (Child Trends, 2021). Alaska’s TANF program “provides cash assistance and work services for low-income families with children to help them with basic needs while they work toward becoming self-sufficient” (2021).

SSBG

The Social Services Block Grant (SSBG) (45 CFR § 96.74) is another source of federal funds to reduce institutional care, prevent maltreatment and promote self-sufficiency. Alaska uses it for child protection, foster care, and case management services. In the 2018 SFY, OCS spent \$3,297,777 in SSBG funds (Child Trends, 2021).



In the 2018 SFY, OCS spent **\$3,297,777** in SSBG funds.

Medicaid

Children in foster care and those who are eligible for Title IV-E Adoption or Guardianship programs are eligible for Medicaid. Alaska uses Medicaid for treatment foster care and rehabilitative services.

The 1115 Behavioral Health Medicaid Waiver and The Existing State Plan Medicaid Waiver Services

In January of 2018, the Alaska DHSS applied for a Section 1115 Demonstration Waiver from the U.S. Centers for Medicare and Medicaid Services. Through emergency regulation mental health and substance use disorder waivers became available in May 2020 and were made permanent in October 2020. There is a five-year time constraint for proving efficacy and budget neutrality.

The 1115 Waiver enhances Medicaid coverage for three target populations. Population 1 is children and adolescents (0-21) and the parents or caregivers, with, or at risk, of mental health or substance use disorders. Population 2 is transitional age youth and adults (18+) with acute mental health needs. Population 3 is adolescents and adults with substance use disorders (State of Alaska Department of Health and Social Services, 2021).

The Medicaid 1115 expansions related to child welfare will provide funding for community-based outpatient services to include intensive case management services, mental health day treatment, home-based family treatment services, and acute intensive services. These acute intensive services will include mobile outreach and crisis response, 23-hour crisis stabilization, residential treatment, and therapeutic foster care. Community and recovery support services are designed to promote family stability through “coaching, employment support, social/cognitive/daily living skill-building, mentoring, and relapse prevention” (2021, pp. 23-24).

These Medicaid 1115 eligible services are being introduced as organizations can offer new solutions to meet the needs of their community. The process has been slow due to the pandemic, but is expected to accelerate.

How The New Family First Prevention Services Act Interacts with Medicaid

The Family First Prevention Service Act (FFPSA) (H.R. 253) made Title IV-E funding available for child welfare prevention services including substance use disorder treatment, in-home family services, and mental health treatment. The Administration for Children and Families has determined that Title IV-E should be the payer of last resort. This means that if other funding streams (like Medicaid or private insurance) can pay for allowable services that would generally qualify under Title IV-E prevention services, those funders will have the responsibility for paying before the Title IV-E agency pays.

There is an exception that if the service needs to be covered by Title IV-E funds to prevent the delay in appropriate early intervention services, IV-E can pay and then be reimbursed by other responsible funders. This would be exceptionally administratively burdensome to OCS in that they would have to report IV-E expenditure and then back out those expenditures once reimbursed.

Because FFPSA requires 50% of State child welfare prevention spending to be on supported and well-supported evidence-based practices, this will require states to implement services meeting this criterion that are not already eligible for Medicaid funding. There is not an abundance of well-supported practices approved for FFPSA funding, thereby creating a limitation on what prevention programs states can use in the FFPSA Plan and draw down funds for. As more programs are rated as well-supported evidence-based practices in the Clearinghouse, this should become less of an issue.

Child welfare funding is complex and comes from multiple sources. A coordinated effort with OCS, Tribes, private agencies, Medicaid, and healthcare service providers will be necessary for training providers on billing and building an efficient delivery model that utilizes available funding.



SOLUTIONS

Sustainable program funding has been a barrier for organizations hoping to bring long-term success in child welfare prevention. Through collaborative multi-agency initiatives, a more thoughtful and deliberate approach will appear.

Understanding the nuances of FFPSA funding and the Medicaid 1115 Waiver is a complicated endeavor. In addition to these complexities, rigid program requirements are tied to these funds. It will require a team of knowledgeable and willing collaborators to provide advice and design expertise.

Until preventions begin to reduce the number of children in care, OCS will have a limited budget for funding new services. Community investment and public/private grant funding will most likely be the initial seed for new community-based preventions. As communities launch their chosen preventions, their investments of time and financial resources should leverage public and private investors, including OCS. It is reasonable to expect that by utilizing centralized administration and shared systems, the overall cost of establishing services in multiple communities will decrease.

As prevention efforts advance, it is critical to build programs with sustainable funding streams, explicit target populations, concrete evaluations, and documented outcomes. The necessity for evaluation and funding tied to performance is a critical component for success, even if the programs chosen are not evidence-based practices approved by FFPSA or Medicaid.

There is tremendous wisdom in utilizing a collective group of agency leaders to determine the programming strategy and applicable funding. This collective impact approach will reduce the prevalence of uncoordinated and ineffectual work.



DIVERSITY, ACCESSIBILITY, AND LIMITED WORKFORCE

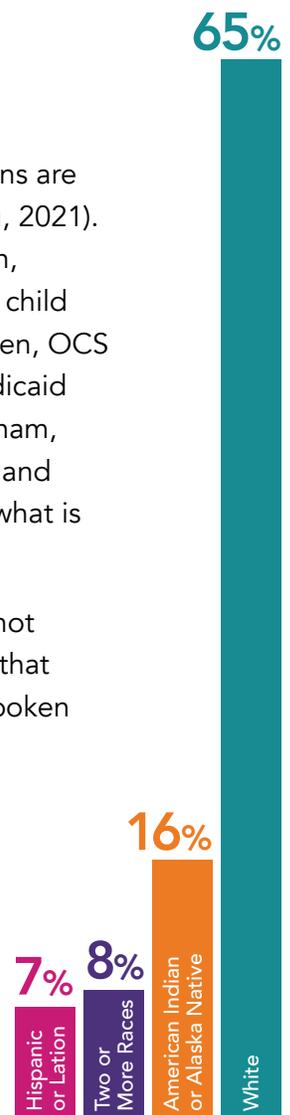


ISSUES

Alaska is a state rich in culture, natural resources, and resilient people. 731,000 Alaskans are living in the great land, spanned out over 570,641 miles (United States Census Bureau, 2021). Alaska's public welfare system is state-run and divided into five main regions: Northern, Western, Southcentral, Anchorage, and Southeast (2021). The management of a state child welfare system, where only 20% of the state is accessible by road, is no small feat. Often, OCS investigators must travel by small private aircraft or boat to assess a child's safety. Medicaid reimbursed more than \$164,000 for transportation costs in Alaska (Damler & Cunningham, 2019). Along with high travel expenses, these locale constraints create painful familial and cultural separations when foster care placement or medical care is necessary beyond what is available in a child's local community.

In addition to its geographical vastness, Alaska is diverse in ways that most states do not experience. The most prominent racial categories are shown at right. More notable is that Alaska is home to one of the most diverse school systems, with over 100 languages spoken (Brehmer, 2021). Since Alaska ranks the lowest of all states for internet connectivity, accessibility to online education and other social services is difficult at best (Broadband Now, 2021).

Only three cities in Alaska have populations over 20,000, Anchorage, Juneau, and Fairbanks (Alaska Demographics, 2021). There are more than 300 communities in Alaska that are rural with much lower populations. Children born in rural communities have a higher likelihood of being reported to OCS for suspected physical or sexual abuse. "Although children living in rural communities have an elevated risk of experiencing a physical abuse and/or sexual abuse report,



(United States Census Bureau, 2021)

it appears that this disparity is driven primarily by substance use and economic challenges (Parrish & Rittman, 2021).” Regional population size is not the primary contributing factor to child welfare involvement but rather a lack of programs and supports to prevent child maltreatment.



27,200
lost Alaskan
jobs in 2020

The lack of workforce within the disciplines needed for child welfare prevention programs continues to be a significant barrier for program implementation. Although job loss for professional services and health care were just 11% of the 27,200 Alaskan jobs lost in 2020, the effect on a state of Alaska’s population size is significant (Alaska Department of Labor & Workforce Development, 2021). Finding certified behavioral and mental health clinicians to administer or oversee programs related to family and child wellbeing has been difficult for most agencies, particularly those who bill Medicaid for services. This causes a problem because most evidence-based practice models require clinician- level practitioners and oversight.

Recruiting practitioners to rural communities is an even greater hurdle as lack of housing and amenities reduce the appeal to those that may consider working in Alaska’s smaller communities. For AI/AN communities, access to behavioral health care is limited due to remote location, cultural differences in treatment, and lack of resources. The Federal government identified areas with Federally recognized Tribes and automatically designated them as shortage areas eligible for programs that seek to reduce provider shortages (Bagalman & Heisler, 2016). “The Indian Health Service system noted that it has approximately 1,500 vacant health care provider positions and that it has difficulty recruiting providers because of the remote locations of many of its facilities (2016, p. 9).”



Alaska’s land and population diversity are two of its greatest strengths, but these strengths create complexities in serving Alaska’s children and families. Child welfare prevention programs in Alaska must operate well in small communities, with strategic on-site delivery and internet demands, and be created with inclusive cultural practices. Prevention programs will need to rely heavily on the labor force available within communities without a burdensome demand for clinical-level practitioners.

Urban and rural communities face different complexities in establishing and maintaining child welfare prevention programs. Before initiating any new prevention services, an in-depth search and identification of available resources and services are necessary.

Creating new agencies or services is often not viable in smaller communities with limited accessibility, resources, and workforce. The most appropriate approach in smaller Alaskan communities will be to build capacity and strengthen existing organizations to take on new prevention services. To qualify services for the Medicaid 1115 Waiver or FFPSA funding, existing community programs may need to be replaced with evidence-based practice models if a direct Tribal IV-E organization does not administer the program.

Because rural Alaskan communities experience limited access to dependable internet and an abundance of gathering spaces, programs utilized should be deliverable in-person through one-on-one or small group meetings that are normative of culture. Training programs should be offered in recorded format when possible. If the internet is available in a rural community, this should be relied on heavily to provide access to tele behavioral health services and virtual in-home visitation programs.

Recruiting and retaining a qualified workforce is difficult, even more so for rural communities. Child welfare work requires dedicated individuals to work in challenging and often traumatic environments while maintaining empathy and hope. Most child welfare employment positions require a minimum of a bachelor's degree. A common complaint among behavioral health agencies is the difficulty of finding clinicians to administer or oversee programming. This is a substantial issue because most evidence-based practices require varying levels of clinical expertise. This issue needs to be top-of-mind for determining feasibility. Programs chosen should require the least amount of clinical oversight while maintaining fidelity to the model.



Recruiting and retaining a qualified workforce is difficult, even more so for rural communities.

Urban communities in Alaska are small in comparison with most of the United States. This makes it possible to build a tight-knit prevention network and means there are a finite number of service providers. Alaska does not typically attract large corporations and organizations, and the brunt of prevention work falls to relatively small agencies with limited business expertise, financial and staffing resources.



Building a child welfare prevention system of evidence-based programming with acceptable evaluation mechanisms and billing systems for Medicaid and FFPSA is a considerable step from where most local organizations are now. System complexity alone is enough to jeopardize viability. As has been seen over the last decade, agencies working toward the goal of prevention but in silos does not bring large-scale impact.

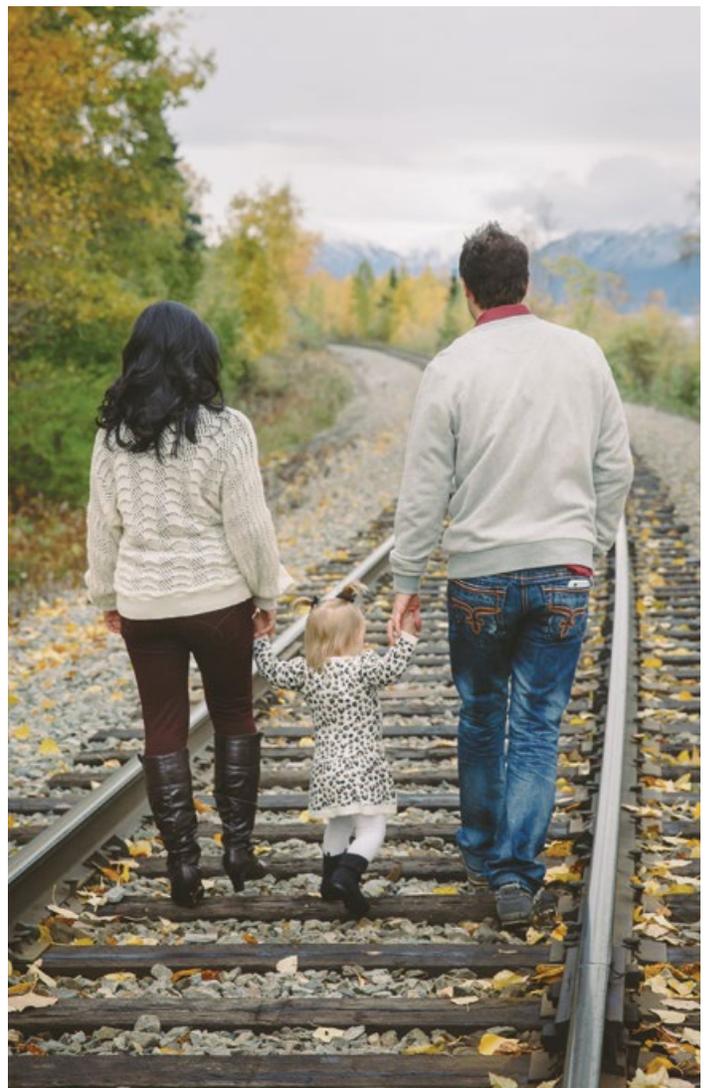
After analysis, it may be determined that most evidence-based programs eligible for FFPSA or Medicaid funding are inappropriate services for Alaska's Native families. If so, culturally appropriate promising practices should be utilized and supported through Tribal, agency, and stakeholder collaboration.

Alaska's Tribes, State, and private entities must band together to share staffing and systems resources. Agency organizational development will be most impactful when done through a collaborative lens. Examples of this would be:

- sharing clinical oversight of multiple programs
- centralizing administration
- building cultural competence within network providers
- designing culturally appropriate programs
- utilizing a universal statewide assessment tool to easily measure outcomes
- sharing software and billing systems
- sharing evidence-based and promising practice methods training
- sharing evaluation science methods
- communicating best practices regularly through dependable channels
- openly sharing successes and failures for all to celebrate and learn from



Alaska's leaders and communities want to work toward strengthening families and reducing child welfare involvement. Prevention work can be done more effectively through a collective approach. Valuable partnerships and system efficiencies will be discovered as work-flows progress. The vital element is that Tribes, State, and private agencies be diligent in seeking ways to collaborate and share resources.



INFORMATION SHARING



ISSUES

One of the significant hurdles in referring families to needed supports and services is the complexity and legality of information sharing between agencies. The Child Abuse Prevention and Treatment Act (CAPTA) (P.L. 93-247) and the CAPTA Reauthorization Act of 2010 (P.L. 111-320) require that states must keep confidential all child abuse and neglect reports and records (United States Congress, 2021). This is to protect the privacy rights of the child and the child's parents or guardians, except in certain circumstances. In addition, there are Federal laws specific to Federal benefits programs regarding the sharing of applicant and beneficiary information. States also have their laws and statutes that provide further guidance on how information is shared between public and private agencies.



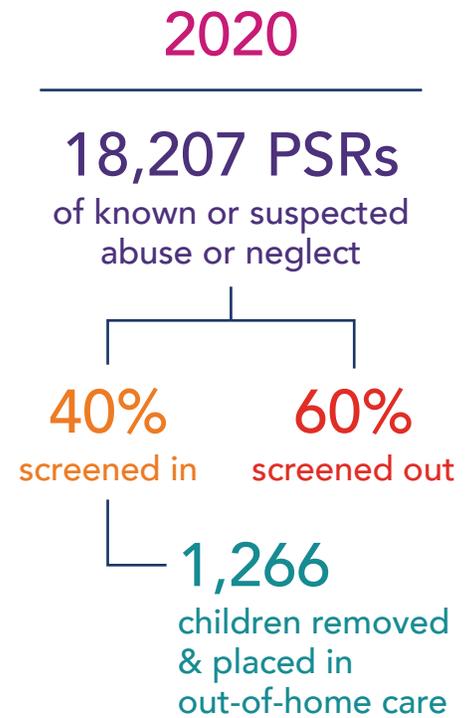
States are required to keep all child abuse and neglects reports and records confidential.

It would seem like common sense to refer all families known to be struggling with housing costs to food assistance programs to further assist them financially, but this is not possible without first asking consent and obtaining a release of information. In the case of public benefits, this permission to release information feels contiguous because the family has already approached one provider for assistance. When there are concerns about a child's welfare, the referral process is fraught with resistance. When OCS receives a report about a family struggling to provide for their children physically or mentally, they should be able to refer that family to community service providers for supports instead of automatically beginning a neglect or abuse investigation. However, this is not currently possible without a release of information from the same parents or caregivers reported to OCS. Often these parents are not even aware that they have been reported to OCS. Indeed wrap-around supports are needed for vulnerable families, and OCS wants to work with community partners to provide this, but there are many barriers.

Information Given to OCS

A Protective Service Report (PSR) is generated when someone calls the Alaska Office of Children's Services to report known or suspected child abuse or neglect. In 2020, there were 18,207 (1,517 monthly average) of these calls coming into the Intake department of OCS. Intake is a centralized department for the entire State, with 17 employees receiving calls. Once assessed for present or impending danger, maltreatment, AI/AN status (for ICWA compliance), relative and family supports, the case is either "screened in" to the Initial Assessment unit or "screened out," and the PSR is closed. Tribes who want access to reports on their citizens are provided copies.

Of the 18,207 PSRs in 2020, 7,268 (40%) were screened into the Initial Assessment unit. Of those 7,269 screened in, 1,266 children were removed from their homes and placed in out-of-home care (Alaska Department of Health and Social Services, 2021). These numbers highlight the importance of finding ways to support struggling families that comprise the screened out 60%. These families are not at the point of having their children removed but are at increased vulnerability for such.



State Information Sharing Laws

Most of the reports of harm coming into OCS are being placed by mandatory reporters. Alaska Statute §§ 47.17.020 defines a person required to report (The Alaska State Legislature, 2021). In 2020 the occupations of the largest reporting groups were educators, law enforcement, and health care professionals (Alaska Department of Health and Social Services, 2021). Alaska Statute §§ 47.17.040 requires OCS to maintain a child protection registry of all investigation reports, including substantiated findings (The Alaska State Legislature, 2021).

Alaska Statute §§ 47.10.093 states that all information prepared by, or in possession of, a Federal, state, or municipal agency or employee, regarding children identified in a PSR is privileged and may not be disclosed to anyone absent of a court order (The Alaska State Legislature, 2021). The exceptions to this rule are (when necessary): a court-appointed guardian ad litem, parents/guardians/caregivers or siblings, child support agencies, child placement agencies, state or municipal agencies, law enforcement, alleged perpetrators charged with a crime, members of a multidisciplinary child protection team, the state medical examiner, the person who made the report of harm, and the commissioner of Health and Social Services when there has been a fatal or near-fatal incident.

The requirement for a court order to release information is negated if the parent or guardian willingly signs a release of information for their personal information and report data to be shared with a designated service provider.



Most of OCS reports are placed by mandatory reporters.

There is also an issue of notice to the parties listed in a PSR. Under Alaska Statute §§ 47.17.040, a substantiated finding of child maltreatment cannot be placed on the child protection registry without adequate notice to the parties involved and an opportunity to appeal the determination (The Alaska State Legislature, 2021).



Sharing Information with Community Partners

OCS works with many community partners and agencies to provide services for families. Services utilized by OCS range from primary prevention (general family and child wellness initiatives) and secondary prevention (targeted initiatives for families at an increased risk for potential maltreatment) to tertiary services for children and families who are already involved with OCS due to an occurrence of maltreatment. OCS provides some prevention funding for several agencies through grants. Many agencies providing services for families involved with OCS are funding their operations through private donations or public funding outside of OCS.

When an agency is offering a service that clients of OCS would benefit from, it is beholden on the agency to inform OCS of the services available. This can be difficult as the caseworkers who need the information are hard to reach, and turnover is high. A common complaint among community service providers is that once they have gotten the word out to OCS caseworkers about their services and are starting to receive referrals, the OCS workforce turns over, and they must start all over.

There is no standard referral process within OCS. Each region works autonomously and engages its community according to the perceived necessity and time available. The referral process is broken for both grant-funded and non-grant-funded community partners. For grant-funded partners, this lack of referrals means that the State funded programs cannot effectively serve the grant's target population. For non-grant funded partners, this disconnect results in unused resources and an inability to be connected to those that need them.

Child welfare prevention services are being implemented across Alaska, and yet they function at partial capacity due to the information sharing and referral process barriers. A statewide child welfare prevention network will require developing and executing a comprehensive referral system to increase the utilization of prevention programs. A proactive community outreach program is also needed, so that vulnerable families are aware of the services available without the stigma of being referred by a child protection agency. The legal issues of information sharing have several possible solutions that should be analyzed and moved toward further action.



SOLUTIONS

Referral Process for Screened-In Cases

Community-based services for families that are child welfare involved are engaged mostly using referrals from OCS. Some OCS grants require that referrals come directly from OCS and not a third party. However, this referral pipeline from OCS is sporadic and underutilized for several reasons. OCS has a very high turnover of front-line workers who engage families. The short employment tenure yields staff with little knowledge of available services to refer families. The lack of OCS caseworkers also yields high caseloads making it challenging to prioritize referrals to important services but not necessarily emergent from the perspective of a caseworker. In addition, referrals require time and can be cumbersome for an already overloaded worker.

There is also a lack of standardized referral procedures across OCS regional offices. Some private agencies have found an internal OCS champion of their services who actively seeks out referrals and filters those referrals to the agencies. This has been a reasonably adequate workaround for a limited number of agencies but does not address the root systems gap.

One solution may be to have a dedicated team of referral associates within OCS who are responsible for community resource knowledge, gathering ROI authorizations, referral processing, referral follow-up, and case note updates in ORCA (OCS’s data platform). The oversight of this team could be centralized in processing but dedicated by region to develop localized knowledge.

Another solution would be to contract with a referral organization (i.e., Help Me Grow, United Way’s 2-1-1, or another navigator) to handle all referrals. It would be most efficient in this scenario to have an ROI required by each family within the case origination clarifying that OCS contracts with vendors for the support services a family may need. The ROI extends to the referral navigation contractor and the providers of those services. Medical insurance companies and group benefits providers with similar confidentiality constraints utilize concierge/coordinator companies with increasing frequency to address this referral connection issue.

Referral tracking information is precious in determining efficacy in programming and organizational capacity. It informs stakeholders on the availability of services and will aid in evaluating outcomes. This tracking data would need to update continually in an easily accessible database and ORCA.

Referral Process for Screened-Out Cases

It is important to note that when OCS receives a PSR on a family, it may not be the first time they have been called and have not yet intervened. In 2020, OCS initiated investigations on 2,039 families for the first time. Of these 2,039, 656 had at least one prior PSR that had been screened out. There was a monthly average of 911 screened-out reports in 2020 (2021). Any efforts to refer these families to services would require increased capacity within local service providers. Clearly, screened-out referrals are where focused

2020

2,039 PSRs
for first time families



656

had at least one prior
PSR that screened out

prevention efforts should concentrate; however, this requires a comprehensive outreach and community-based service offering.

When OCS screens out reports of harm, nothing further is done with this information outside of recordkeeping and communication of the decision with Tribes that have opted-in for this information. Due to the confidentiality and information sharing issues, referring a screened-out case to a third party for services without an ROI or notice to the family is legally prohibited. Getting an ROI from parents who are unaware of being reported to OCS is problematic.



In 2020, on average
911 PSRs are
screened out per month.

Notice

Notice of being reported to OCS could be provided to families via phone or mail. This would involve a dedicated team within OCS or a contract with a third party. Phone notice would involve a call to the family notifying them that they were brought to the attention of OCS, but that the case is being closed for now, and the caller would ask if the family needs assistance and would refer them to needed resources like counseling, housing, or substance treatment. A notice could also be provided by mail stating that OCS had received a report but has decided to close the investigation. Still, the letter contains a list of resources available to the family if they choose to utilize them.

Notice is an often-overlooked element of prevention. Although some families may not adjust their behavior after being reported to OCS, some would, and to not notify them of reports places families that would like help at a disadvantage.

Reports are screened out for a variety of reasons. If someone called OCS because a child kept coming to school dirty or lacked outerwear for recess, or if a family was reported because a friend knew they were sleeping in their car, these are situations that do not need investigation and child welfare involvement. These families need support and may be unsure how to access services. Vulnerable families might be more inclined to utilize services if they knew they were in jeopardy of OCS involvement. Suppose a citizen is made aware that the municipality as received notice regarding their pet. How much more important is it that notice is provided to families about concern for their child's wellbeing?

Outreach

Community outreach is undeniably the best way to reach families in need of supports. Creating public awareness of available resources and placing those services in welcoming environments is a fundamental prevention tactic.

Poverty plays a dominant role in child welfare involvement.

"Children in low socioeconomic status households had significantly higher rates of maltreatment in all categories....They experienced some type of maltreatment at more than five times the rate of other children; they were more than three times as likely to be abused and about seven times as likely to be neglected (Sedlak, et al., 2010)."

Prevention efforts that reduce the effects of poverty by providing concrete resources reduce a child's risk of maltreatment. Some of these resources are housing assistance, food, childcare, and temporary

Children in low socioeconomic
status households are:

5X as likely to be maltreated

3X as likely to be abused

7X as likely to be neglected

financial assistance. Placing these resources within communities at schools, libraries, churches, storefronts, and community centers reduces stigmatization and encourage engagement.

Family Resource Centers (FCRs) are being utilized all over the country. They are community-based hubs that offer services like job training, parenting classes, mental health or substance abuse interventions, and concrete supports like food and clothing. FCRs are partners to families and provide services using a strength-based and culturally sensitive approach.

Current research is showing the effectiveness of Family Resource Centers. Allegheny County, PA, has had great success with its Family Support Center Network. The county's neighborhoods with FSCs had 30.5 investigations per 1,000 children compared to the 41.5 investigations per 1,000 children in neighborhoods without FSCs (2021).



Brooklyn's Center for Family Life in Sunset Park serves up to 300 families at a time who come in on their own or are referred by child welfare professions. "Recent data shows that out of 1,012 children served, none entered foster care. In the previous program year, out of a total of 1,189 children served, only one child entered foster care (Casey Family Programs, 2021)."

Community outreach programs like Family Resource Centers reduce the need for information sharing and provide effective preventions so that a family does not become child welfare involved.

Statutory Language

Protection Service Reports that OCS has screened out cannot be transferred as a referral to a prevention provider without a release of information from the parent. This issue could be changed with new laws. However, without notice and buy-in from the parent. These referrals may fall flat.

Indiana's Department of Child Services developed a prevention service for families that have been screened out or have not yet come to the attention of public child welfare called Community Partners for Child Safety (2021). The program provides home-based case management and connects families with needed supports. It is important to note that families gain access to this program by self-referral or referral from a community partner. The Community Partners for Child Safety is essentially an internal prevention program of the Indiana Department of Child Services.

According to a recent survey commissioned by R.O.C.K Mat-Su and written by the Butler Institute for Families, Minnesota and Colorado have changed their information sharing statutes (Wilcox, 2019). Minnesota changed its statute to include information sharing with vendors as agents of the child welfare system. Colorado changed their statute to allow for information sharing to prevention providers who may reach out to a family that has been screened out. Colorado Community Response has been particularly successful. An evaluation from 2014 to 2017 found that families who completed the program had "fewer founded assessments and out-of-home placements during a one-year follow up period than did families with similar demographics and case characteristics" (2019, p. 12).

Many states seeking to reach families that fall into the lower risk category have deployed a different referral strategy by screening in cases (that may have been screened out previously) but assigning the families to a prevention services track that refers them to community prevention providers in contract with the state. Some states have in-home service support units that provide these prevention services. This alternate response to Protective Service Report processing is referred to as differential response.

Differential Response

Differential response is a philosophical shift in child welfare practice away from the investigation of the family toward reinforcement of a family. Differential response is not a primary prevention strategy in that families have already been reported to OCS. Still, it is a prevention strategy seeking to limit the removal of children from their parents. It also promotes family strengthening and community interconnectedness.

Employing differential response at the point of initial assessment requires filters for which assessment path the family is served through. Reports with a high safety risk are sent through the investigation path. Low to moderate risk reports are referred to the prevention path, and families are served without intensive investigation. This child welfare approach is less adversarial for families.

State agencies have developed their criteria for the prevention path. For instance, if a family has had more than one report or previous child welfare involvement, they may be ineligible for the prevention path. The age of the children and severity of allegations is also a significant factor.

A study of differential response in six states was released in 2016 by the Office of the Assistant Secretary for Planning and Evaluation (Fluke, et al., 2021). The study found that “overall, higher rates of alternative response were associated with lower re-reports” and of the states that did not have lower re-reports, there was no association (2021, p. 1).

The Anchorage OCS office implemented an alternate response program over ten years ago in partnership with Cook Inlet Tribal Council (CITC). Lower risk cases were screened in and referred to CITC for outreach and follow-up. This information sharing arrangement was legal because CITC was a contractor for OCS, and OCS maintained oversight of the case. The project was abandoned after three years primarily due to a lack of funds and concrete evaluations to determine efficacy. It was noted by the project’s manager that cold calling a family that has been referred to OCS and offering services is not the best approach for family engagement. The consensus among those involved in this project is that engaging at-risk families through safe and attractive community outreach programs is a superior prevention strategy.

Effective preventions require an interconnected approach to reaching families. Building a comprehensive referral system with the workforce to manage it would improve referral delivery to partnering agencies. Establishing Family Resource Centers or other community outreach programs can strengthen Alaska’s families and reduce maltreatment. Re-imagining differential response and embracing its philosophical approach to child welfare is a worthy endeavor. Let us see Alaska’s family’s strengths and build from there.

CHILD WELFARE RESPONSIBILITY



ISSUES

Of the 574 Federally recognized American Indian and Alaska Native (AI/AN) tribes and villages, roughly 40% (229) are in Alaska. This creates a unique authority dynamic because, in addition to a traditional Federal and state governance, there are 229 uniquely sovereign tribal nations.

When it comes to the relationship between U.S. governmental entities, the Federal government has been tasked with protecting “tribal self-governance, tribal lands, assets, resources, and treaty rights, and to carry out the directions of Federal statutes and court cases (2020, p. 23).” This self-governance is the crux of the issue related to child welfare decisions. In the U.S. Federalism model, each state is responsible for the welfare of its citizens; this includes child protective services. Since the beginning of statehood, Alaska’s Office of Children’s Services has been responsible for protecting Alaska’s children. However, historically, this issue has blurred the lines on how decisions are made for Native children. In 2020, 65% of all Alaskan children in foster care are Alaska Native despite only 16% of the overall population in the state being American Indian or Alaska Native (Alaska Department of Health and Social Services, 2021).

Within child welfare systems in Alaska, the problems have been the disproportionate number of Native children in foster care compared to non-Native children, the separation and resulting trauma from Native children being removed from their culture and communities, the low family reunification rates, and the adoption of Native children into non-Native homes. The Tribal State Collaboration Group was started 25 years ago as a collaboration between state and Tribal representatives to address these problems. This group still exists today and has been the breeding ground for what became the Alaska Tribal Welfare Compact.

40%
of federally recognized
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65%
of Alaska’s children
in foster care are
Alaska Native

The Alaska Tribal Welfare Compact was a first-of-its-kind legal agreement made in 2017 between the State of Alaska and participating Alaska Native Tribes and Tribal Organizations to address the problem. The Compact recognizes tribes as sovereign over their citizen's child welfare, and for tribes that want to manage all or part of their child welfare, it provides the funding and operational structure to delegate the oversight and management to them.

There are currently 15 AI/AN or Tribal organizations as co-signers of the Alaska Tribal Child Welfare Compact. These entities include Aleut Community of St. Paul Island, Aleutian Pribilof Islands Association, Association of Village Council Presidents, Bristol Bay Native Association, Central Council Tlingit & Haida Indian Tribes of Alaska, Chugachmiut, Cook Inlet Tribal Council, Copper River Native Association, Kawarek, Inc., Kenaitze Indian Tribe, Maniilaq Association, Native Village of Eyak, Nome Eskimo Community, Sun'aq Tribe of Kodiak, and Tanana Chiefs Conference.

The Compact has defined the work of Tribal child welfare into five scopes of service as shown below.



Each Co-Signer is at a different stage of capacity building or implementation. Casey Family Programs, who has long been a partner of Alaskans, assists the Tribes with the financial and technical assistance needed to incorporate national best practices into their service models.

The Tribal-State Compact implementation teams are working hard to move toward a remarkable and historic Tribal-led child welfare system. The importance of the Compact cannot be over-stated. The disproportionality of AI/AN children in foster care is alarming. Any approach to address the disparity must be based on a model where family proximity, culture, and belonging are the foundation of all services.



SOLUTIONS

Alaska's Tribes and Tribal organizations are at the beginning stages of Compact implementation. Each organization is in a unique stage of capacity and program building. Funding, management, staffing, training, programming, and evaluation systems are needed for each scope of work a Tribe intends to assume responsibility for.

Now is the time for Alaska's stakeholders to come alongside Tribal child program leaders and provide any services and support they may need to stand up their child welfare programs.

NETWORKS AND SUPPORT



ISSUES

For child welfare agency leaders, workers, and experts, their work often feels bottomless. New tactics and programs are being tried all over the state to better the lives of Alaska's most vulnerable children and families, and yet the number of children in foster care is not decreasing. Many times, agency leaders and workers are unaware of what efforts are occurring in their own community, much less in other parts of Alaska. Implementation agencies could benefit tremendously from collaborating with and learning from a group of peers, sharing resources and knowledge.

The grant-based funding system has produced an element of competition among providers and is a factor in creating unsustainable and fitful prevention efforts. Agencies expand their services to fulfill grant requirements, spend two to three years building a program, and then the funding is gone, and those services end. Sometimes the funding ceases because there are not enough outcomes to justify the cost, and yet, concrete evaluation mechanisms are rare to find as a means to judge outcomes. Other times the funding ends because the State has shifted priorities. Prevention is not an overnight journey; effective preventions take many years to show significant and statistical progress.

Utilizing a statewide collective impact approach, child welfare implementers will do well to join as a unified voice and address systems issues related to their interactions with OCS and each other. An alliance of practice professionals with a shared child welfare prevention plan, an agreed-upon approach, shared measurement, and a commitment to each other and the vision would create momentum toward progress.



SOLUTIONS

Due to the limited personnel and system resources, and the access to them in Alaska, we recommend that a formal working group of implementers and innovators be convened and commissioned to begin creating a prevention network in the State. We are proposing the establishment of the Alaska Impact Alliance (AIA).

The Alaska Impact Alliance is not a non-profit or legal entity. It is a group of Tribal, public, and private sector innovators and agency leaders to create a Statewide child welfare prevention system driven by communities and not the government. This group understands that prevention is not a state agency problem to solve; it is a community mindset to embrace.



The Alaska Impact Alliance will approach child welfare prevention by building or strengthening community-led programs through funding and hands-on collaboration. As community leaders choose prevention efforts that will strengthen their families, the Alaska Impact Alliance will come alongside them to design and build community-based prevention programs using the latest research and promising practices being used by child welfare organizations all around the country and world.



Alaska Impact Alliance members will not only create an action plan, but they will also work with local agencies and Tribes to implement and support these programs.

Establishing a working group like this is coming at a critical point in Alaska’s child welfare history. The Federal push to innovate and invest in prevention is unprecedented. Sustainable funding mechanisms are now a reality. The FFPSA provides funding for prevention services that was not available before, but it will require evaluation to determine its utility in Alaska. The 1115 Behavioral Health Medicaid Waiver is being rolled out to begin funding services for at-risk children, adolescents, and their parents or caretakers at risk for mental health or substance abuse disorders. This provides a new source of funding for much-needed behavioral health services that have a proven record of preventing child maltreatment. The Alaska Child Welfare Tribal Compact is being activated in stages, and Tribal co-signers will benefit from having a group to support and collaborate on their work to stand up child welfare services for their children.



The action plan of the AIA will work on building data-driven and culturally appropriate prevention programs around the State. The Impact Alliance members will work alongside each other and create a network for implementation agencies. We will offer each other support, training, development, research, centralized administration, and anything else better done together than apart.

We will continuously evaluate each new program and can duplicate successful prevention programs across the State as communities choose. Effective prevention programs will become a part of a larger Statewide network of supports for Alaska’s families.

We would like to engage a cohort of academics and researchers from Alaska Pacific University and the University of Alaska to conduct program evaluations. Training implementers of evidence-based practices could be done by local training agencies like Alaska Behavioral Health, the Child Welfare Academy, and the Family Services Training Center at UAA’s Center for Human Development. The idea is to keep the work of the AIA as home-grown, and community based as possible.

Other Networks and Supports

The Alaska Children's Trust is the statewide umbrella agency with the mission to prevent child abuse and neglect. They provide Alaska's children and families with advocacy, research, program funding, and convening (Alaska Children's Trust, 2021). ACT is a catalyst in Alaska for all things related to child maltreatment prevention. There are several other exciting locally based prevention efforts occurring in Alaska. Ketchikan Revilla Island Resilience Initiative, R.O.C.K. Juneau, R.O.C.K. Mat-Su, Southern Kenai Peninsula Resilience Coalition, and the Seward Prevention Coalition are active groups working within their communities.

The goal of the Alaska Impact Alliance is not to duplicate the work of these partners but to complement their efforts by providing a hands-on implementation and innovation team to build and maintain prevention programming in the state.

The World Health Organization published a report on *Implementing Child Maltreatment Prevention Programmes: What the Experts Say*, highlighting the importance of building a team like the Alaska Impact Alliance (Hardcastle, Bellis, Hughes, & Sethi, Dinesh, 2021). "Building partnerships at a local level across agencies and disciplines is essential when planning for the sustainability of an intervention. It is crucial to create a shared vision between stakeholders and ensure that the protection of children and the prevention of child maltreatment is not seen as the exclusive responsibility of any one individual agency (2021).

Notable Statewide Collaborations



Bring Up Nebraska is a statewide collaborative that is the administrative lead "working with communities, as well as state and national partners to bring additional partners, resources, and solutions together to address and further support prevention efforts" (Bring Up Nebraska, 2021). Bring up Nebraska did not create many new resources but instead connected the existing resources, coordinating local and state strategies and "encouraging other communities and partners to join the effort" (2021). The group partnered with Casey Family Programs to build the Nebraska Community Opportunity Map, an interactive tool that provides child and family well-being data to better equip partners working in those areas.

"Bring Up Nebraska is generating impressive results. The number of Nebraska children in need of foster care in 2018 decreased about 18% from 2017, and the number of entries into care decreased nearly 30% over the same period. The number of children re-entering care is 4% below the national average of 7% (Casey Family Programs, 2021)."



Colorado's Tennyson Center for Children is partnering with the Colorado Health Institute on a statewide collaboration called Rewiring (2021). The collaboration launched in 2019. To date, the group of public and private agency leaders and community investors have seeded community-based prevention projects in 4 Colorado counties. They began by asking counties how they wanted to prevent their children from becoming child welfare involved and then worked with the local agencies to develop and implement prevention programs. They also contracted with a third party to conduct measurement and evaluation. The mantra of the group was to "buy a better outcome" for children in Colorado by utilizing private investment to fund small pilot prevention projects that can then be funded with state or federal dollars after improved outcomes. The goals of Rewiring are to 1) reduce the number of children and families entering the child welfare system by engaging in early interventions, 2) improve the quality of child welfare services, and 3) reshape the flow of local, state, and national funding to primary and secondary prevention in a sustainable manner (2021).

The Rewiring collaboration has implemented several prevention programs, including offering tangible resources through outreach programs, providing free behavioral health and family counseling for children who are exhibiting threatening behavior at school, funding and supporting Safe Families for Children, which offers respite care for children while their families are in crisis, and creating coordinated community response models to reduce contact with child welfare systems.

It is too early to determine the efficacy of each program as the COVID-19 pandemic occurred shortly after program implementation. Still, the county leaders are encouraged with preliminary outcomes of the collaboration.



Collaboration is wanted in needed amongst child welfare professionals in Alaska. By working together, we can create sustainable programming that strengthens families and reduces child maltreatment.



CONCLUSION

Child welfare leaders are at a pivotal moment in Alaska's history. We are facing new challenges while being provided unique opportunities to change the way we serve families that are vulnerable to child welfare involvement.

The number of children in foster care is staggering, the State's budget and workforce is decreasing, and yet new federal prevention funding streams are available at an unprecedented level. The Alaska Tribal Welfare Compact is the first Tribal-State partnership of its kind to empower and fund Tribal child welfare systems. We are poised for positive change.

It is critical that stakeholders come together now to design and build a community-led prevention network that is scalable and sustainable. Through agency collaboration and public-private partnerships, we can strategically create effective services.

If ever there were an effort worthy of our passion, resources, and time, it is to improve the lives of Alaska's children and strengthen Alaska's families.

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