Mat-Su Behavioral Health Environmental Scan Report 3 – Keeping our Children Well-Cared-For and Safe in Mat-Su

Prepared for and with assistance from:

Mat-Su Health Foundation

and

Participatory Research Consulting LLC

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McDowell GROUP

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Executive Summary

Background and Methods

In 2013, the Mat-Su Health Foundation (MSHF) and community partners conducted a Mat-Su Community Health Needs Assessment (CHNA).[1] As part of the CHNA process, more than 500 Mat-Su residents and professionals participated in 23 meetings across the Mat-Su Borough. At the community meetings, participants identified the following as the top health and wellness goal for Mat-Su:

All Mat-Su children are well-cared-for and safe.

This report is in response to the identification of this goal. Information for this report comes from analysis of secondary sources such as the U.S. Census, the Behavioral Risk Factor Surveillance System, and other surveys, in-depth interviews and meetings with community residents, an extensive literature review, a service gap analysis, and a policy and funding inventory and analysis.

Three Key Components

There is no one system that focuses solely on promoting resilient families and keeping children safe. Rather, each community creates its own system to do this work. In Mat-Su, that system is made up of all people – relatives, neighbors, professionals and organizations that care about and/or work with children and parents/caregivers. There are three key components of this system:

1. Services and programs exist to support children and families.
2. All sectors in the community have supportive child and family-friendly policies and practices, including employers, health-care providers, hospitals, schools, law enforcement, and government.
3. The community is close-knit and, when necessary, organizes to support children and families.

Using the Public Health Framework to Support Children and Families

Resilience is a concept that is key in strategizing to support children and families. The most authoritative general definition of resilience comes from the American Psychological Association (2014): *"The process of adapting well in the face of adversity, trauma, tragedy, threats or even significant sources of stress."* Exposure to some adversity during childhood is normal and necessary for healthy development, but sustained or repeated exposure to severe adversity without supportive relationships can be detrimental for children. Research has shown strong connections between negative experiences in childhood and adult emotional health, physical health, and mortality in the U.S. (Felitti et. al, 1998).

[1] The full Mat-Su CHNA can be viewed at *222.healthymatsu.org*.

As a means of coping with prior trauma or, because of impaired development resulting from trauma, youth and adults may adopt high-risk behaviors - such as excessive alcohol consumption or criminal behavior during adolescence and adulthood. When individuals who adopt "high-risk behaviors" as a result of the trauma, become parents, they are exposing their children to "adverse childhood experiences" (ACEs). When trauma is transferred from one generation of trauma survivors to future generations, it is referred to as the "intergenerational transmission of trauma."

While resilience offers an opportunity to diminish the experience of the long-term exposure to childhood adversity, prevention is the first line of action. Safe, stable, nurturing relationships and environments help to prevent childhood adversity and to ensure children reach their full potential (Prevention, 2016).

The public health framework for prevention of child maltreatment includes three levels of services: primary prevention, secondary prevention, and tertiary prevention. A comprehensive system of child maltreatment prevention will include strategies across the three levels of prevention.

- **Primary prevention** activities are directed at the whole community and are intended to promote child and parent resilience to prevent maltreatment.
- **Secondary prevention** activities target families that are under stress and may have increased risk for child maltreatment and are designed to decrease the risk of maltreatment.
- **Tertiary prevention** activities focus on children and families already impacted by child maltreatment. These efforts are meant to reduce harm from exposure to trauma and prevent maltreatment.

Funding for Community Support of Children and Families

Services, programs, and local policies are often developed based on state and national policy and funding. The State of Alaska Department of Health and Social Services awards grants that support early intervention and prevention, and promote well-being. In all, approximately $7.6 million, or about 13 percent of DHSS grant program funding statewide (excluding programs funded to support seniors), is funneled through the Mat-Su Borough. Borough residents (excluding seniors age 65+) represent 14 percent of Alaska's population. Each of these residents received the equivalent of $84.90 in behavioral health prevention grant funding. Statewide, the average was approximately $86.61 per Alaskan under age 65.

An analysis of DHSS SFY2015 spending in Mat-Su by level of prevention revealed:

- Primary prevention: 15 percent - $1.2 million
- Secondary prevention: 61 percent - $4.7 million
- Tertiary prevention: 24 percent - $1.8 million

It is also informative to examine the life stage the funding addresses:

- Prenatal/Preconception: None, although, primary medical care support (such as Medicaid/Denali KidCare) for pregnant women is available and may be used to address the behavioral health needs of pregnant women.
- Early childhood (0-3 years): 28 percent - $2.2 million
- Childhood (6-10 years): 11 percent - $692,453

- Adolescence (10-18 years): 13 percent - $771,538
- Adulthood: 41 percent - $2.5 million

Based on data and findings in this report, the following challenges and recommendations stand out as important to address in order to create a system in Mat-Su that keeps children well-cared-for and safe. This section is organized around the Strengthening Families Framework for supporting family resilience through a focus on five evidence-based protective factors.[2]

Protective Factor #1:
Social Connections – Parents need people who care for them and their children, who can be good listeners, whom they can turn to for advice and whom they can ask for help in solving problems. These people may include supportive family members, friends, neighbors, co-workers, and other community members.

MAT-SU CHALLENGE: *In Mat-Su, some residents are well-connected and can avail themselves of opportunities for support that benefit their families and children. These residents with high levels of social support are more likely to report positive health status and satisfaction with life. A smaller group of residents do not appear to have a robust support system:*

- *13 percent of Mat-Su residents report not being comfortable going to a neighbor for help in an emergency.*
- *19 percent of residents say they would be somewhat or very unlikely to ask for help with caring for their children, such as someone to watch them for a few hours or pick them up from school.*
- *10 percent of residents say they had none or only 1 person they could count on to help them with a practical problem, like finding a ride to medical appointment.*

Recommendation 1. Create a community where it is easy for all parents to build supportive relationships with other parents, seniors, and other residents. Approaches may include:

- Create a voluntary community-wide peer parent support program for all parents, including those who have an open Office of Children's Services case or Child in Need of Aid court case
- Increase community gatherings in public spaces to reduce parent and family isolation
- Develop a volunteer hub to connect community members with others in need and organizations with needs to increase social connectedness in Mat-Su
- Bring back "Community Schools"[3]

[2] The Strengthening Families Program is a nationally and internationally recognized evidence-based parenting and family strengthening program for high-risk and general population families.
[3] Community Schools is a program that has a coordinator who organizes programming in public schools in the evenings, weekends, and during vacations when schools are not normally used. Community schools offer a host of opportunities and supports built on that give students and parents tools they need to learn and grow. Offerings can include a broad range of topics. Examples of programming in Juneau and Sitka include youth basketball league, woodworking, family roller skating, Tai Chi, preserving wild meat and parenting proactively.

Recommendation 2. Use community-organizing to identify and unify parent leaders to create community driven solutions to family issues.

> **Protective Factor #2:**
> **Knowledge of Parenting and Child Development** – All parents, guardians, and child-care providers have accurate and timely information on child development and age appropriate expectations for children's behavior. Developing brains need proper nutrition, regular sleep, physical activity, a variety of stimulating experiences, and caregivers who respond to their needs in a nurturing way that is necessary to form a secure attachment between the child and the adult.

MAT-SU CHALLENGE: *There is no universal program/process that informs all Mat-Su parents and others about child development, teaches parenting skills or helps parents support and teach each other. At the extreme opposite of developmentally appropriate care – child maltreatment can have huge costs to children throughout their lives, as well as to society. In 2015, 248 Mat-Su children had at least one substantiated report of child abuse and neglect with an estimated lifetime cost of $55.4 million (this is the sum of short-term and long-term health care costs, loss or earnings, child welfare costs, criminal justice costs, and special education costs). The precursor to "knowledge of parenting and child development is making an informed decision on whether to be a parent. In Mat-Su, 7.1 percent of births in 2015 were "unwanted" and 21.1 percent were to mothers who did not want to be pregnant then, wanted to be pregnant later, or never wanted to be pregnant. In 2015, 67 babies were born to teenage mothers.*

Recommendation 3. Ensure widespread access to family planning for all Mat-Su residents, including family planning imbedded in robust teen pregnancy prevention efforts.

Recommendation 4. Support the development of a wide array of parent training classes, support groups and other initiatives to educate all parents on the effects of ACEs, resilience, child development and appropriate parenting skills. Approaches may include:

- Media campaigns and workplace trainings
- Education efforts for pregnant women on what to expect during their child's first year and where to find information on child development and parenting techniques
- Parenting classes and support groups for all parents, including those who are in crisis
- The adoption of Ages and Stages child development questionnaire and teaching approaches for health care providers

Recommendation 5. Promote affordable, high quality childcare, afterschool care, and home-visiting programs that support optimal child development and youth resilience. Approaches may include:

- Improve the child care workforce through training and credentialing
- Support the thread Alaska tracking system for quality care in Mat-Su
- Expand home visiting programs as needed in Mat-Su
- Create therapeutic child care for children who have experienced trauma and/or have behavioral health challenges

- Increase afterschool programming with structured opportunities to increase youth resilience

Protective Factor #3:
Parental Resilience – Parents are resilient when they can handle personal challenges and those of their children, manage adversity, heal from the effects of trauma in their own lives, and thrive, given the characteristics and circumstances of their families. Also, by managing stressors, parents are more able to provide their children with nurturing attention and a secure emotional attachment – which is important for children to develop their own resilience.

MAT-SU CHALLENGE: *Many Mat-Su parents have experienced ACEs. In 2013-14, 12 percent of Mat-Su adults stated that they had experienced two ACEs. A total of 42 percent said they had experienced three or more ACEs. If these individuals have not healed from these ACEs, it may be more difficult for them to handle personal challenges of their own and of their children. Parents need access to counseling services, substance abuse treatment and integrated medical and behavioral health care to care for themselves so they can care for their children. In Mat-Su, there are not enough services for parents in terms of substance abuse detox, residential care, crisis care and crisis prevention services, family behavioral health programs, and integrated behavioral and primary care. Further, many people who are seeking help for themselves and others do not know where to go for support and services.*

Recommendation 6. As mentioned in the first two Behavioral Health Scan reports, filling the gaps in the behavioral health system and increasing access to information and existing programs through a central resource center which is available via phone, internet, and in-person to provide information and referral, and navigation, as needed, to parents, relatives and others seeking to support families.

Recommendation 7. Ensure support for the "whole" parent and child in medical settings with integrated physical and behavioral health care; trauma-informed practices and policy, and universal screening for trauma and referral for social service needs.

Recommendation 8. Ensure family-friendly workplaces with work-related stress reduction strategies, parental leave, employee assistance programs, flexible and consistent work schedules and an environment for addressing behavioral health issues that is stigma-free.

Recommendation 9. Implement trauma-informed policies in workplaces, social service agencies, medical care providers, and schools to support parents and families who are healing from traumatic experiences.

Protective Factor #4:
Social and Emotional Competence of Children – When a young child has positive interactions with others, self-regulates his or her behavior, and effectively communicates his or her feelings, this has a positive impact on that child's relationship with family, other adults and peers, and on the child's ability to learn in school. When the strengths of adolescents are fostered through the intentional and deliberate process of providing supportive relationships, experiences and opportunities, they develop into healthy, responsible adults who have the capacity to give back to their community. While social emotional learning is important for all children, it is crucial for children who have experienced ACEs that may significantly affect their emotional development.

MAT-SU CHALLENGE: *In Mat-Su, the School Climate and Connectedness Survey assesses social emotional competency for students grades 6-12. The index is composed of questions measuring how easy or difficult it is for students to do certain social emotional skills. Areas where Mat-Su youth had difficulties include finishing tasks that are hard for them (38 percent); setting goals (27 percent); doing schoolwork even when they didn't feel like it (46 percent); being prepared for tests (35 percent) and getting through something even when they felt frustrated (44 percent).*

Recommendation 10. Support universal access to early learning and preschool programs to ensure kindergarten readiness around social emotional competency of Mat-Su children (i.e., create more early learning slots in Head Start, Early Head Start and MSBSD preschools).

Recommendation 11. Promote social emotional competency for all Mat-Su school-age children and young adults, including those who have experienced trauma. Approaches may include:

- Social emotional learning integrated into curriculum for all ages at school
- Support for homeschool parents with social emotional learning
- Social emotional supports for youth aging out of the foster care system
- A position within the Mat-Su Borough School District that includes the authority to establish system-wide policies on social emotional competency and implement programs, such as curriculum development and teacher assessment.

Recommendation 12. Fill gaps in the behavioral health continuum of care for children mentioned in Reports 1 and 2 of this Scan, including making counseling available in schools, integrated pediatric primary and behavioral health care; and the development of child-crisis care services.

Protective Factor #5:
Concrete Supports in Times of Need – To thrive, families' basic needs must be met. Adequate concrete supports, (e.g., housing, income, and transportation) must be in place to provide stability and help for families in need. These services should be provided in a way that ensures parents' dignity and does not increase parental stress. Services should help parents identify their assets and strengths, and become active participants in negotiating their support system and independence.

MAT-SU CHALLENGE: *Parents in Mat-Su face challenges in raising children that include handling their own health and wellness (see parent resilience) as well as providing financially for their households. From 2010-14, there were 4,581 single-parent family households in Mat-Su. Children in single-parent households are often more likely to experience poverty (female-headed 44.0 percent, male-headed 17.2 percent) as compared to two parent households (6.3 percent). Additionally, children are more likely to live in a household accessing public assistance headed by a single parent (female-headed 47.5 percent or male-headed 27.2 percent) compared to two parent households (15.1 percent). In 2012-13, one in five mothers, or their partners, experienced a cut in pay or work hours before their baby was born. Also, one in four mothers of 3-year-old children report that since their child was born they have had a lot of bills they could not pay. In the 2014-15 school year, approximately 6,151 students (34 percent) were identified as economically disadvantaged, and in 2015/16, 695 students experienced homelessness.*

Recommendation 13. Create a more connected, complete network of concrete support service providers who leverage efforts to adequately meet the needs of Mat-Su parents. These providers should promote a culture of serving families in a way that maintains their dignity and promotes resilience and self-advocacy.

System-Related Recommendations

Unlike the recommendations organized by protective factors listed above, the following recommendations focus on promoting collaboration between system components through shared data, communication, tracking, and reporting to ensure the progress continues. These recommendations are developed in response to research conducted for Reports 1-3 of the Behavioral Health Environmental Scan, as well as additional community work conducted by Mat-Su Health Foundation.

Recommendation 14. Adopt a balanced view of prevention, emphasizing health promotion and primary prevention, as well as secondary and tertiary prevention. Promote prevention strategies that have proven successful in the community so they are accessible to all families and all can benefit from them.

Recommendation 15. Promote wellness and resilience data collection. Invest in enhanced development of data infrastructure, data management, and data tools, including training for providers, community groups and other collaboratives who are collecting and using the data.

Recommendation 16. Promote policy change in the following areas:

- Address policy challenges that prevent local law enforcement and the Alaska State Troopers from sharing child maltreatment data with the Surveillance of Child Abuse and Neglect data tracking system.
- Ensure that parents have continuous Medicaid and insurance coverage, even those who have temporarily lost custody of their children. This policy would ensure continuity of behavioral and physical health care and support resilience.
- Conduct an assessment and develop a policy/advocacy agenda that creates structural changes in the system that is inclusive of homeless youth and young adults, as well as those involved with the foster care system, and helps youth to thrive.

Recommendation 17. Prepare a full assessment and plan of improvement for the Mat-Su OCS, including tools or programs to convert policy into practices (such as trauma-informed approaches) and workforce development. Components of this plan should include:

- A more extensive system for all levels of visitation and family contact for families involved with OCS.
- A support program for all personnel who work with child maltreatment cases to prevent secondary trauma and support self-care.
- A Differential Response Program for low-risk families with a report of harm to OCS Services to enhance the child welfare system and increase parents' voluntary engagement in services.
- Peer support groups for parents whose children are in OCS custody.
- Innovative solutions to cross-sector collaboration and information sharing to protect children, and help traumatized children heal and thrive.

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Definitions

ALLEGATION

Child abuse statements and/or descriptions by a reporter that consist of one alleged perpetrator, one alleged victim, and one of the four types of maltreatment. (See "Maltreatment," below.)

BEHAVIORAL HEALTH (BH)

In the context of this analysis, behavioral health (BH) includes mental health and substance abuse.

INITIAL ASSESSMENT (IA)

An evaluation of child safety completed for each screened in Protective Service Report (PSR – see below). The Initial Assessment process consists of gathering sufficient information (via face-to-face interviews with the alleged victim, family members and collateral contacts) to determine if a child is safe or unsafe and determining the finding for each allegation (Substantiated or Not Substantiated). A determination is also made as to whether the children and/or other persons involved in the report of alleged maltreatment need services. An IA may include multiple PSRs.

MALTREATMENT

An act or omission that results in circumstances in which there is reasonable cause to suspect that a child may be a child in need of aid; an injury and/or damage to a child's physical or mental well-being. Alaska divides maltreatment into four types: Mental Injury, Neglect, Physical, or Sexual.

- **Mental Injury** – An injury to the emotional well-being or intellectual or psychological capacity of a child as evidenced by an observable and substantial impairment in the child's ability to function.
- **Neglect** – Failure by a caregiver to provide necessary food, care, clothing, shelter, medical attention, or education for a child.
- **Physical** – As defined in AS 47.10.015, conduct or conditions created by the caregiver resulting in physical injury to, physical mistreatment of, or sexual contact with, the child. It also includes "substantial risk of physical harm" as a negligent act or omission by a child's caregiver that creates a substantial risk of physical injury to the child.
- **Sexual** – The child has suffered sexual abuse, or is at substantial risk of suffering sexual abuse, because of conduct by or conditions created by, the child's caregiver, or by the failure of the caregiver, to supervise the child adequately. If the caregiver has actual notice that a person has been convicted of a sex offense against a minor within the past 15 years, is registered, or required to register, as a sex offender, or is under investigation for a sex offense against a minor, and the caregiver subsequently allows a child to be left with that person, this alone may constitute sufficient evidence that the child is at substantial risk of being sexually abused.

PREVENTION

- **Health Promotion** – Activities that take a holistic approach and focus on the whole person, taking context into account, and operates from a positive definition of health. Like primary prevention, health promotion emphasizes health among the whole population, as well as marginalized groups. Health

promotion interventions often address socio-political factors that challenge what is normal in society and attempt to provide tools for people to take control over the determinants of their health and lives.

- **Primary Prevention** – Prevention activities that are directed at the whole community and are intended to prevent maltreatment before it occurs.
- **Secondary Prevention** – Secondary prevention activities target families that have increased risk for child maltreatment and are designed to decrease risk of maltreatment occurring. These more targeted activities may focus on neighborhoods or key populations that have a high occurrence of risk factors associated with child maltreatment.
- **Tertiary Prevention** – Tertiary prevention activities focus on children and families already impacted by child maltreatment. These efforts and are meant to reduce the harm from the trauma and prevent maltreatment from happening again in the future.

PROTECTIVE SERVICE REPORT (PSR)

A report of child Maltreatment. A PSR may contain multiple allegations, each of which consists of one Alleged Victim/Alleged Perpetrator/Maltreatment combination.

SUBSTANTIATED ALLEGATION

A type of initial assessment disposition which concludes that the allegation of maltreatment, or risk of maltreatment, was supported or founded by State law or policy. This is the highest level of finding by OCS.

TRAUMA-INFORMED CARE

An approach to care that changes the perspective of providers from "What's wrong with you?" to "What happened to you?" The care is delivered in a manner that recognizes the history of trauma of the individual and incorporates that history and the presence of trauma symptoms in an approach that addressed the needs of the individual and does not re-traumatize them.

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Abbreviations

ACA	Affordable Care Act
ACS	American Community Survey
ACEs	Adverse Childhood Experiences
BEA	Bureau of Economic Analysis
BH	Behavioral Health
BRFSS	Behavioral Risk Factor Surveillance System
CDC	Centers for Disease Control and Prevention
CHIP	Children's Health Insurance Program
CI	Confidence Interval
CUBS	Childhood Understanding Behaviors Survey
DCCED	Alaska Department of Commerce, Community, and Economic Development
DEED	Alaska Department of Education and Early Development
DHSS	Alaska Department of Health and Social Services
DOLWD	Alaska Department of Labor and Workforce Development
EBP	Evidence-Based Programs
ED	Emergency Department
EHS	Early Head Start
EITC	Earned Income Tax Credit
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
FIT	Families in Transition
FTE	Full-time Equivalent
HS	Head Start
MHA	Mental Health America
MSHF	Mat-Su Health Foundation
MSBSD	Mat-Su Borough School District
MSRMC	Mat-Su Regional Medical Center
OCS	Office of Children Services
PSR	Protective Service Report
PRAMS	Pregnancy Risk Assessment Monitoring System

SAMHSA	Substance Abuse and Mental Health Services Administration
SCAN	Alaska Surveillance of Child Abuse and Neglect Program
SEL	Social Emotional Learning
SF	Strengthening Families
SUD	Substance Use Disorder
TANF	Temporary Assistance for Needy Families
WHO	World Health Organization
YRBS	Youth Risk Behavior Survey

Background

In 2013, the Mat-Su Health Foundation (MSHF) and community partners conducted a Mat-Su Community Health Needs Assessment (CHNA).[4] As part of the CHNA process, more than 500 Mat-Su residents and professionals participated in 23 meetings across the borough. At the community meetings, participants revealed an overwhelming consensus that Mat-Su's greatest health challenges are:

- Alcohol and Substance Abuse
- Children Experiencing Trauma and Violence
- Depression and Suicide
- Domestic Violence and Sexual Assault
- Lack of Access to Behavioral Health (BH) Care

They identified the following as the top two health and wellness goals for Mat-Su:

1. All Mat-Su children are safe and well-cared-for.
2. All Mat-Su residents are drug free (illegal drugs) and sober, or drink responsibly.

These goals are fundamental to promoting optimal behavioral health for Mat-Su residents. BH refers to mental and emotional health, including the abuse of alcohol, non-prescribed drugs, and illegal substances. Promoting optimal BH requires a supportive environment where children live in families without violence or substance abuse, and with parents who themselves are healthy and happy. Promoting optimal BH includes providing treatment for substance abuse and/or mental and emotional health challenges.

To better understand how the BH system functions and what can be done to fix areas that are not working, the MSHF, in cooperation with Mat-Su's BH providers, launched a Behavioral Health Environmental Scan (BHES). MSHF engaged the following contractors to help complete the BHES: McDowell Group, Western Interstate Commission for Higher Education, and Participatory Research Consulting. Additionally, the MSHF hired Community Health Fellows, Megan Villwock, MPH, MS, and Nancy Blake to assist with the Scan.

The Scan consists of three reports:

1. Part 1 The Crisis Response System[5]
2. Part 2 The Behavioral Health System of Care[6]
3. Part 3 The Mat-Su System that Keeps Children Well-Cared-For and Safe

This report describes the Mat-Su support system for children and families and provides recommendations to help Mat-Su achieve the goal that all children are well-cared-for and safe.

[4] The full Mat-Su CHNA can be viewed at *222.healthymatsu.org*.
[5] Part 1 can be viewed at http://www.healthymatsu.org/health-resources/health-resources.
[6] Part 2 can be viewed at http://www.healthymatsu.org/health-resources/health-resources.

Report Format

Chapter 1 provides an overview of the driving concepts behind this report: ACEs, resilience, and prevention, as well as a description of the system-level perspective on prevention that this report uses to promote child safety and well-being. Chapter 2 is a detailed assessment of the status of child well-being in Mat-Su. Chapter 3 summarizes data on the social connectedness of the Mat-Su community. Chapter 4 presents a gap analysis of programs, services and community level efforts to support children and families. Chapter 5 examines funding for prevention according to life stage and system level. Chapter 6 examines recommended best practices to prevent child abuse and neglect. Chapter 7 proposes recommendations specific to the Mat-Su system that promotes well-cared-for and safe children.

Authorship

This report is co-authored by McDowell Group, MSHF, and Participatory Research Consulting LLC. MSHF compiled and completed chapters 1, 3, and 4, as well as appendices F-G with assistance from Participatory Research Consulting LLC. McDowell Group analyzed data and wrote chapters 2, 5, and 6, as well as appendices A-E. Additionally, the McDowell Group study team supported chapters 1, 3, and 4 with background research and preliminary data analysis. MSHF and McDowell Group co-authored chapter 7, the executive summary and the recommendations chapter.

Methodology

Information for this report comes from analysis of secondary sources, literature review, service gap analysis, and a policy and funding inventory and analysis. Following are descriptions of data sources and methodology.

Secondary Data Analysis

Secondary data included a summary of protective and stressor data from the Behavioral Risks Factor Surveillance System (BRFSS), Childhood Understanding Behaviors Survey (CUBS), Pregnancy Risk Assessment Monitoring System (PRAMS), Youth Risk Behavior Survey (YRBS), Alaska Surveillance of Child Abuse and Neglect Program (SCAN) (Office of Children Services data), CCS Early Learning (Head Start Preschool), Alaska Department of Education and Early Development (DEED), Mat-Su Borough School District (MSBSD), Alaska Department of Health and Social Services (DHSS), American Community Survey (ACS), U.S. Census, and the School Climate and Connectedness Survey (SCCS).

ALASKA SURVEILLANCE OF CHILD ABUSE AND NEGLECT PROGRAM (SCAN)

The Alaska Surveillance of Child Abuse and Neglect Program (SCAN), located in the State of Alaska Section of Women's, Children's, and Family Health, analyzed Office of Children Services (OCS) maltreatment data for children ages 0-17 and conveyed it to McDowell Group in summarized form.

The Office of Children's Services investigates allegations of maltreatment and acts upon those allegations that are proven to be substantiated. Presented in this study are the number of individual children for whom at least one maltreatment allegation was filed. A child with multiple allegations is counted just once. Also presented are the number of individual children with at least one substantiated allegation of maltreatment. Again, children are counted once, even if they have multiple substantiated allegations. It is important to note that reported allegations may not reflect actual maltreatment experiences and serve only as an indicator of maltreatment. Additionally, although some allegations are not substantiated, this does not mean they are without significance. Research suggests both substantiated and unsubstantiated maltreatment allegations are associated with increased risk for negative behavioral and developmental outcomes.[7,8]

Region was determined by the location of maltreatment allegation. Not all allegations were included in the data and were removed for various reasons. At the time when an allegation was filed, some had insufficient information to locate a child, were created in error, had multiple references on the same incidence, or referred the child to another state. Other allegations were removed because of missing information needed to identify a child such as date of birth, first or last name, or with an unlikely first or last name (such as baby, child, etc.).

Prevalence estimates were calculated using Alaska Department of Labor and Workforce Development population figures. Included with the prevalence estimates are 95 percent Wald confidence intervals.

[7] Jonson-Reid, M., & Drake, B. (2008). Multi-Sector Longitudinal Administrative Databases: An Indispensable Tool for Evidence-Based Policy for Maltreated Children and Their Families. *Child Maltreatment*, *13*(4), 392–399. http://doi.org/10.1177/1077559508320058
[8] Hussey, J. M., FAU, M. J., FAU, E. D., FAU, K. E., FAU, L. A., Dubowitz H FAU - Kotch, Jonathan, B., et al. (1027). Defining maltreatment according to substantiation: Distinction without a difference? *Child Abuse Negl, 29(5), 461-77.*

BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM

The Behavioral Risk Factor Surveillance System (BRFSS) is a national system of health-related telephone surveys that collect state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services. In 2013, as a new component of BRFSS, Alaska began surveying for Adverse Childhood Experiences (ACEs) among adults ages 18 and older. The BRFSS survey asked 15 ACEs-related questions.

This analysis combined data from 2013 and 2014 to create a larger sample of responses and meaningful demographic breakouts. Throughout this report, the questions for ACEs have been shortened to phrases of one to a few words. Appendix D contains a detailed list of the questions.

CHILDHOOD UNDERSTANDING BEHAVIORS SURVEY (CUBS)

The Childhood Understanding Behaviors Survey (CUBS) surveys all mothers of 3-year-old children who answered the PRAMS survey and still live in Alaska. CUBS information assists community and state programs aimed at improving early childhood. CUBS collects information, by mail or phone, related to toddler behavior, parenting behaviors, health care utilization and access, safety, child development, and school readiness. In this report, the data combines all years for the CUBS Phase 4 survey 2012-2014.

PREGNANCY RISK ASSESSMENT MONITORING SYSTEM (PRAMS)

The Pregnancy Risk Assessment Monitoring System (PRAMS) surveys mothers of newborns based upon a stratified random sample from Alaska birth records. PRAMS collects information to assist community and state programs aimed at improving the health of mothers and infants. The survey collects information, by mail or phone, on a range of topics including attitudes about the most recent pregnancy, content of prenatal care, health insurance, alcohol, tobacco, and drug use, interpersonal violence, stressors, oral health, and others. In this report, the data reported includes combined years of 2012 and 2013.

YOUTH RISK BEHAVIOR SURVEY (YRBS)

The Youth Risk Behavior Survey (YRBS) surveys middle and high school students in the classroom in grades 9 through 12 regarding behaviors in the following six areas:

1. Unintentional and intentional injuries
2. Tobacco use
3. Alcohol and other drug use
4. Interpersonal relationships
5. Diet
6. Physical activity

The survey collects data every other year and provides population-level information on adolescent and early adulthood behaviors for use in program and policy planning. The data collects information from traditional, alternative, and correctional high schools. In the Mat-Su, the alternative high schools include American Charter Academy, Burchell High School, Mat-Su Day School, and Valley Pathways. The Mat-Su traditional high schools include Alaska Middle College School, Colony High School, Houston Middle School, Mat-Su Career & Technical Education High School, Palmer High School, Susitna Valley High, and Wasilla High School. This report displays

the Mat-Su traditional and alternative high school results. While Mat-Su participates in the middle school survey, the 2015 data was not available at the time of this report.

Technical Notes

Throughout the report, the confidence intervals and margin of errors are reported at the 95 percent confidence interval unless otherwise noted.

In efforts to summarize the data into user-friendly tables for the public, symbols were used to quickly summarize the data within context of meaningful comparisons. For those interested in the statistical comparisons and validity of the comparisons, the appendices contain detailed percentages, confidence intervals, number of question respondents, and estimated numbers. While the symbols summarize the data at a high-level, it is statistically possible that there is not a true difference and we encourage interested readers to reference the detailed tables in the appendix.

Literature Review

The study team reviewed literature covering evidence-based models for preventive systems relevant to the Mat-Su Borough. A bibliography of the literature reviewed may be found in the *References* chapter.

Gap Analysis

Data for the Gap Analysis was collected from websites, resource guides, reports on statewide, regional, and local services, as well as from email, phone, and in-person conversations with Mat-Su child and family service providers. Additionally, some data was collected from in-depth interviews with local behavioral health service providers that were conducted for the first and second reports in the Mat-Su Behavioral Health Environmental Scan.

Social Connectedness Analysis

The data for measures of social connectedness in Mat-Su comes from the 2016 Household Survey, and in-depth interviews with Mat-Su residents conducted in 2014.

2016 Household Survey

The Mat-Su Health Foundation (MSHF) contracted with McDowell Group to conduct a survey of households in the Mat-Su Borough as part of its 2016 Mat-Su Borough Community Health Needs Assessment. The purpose of the survey was to capture perceptions of individual and community health, information about health needs and priorities that was not available from secondary data sources, social connectivity, and relationships with the natural environment. The telephone survey of 700 Mat-Su households included both land-lines and cellphones. The survey was designed with input from the MSHF, Strategies Solutions Inc., Identity Inc., Chickaloon Tribal Council, Mat-Su Mental Health Services, and other service providers in the Mat-Su. McDowell Group conducted a Community Health Needs Assessment Household Survey in 2012; several questions asked in this survey were repeated to benchmark response trends.

The sample was designed to yield results representative of the Mat-Su population and permit sub-group analysis. The maximum margin of error at the 95 percent confidence level is +/- 3.6 percent for the full sample. As the sample size decreases among sub-samples (such as age group, household income levels, gender, etc.), the potential margin of error increases.

The survey results were weighted for age and gender to provide a highly representative sample of borough households. Responses were analyzed by household location, gender, household income, educational attainment, perceptions of health status and quality of life, employment status, health insurance coverage, household size, children in the household, and ethnicity/race.

Mat-Su In-Depth Resident Interviews

In the summer of 2014, a community health fellow from MSHF conducted 59 in-depth telephone interviews with Mat-Su residents. The health fellow recruited residents using a convenience sampling design through social media and fliers distributed throughout the borough and handed out by BH providers. She tried to ensure that the sample was representative by recruiting individuals from a variety of demographic groups—parents, veterans, different ethnicities/races; the gay, lesbian, bisexual, transsexual, and queer community (LGBTQ); and behavioral health patients. Participants were promised anonymity and received a $25 gift card. The interviews were composed of open-ended questions and lasted approximately 20 minutes. Questions focused on perceptions of the services and supports that are available in Mat-Su for residents with behavioral health issues and children and families. The data was analyzed using NVIVI qualitative analysis software.

Policy Implications Analysis

Based on literature review and review of international, U.S. and Alaska policies, an assessment of policy approaches was summarized.

State Funding Analysis

State fiscal year 2015 funding data for individual programs offered in the Mat-Su was obtained from the Alaska departments of Health and Social Services, Education and Early Development, Labor and Workforce Development, and Public Safety.

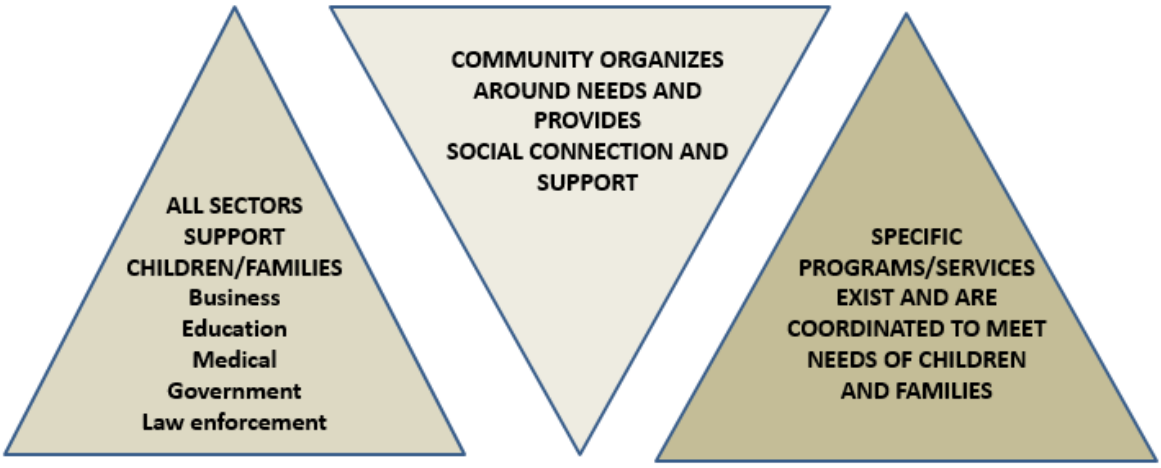
Chapter 1: A System that Keeps Children Well-Cared for and Safe

There is no one system that focuses solely on promoting resilient families and protecting children. Rather, each community creates their own system to do this work. In Mat-Su, that system is made up of all people, professionals, and organizations who care about and work with children and parents/caregivers.

To be successful, this system must focus equally on working with children and parents. This is because parents must have access to the resources, skills, education, and support they need to create the optimal environment in which to raise a child. Children are more likely to develop into healthy adults when they have safe, stable, and nurturing relationships and environments. A two-generation approach helps to ensure that both children and parents' needs are met, and helps to create safe, connected, and resilient families.

This approach to creating a system out of a community's existing resources has three major components (*See the figure below*). First, all sectors support children and families and help to create a community where it is easy for families to care for their children and keep them safe. The different sectors in a community also understand, recognize, and respond to the effects of all types of trauma experienced by children and their parents. The common sectors that touch all children and families are business, health care, child care, education, government, and law enforcement. Additionally, there are sectors that are involved during a family crisis such as the Office of Children's Services, the Judicial System, and programs that offer concrete support during times of need. The second component is a community that organizes around the needs of children and families and provides social connection and support. This type of community organizing and cross-sector collaboration can actually decrease child maltreatment and promote positive results for children and families. Additionally, communities that are tightly connected and offer residents many options for social connection help to prevent maltreatment and support the health and wellness of all residents. Finally, the third component is specific programs and services that exist, and are coordinated to meet the needs of children and families. These programs include services such as child care, education, and medical care that are used by all families, as well as services that aid, when a crisis or trauma occurs.

Figure 1. Three Key Ingredients to Create a Community that keeps Children Well-Cared-For and Safe



When Children Are Not Well-Cared-For and Safe

All children deserve to be safe and well-cared-for; however, we know that this doesn't always occur. For some children, household dysfunction, or outside influences, such as predation at the hands of a stranger, negatively impact the safety and well-being of a child. In this report, we will outline the ways that prevention can occur at the level of the individual, child, family, system, and across the community and throughout the lifespan to help create connected, resilient families and safe children.

Trauma

"The future of any society depends on its ability to foster the healthy development of the next generation." (Center on the Developing Child, n.d.). Healthy child development includes learning how to cope with adversity. However, extensive research has shown that the experience of chronic, strong or frequent adversity can have a cumulative effect on a child's development that can last throughout the child's life. The potential sequelae that can occur through the lifespan because of those childhood adversities are so diverse, and well-documented, that the Centers for Disease Control and Prevention have identified child abuse and neglect as significant public health problems in the United States (Prevention, 2016).

Too often, trauma in childhood occurs through the experience of child maltreatment. In the State of Alaska, child maltreatment is "*an act or omission that results in circumstances in which there is reasonable cause to suspect that a child may be a child in need of aid; an injury and/or damage to a child's physical or mental well-being.*" Alaska State statutes divide maltreatment into four types: Mental Injury, Neglect, Physical, or Sexual.

- **Mental Injury** – *An injury to the emotional well-being or intellectual or psychological capacity of a child as evidenced by an observable and substantial impairment in the child's ability to function.*
- **Neglect** – *Failure by a caregiver to provide necessary food, care, clothing, shelter, medical attention, or education for a child.*
- **Physical** – *As defined in AS 47.10.015, conduct or conditions created by the caregiver resulting in physical injury to, physical mistreatment of, or sexual contact with, the child.* It also includes "substantial risk of physical harm" as a negligent act or omission by a child's caregiver that creates a substantial risk of physical injury to the child.
- **Sexual** – *The child has suffered sexual abuse, or is at substantial risk of suffering sexual abuse, because of conduct by, or conditions created by, the child's caregiver, or by the failure of the caregiver to supervise the child adequately.* If the caregiver has actual notice that a person has been convicted of a sex offense against a minor within the past 15 years, is registered or required to register as a sex offender, or is under investigation for a sex offense against a minor, and the caregiver subsequently allows a child to be left with that person, this alone may constitute sufficient evidence that the child is at substantial risk of being sexually abused.

Overview of Adverse Childhood Experiences (ACEs)

The ACEs Study represented a significant shift in understanding the relationship between adult health status and childhood experiences. The study revealed a powerful correlation between negative experiences in childhood and adult emotional health, physical health, and mortality in the U.S. (Felitti et. al, 1998). Exposure to some adversity during childhood is normal and necessary for healthy development, but sustained or repeated exposure to severe adversity without supportive relationships can be detrimental for children. ACEs may harm children's brains and bodies so profoundly that the effects persist throughout the child's life and are passed on to the next generation.

In the ACEs study, the authors identified a dose response relationship between the number of ACEs a child experienced and the likelihood of negative life experiences as an adult, such that more ACEs were associated with increased risk. People who experience four or more ACEs during childhood have an elevated risk for numerous health issues, including alcoholism, drug abuse, depression, suicide, and early death (Felitti et al., 1998).

Original surveys of ACEs measured 10 types of adversities experienced by children under age 18. These adversities happen in the household or to the individual child.

HOUSEHOLD DYSFUNCTION

- Household member with mental illness
- Incarcerated household member
- Divorced or separated parents
- Witnessing domestic violence
- Household member addicted to substances

CHILD ABUSE AND NEGLECT

- Physical neglect
- Emotional neglect
- Physical abuse
- Sexual abuse
- Emotional abuse

Many researchers now track other types of adversity as well, such as bullying and extreme poverty. Adversities experienced by communities and cultures – such as natural disasters, suicide, and historical/cultural trauma – also harm children. Researchers have found that ACEs tend to cluster together: if a person has experienced one ACE, he or she has an 80 percent chance of having experienced another ACE (Felitti et. al, 1998).

Toxic Stress

When children are exposed to ongoing adversity they experience toxic stress. Experiencing toxic stress during childhood can set an individual on an altered developmental pathway and can have negative consequences at various life stages. Unlike manageable stress, toxic stress can disrupt normal brain development and can lead to life-long physical, emotional, cognitive, social, and genetic impacts. Toxic stress can also alter

neurodevelopment, which, in turn, can restrict social, cognitive, and emotional development. Exposure to adversity can also weaken a child's organ systems leading to illness, chronic disease and early death. Finally, toxic stress can have epigenetic effects. Exposure to toxic stress can alter how children's DNA is expressed, and these changes are passed on to the next generation.

Intergenerational Transmission of Trauma

As a means of coping with prior trauma or because of impaired development resulting from trauma, some individuals who experience toxic stress as children adopt high-risk behaviors during adolescence and adulthood. When individuals who adopt high-risk behaviors because of the trauma, such as excessive alcohol consumption or criminal behavior, have children, they are exposing their children to ACEs. When trauma is transferred from one generation of trauma survivors to future generations, it is referred to as the intergenerational transmission of trauma.

Figure 2. Intergenerational Effects of ACEs

Adverse Childhold Experiences	Increased Risk	Intergenerational Effects
	Dysregulation	**ACEs for the next generation**
	Alcohol, tobacco, drugs	• Abuse or neglect
Abuse or Neglect	Mental health problems	• Household dysfunction
	Adult incarceration	
Household Dysfunction	Divorce	**ACEs Health Effects and Other Factors**
	Homelessness	
	Disability	• Poverty
	Low education levels	• Homelessness
	Unemployment	• Parent with chronic disease
	On-the-job injury or illness	• Social isolation

Source: Self-healing Communities: A Transformational Process Model for Improving Intergenerational Health (2016).

Resilience

Not every individual who experiences great adversity and toxic stress as a child will experience negative consequences from those experiences. Resilience, the ability to overcome adversity, is the key factor to understanding how the effect of adversity can be mitigated (Harvard University, 2016). Research over the last few decades has led to an evolving definition of resilience. The most authoritative general definition of resilience comes from the American Psychological Association (2014):

"The process of adapting well in the face of adversity, trauma, tragedy, threats or even significant sources of stress." There is also general agreement that resilience is not 'present or absent,' but exists in a continuum, requires reinforcement through time, and is accumulated across social domains through a process of interaction between biological, psychological, social and cultural factors.

"Resilience may therefore change over time as a function of development and one's interaction in the environment… Each of the (environmental) contexts (peer, family, school, neighborhoods and communities) may be more or less resilient in their own right and, therefore, more or less capable of supporting the individual."

The three major components of resilience include:

1. Mindfulness and hope
2. Attachment and belonging
3. Capability

Figure 3. Three Major Components of Resilience

Mindfulness and Hope	Attachment and Belonging	Capability
• Faith, hope, and sense of meaning	• Bonds with parents and/or caregivers	• Intellectual & employable skills
• Engagement with effective organizations (schools, work, social groups)	• Positive relationships with competent and nurturing adults	• Self-regulation • Executive thinking • Flexible thinking
• Cultures providing positive standards, expectations, rituals, relationships & supports	• Friends or romantic partners who provide a sense of security and belonging	• Ability to direct & control attention, emotion, and behavior
• Networks of support/services & opportunities to help others		• Efficacy

Resilience in Children

All children are born with the ability to build resilience. Both outside supports and inner strengths are needed to assist children with this development. For example, children need both caring relationships, role models, and a positive outlook to build resilience (Best Start, 2015). Helping children to build resilience will help them to manage stress, however, it does not mean they won't experience distress because of the adversity (American Psychological Association, 2016).

The evidence suggests that children with higher resilience are better able to cope with subsequent trauma, thus reducing the likelihood of brain damage occurring because of toxic stress. Less well-known is whether interventions to increase resilience, like mindfulness practices, may reverse cumulative brain damage, at least in part.

Recent research studies (Lazar) using brain scans, provide hopeful results of increasing resilience leading to the following improvements:

- The amygdala, the 'fight or flight' part of the brain important for anxiety, fear and stress, got smaller.
- The left hippocampus, which assists in learning, cognition and emotional regulation, got larger.
- Changes in grey matter concentrations occurred.

Parental Resilience

Being a parent can be stressful. Parental stress can result from issues related to the child, e.g., a crying baby or child with a chronic medical condition, as well as individual factors, e.g., parental experience of childhood trauma or substance abuse. While some stresses parents experience can be fixed, such as having a family member watch the crying child so the parent can take a break, other parental stress requires resilience to overcome. Parents demonstrate resilience when they can positively address personal and family challenges, overcome the effects of their personal trauma, manage difficulties, and flourish within the unique environment of their family. Parents often call forth their inner strength to proactively meet personal challenges and those in relation to

their child, manage adversities, heal the effects of trauma and thrive given the unique characteristics and circumstances of their family (Center for the Study of Social Policy, 2013).

All families and parents experience stress. Parental resilience in the face of stress can be more impactful on the lives of parents and their children than the experience of stress, making parental resilience an important process for all parents. Given the importance of parental resilience, it is important to note that resilience can be built throughout the lifespan. A key to building parental resilience is the establishment of positive social connections with other people who can provide emotional, informational, and concrete support (Center for the Study of Social Policy, 2013).

Strengthening Families Framework

Strengthening Families (SF) is a framework for supporting family resilience through a focus on five evidence-based protective factors. Protective factors, according to the Center for the Study of Social Policy, are, "conditions or attributes of individuals, families, communities, or the larger society that mitigate or eliminate risk" (Center for the Study of Social Policy, 2013). SF focuses on the following five protective factors that research shows can reduce risk for children and families.

- Parental Resilience - Parents develop problem-solving skills, build trusting relationships and know how to ask for help when necessary.
- Social Connections - Parents have sustaining, trusting relationships that provide parenting support, emotional support, and concrete supports in times of need.
- Concrete Supports in Times of Need - To thrive, families' basic needs must be met. Adequate concrete supports, e.g., access to substance abuse services or transportation, must be in place to provide stability and help for families in need.
- Knowledge of Parenting and Child Development - Accurate and timely information on child development and appropriate expectations for children's behavior based on their age is effective at helping parents promote healthy child development.
- Social and Emotional Competence of Children - When a child has positive interactions with others, self-regulates his or her behavior, and effectively communicates his or her feelings, this has a positive impact on that child's relationship with family, other adults and peers.

Family serving organizations across the country are using SF to help build protective factors with the families they serve. Additionally, individual states agencies and communities use SF to benefit all families through alignment of services that serve families and children. The use of SF in a community, then, can build on the strengths of existing programs and systems as well as building on the strength of individual families.

Community Resilience

Resilience, is not only an attribute that can be acquired by an individual, it can also be a characteristic of a community. There are cultural beliefs and practices that can be found in families, schools, neighborhoods, businesses, health care agencies and the community in general that can support individuals and buffer or

moderate the impact of ACEs by helping individuals avoid and successfully work through traumatic experiences. These practices create interaction between children, parents, and others that provide them with a meaningful connection to the larger world and support them. A community that increases its capacity to define and solve current problems and generates new cultural norms that are supportive of improving the positive aspirations of their children and parents is termed a "Self-healing Community" (Porter, Martin, & Anda, 2016). This type of community can prevent child maltreatment and the occurrence of ACEs by providing support to families when they are in times of high stress, and help parents heal from ACEs, thus creating a nurturing environment in which to raise their children.

The Self-Healing Communities Model (SHCM) is a process model focused on building the capacity of a community to solve the problems identified by community members. In part, children and families build resilience through access to supports, both at the systems and social levels, that are appropriate to their needs and cultures. Through planned systemic interventions, communities and service providers can create environmental conditions to help families and children thrive (Ungar, 2007).

Family, community and culture can all positively impact the lives of community members. The SHCM encourages public engagement, inspired innovation, and peer supports to help build up parental resilience and improve outcomes for families. This requires a shift in how we view social problems and solutions. SHCM helps community members generate new cultural norms that reflect the goals and values community members have for their children (Porter, Martin, & Anda, 2016). It also requires a change in how communities invest in community health and the promotion of healthy families. Across systems and cultures partners must share resources, values, and a commitment to creating a community that is designed to support all community members in increasing their resilience.

A new culture develops in the community that encourages people to come together to increase the number of supportive relationships they have and work with each other to understand the problems facing the community. Resident leaders arise and organize collaborative efforts to develop innovative solutions that can impact social and health equity for all residents. Porter, et al. state that through this approach the existing programs and strategies for dealing with problems become more aligned with community needs and the ways residents relate and interact with each other. When community residents work together to solve problems, a sense of excitement and self-determination results that can fuel more collaboration and efforts. For more on the SHCM, see (Appendix F).

Prevention of ACEs, Toxic Stress, and Intergenerational Transmission of Trauma

While resilience offers an opportunity to diminish the experience of the long-term consequences of childhood adversity, prevention of childhood adversity is the first line of action. Safe, stable, nurturing relationships and environments help to prevent childhood adversity and to ensure children reach their full potential (Prevention, 2016). Communities invested in the healthy development of the next generation can come together to create the social systems and services needed to create those environments.

Historically, child abuse and neglect prevention focused heavily on the individual and family dynamics (Zimmerman & Mercy, 2010). Recent recognition that many of our most serious health concerns as a society

can be linked to early childhood experiences of trauma have encouraged a shift in how we view prevention in this area. Now there is an understanding that preventing trauma in childhood can help move many population health indicators, and the use of a public health framework for child maltreatment prevention has become common (Child Welfare Information Gateway, n.d.). This shift has included a move to a wider range of strategies that include not only program implementation but also policy changes, engaging individuals from nontraditional partner systems (e.g., faith groups, community leaders, and health care providers), and community education. The public health framework for child maltreatment prevention includes three levels of services: primary prevention, secondary prevention and tertiary prevention. A comprehensive system of child maltreatment prevention will include strategies across the three levels of prevention. Following is a framework of prevention that may be applied to the Mat-Su support system.

The public health framework for prevention includes three levels - primary prevention, secondary prevention and tertiary prevention - preceded by health promotion. A comprehensive system of ACEs prevention will include strategies across all levels.

Health Promotion

Health promotion takes a holistic approach and focuses on the whole person, taking context into account, and operates from a positive definition of health. Like primary prevention, health promotion emphasizes health among the whole population, as well as marginalized groups. Health promotion interventions often address socio-political factors that challenge what is normal in society and attempt to provide tools for people to take control over the determinants of their health and lives (Tengland, 2010). Examples of health promotion could include public service campaigns for bike safety or use of parks. In practice, health promotion can be difficult to distinguish from primary prevention. As primary prevention and health promotion strategies for promoting resilient families and safe, well-cared-for children may be quite similar, the term primary prevention will be used to describe strategies that would fall into both categories.

Primary Prevention

Primary prevention activities are directed at the whole community and are intended to prevent maltreatment before it occurs and promote child and parent resilience. Activities and information are available to all members of the community and any community member can access services. Primary prevention efforts seek to raise awareness of the issue among parents and service providers as well as decision-makers.

Primary prevention activities may include:

- A media campaign educating the community on developmental stages of young children
- A toll-free resource line linking parents to information on parenting support services
- Universal home visiting for all infants born at a local hospital

Secondary Prevention

Secondary prevention activities target families that are under stress and may have increased risk for child maltreatment and are designed to decrease the risk of maltreatment occurring. These more targeted activities

may focus on neighborhoods, or key populations, that have a high occurrence of stress and risk factors associated with child maltreatment. Secondary prevention activities may include:

- Parent education programs focusing on parents in a substance abuse treatment program
- Parent support groups for parents of children with special needs
- Home visiting programs for teen parents
- Programs that help families met their basic needs such as housing, food security, and income assistance

Tertiary Prevention

Tertiary prevention activities focus on children and families already impacted by child maltreatment. These efforts and are meant to reduce the harm from the trauma and prevent maltreatment from happening again in the future. Tertiary prevention activities may include:

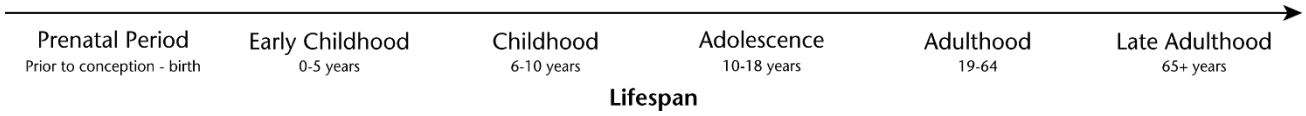
- A Safe Babies Court serving families with children ages 0 – 36 months.
- Therapeutic daycare for foster children.
- Peer mentor programs for families in crisis.

Life Stage Prevention Framework

Just as a comprehensive system of ACEs prevention will include strategies across the three levels, strategies across the lifespan can also be integrated. A life-course perspective of prevention views health, well-being, and disease within the context of the entire lifespan, from birth until death. This approach recognizes connections between health and illness in later life and root causes during formative stages of development. From this perspective, health or illness are trajectories that begin to be shaped at conception (Haflon & Hochstein, 2002).

Changing trajectory is possible, but the longer a person has traveled on a trajectory, the more difficult and costly change is. A life course perspective emphasizes that each developmental stage forms the foundation for subsequent developmental stages and identifies specific developmental windows and transition points for prevention and intervention. Figure 4 displays the stages used throughout this report.

Figure 4. Life Stages



This approach suggests prevention efforts should:

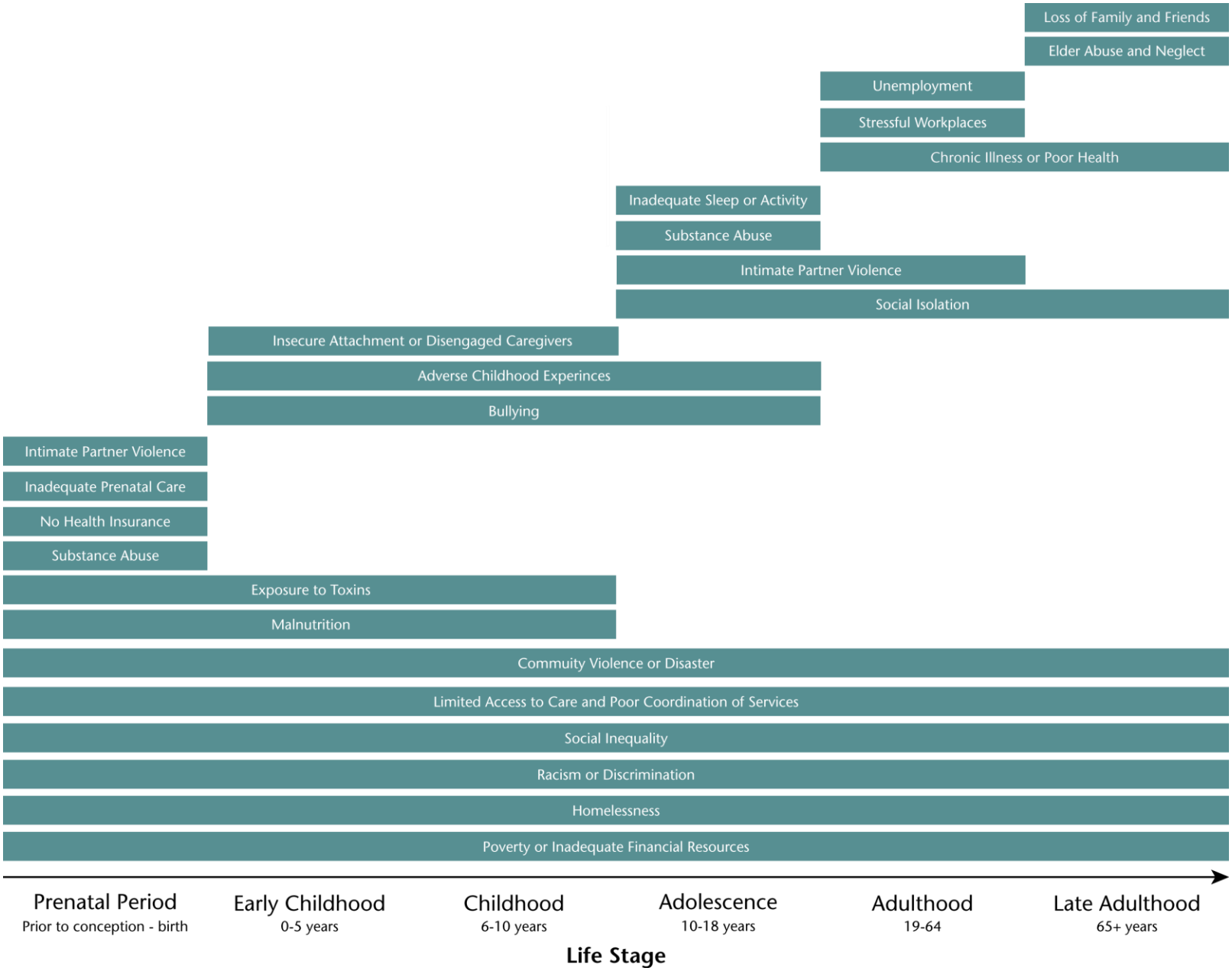
1. Consider the entire lifespan ripe for prevention, not just the period immediately prior to the outcome.
2. Focus on early years of child development, reproductive years, and points of life transition.
3. Be tailored to developmental stage and context.

Approaching ACEs prevention from a lifespan perspective has several benefits. This approach:

- Reinforces public understanding of how ACEs affect children and adults, how ACEs are transmitted, and how ACEs lead to long-term consequences.
- Identifies effective places in development to intervene (Mistry et al., 2012).
- Conveys that early investments may have significant payoffs.
- Indicates early childhood policies will likely yield benefits in adult years (Mistry et al., 2012).

Figure 5 depicts an overview of stressors related to ACEs and BH issues according to life stage. Detailed descriptions of needs according to life stage are discussed in Chapter 5: Gap Analysis.

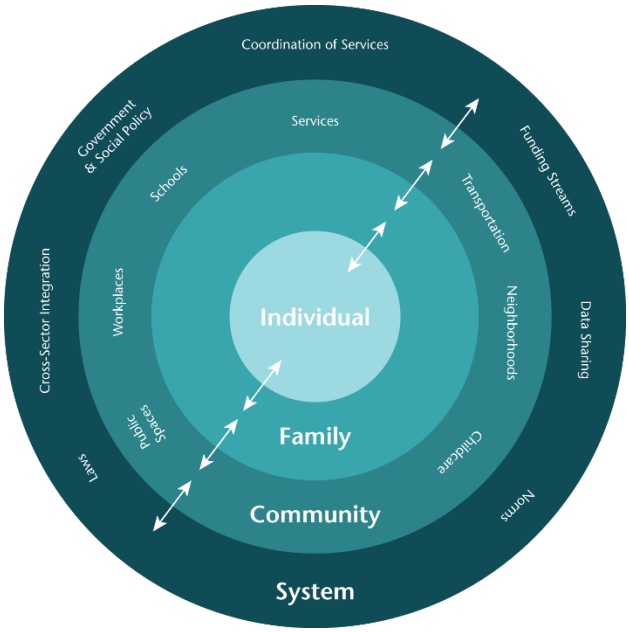
Figure 5. Stressors Throughout Each Life Stage



Multi-Level Prevention Framework

In addition to the models above, a comprehensive system of prevention will integrate individual and family, community, and system-level approaches to support well-being of children and families throughout their lifetimes. The figure below outlines a strategy that uses prevention at four different levels of society.

Figure 6. Levels of Prevention



Source: Adapted from Kail, R. V., & Cavanaugh, J. C. (2010). Human Development: A Life-Span View.

Individual Level

In the context of this report, individual level refers to prevention efforts that focus on changes within an individual or between an individual and his or her immediate environment. An individual in this case is a resident of the Matanuska-Susitna Borough. Risk factors are elements of, or experiences during, a person's life that increase their chance of poor health and health-related outcomes. Protective factors are elements or experiences that are linked with positive outcomes (Bernat and Resnick, 2006). Both risk factors and protective factors tend to group together. If a person has one protective or risk factor, he or she is more likely to have other related factors. Researchers believe an imbalance of risk and protective factors leads to negative outcomes. This means, if a person has enough protective factors in his life, he may be able to navigate even numerous risk factors to positive outcomes (Bernat and Resnick, 2006).

Family Level

Family-level approaches support family members (residents of the Mat-Su) and the family unit. Because the well-being of children is so closely tied to their environment and caregivers, building family capacity can optimize early childhood health and well-being. Families that have financial resources, have available time to spend with their children, and have psychological resources to manage stress often have healthier children (Mistry et al., 2012). Chapter Three focuses on this level of prevention in terms of formal programs and interventions that exist in the Mat-Su. A service gap analysis will examine the programs that exist against the

backdrop of child development and existing best practices and research driven theory on how to support children and families. Chapter Five reviews the recently released Center for Disease Control's (CDC) technical package on preventing child abuse and neglect which outlines discrete strategies to support and build family capacity (Fortson, Klevens, Merrick, Gilbert, & Alexander, 2016). Recommended efforts to build family capacity include:

- Strengthening economic supports for families through household financial security and family-friendly work policies.
- Changing social norms to support parents and positive parenting.
- Enhancing parenting skills to promote healthy child development.

Community Level

Community-level approaches refer to prevention efforts that cut-across environments (workplaces, neighborhoods, public spaces, schools, clinical services) and support well-being of all members of the community, in this case the Matanuska-Susitna Borough. Chapter 3 provides a case study of Mat-Su through the lens of community-level approaches, and Chapter 4 examines social connectedness which is rooted in the community. Working directly with children and families is not enough, because much of human development and family functioning are influenced by structures and environments outside the home. Many of the roots of adversity and disparity occur at the community level and escalate from individual to collective problems (Perkins et. al., 2004). According to Shonkoff, explicit focus on strengthening neighborhood-level resources that protect children against the results of trauma is likely the most important component of any system-level effort to promote health and reduce inter-generational disparities (2012). Developing healthy people requires healthy communities; healthy communities require healthy people.

Many different aspects of neighborhoods and homes affect childhood health.

- Quality of primary and secondary schools
- Access to jobs and higher education
- Quality of social environments
- Concentration of poverty
- Safety of neighborhoods
- Opportunities for physical activity
- Safety of public transportation
- Quality of grocery stores
- Density of fast food businesses
- Access to liquor stores
- Pollution and environmental toxins
- Affordability of housing
- Access to health care clinic

Healthy communities support healthy development by providing two important assets (Mistry et al., 2012):

- Institutional resources — parks, affordable housing, early education centers etc. — that encourage healthy behaviors and provide necessary resources for families.
- Collective efficacy—norms, social structures, mutual trust, and shared values—that bolster the healthy development and well-being of community members by creating connected, supportive environments for families and children.

To be most effective, community layers and settings should be mutually reinforcing (Woolf, Dekker, Byrne, & Miller, 2011).

System Level

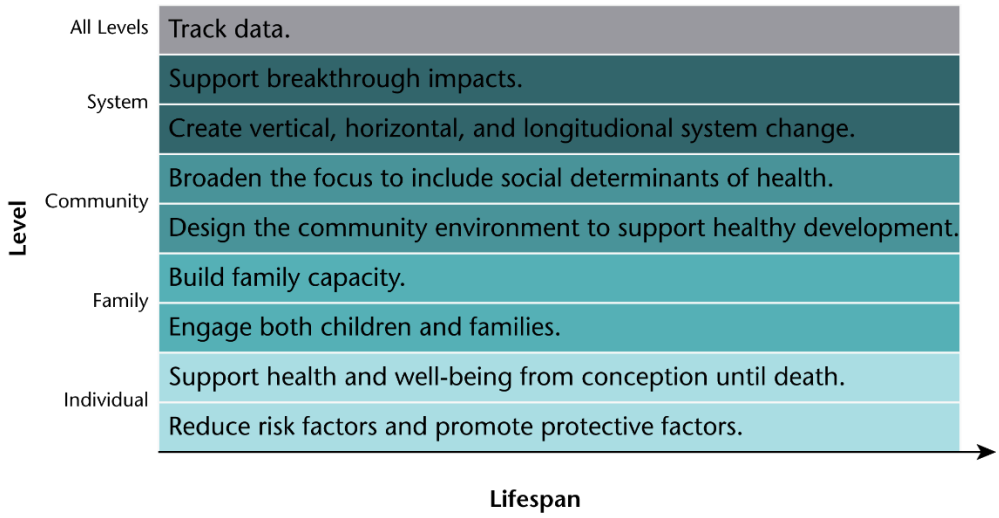
System-level approaches are prevention efforts that address the structures, patterns, and laws that influence community environments and create opportunities or limitations for individuals and families. In this analysis, a system may be contained entirely within the Matanuska-Susitna Borough, or extend beyond the community. Each approach, in turn, applies to the entire lifespan. Chapter 5 examines policy and funding through this lens. Another system-level approach includes using data to drive change. This includes identifying indicators, tracking them over time, and grounding preventive work in analysis of local data. Data analytics can help generate actionable information to identify needs and gaps, provide services, and predict, or prevent, crises (Raghupathi and Raghupathi, 2014). Digitizing, combining, and effectively using data also helps track and manage individual and population trajectories throughout the lifespan (Raghupathi and Raghupathi, 2014).

Tracking data involves both analyzing data and establishing structures and norms to facilitate data sharing. In their report 'Unleashing the Power of Prevention,' the Institute of Medicine recommends: (1) grounding prevention efforts in systematic monitoring of community indicators and assessments, and (2) establishing integrated data structures that enable cross-agency collaboration (Hawkins et al., 2015). Establishing data infrastructure to capture, track, and fuel analysis is a key component of driving transformative system change, (according to Haflon, DuPlessis, & Inkelas, 2007). The ideal prevention environment will leverage data to drive change at all levels of the social ecology.

Support System for Children and Families

The following section outlines a nine-point strategy to support children and families. The overarching strategy – coordinated prevention at all levels of the social ecology throughout the life span – reflects leading research and blends developmental and ecological strategies. The approaches were selected from the scientific literature based on their: (1) potential for impact, (2) basis in research, (3) applicability to the Mat-Su, and (4) capacity to cross-pollinate. While the approaches are described one-by-one, they do not represent a menu of options; rather, each approach is a necessary component of a unified prevention strategy.

Figure 7. Multi-Level, Developmental Prevention Strategy



Individual Level

REDUCE RISK FACTORS AND PROMOTE PROTECTIVE FACTORS THAT IMPACT CHILDREN AND ADULTS

Risk factors are elements of, or experiences during, a person's life that increase their chance of poor health and health-related outcomes. Protective factors are elements or experiences that are linked with positive outcomes (Bernat and Resnick, 2006). Both risk factors and protective factors tend to group together. If a person has one protective or risk factor, he or she is more likely to have other related factors. Researchers believe an imbalance of risk and protective factors leads to negative outcomes. This means, if a person has enough protective factors in his life, he may be able to navigate even numerous risk factors to positive outcomes (Bernat and Resnick, 2006).

Protective factors can: (1) mitigate the effects of risk factors, (2) interrupt the cumulative effects of risk factors, and (3) help prevent the negative effects of risk factors (Harper Browne, 2014). Successful prevention efforts both reduce adversity undermines the foundations of health and promote positive experiences and environments needed for optimal development (Mistry et al., 2012; Bernat and Resnick, 2006).

SUPPORT RESILIENCE

Resilience refers to a pattern of behaviors that helps buffer against the long-term impacts of toxic stress. It is characterized by a positive, adaptive response to significant adversity (National Scientific Council on the Developing Child [NSCDC], 2015).

Many prevention efforts, in particular ACEs prevention, focus on developing the protective factor of resilience in children. Some prevention efforts also include family and community resilience. Resilience is not a quality grown in isolation or endowed at birth. Decades of research show that a combination of supports — caring relationships with adults, adaptive skill-building and positive experiences — is required to develop resilience (NSCDC, 2015).

SUPPORT PREVENTION FROM BEFORE CONCEPTION UNTIL DEATH

A life-course perspective of prevention views health, well-being, and disease within the context of the entire lifespan, from birth until death. This approach recognizes connections between health and illness in later life and root causes during formative stages of development. From this perspective, health or illness is a trajectory that starts at conception (Haflon & Hochstein, 2002).

When a child experiences a nurturing, stable environment with adequate financial resources to meet basic needs and the support of caring relationships, the child is launched toward long-term physical, emotional and mental health. Likewise, when a child deals with repeated or sustained adversity, disruption, without supportive relationships, the child starts on a trajectory toward poor physical, emotional and mental health.

Changing trajectory is possible, but the longer a person has traveled on a trajectory, the more difficult and costly change is. A life course perspective emphasizes that each developmental stage forms the foundation for subsequent developmental stages and identifies specific developmental windows and transition points for prevention and intervention.

RECOGNIZE THE CRITICAL ROLE OF EARLY DEVELOPMENT

The influence of the prenatal, perinatal and early childhood environments on long-term health cannot be overstated. A disproportionate number of developmental options, choices, and resources are only available during the early years of life (Haflon & Hochstein, 2002). An overview of the importance of early childhood is included early in Chapter 1. Neuroscience research shows that early prevention and intervention are essential to support long-term health, especially for families and children experiencing toxic stress. The longer children and families experience toxic stress, the more difficult and costly it is to achieve positive life outcomes (Center on the Developing Child [CotDC], 2016). The life-course perspective suggests that prevention efforts need to target pregnant mothers and young families in addition to infants and young children.

Family Level

ENGAGE BOTH CHILDREN AND PARENTS

The well-being of children and their parents is inextricably linked. When parents are physically, mentally, emotionally, and financially secure, their children do better. When parents are stressed, mentally unwell, physically unsafe, and struggling to make ends meet, their children do worse. Parents and children therefore have overlapping needs for supportive, stable environments. Multi-generational approaches that engage children and their parents are one of the most effective means of ensuring that the needs of infants, toddlers and preschoolers are met (NSCDC, 2008/2012).

Two-generation approaches often focus on one, or a combination, of the following three goals (Center for High Impact Philanthropy, 2015):

1. Improving the quality of parent-child relationships
2. Building parent and child knowledge and skillsets
3. Addressing underlying family issues and the overlapping needs of children and parents through direct provision of services

Many of the prevention resources and promising practices discussed in this report integrate multiple generations in their efforts, recognizing that supporting children requires supporting their caregivers.

BUILD FAMILY CAPACITY

Because the well-being of children is so closely tied to their environment and caregivers, building family capacity can optimize early childhood health and well-being. Families that have financial resources, available time to spend with their children, psychological resources to manage stress, and human capital have healthier children (Mistry et al., 2012). Mistry et al. write:

- When families have the economic capacity to purchase material goods and services, caregivers are able to provide health care, housing, child care, food, and fulfill their children's immediate needs.
- Families who are able to take time off of work to care for their children and have access to paid parental leave form stronger relationships with their children, are more likely to engage in practices that support long-term health, and ultimately have healthier children.
- When parents are psychologically supported and healthy, they are more capable of parenting their children.

- Caregivers who have human capital – necessary knowledge and skills to make basic health-related decisions – make better choices and have healthier children (2012).

The recently released Center for Disease Control's (CDC) technical package on preventing child abuse and neglect outlines discrete strategies to support and build family capacity (Fortson, Klevens, Merrick, Gilbert, & Alexander, 2016).

Community Level

DESIGN THE COMMUNITY ENVIRONMENT TO SUPPORT HEALTHY DEVELOPMENT

Like the Multi-level prevention Framework outlined above, strengthening neighborhood-level resources that protect children against the results of trauma is likely the most important component of any system-level effort to promote health and reduce inter-generational disparities.

Many different aspects of neighborhoods and homes affect childhood health.

- Quality of primary and secondary schools
- Access to jobs and higher education
- Quality of social environments
- Concentration of poverty
- Safety of neighborhoods
- Opportunities for physical activity
- Safety of public transportation
- Quality of grocery stores
- Density of fast food businesses
- Access to liquor stores
- Pollution and environmental toxins
- Affordability of housing
- Access to health care clinic

Healthy communities support healthy development by providing two important assets (Mistry et al., 2012):

- Institutional resources that encourage healthy behaviors and provide necessary resources for families
- Collective efficacy that bolster the healthy development and well-being of community members by creating connected, supportive environments for families and children

To be most effective, community layers and settings should be mutually reinforcing (Woolf, Dekker, Byrne, & Miller, 2011).

BROADEN THE FOCUS TO INCLUDE SOCIAL DETERMINANTS OF HEALTH

Social determinants of health are a crucial lever

Many factors influence human health. Focusing prevention efforts on modifiable factors that have the potential for greatest impact (on both an individual and population-level scale) increases the chance of significant, positive results. These include social determinants of health, which are an essential lever for supporting children and families who are in times of need and crisis:

Researchers argue that broadening the focus of efforts to prevent behavioral health issues by including underlying social determinants of health is necessary if those efforts are to be socially equitable for the following reasons:

1. Focusing on access alone is not enough to shift the needle substantially on socioeconomic and racial disparities in health (Haflon and Hochstein, 2002).
2. There is limited evidence that increasing awareness changes long-term disparities in health, and there is some evidence that done poorly, targeted interventions can exacerbate health inequalities (Braveman et al, 2011; CotDC, 2016).

System Level

CREATE VERTICAL, HORIZONTAL AND LONGITUDINAL SYSTEM CHANGE

Beyond the home and community, children and families need support from the larger systems that surround individuals, families, and their communities. Numerous researchers have described the necessity of primary prevention efforts that focus on greater system change, for example:

- Perkins et al. describes "both strengths and adversities must be examined from an ecological perspective, which places individuals, families, and communities in context. That context includes multiple systems, institutions, and environments that interdependently, both affect people and are affected by them" (2004).
- Barter writes, "Promoting the health and well-being of children…requires extending interventions beyond the family or individual levels… risk and protective factors have to be considered beyond the four walls of parenting to embrace the social, economic, and political forces that affect families and communities" (2005).
- Supporting health development througout the life course requires "changes in the systems that support and maintain the delivery of health services, as well as in the other systems linked to health care, such as early and primary education, care of people with developmental disabilities, and child and family welfare. It will also require policy and programmatic changes at the practice, health care system, community, and policy levels" (Haflon & Hochstein, 2002).
- Tomison and Wise write "No program can enable children to develop optimally when their larger child rearing environment is not conducive to healthy development, supporting calls for greater attention to the structural societal forces that impact on the quality of children's and families' lives" (1999).
- In 1998, the first ACEs study described how "[p]rimary prevention of adverse childhood experiences …will ultimately require societal changes that improve the quality of family and household environments during childhood" (1998).
- **"**The greatest impacts on the largest number of people would thus be achieved by successfully targeted efforts, at a community or societal level, that focus on mitigating the effects of poverty, violence, discrimination, and other threats to well-being" (CotDC, 2016).

ALL LAYERS OF THE SOCIAL ECOLOGY MATTER

Every person, at all ages, is surrounded by a nested series of systems that influence and guide his or her growth either positively or negatively. Bronfenbrenner's ecological model is commonly used to understand systems. According to Bronfenbrenner, five organized subsystems help support and guide human growth (Bronfenbrenner, 1994).

1. Microsystem – relationship between the individual and the immediate environment (such as the home, school or work)
2. Mesosystem – linkages between microsystems that surround the individual (such as the relationship between school and home or the relationship between the medical clinic and school).
3. Exosystem – linkages between an environment that contains the person and one that does not (such as for a child, the relationship between home and his or her parent's workplace).
4. Macrosystem – overarching patterns among the microsystem, mesosystem, exosystem (such as institutional patterns, cultures).

The ideal prevention environment will align these systems to fluidly support healthy development.

INTEGRATE SERVICES WITHIN SECTORS, BETWEEN SECTORS AND THROUGHOUT THE LIFESPAN

Long-term prevention of child maltreatment and support of healthy development requires structural change in service delivery. In a review of the child health system, researchers found that compared to other developed nations, "U.S. children have spotty coverage to use in a very fragmented system" and advocate for transformative vertical, horizontal and longitudinal system change as a solution (Halfon, DuPlessis, & Inkelas, 2007). The National Scientific Council on the Developing Child echoes these findings: "Effective intervention often requires the coordination of services from multiple sources that do not relate easily. These might include early care and education, social service and welfare departments, health care, schools, child welfare agencies, and early intervention programs..." (2008/2012). Vertical change refers to the need for increased coordination and integration within sectors — medical, education, social services etc. — that serve children and their families. Services must also be integrated horizontally across sectors to create more-functional continuums of care (Halfon, DuPlessis, & Inkelas, 2007). Longitudinal change refers to integration of services across the lifespan by supporting relationships and communications between organizations that care for individuals at different stages of their lives (Haflon & Hochstein, 2002).

SEEK AND FUND BREAKTHROUGH IMPACTS

As the current section and subsequent promising practices show, established approaches are not enough to generate the shifts in care, services, prevention, and interventions necessary to prevent child maltreatment. Addressing disparities in health and development requires a new generation of strategies (Shonkoff, 2012). While effective programs and models exist, such as the Nurse Family Partnership, or Triple P Parenting, prevention requires breakthrough impacts from disruptive and creative thinking.

To find and develop these innovations, funding must be available for promising programs and approaches that fall outside the strict definition of evidenced-based best practices. Resource allocation that relies solely on evidenced-based practices inevitably limits testing of new strategies, precisely the kind of innovation that primary prevention efforts for long-term health development need. Moreover, an over-emphasis on evidenced-based programs can focus too much attention on small or short-term impacts at the expense of new methods that could yield more significant results over the long-term.

The Center for the Developing Child warns that "widespread preference for "evidence-based" programs, many of which have produced small effects on random categories of outcomes that have not been replicated, seriously limits the likelihood of achieving increasingly larger impacts at scale over time," (2016). In contrast, "[p]olicies

that incentivize small-scale pilots, rapid-cycle evaluation, and a mindset that values *both* discovery *and* verification would accelerate innovation" (Center for the Developing Child, 2016). Both evidence-based practices and innovative practices are necessary to support children and families on a long-term basis.

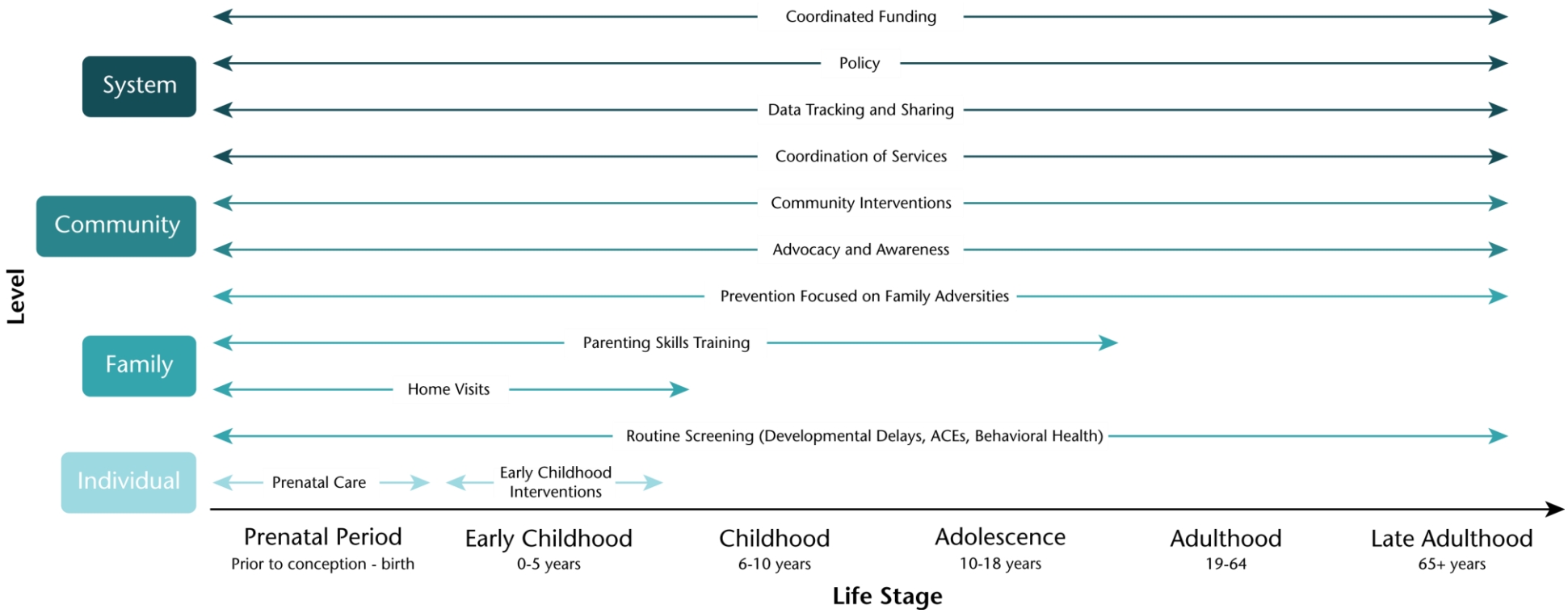
Applying a Multi-Level, Developmental Prevention Strategy

Figure 8 provides a high-level example of an applied prevention strategy that emphasizes three points:

1. Multi-dimensional approaches are critical to create the ideal prevention environment.
2. Coordinated interventions at the individual, family, community and system level take place simultaneously and reinforce one another.
3. Interventions should be viewed within the context of a person's life span; whether they target a specific stage, or the entire life course.

(See table next page.)

Figure 8. Applied Prevention Strategy



Source: Adapted from Beardslee, W. R., Chien, P. L., & Bell, C. C. (2011). Prevention of mental disorders, substance abuse, and problem behaviors: A developmental perspective. *Psychiatric Services*.

Chapter 2: Status of Child Health and Well-being in the Mat-Su

This chapter provides an overview of the status of child well-being in the Mat-Su Borough. Data regarding children and family demographics, household characteristics, and public health are summarized. It also analyzes child maltreatment data and the prevalence of Adverse Childhood Experiences (ACEs). Finally, this chapter summarizes prevention related stressors and protective factors by the following life stages, including prenatal, early childhood, childhood, adolescence and early adult, and adulthood. These data are particularly useful to understand issues, and to revisit as strategies and policies are developed in the Mat-Su. More detailed data are found in Appendix A.

Matanuska-Susitna Borough Family and Household Demographics

Overall Population

In 2015, there were an estimated 100,178 residents in the Mat-Su Borough, approximately 14 percent of the state's total population. Of the total Mat-Su population, 23,695 were children 14 years and younger (24 percent of the Mat-Su population), 27,942 were under age 18 (28 percent of Mat-Su population), and 10,284 were 65 years or older (10 percent of the Mat-Su population). The Mat-Su median age is 35.1 years.

(See table next page.)

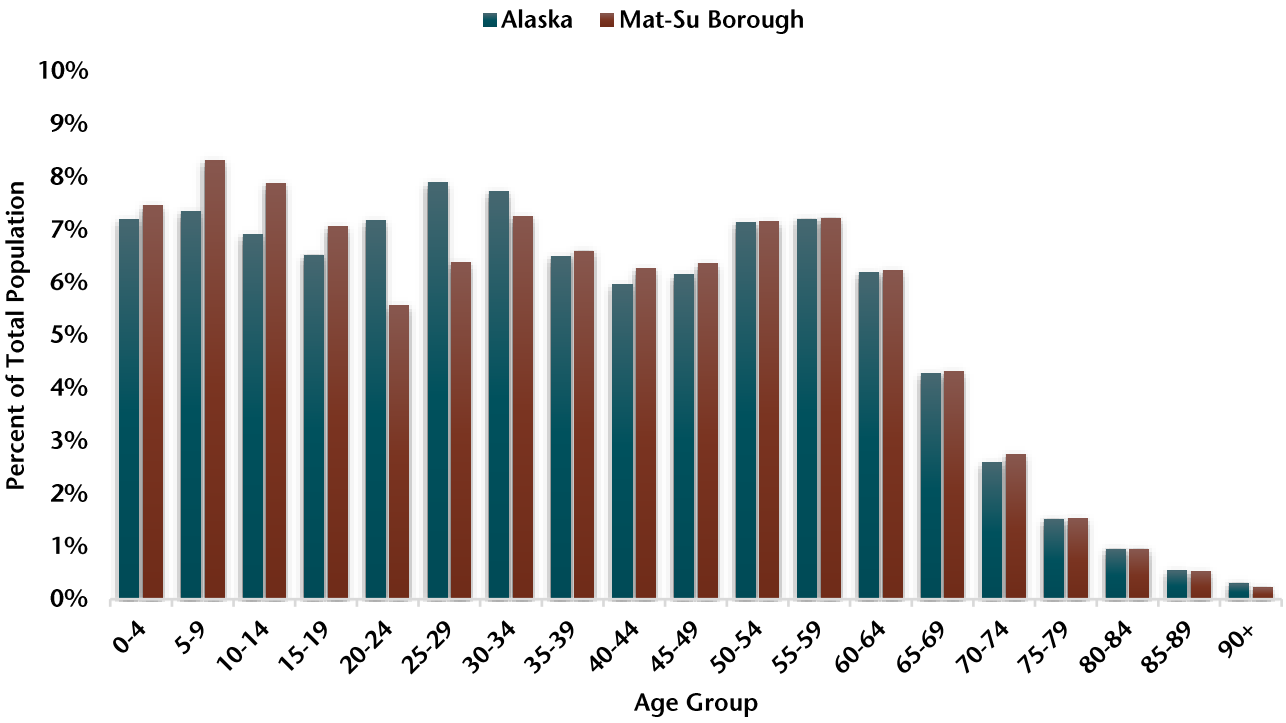
Table 1. Alaska and Mat-Su Borough Population, by Age Group and Gender, 2015

	Matanuska-Susitna Borough			Alaska		
Age Group	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**
0-4	3,779	3,699	7,478	27,081	25,973	53,054
5-9	4,348	3,976	8,324	28,051	26,113	54,164
10-14	4,072	3,821	7,893	26,105	24,793	50,898
15-19	3,837	3,241	7,078	25,214	22,871	48,085
20-24	2,918	2,652	5,570	28,839	24,086	52,925
25-29	3,249	3,139	6,388	30,541	27,682	58,223
30-34	3,693	3,574	7,267	29,569	27,402	56,971
35-39	3,424	3,182	6,606	24,748	23,095	47,843
40-44	3,243	3,031	6,274	22,743	21,243	43,986
45-49	3,314	3,058	6,372	23,355	21,953	45,308
50-54	3,745	3,420	7,165	27,398	25,204	52,602
55-59	3,766	3,468	7,234	27,400	25,722	53,122
60-64	3,161	3,084	6,245	23,807	21,784	45,591
65-69	2,260	2,053	4,313	16,620	14,872	31,492
70-74	1,403	1,342	2,745	9,751	9,349	19,100
75-79	829	707	1,536	5,492	5,673	11,165
80-84	458	488	946	3,148	3,864	7,012
85-89	225	302	527	1,559	2,388	3,947
90+	75	142	217	706	1,431	2,137
Total	**51,799**	**48,379**	**100,178**	**382,127**	**355,498**	**737,625**
Median Age	**35.1 years**	**35.0 years**	**35.1 years**	**34.2 years**	**34.8 years**	**34.5 years**
% under 14 years	**-**	**-**	**24%**	**-**	**-**	**21%**
% under 18 years	**-**	**-**	**28%**	**-**	**-**	**25%**
% 18 to 64 years	**-**	**-**	**62%**	**-**	**-**	**65%**
% over 65 years	**-**	**-**	**10%**	**-**	**-**	**10%**

Source: DOLWD Population Estimates.

In 2015, a higher percentage of Mat-Su Borough residents were under age 18 than for Alaska as a whole (28 percent versus 25 percent). Similarly, a lower percentage of Mat-Su residents were age 18 years to 64 years (62 percent and 65 percent statewide). The proportion of residents 65 years and older was similar at 10 percent. Overall, Mat-Su had a slightly higher median age than Alaska as a whole, 35.1 years compared to 34.5 years.

Figure 9. Mat-Su Borough and Alaska Population Distribution by Age Group, by Percentage, 2015



Source: DOLWD Population Estimates.

Households and Families

According to the U.S. Census Bureau's American Community Survey (ACS) 2010-2014 Five-Year Estimates, there are 31,104 households in the Mat-Su Borough with an average household size of 2.96 people, larger than Alaska's average household size of 2.79 people.

Of these households, 22,285 identify as family households, with an average family size of 3.47. Alaska's average family size was 3.36.

Of these family households:

- 17,704 identify as married-couple households with 46.8 percent of them including at least one person under age 18.
- 1,702 are male households with no wife present, and 65 percent of these include at least one person under age 18.
- 2,879 female households with no husband present, and 73.8 percent of these include at least one person under age 18.

Table 2. Alaska and Mat-Su Borough Households and Family, Selected Characteristics, 2010-2014 Five-Year Estimates

	Mat-Su Borough		Alaska	
	# / %	Margin of Error (+/-)	# / %	Margin of Error (+/-)
Households	**31,104**	**431**	**251,678**	**1,303**
Average size	2.96	0.04	2.79	0.01
Families	**22,285**	**403**	**168,552**	**1,583**
Average size	3.47	0.06	3.36	0.02
Married-couple family household	**17,704**	**474**	**125,898**	**1,663**
% with 1+ people under 18 years	46.8%	1.5%	47.5%	0.7%
Male householder, no wife present	**1,702**	**218**	**14,419**	**862**
% with 1+ people under 18 years	65.0%	7.1%	65.8%	2.4%
Female householder, no husband present	**2,879**	**239**	**28,235**	**1,046**
% with 1+ people under 18 years	73.8%	+4.0%	74.2%	1.5%

Source: U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates.
Note: The "Margin of Error" is the difference between an estimate and the 90 percent upper and lower confidence intervals.

Grandparents and Grandchildren in the Household

The Mat-Su Borough has an estimated 1,661 grandparents living with their own grandchildren under 18 years. Of these, 46.0 percent, or 764 grandparents, have primary parental responsibility for their grandchildren.

Table 3. Alaska and Mat-Su Grandparent Responsibility of Grandchildren, 2010-2014 Five-Year Estimates

	Mat-Su Borough		Alaska	
	# / %	Margin of Error (+/-)	# / %	Margin of Error (+/-)
Grandparent living with own grandchildren under 18 years	**1,661**	**240**	**15,526**	**866**
Count responsible for grandchildren	764	160	6,668	571
Percentage responsible for grandchildren	46.0%	7.1	42.9%	2.9

Note: The "Margin of Error" is the difference between an estimate and the 90 percent upper and lower confidence intervals.
Source: U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates

Householder Relations to Children in Household

The table below outlines various living arrangements for children based on their relationship to the householder. The majority of children in Alaska and in the Mat-Su Borough are living in households with at least one parent, regardless of family type.

Of the estimated 26,237 children in households in the Mat-Su Borough, 90.8 percent are children of the householder. In married-couple families, 94.4 percent of children are children of the householder. In families headed by a male adult and no wife present, 82.4 percent are children of the householder, and in families headed by a female adult and no husband present, 84.2 percent are children of the householder.

Table 4. Alaska and Mat-Su Borough Children in Households, by Living Arrangement, 2010-2014 Five-Year Estimates

	Mat-Su Borough		Alaska	
	# / %	Margin of Error (+/-)	# / %	Margin of Error (+/-)
Children under 18 years in households	**26,237**	**41**	**187,397**	**184**
% relationship to householder – own child	90.8%	1.1%	89.9%	0.5%
% relationship to householder – grandchild	4.8%	0.8%	6.3%	0.5%
% relationship to householder – other relatives	1.9%	0.6%	1.8%	0.2%
% relationship to householder – foster child or unrelated child	2.5%	0.6%	2.0%	0.2%
Children under 18 years in married-couple family household	**19,513**	**623**	**128,317**	**1,767**
% relationship to householder – own child	94.4%	0.9%	93.4%	0.5%
% relationship to householder – grandchild	3.7%	0.8%	4.7%	0.4%
% relationship to householder – other relatives	1.0%	0.5%	1.0%	0.2%
% relationship to householder – foster child or unrelated child	0.9%	0.4%	0.9%	+0.2%
Children under 18 years in male householder, no wife present	**2,208**	**372**	**17,601**	**1,410**
% relationship to householder – own child	82.4%	5.6%	85.9%	1.6%
% relationship to householder – grandchild	3.6%	2.2%	5.7%	1.3%
% relationship to householder – other relatives	8.9%	5.0%	4.6%	1.0%
% relationship to householder – foster child or unrelated child	5.1%	2.9%	3.8%	1.0%
Children under 18 years in female householder, no husband present	**4,255**	**468**	**40,291**	**1,747**
% relationship to householder – own child	84.2%	3.6%	82.9%	1.7%
% relationship to householder – grandchild	10.6%	3.4%	12.1%	1.5%
% relationship to householder – other relatives	2.5%	1.3%	3.5%	0.7%
% relationship to householder – foster child or unrelated child	2.7%	2.1%	1.6%	0.5%

Note: The "Margin of Error" is the difference between an estimate and the 90 percent upper and lower confidence intervals.
Source: U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates.

Children in Poverty

In the Mat-Su Borough, there are an estimated 25,741 children in all households. Of these, 13.5 percent of children in Mat-Su households live in households below the poverty line during the last 12 months (approximately 3,475 children).

Of the children living in the borough:

- An estimated 19,395 are living in married-couple family households, and 6.3 percent of these children (approximately 1,222 children) are living below the poverty line
- 2,107 children are living in households with male head of household and no wife present, and 17.2 percent of these children (approximately 362 children) live below the poverty line.
- A total of 4,182 children are living in households with female head of household and no husband present, and 44.0 percent of these children (approximately 1,840 children) live below the poverty line. This is much greater than the statewide estimation of 32.5 percent.

(See table next page.)

Table 5. Alaska and Mat-Su Borough Poverty Status in the Past 12 Months of Families, 2010-2014 Five-Year Estimates

Category	Mat-Su Borough # / %	Mat-Su Borough Margin of Error (+/-)	Alaska # / %	Alaska Margin of Error (+/-)
Number of children in all households	**25,742**	**128**	**184,520**	**446**
Percentage of children in households below poverty level	13.5%	2.0%	13.8%	0.8%
Estimated number of children in households below poverty line[1]	*3,475*	-	*25,464*	-
Number of children in married-couple family households	**19,395**	**617**	**127,495**	**1,735**
Percentage of married-couple family household children below poverty level	6.3%	2.0%	6.6%	+0.7%
Estimated number of children in married-couple family household below poverty line[1]	*1,222*	-	*8,415*	-
Number of children in male household, no wife present family household	**2,107**	**368**	**16,999**	**1,379**
Percentage of male household, no wife present family household children below poverty level	17.2%	8.2%	22.7%	2.8%
Estimated number of children in male householder, no wife present family household below poverty line[1]	*362*	-	*3,860*	-
Number of children in female household, no husband present family household	**4,182**	**453**	**39,810**	**1,726**
Percentage of female household, no husband present family household children below poverty level	44.0%	5.6%	32.5%	2.0%
Estimated number of children in female household, no husband present family household below poverty line[1]	*1,840*	-	*12,938*	-

Note: The "Margin of Error" is the difference between an estimate and the 90 percent upper and lower confidence intervals.
[1]These are McDowell Group calculations. The calculated estimated number of children in married-couple households; male households, no wife present; and female households no wife present will not equal the overall estimated number due to margins of error.
Source: U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates, Table S0901.

An estimated 4,300 households in the Mat-Su Borough received cash public assistance or Food Stamps/SNAP benefits in the past 12 months. Of the estimated 26,237 children under 18 years in households in the borough, 21.9 percent are in households that receive some form of public assistance. Among children living in married-couple households, 15.1 percent are in households that receive public assistance. Among children in male households, 27.2 percent are in households that receive public assistance, and among children in female households, 47.5 percent are in households that receive public assistance.

Table 6. Alaska and Mat-Su Borough Children in Households Accessing Public Assistance, 2010-2014 Five-Year Estimates

	Mat-Su Borough		Alaska	
	# / %	Margin of Error (+/-)	# / %	Margin of Error (+/-)
Households with cash public assistance or Food Stamps/SNAP in the past 12 months	**4,300**	**289**	**32,593**	**1,043**
Children under 18 years in households	**26,237**	**41**	**187,397**	**184**
% children living in households accessing public assistance	21.9%	2.3%	23.9%	0.8%
Children under 18 years in married-couple family household	**19,513**	**623**	**128,317**	**1,767**
% children living in households accessing public assistance	15.1%	2.7%	16.2%	0.9%
Children under 18 years in male household, no wife present	**2,208**	**372**	**17,601**	**1,410**
% children living in households accessing public assistance	27.2%	6.8%	32.2%	3.23%
Children under 18 years in female household, no husband present	**4,255**	**468**	**40,291**	**1,747**
% children living in households accessing public assistance	47.5%	5.6%	44.3%	2.5%

Note: The "Margin of Error" is the difference between an estimate and the 90 percent upper and lower confidence intervals.
Source: U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates.

Employment Characteristics of Families

There are an estimated 10,730 families in the Mat-Su Borough that include children of the head of household who are under 18 years. In married-couple families, 53.6 percent have both parents in the labor force. Of female householders with no husband present, 47.6 percent are in the labor force, and of male householders with no wife present, 27.0 percent are in the labor force.

Table 7. Alaska and Mat-Su Employment Characteristics of Families, 2010-2014 Five-Year Estimates

	Mat-Su Borough		Alaska	
	# / %	Margin of Error (+/-)	# / %	Margin of Error (+/-)
Families with own children under 18 years	**10,730**	**380**	**83,087**	**1,242**
Married-couple families with own children under 18				
% both husband and wife in labor force	53.6%	3.4%	62.9%	1.2%
% husband in labor force, wife not	37.8%	3.0%	29.4%	1.1%
% wife in labor force, husband not	5.6%	1.4%	5.5%	0.6%
% both husband and wife not in labor force	3.0%	1.0%	2.2%	0.4%
Female householder, no husband present family with own children under 18 in labor force	**47.6%**	**5.5%**	**55.9%**	**2.3%**
Male householder, no wife present family with own children under 18 in labor force	**27.0%**	**3.8%**	**28.2%**	**2.0%**

Note: The "Margin of Error" is the difference between an estimate and the 90 percent upper and lower confidence intervals.
Source: U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates.

Mat-Su Births

- A total of 67 births occurred to mothers less than 20 years old – (6.2 percent of all Mat-Su births).
- Most Mat-Su births (485) occurred among women ages 25-29 (31.6 percent of all births).

Table 8. Number and Percentage of Births by Age Group, Mat-Su and Rest of Alaska, 2015

Age of Mother	Mat-Su Number of Births	Mat-Su % of Total Births	Rest of Alaska Number of Births	Rest of Alaska % of Total Births
<=17	9	0.6	143	1.5
18-19	58	3.8	461	4.7
20-24	361	23.5	2367	24.3
25-29	486	31.6	3036	31.1
30-34	409	26.6	2482	25.5
35-39	174	11.3	1056	10.8
40+	42	2.7	204	2.1
Total	**1,539**	**100.0%**	**9,749**	**100.0%**

Note: This includes Alaska residents based upon the birth certificates for births in 2015.
Source: Alaska Vital Statistics – Birth Certificate Data.

- Just over half (51 percent) of Mat-Su births occur at the Mat-Su Regional Medical Center. The remaining half occur in several locations, including Providence Alaska Medical Center (15 percent), Alaska Native Medical Center (11 percent), among others.

Table 9. Birth Location Among Mat-Su Mothers, 2105

Birth Location	Number of Mat-Su Births	Mat-Su Births Percent of Total
Mat-Su Regional Medical Center	785	51.0%
Providence Alaska Medical Center	229	14.9
Alaska Native Medical Center	165	10.7
Mat-Su Midwifery	82	5.3
Combined Locations*	81	5.3
Alaska Regional Hospital	56	3.6
Integrated Women's Wellness & Center for Birth	56	3.6
Joint Based Elmendorf-Richardson Hospital	31	2.0
The Birth Place	29	1.9
Heritage Birth Center	25	1.6
Total	**1,539**	**100.0%**

*Includes home births, Labor of Love Midwifery, Geneva Woods Birth Center, One Family Birth Center, Anchorage Birth Center and other out of state locations.
Note: This includes Alaska residents based upon the birth certificates for births in 2015.
Source: Alaska Vital Statistics – Birth Certificate Data.

- In 2015, 10 births occurred at less than 28 weeks (0.7 percent of all Mat-Su births).
- Most Mat-Su births reached 37 or more weeks in duration (90.5 percent).
- Nearly 9 percent of the births occurred between 28-36 weeks.

Table 10. Birth Term Gestation, Mat-Su and Rest of Alaska, 2015

Birth Term	Mat-Su Number of Births	Mat-Su % of Total Births	Rest of Alaska Number of Births	Rest of Alaska % of Total Births
<28 Weeks	10	0.7%	60	0.6%
28-36 Weeks	135	8.8	963	9.9
37+ Weeks	1,388	90.5	8,716	89.5
Total	**1,533**	**100.0%**	**9,739**	**100.0%**

Note: This includes Alaska residents based upon the birth certificates for births in 2015.
Source: Alaska Vital Statistics – Birth Certificate Data.

- Most Mat-Su infants were born at a normal birthweight (80.1 percent).
- Twelve infants were born with very low birthweights and 73 infants were born with a low birthweight.

Table 11. Status of Birthweight, Mat-Su and Rest of Alaska, 2015

Birthweight Category	Mat-Su Number of Births	Mat-Su % of Total Births	Rest of Alaska Number of Births	Rest of Alaska % of Total Births
Very Low	12	0.8%	96	1.0%
Low	73	4.7	476	4.9
Normal	1,232	80.1	7,936	81.4
Birthweight >= 4,000g	222	14.4	1,241	12.7
Total	**1,539**	**100.0%**	**9,749**	**100.0%**

Note: This includes Alaska residents based upon the birth certificates for births in 2015.
Source: Alaska Vital Statistics – Birth Certificate Data.

- Most Mat-Su mothers (85.1 percent) did not report they smoked while pregnant; 13.9 percent of Mat-Su mothers (or 214 mothers) reported they did smoke.

Table 12. Mothers Who Smoked, Mat-Su and Rest of Alaska, 2015

Response	Mat-Su Number of Births	Mat-Su % of Total Births	Rest of Alaska Number of Births	Rest of Alaska % of Total Births
Yes	214	13.9%	1,841	18.9%
No	1,309	85.1	7,282	80.3
Unknown	16	1.0	80	0.8
Total	**1,539**	**100.0%**	**9,749**	**100.0%**

Note: This includes Alaska residents based upon the birth certificates for births in 2015.
Source: Alaska Vital Statistics – Birth Certificate Data.

- Among Mat-Su mothers reporting prenatal visit history, 81.3 percent received their first prenatal care in the first trimester; 15.3 percent received their first prenatal care in their second trimester (or 223 mothers) and 3.4 percent in the third trimester (or 50 mothers).

Table 13. Among Women with a Known Prenatal Month, 1st Month of Prenatal Care by Month, Mat-Su and Rest of Alaska, 2015

Month of Gestation	Mat-Su Number of Births	Mat-Su % of Total Births	Rest of Alaska Number of Births	Rest of Alaska % of Total Births
1	216	14.8%	1,259	13.4%
2	661	45.3	4,149	44.1
3	308	21.1	2,077	22.1
4	106	7.3	802	8.5
5	80	5.5	447	4.8
6	37	2.5	269	2.9
7	27	1.9	208	2.2
8	16	1.1	143	1.5
9	7	0.5	51	0.5
Total	**1,458**	**100.0%**	**9,405**	**100.0%**

Note 1: This includes Alaska residents based upon the birth certificates for births in 2015.
Note 2: There were 81 Mat-Su and 338 Alaska births with an unknown prenatal month.
Source: Alaska Vital Statistics – Birth Certificate Data.

- Most women (84.0 percent of Mat-Su mothers) had 6-15 prenatal care visits before the birth of their child.
- In 2015, there were eight births in the Mat-Su where zero prenatal visits were reported.

Table 14. Number of Prenatal Visits Associated with Each Birth, Mat-Su and Rest of Alaska, 2015

Number of Prenatal Visits	Mat-Su Number of Births	Mat-Su % of Total Births	Rest of Alaska Number of Births	Rest of Alaska % of Total Births
None	8	0.6%	104	1.1%
1-5	81	5.7	918	9.8
6-15	1,190	84.0	7,507	79.9
>15	137	9.7	864	9.2
Total	**1,416**	**100.0%**	**9,393**	**100.0%**

Note 1: This does not include 123 Mat-Su and 356 Rest of Alaska births with missing information.
Note 2: This includes Alaska residents based upon the birth certificates for births in 2015.
Source: Alaska Vital Statistics – Birth Certificate Data.

Mat-Su Population Under Age 5

An estimated 7,478 children under age 5 lived in Mat-Su in 2015. If that population is distributed evenly by age, approximately 4,500 children age 0-2 and 3,000 children age 3-4 live in Mat-Su. The following maps display the geographic distribution of children under age 5 in the Mat-Su by census block group. The first displays the number of children under age 5; the second displays the percent of the total population under age 5. The largest group of children under age 5 live in the Knik-Fairview region. That same region, along with a block group just north of Spruce Avenue, boast populations with the highest proportion of children under age 5.

(See figures next pages.)

Figure 10. Population Under Age 5, by Census Block Group, Mat-Su Borough, 2010

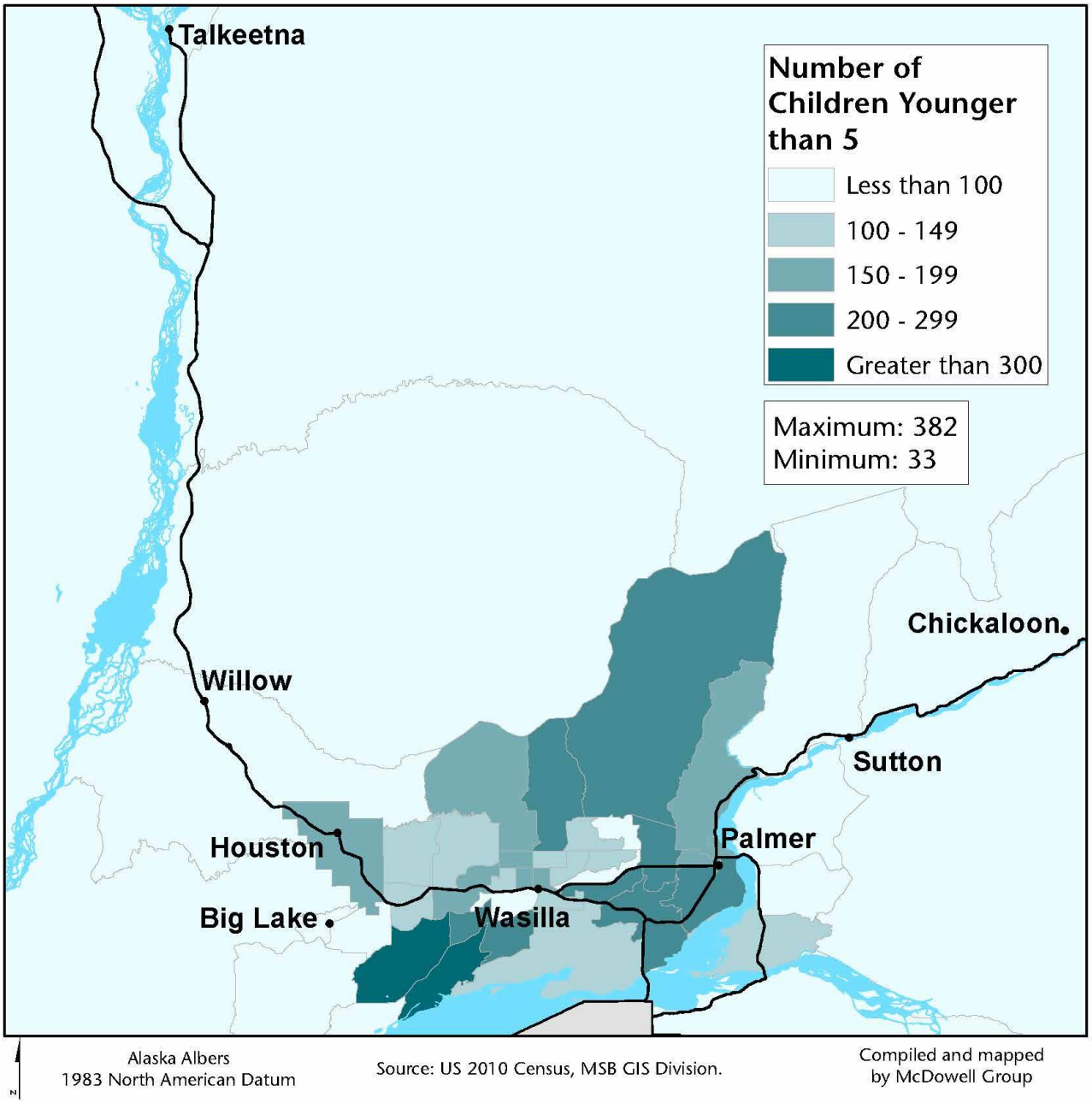
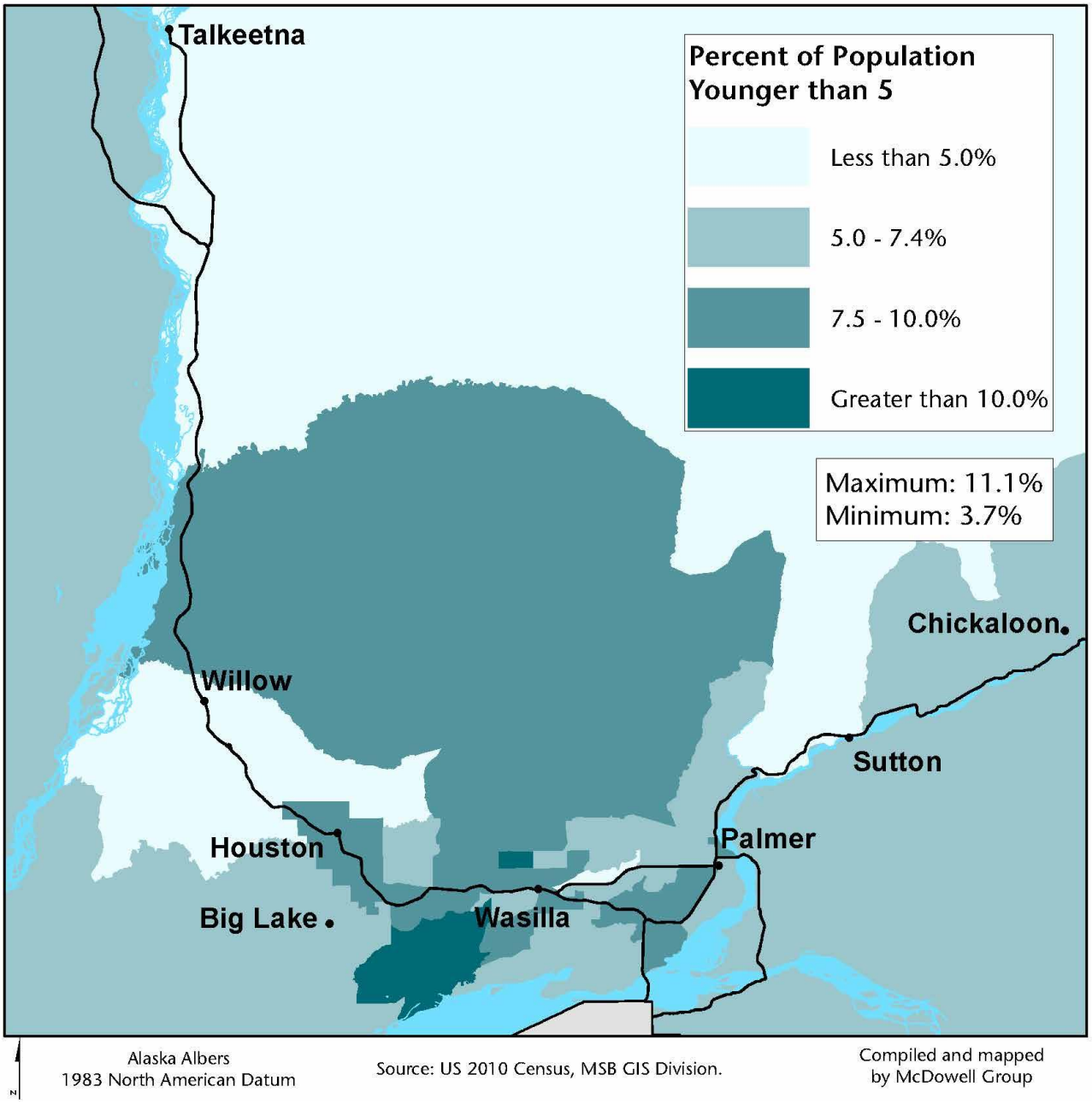


Figure 11. Percent of Total Population Under Age 5, by Census Block Group, Mat-Su Borough, 2010



Protective and Stressor Indicators by Life Stage

"Protective factors" are conditions or attributes in individuals, families, communities, or the larger society that, when present, mitigate or eliminate risk in families and communities and can increase the health and well-being of children and families. Protective factors help parents to find resources, supports, or coping strategies that allow them to parent effectively, even under stress. Research shows that protective factors are linked to a lower incidence of child abuse and neglect:

- Nurturing and attachment
- Knowledge of parenting, and of child and youth development
- Parental resilience
- Social connections
- Concrete supports for parents
- Social and emotional competence of children[9]

"Stressors" are characteristics at the biological, psychological, family, community, or cultural level that precede and are associated with a higher likelihood of negative behavioral health outcomes which may contribute to or be the result of child abuse and neglect.[10]

In the Mat-Su, there are several protective factors that indicate higher positive outcomes than experiences elsewhere in Alaska, including:

- Nine out of 10 mothers of newborns received a prenatal care visit where providers:
    - Discuss tests to screen for birth defects or diseases that run in the family.
    - Talk about the signs and symptoms of preterm labor.
- Eight out of 10 mothers of newborns received a prenatal care visit where providers discussed how smoking while pregnant can affect the baby.
- Seven out of 10 mothers of newborns received a prenatal care visit where providers discussed physical abuse to women by their husbands or partners.
- Eight out of 10 alternative high school students agreed that their teachers really cared about them and give them a lot of encouragement.
- Almost one out of seven adults used food assistance from community programs.

More detailed findings regarding protective factors (and stressors) by life stage are found below.

[9] https://www.childwelfare.gov/topics/preventing/promoting/protectfactors/ (accessed August 26, 2016).
[10] http://www.samhsa.gov/capt/practicing-effective-prevention/prevention-behavioral-health/risk-protective-factors (accessed August 26, 2016).

Throughout this next section, the following table serves as a reference for the symbols used within the tables.

Table 15. Symbols for Statistical and Non-statistical Comparison for Tables

Symbol	Comparison Indication
√	Indicates there is a statistical difference between the Mat-Su and the region compared, and the Mat-Su percent is better than the comparison percent.
□	Indicates a statistical difference within this variable
↔	Indicates there is not a statistical difference or no difference between the Mat-Su and Alaska.
X	Indicates a statistical difference between the Mat-Su and the area compared, and the Mat-Su percent is worse than the comparison percent.
NA	Indicates the data are not available for this comparison.
↑	Indicates that the Mat-Su is higher than the comparison region, but there is not a statistical test.
↓	Indicators that the Mat-Su is lower than the comparison, but there is not a statistical test.

Pre-pregnancy and Prenatal Indicators

Protective Factors

√ In Mat-Su, 89.9 percent of mothers with newborns, representing more than 1,100 women, had a prenatal care visit in which a doctor, nurse, or other health care worker talked with them about tests to screen for defects or diseases that run in the family. Mat-Su mothers received this information at a higher rate than the rest of Alaska ($p<.05$), where 83.5 percent of mothers of newborns reported this experience.

√ Of mothers with newborns in Mat-Su, 89.4 percent, or about 1,100 women, had a prenatal care visit in which a doctor, nurse, or other health care worker talked about the signs and symptoms of preterm labor. A higher proportion of mothers of newborns in Mat-Su experienced this than in the rest of Alaska ($p<.05$). In the rest of Alaska, 82.3 percent of mothers of newborns were talked to about preterm labor.

√ In Mat-Su, 80.7 percent of mothers with newborns, about 1,000 women, had a prenatal care visit in which a doctor, nurse, or other health care worker talked about the effect on the baby of smoking when pregnant. A lower proportion of mothers in the rest of Alaska (72.1 percent) had this conversation ($p<.05$).

√ In Mat-Su, 70.9 percent of mothers with newborns, close to 900 women, had a prenatal care visit in which a doctor, nurse, or other health care worker talked about physical abuse to women by their husbands or partners. With respect to this indicator, Mat-Su provided more prenatal care than the rest of Alaska ($p<.05$), where 59.3 percent of mothers of newborns had this conversation.

X Of mothers with newborns in Mat-Su, 9.9 percent, or 125 women, got checked for diabetes by a health care worker in the 12 months before they got pregnant. This was a worse percentage than the rest of Alaska ($p<.05$), where 17.6 percent of mothers of newborns were checked.

Table 16. Prevalence of Selected Pre-pregnancy and Prenatal Protective Factors, Mat-Su and Rest of Alaska Statistical Comparison, 2012-2013

Indicators (% answering "Yes")	% of Mat-Su Mothers with New Babies	Estimated Annual Average # of Mat-Su Mothers with New Babies	Mat-Su Statistically Compared to Rest of Alaska
Pre-pregnancy: At any time during the 12 months before you got pregnant with your new baby, did you ...			
Have your teeth cleaned by a dentist or dental hygienist?	59.3	744	↔
Exercise 3 or more days of the week?	53.9	681	↔
Talk to a health care worker about your family medical history?	29.8	376	↔
Diet to lose weight?	28.9	362	↔
Visit a health care worker and get checked for high blood pressure?	20.6	256	↔
Regularly take prescription medicines other than birth control?	15.1	190	↔
Visit a health care worker and get checked for depression or anxiety?	13.5	171	↔
Visit a health care worker and get checked for diabetes?	9.9	125	X
Prenatal: During any of your prenatal care visits, did a doctor, nurse, or other health care worker talk with you about...			
Medicines that are safe to take during your pregnancy?	90.3	1,122	↔
Testing to screen for birth defects or diseases that run in your family?	89.9	1,118	√
The signs and symptoms of preterm labor?	89.4	1,108	√
Breastfeeding your baby?	87.4	1,087	↔
How smoking during pregnancy could affect your baby?	80.7	1,003	√
What do you do if you feel depressed during your pregnancy or after your baby is born?	80.0	994	↔
How drinking alcohol during pregnancy could affect your baby?	79.1	984	↔
How much weight you should gain during pregnancy?	79.1	982	↔
Physical abuse to women by their husbands or partners?	70.9	872	√
How using illegal drugs could affect your baby?	68.8	847	↔
Getting tested for HIV?	66.4	821	↔
Using a seat belt during pregnancy?	62.0	770	↔

Note: See Appendix A for more detailed data. The weighted number and percentages represent the whole population.
Source: Pregnancy Risk Assessment Monitoring System (PRAMS).

STRESSOR FACTORS

X Mothers with newborns or her partner experienced a cut in pay or work hours in the 12 months before birth for 21.4 percent of mothers of newborns in Mat-Su, an estimated 250 women. This is a lower proportion than among mothers of newborns in the rest of Alaska ($p<.05$); 13.5 percent faced the same challenge.

Table 17. Prevalence of Selected Pre-pregnancy and Prenatal Stressor Factors, Mat-Su and Rest of Alaska Statistical Comparison, 2012-2013

Indicators (% answering "Yes")	% of Mat-Su Mothers with New Babies	Estimated Annual Average # of Mat-Su Mothers with New Babies	Mat-Su Statistically Compared to Rest of Alaska
For mothers with a live birth, just before you got pregnant with your new baby…			
I didn't want to be pregnant then, or at any time in the future (unwanted pregnancy)	7.1	89	↔
I wanted to be pregnant later, or didn't want to be pregnant then, or at any time in the future (unintended pregnancy)	21.1	264	↔
During the 12 months before your new baby was born…			
I moved to a new address.	39.4	488	↔
A close family member was very sick and had to go into the hospital.	22.4	276	↔
My husband, partner, or I had a cut in work hours or pay.	21.4	265	X
I had problems paying the rent, mortgage, or other bills.	20.9	256	↔
I argued with my husband or partner more than usual.	19.6	242	↔
Someone very close to me died.	17.6	218	↔
Someone very close to me had a problem with drinking or drugs.	17.5	216	↔
I was apart from my husband or partner due to military deployment or extended work-related travel.	12.3	151	↔
My husband or partner lost his job.	11.9	147	↔
My husband or partner said he didn't want me to be pregnant.	9.2	113	↔
I got separated or divorced from my husband or partner.	8.7	108	↔
I lost my job even though I wanted to go on working.	7.8	97	↔
My husband, partner, or I went to jail.	7.0	87	↔
During the 12 months before you got pregnant with your new baby, did your husband or partner push, hit, slap, kick, choke, or physically hurt you in any other way?	3.8	47	↔
During the 12 months before your new baby was born, were you homeless or did you have to sleep outside, in a car, or in a shelter?	3.6	45	↔
During your most recent pregnancy, did your husband or partner push, hit, slap, kick, choke, or physically hurt you in any other way?	2.9	36	↔

Note: See Appendix A for more detailed data. The weighted number and percentages represent the whole population.
Source: Pregnancy Risk Assessment Monitoring System (PRAMS).

Infancy and Early Childhood Indicators

Protective Factors (Infancy)

X In Mat-Su, 38.9 percent of mothers of newborns, about 500 women, were told about support groups for new parents by a doctor, nurse, or other health care worker. A higher proportion of mothers of newborns in the rest of Alaska – 49.1 percent – were told of support groups for new parents by a doctor, nurse, or other health care worker ($p<.05$).

X Of Mat-Su mothers of newborns, 39.9 percent, representing close to 500 women, had talked with a doctor, nurse, or other health care worker after delivery about resources in the community such as nurse home visitation programs, telephone hotlines, or counseling. Mat-Su reported less discussions about these topics than the rest of Alaska ($p<.05$), where 51.4 percent of mothers of newborns received that information.

Table 18. Prevalence of Selected Infancy Protective Factors, Mat-Su and Rest of Alaska Statistical Comparison, 2012-2013

Indicators (% answering "Yes)	% of Mat-Su Mothers with New Babies	Estimated Annual Average # of Mat-Su Mothers with New Babies	Mat-Su Statistically Compared to Rest of Alaska
Since your baby was born, have you had a postpartum checkup for yourself?	89.8	1,117	↔
Since your baby was born, did a doctor, nurse or other health care worker talk with you about…			
Help with, or information about, breastfeeding?	89.3	1,073	↔
Postpartum depression?	88.5	1,062	↔
Birth control methods that you can use after giving birth?	87.9	1,056	↔
How long to wait before getting pregnant again?	61.6	740	↔
Getting to, and staying at, a healthy weight after delivery?	45.6	544	↔
Resources in your community, such as nurse home visitation programs, telephone hotlines, or counseling?	39.9	475	X
Support groups for new parents?	38.9	467	X

Note: See Appendix A for more detailed data. The weighted number and percentages represent the whole population.
Source: Pregnancy Risk Assessment Monitoring System (PRAMS).

PROTECTIVE FACTORS (EARLY CHILDHOOD)

X Of Mat-Su mothers with 3-year-olds, 37.7 percent, or about 1,650 women, delayed or decided not to get vaccine shots or immunizations for their child. With respect to this indicator, Mat-Su mothers are less likely to follow the recommended immunization guidelines than the rest of Alaska ($p<.05$) where 27.3 percent of mothers with 3-year-olds had made the same decision.

X In Mat-Su, 35.5 percent of mothers with a 3-year-old child, about 1,550 women, have routine child care arrangements. This figure is higher in the rest of Alaska ($p<.05$), where 46.1 percent of mothers with a 3-year-old child have routine child care arrangements.

(See table next page.)

Table 19. Prevalence of Selected Early Childhood Protective Factors, Mat-Su and Rest of Alaska Statistical Comparison, 2012-2014

Indicators	% of Mat-Su Mothers with 3-Year Olds	Estimated Annual Average # of Mat-Su Mothers with 3-Year-Olds	Mat-Su Statistically Compared to Rest of Alaska
I know someone who would listen to me if I needed to talk.	97.5	1,456	↔
I am confident in my ability to raise and take care of my child.	96.7	1,442	↔
I know where to go for parenting information, or if I have questions or concerns about my child's development.	96.6	1,441	↔
I know someone who would take me to the clinic or doctor's office if I needed a ride.	93.6	1,397	↔
I have steps I can take to manage stress.	92.8	1,384	↔
My child has a caring relationship with at least one adult other than his or her parents.	94.9	1,382	↔
I know someone who would help me if I was sick and needed to be in bed.	90.1	1,344	↔
My child's bedtime is usually the same every day.	89.7	1,307	↔
I know someone who would loan me money for bills if I needed it.	85.6	1,277	↔
I feel comfortable asking for help when I need it.	84.9	1,267	↔
My child plays with children outside the family on a regular basis.	74.9	1,092	↔
Is there a doctor, nurse, or other health care worker who knows your child well and is familiar with your child's health history? ("Yes" response)	85.1	1,241	↔
During the past 12 months, has your child seen a health care worker for routine medical care such as a well-child check-up or physical exam? ("Yes" response)	84.3	1,228	↔
Have you ever delayed or decided not to get vaccine shots or immunizations for your child? ("Yes" response)	37.7	550	X
During the past 12 months, did a doctor, nurse or other health care or mental health worker talk to you about depression or how you are feeling emotionally? ("Yes" response)	35.0	522	↔
Do you now have routine child care arrangements for your 3-year old child? ("Yes" response)*	35.5	518	X
Do you regularly use a child care center, preschool, Head Start or other center that is not a caregiver's home? ("Yes" response)*	60.9	327	↔
Did you delay or decide not to get a specific vaccine shot or immunization for your child? ("Yes" response)	37.0	212	↔
Do you regularly use child care in a relative's home? ("Yes" response)*	31.4	169	↔
Do you regularly use child care in a non-relative's home? ("Yes" response)*	21.6	116	↔
Do you regularly use child care in your home by a relative? ("Yes" response)*	19.0	102	↔
Do you regularly use child care in your home by a non-relative? ("Yes" response)*	12.5	67	↔
Do you regularly use another type of child care? ("Yes" response)*	2.1	11	↔

Notes: See Appendix A for more detailed data. The weighted number and percentages represent mothers of 3-year olds born during 2009-2011. *indicates mothers who reported currently using childcare regularly.
Source: Alaska Childhood Understanding Behaviors Survey (CUBS).

Stressor Factors

- √ Mothers with 3-year-olds in Mat-Su paid less for child care than mothers with 3-year-olds in the rest of Alaska ($p<.05$). In Mat-Su, 9.5 percent, almost 450 women, paid at least $600 per month, compared to 16.7 percent of in the rest of Alaska.

- In Mat-Su, only 6.4 percent of children age 3 had experienced a death in the immediate family. In the rest of Alaska, a higher proportion of 3-year-olds – 12.7 percent – endured this experience ($p<.05$).
- In Mat-Su, 93.2 children for every 1,000 children age 0-4 had at least one maltreatment allegation made on their behalf to the Office of Children's Services. This rate represents a total of 697 Mat-Su children. This rate is lower than the rate in the rest of Alaska, where 103.9 children of every 1,000 children age 0-4 had at least one maltreatment allegation made on their behalf.
- The rate for substantiated allegations of maltreatment was lower in Mat-Su than the rest of Alaska. In Mat-Su, 13.1 children for every 1,000 children age 0-4, or 98 total children, had a substantiated allegation of maltreatment, compared to a rate of 18.4 for the rest of Alaska.
- Of Mat-Su mothers with a recent delivery, none had felt down, depressed, or hopeless since the birth. A higher prevalence existed for mothers of newborns in the rest of the state ($p<.05$). In the rest of Alaska, 0.9 percent of mothers with a recent delivery had felt down, depressed, or hopeless since the birth.

(See table next page.)

Table 20. Prevalence of Selected Early Childhood Stressor Factors, Mat-Su and Rest of Alaska Statistical Comparison, 2012-2014

Indicators (% answering "Yes")	% of Mat-Su Mothers with 3-Year Olds	Est. Annual Average # of Mat-Su Mothers with 3-Year-Olds	Mat-Su Statistically Compared to Rest of Alaska
Has your child ever experienced change in household members (including a new sibling)?	50.6	737	↔
Since your 3-year old child was born, have you moved to a new address?	49.0	731	↔
Since your 3-year old child was born, have you had a lot of bills you couldn't pay?	26.6	396	↔
Since your 3-year old child was born, has someone very close to you died?	20.7	309	↔
Has your child ever experienced conflict between parents?	20.6	301	↔
Has your child ever experienced being away from either parent for longer than a one-month time period?	17.6	257	↔
Since your 3-year old child was born, has your marital status changed?	15.9	237	↔
Since your 3-year old child was born, have you lost your job?	14.0	208	↔
Since your 3-year old child was born, has someone very close to you been depressed, mentally ill, or suicidal?	13.5	201	↔
Since your 3-year old child was born, has someone very close to you had a problem with drinking or drugs?	13.0	194	↔
Since your 3-year old child was born, has your husband or partner lost his job?	12.6	188	↔
Is the average cost per month that you pay now for childcare for your 3-year-old $600 or more?	9.5	142	√
Since your 3-year old child was born, have you been diagnosed with depression?	8.5	127	↔
Has your child ever experienced an overnight stay in hospital (not including right after birth)?	7.3	107	↔
Has your child ever experienced alcoholism or mental health disorder in the family?	6.7	98	↔
Has your child ever experienced death of a close family member?	6.4	93	√
Percentage of respondents who read a book or story to their child fewer than 3 days per week.	5.7	85	↔
Would you prefer to use a form of child care for your child other than what you are using now?*	14.2	76	↔
Since your 3-year old child was born, have you or your husband/partner been to jail?	3.3	49	↔
Since your 3-year old child was born, have you been homeless?	1.7	25	↔
Has your child ever experienced seeing violence or physical abuse in person?	1.5	22	↔
During the past 12 months, did your husband or partner push, hit, slap, kick, choke or physically hurt you in any other way?	1.4	21	↔
Number of respondents who sat down and ate fewer than 3 meals per week with their child.	0.8	12	↔

Notes: See Appendix A for more detailed data. The weighted number and percentages represent mothers of 3-year olds born during 2009-2011. *indicates mothers who reported currently using childcare regularly.
Source: Childhood Understanding Behaviors Survey (CUBS).

Table 21. Prevalence of Selected Early Childhood Stressor Factors, Mat-Su and Rest of Alaska Statistical Comparison, 2012-2013

Indicator Since your new baby was born, have you always or often…	% of Mat-Su Mothers with Newborns	Estimated # of Mat-Su Mothers with Newborns	Mat-Su Statistically Compared to Rest of Alaska
Felt down, depressed, or hopeless? ("Yes" response)	5.1	63	↔
Had little interest, or little pleasure, in doing things? ("Yes" response)	6.8	84	↔

Note: See Appendix A for additional data information. The weighted number and percentages represent the whole population.
Source: Pregnancy Risk Assessment Monitoring System (PRAMS).

Table 22. Number and Rate of Children Age 0-4 with OCS Maltreatment Allegations and Substantiated Maltreatment Allegations, Mat-Su and Alaska Statistical Comparison, 2015

Indicators	Rate of Mat-Su Children per 1,000 Children	Annual # of Mat-Su Children	Mat-Su Statistically Compared to Alaska
Children with OCS maltreatment allegations	93.2	697	√
Children with OCS substantiated maltreatment allegations	13.1	98	√

Source: Alaska Office of Children's Services, prepared by SCAN.

Childhood, Adolescence and Early Adulthood Indicators

PROTECTIVE FACTORS

- Compared to school districts across the entire state, Mat-Su Borough School District school climate average indices were relatively similar to indices experienced in Alaska.
- In Mat-Su, 54.0 percent of students had heard a message in the past year saying most students do not drink. In all Alaska, 56.0 percent of students received this message.
- The attendance rate for preschool through 12th grade was 92.3 percent in Mat-Su, lower than the attendance rate statewide of 93.1 percent.
- In Mat-Su, 80.1 percent of alternative high-school students agreed, or strongly agreed, that their teachers really care about them and give them a lot of encouragement. The figure is more positive for Mat-Su than for alternative students in all Alaska, of whom 73.3 percent felt as strongly about their teachers.

(See table next page.)

Table 23. Childhood, Adolescent, and Early Adulthood Protective Factors, Mat-Su and Alaska Comparison, School Year 2014-2015

Indicators	Grades	Mat-Su Index (Average)	Mat-Su Compared to Alaska
Parent and Community Involvement Index	6th-12th	3.52	↓
Caring Adults Index	6th-12th	3.57	↓
Caring Others Index	3rd-5th	2.54	↓
Peer Climate Index	6th-12th	3.20	↑
Respectful Climate Index	6th-12th	3.54	↔
School Leadership and Student Involvement Index	6th-12th	3.37	↓
School Safety Index	6th-12th	3.96	↑
Social and Emotional Learning Index	6th-12th	3.82	↓
High Expectations Index	6th-12th	4.08	↓
Students who heard a message in the past year saying that most do not drink (Percent)	6th-12th	54.0%	↓
Attendance Rate (Percent)	PreK-12	92.3%	↓

Notes: Results are averages of categorical responses, and index scores are based upon a model summarizing responses. See Appendix A for additional data information.
Source: Alaska School Climate and Connectedness Survey (SCCS) and Alaska Department of Education and Early Development.

Table 24. Prevalence of Selected Adolescence and Early Adulthood Protective Factors, Traditional High School Students, Mat-Su and Alaska Statistical Comparison, School Year 2014-2015

Indicators	% of Mat-Su High School Students	Estimated Number of Mat-Su High School Students	Mat-Su Statistically Compared to Alaska
Percentage of Students Who…			
Would feel comfortable seeking help from at least one adult besides their parents if they had an important question affecting their life	84.8	3,495	↔
Agree, or strongly agree, that their school has clear rules and consequences for behavior	71.1	2,930	↔
Received grades of mostly As and Bs during the past 12 months	67.8	2,794	↔
Agree, or strongly agree, that their teachers really care about them and give them a lot of encouragement	63.7	2,625	↔
Feel it is pretty much true, or very much true, that they do fun things at home with parents or other adults	57.0	2,349	NA
Feel it is pretty much true, or very much true, that there is an adult who notices when they are upset about something	51.8	2,135	NA
Spend one or more hours helping people without getting paid, or volunteering at school, or in the community, during an average week	50.1	2,065	↔
Take part in organized after-school, evening, or weekend activities on one or more days during an average week	50.0	2,061	↔
Feel it is pretty much true, or very much true, that they help make decisions with their family	48.6	2,003	NA
Agree, or strongly agree, that in their community they feel like they matter to people	48.5	1,999	↔
Feel it is pretty much true, or very much true, that they do things at home that make a difference	42.6	1,756	NA
Had a least one parent who talked with them about what they were doing in school every day	42.3	1,743	↔
Feel it is pretty much true, or very much true, that they do interesting activities at school	37.2	1,533	NA

Note: See Appendix A for additional data information.
Source: Alaska Youth Risk Behavior Survey (YRBS).

Table 25. Prevalence of Selected Adolescence and Early Adulthood Protective Factors, Alternative High School Students, Mat-Su and Alaska Statistical Comparison, School Year 2014-2015

Indicators	% of Mat-Su High School Students	Estimated Number of Mat-Su High School Students	Mat-Su Statistically Compared to Alaska
Percentage of Students Who…			
Would feel comfortable seeking help from at least one adult besides their parents if they had an important question affecting their life ("Yes" response)	83.8	370	↔
Agree, or strongly agree, that their school has clear rules and consequences for behavior	82.0	362	↔
Agree, or strongly agree, that their teachers really care about them and give them a lot of encouragement	80.1	354	√
Feel it is pretty much true, or very much true, that there is an adult who notices when they are upset about something	54.7	242	NA
Agree, or strongly agree, that in their community they feel like they matter to people	45.8	202	↔
Received grades of mostly As and Bs during the past 12 months ("Yes" response)	44.5	197	↔
Feel it is pretty much true, or very much true, that they help make decisions with their family	43.8	194	NA
Take part in organized after-school, evening, or weekend activities on one or more days during an average week ("Yes" response)	40.8	180	↔
Feel it is pretty much true, or very much true, that they do interesting activities at school	40.2	178	NA
Feel it is pretty much true, or very much true, that they do fun things at home with parents or other adults	39.3	174	NA
Spend one or more hours helping people without getting paid, or volunteering at school or in the community during an average week ("Yes" response)	38.6	171	↔
Feel it is pretty much true, or very much true, that they do things at home that make a difference	35.6	157	NA
Had a least one parent who talked with them about what they were doing in school every day ("Yes" response)	28.1	124	↔

Note: See Appendix A for additional data information.
Source: Alaska Youth Risk Behavior Survey (YRBS).

STRESSOR FACTORS

- A smaller proportion of Mat-Su students were economically disadvantaged than all Alaska students, 34.1 percent compared to 46.4 percent.
- Students in special education composed a larger percentage of total enrollment in the Mat-Su Borough School District than in Alaska, 14.8 percent (2,765 students) compared to 13.7 percent (18,390 students).
- In Mat-Su, students with the following disabilities accounted for higher proportions of the total number of special education students compared to the statewide makeup:
    - speech/language impairment (17.3 percent compared to 16.6 percent)
    - emotional disturbance (6.2 percent compared to 3.6 percent)
    - visual impairments (0.4 percent compared to 0.3 percent)
- In Mat-Su, students with the following disabilities accounted for lower proportions of the total number of special education students compared to the statewide makeup:
    - specific learning disabilities (37.6 percent compared to 38.9 percent)

- other health impairments (13.6 percent compared to 13.9 percent)
- developmentally delayed (11.1 percent compared to 11.7 percent)
- autism (7.1 percent compared to 7.3 percent)
- cognitive impairments (3.0 percent compared to 3.3 percent)
- multiple disabilities (2.4 percent compared to 2.6 percent)
- hearing impaired (0.8 percent compared to 1.1 percent)

Table 26. Prevalence of Selected Childhood, Adolescence and Early Adulthood Stressor Indicators, Mat-Su and Alaska Comparison, School Year 2015-2016

Indicators	% of Mat-Su Students	Estimated Number of Mat-Su Students	Mat-Su Compared to Alaska
Percentage of Students Economically Disadvantaged Status in School (PreK-12th) (School Year 2014-2015)	34.1	6,151	↓
Percentage of special education students of total enrollment	14.8	2,765	↑
Percentage of special education students - Specific learning disabilities	37.6	1,040	↓
Percentage of special education students - Speech/language impaired	17.3	479	↑
Percentage of special education students - Other health impairments	13.6	376	↓
Percentage of special education students - Developmentally delayed	11.1	307	↓
Percentage of special education students - Autism	7.1	196	↓
Percentage of special education students - Emotional disturbance	6.2	171	↑
Percentage of special education students - Cognitive impairments	3.0	82	↓
Percentage of special education students - Multiple disabilities	2.4	65	↓
Percentage of special education students - Hearing impaired	0.8	22	↓
Percentage of special education students - Orthopedic impairments	0.4	12	↔
Percentage of special education students - Visual impairments	0.4	10	↑
Percentage of special education students - Traumatic brain injury	0.2	5	↔
Percentage of special education students - Deaf-blindness	0.0	0	↔

Source: Alaska Department of Education and Early Development.

Table 27. Prevalence of Selected Adolescence and Early Adulthood Stressor Factors, Traditional and Alternative High School Students, Mat-Su and Alaska Statistical Comparison, School Year 2014-2015

Indicators (% answering "Yes")	% of Mat-Su High School Students	Estimated Number of Mat-Su High School Students	Mat-Su Statistically Compared to Alaska
Traditional High School Students – *Percentage of Students Who…*			
Missed classes or school without permission during the past 30 days	33.8	1,393	↔
Have had serious difficulty concentrating, remembering, or making decisions because of a physical, mental, or emotion problem.	26.5	1,092	↔
Had been bullied on school property during the past 12 months	22.4	923	↔
Were in a physical fight one or more times during the past 12 months	22.2	915	↔
Were electronically bullied during the past 12 months	20.1	828	↔
Among students who dated or went out with someone, the percentage who had been forced by someone they were dating or going out with to do sexual things they did not want to during the past 12 months	13.1	540	↔
Among students who dated or went out with someone, the percentage of students who had been physically hurt on purpose by someone they were dating or going out with one or more times during the past 12 months	9.7	400	↔
Had ever been physically forced to have sexual intercourse when they did not want to	9.5	391	↔
Did not go to school on at least one of the past 30 days because they felt they would be unsafe at school, or on their way to or from school	7.8	321	↔
Usually slept with friends, family, or other people, because their parents, or they, lost their home or cannot afford housing in the past 30 days	2.6	107	↔
Alternative High School Students – *Percentage of Students Who…*			
Missed classes or school without permission during the past 30 days	52.0	230	↔
Have had serious difficulty concentrating, remembering, or making decisions because of a physical, mental, or emotional problem.	38.6	171	↔
Were in a physical fight one or more times during the past 12 months	33.0	146	↔
Were electronically bullied during the past 12 months	19.8	88	↔
Had ever been physically forced to have sexual intercourse when they did not want to	18.7	83	↔
Had been bullied on school property during the past 12 months	18.1	80	↔
Among students who dated or went out with someone, the percentage of students who had been physically hurt on purpose by someone they were dating or going out with one or more times during the past 12 months	16.5	73	↔
Among students who dated or went out with someone, the percentage who had been forced by someone they were dating or going out with to do sexual things they did not want to during the past 12 months	12.5	55	↔
Did not go to school on at least one of the past 30 days because they felt they would be unsafe at school or on their way to or from school	9.8	43	↔
Usually slept with friends, family, or other people, because their parents, or they, lost their home or cannot afford housing in the past 30 days	4.5	20	↔

Note: See Appendix A for additional data information.
Source: Alaska Youth Risk Behavior Survey (YRBS).

Adulthood Indicators

Protective Factors

Table 28. Prevalence of Selected Adulthood (Age 18+) Protective Factor, Mat-Su and Alaska Statistical Comparison, 2013

Indicator	% of Mat-Su Adults	Estimated # of Mat-Su Adults	Mat-Su Statistically Compared to Alaska
In the last 12 months, have you seen a health care professional? ("Yes" response)	71.2	68,320	↔

Note: Mat-Su's estimated number of adults is calculated based on DOLWD 2013 population estimates for the Mat-Su Borough. See Appendix A for more detailed data.
Source: Alaska Behavioral Risk Factor Surveillance System (BRFSS).

Stressor Factors

- Among Mat-Su adults, 13.4 percent used food assistance from community programs such as a food bank or food pantry, a church, Meals on Wheels, or Senior Center Meals. A lower proportion, 7.0 percent, of adults statewide use the same programs.
- Mat-Su adults had higher rates than the rest of Alaska for several adverse childhood experiences ($p<.05$):
  - 36.5 percent were sworn at, insulted, or put down by a parent or adult in the home, compared to 30.0 percent of adults in the rest of Alaska
  - 23.4 percent were hit, beat, kicked, or physically hurt by a parent or adult in the home (not including spanking), compared to 17.6 percent of adults in the rest of Alaska.
  - 19.7 percent felt their parents did not love or appreciate them as a child, compared to 15.0 percent of adults in the rest of Alaska
  - 16.6 percent were touched sexually by an adult or someone at least 5 years older, compared to 12.5 percent of adults in the rest of the state
  - 12.5 percent had an adult or someone at least 5 years older try to make them touch them sexually, compared to 9.4 percent of adults in the rest of Alaska
  - 9.8 percent were forced to have sex with an adult or someone at least 5 years older, compared to 6.0 percent of adults in the rest of Alaska
  - 17.8 percent were sexually abused in any way, compared to 13.0 percent of adults in the rest of the state

Table 29. Prevalence of Selected Adulthood (Age 18+) Stressor Factors, Mat-Su and Alaska Statistical Comparison, 2013

Indicators (% answering "Yes")	% of Mat-Su Adults	Estimated # of Mat-Su Adults	Mat-Su Statistically Compared to Alaska
Have you received food assistance from a government program, such as Food Stamps (also known as Quest or SNAP), WIC (Women, Infants and Children Program), Free or Reduced School Lunch or Breakfast?	17.7	16,996	↔
Have you received food assistance from community programs, such as a food bank or food pantry, a church, Meals on Wheels, or Senior Center Meals?	13.4	12,853	X

Note: Mat-Su's estimated number of adults is calculated based on DOLWD 2013 population estimates for the Mat-Su Borough. See Appendix A for more detailed data.
Source: Alaska Behavioral Risk Factor Surveillance System (BRFSS).

Table 30. Prevalence of Selected Adulthood (Age 18+) Stressor Factors (ACEs), Mat-Su and Rest of Alaska Statistical Comparison, 2013 and 2014 Combined

Indicators	% of Mat-Su Adults	Estimated Annual Average # of Mat-Su Adults	Mat-Su Statistically Compared to Alaska
Before 18 Years of Age...			
Verbal Abuse: *did a parent or adult in your home ever swear at you, insult you, or put you down?*	36.5	25,446	X
Divorce: *were your parents separated or divorced?* ("Yes" response)	34.8	24,295	↔
Alcohol Abuse: *did you live with anyone who was a problem drinker or alcoholic?* ("Yes" response)	32.3	22,537	↔
Physical Abuse: *did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way? Do not include spanking.*	23.4	16,343	X
Domestic Violence: *did your parents or adults in your home ever slap, hit, kick, punch, or beat each other up?*	21.2	14,766	↔
Parental Neglect – Love and Appreciation: *did you feel that your parents or adults in your home did not love you or appreciate you?*	19.7	13,755	X
Depression: *did you live with anyone who was mentally ill, depressed or suicidal?* ("Yes" response)	19.7	13,706	↔
Sexual Abuse – Any: *did you respond yes to any (at least one) of the three sexual abuse questions (touched, touch them, force sex)*	17.8	12,444	X
Sexual Abuse – Touch You: *did anyone at least 5 years older than you or an adult, ever touch you sexually?*	16.6	11,565	X
Drugs: *did you live with anyone who used illegal street drugs or who abused prescription medications?* ("Yes" response)	15.5	10,812	↔
Parental Neglect- Food, Clothes, Protection: *did ANY of the following events apply to you: You didn't have enough to eat, you had to wear dirty clothes or you had no one to protect you?*	13.8	9,605	↔
Prison: *did you live with anyone who served time or was sentenced to serve time in a prison, jail, or other correctional facility?* ("Yes" response)	12.7	8,859	↔
Sexual Abuse – Touch Them: *did anyone at least 5 years older than you or an adult try to make you touch them sexually?*	12.5	8,684	X
Sexual Abuse – Forced Sex: *did anyone at least 5 years older than you or an adult force you to have sex?*	9.8	6,815	X

Note: Data excludes missing or incomplete responses. See Appendix A for more detailed data.
Source: Alaska Behavioral Risk Factor Surveillance System (BRFSS).

Child Maltreatment

Child maltreatment refers to forms of abuse and neglect perpetrated by parents, caregivers or other adults that victimize youth and subject them to short and long-term mental and physical risks[11]. Types of maltreatment include:

- Sexual abuse
- Physical abuse
- Emotional abuse, or
- Failure to provide such needs as food and shelter.

Maltreatment leads to immediate health consequences and has the potential to precipitate enduring effects such as depression, suicide, drug use, poor physical health, and criminal activity[12].

The data below report a 6-year history of child maltreatment in Mat-Su for children ages 0-17, as told by the number of children with maltreatment allegations, number of children with substantiated allegations, the rate of children with allegations per 1,000 children, and rate of children with substantiated allegations per 1,000 children. Presented data includes annual statistics for the years 2010-2015; statistics for girls, boys, and all children; and statewide data for comparison. *(Please refer to the Definitions section for a description of the terms: allegation, initial assessment, maltreatment, protective service report and substantiated allocation.)*

It is important to note that child maltreatment affects more children ages 0-18 than is represented in the data below. Many incidents of abuse and neglect are never disclosed and the picture of maltreatment is much larger than the data may suggest. Additionally, these numbers only include child maltreatment data from OCS. This data, then, does not include cases of maltreatment where OCS was not involved, such as when the perpetrator was a child or was an adult living outside the home.

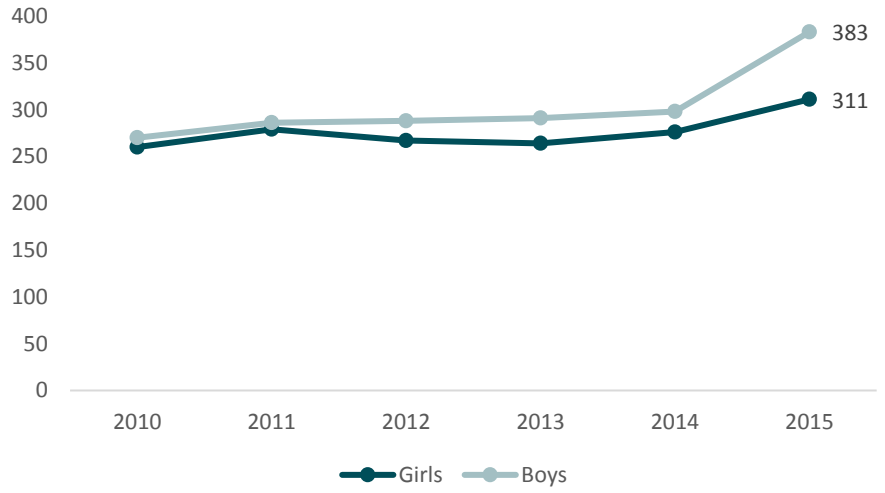
Mat-Su Allegations of Child Maltreatment

CHILDREN AGES 0-4

In 2015, there were 311 girls and 383 boys (total of 697) ages 0-4 with maltreatment allegations. For each population group, the number of children with maltreatment allegations remained steady between 2010 and 2014 and then rose between 2014 and 2015. More detailed data for Mat-Su and Alaska, including population, number of children with allegations, rate per 1,000 children, and confidence intervals can be found in Appendix A.

[11]Gilbert, R., Widom, C. S., Browne, K., Fergusson, D., Webb, E., & Janson, S. Burden and consequences of child maltreatment in high-income countries. *The Lancet, 373*(9657), 68-81.
[12]Norman, R. E., Byambaa, M., De, R., Butchart, A., Scott, J., & Vos, T. (2012). The Long-Term Health Consequences of Child Physical Abuse, Emotional Abuse, and Neglect: A Systematic Review and Meta-Analysis. *PLoS Medicine*,*9*(11), e1001349. http://doi.org/10.1371/journal.pmed.1001349

Figure 12. Number of Children (Ages 0-4) with Maltreatment Allegations, Mat-Su Borough, by Gender, 2010-2015

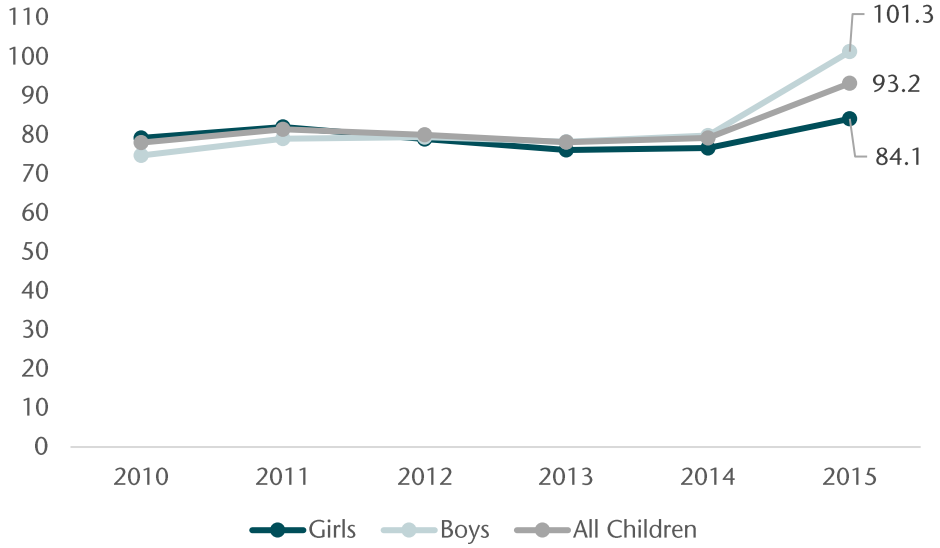


Source: Alaska Office of Children's Services, Prepared by SCAN.

Rate of Children with Maltreatment Allegations per 1,000 Children

The rate per 1,000 children allows for a clearer representation of changes over time and gender comparisons. Between 2010 and 2015, the rate of children with maltreatment allegations per 1,000 children rose from 79.2 to 84.1 for girls, from 74.7 to 101.3 for boys, and from 78.0 to 93.2 for all children. For all three groups, these increases occurred between 2014 and 2015.

Figure 13. Rate of Children (Ages 0-4) with Maltreatment Allegations per 1,000 Children, Mat-Su Borough, by Gender, 2010-2015



Source: Alaska Office of Children's Services, Prepared by SCAN.

The rate of children with maltreatment allegations per 1,000 children also allows for regional comparisons. In addition to data for Mat-Su, SCAN provided data for all Alaska. In Mat-Su, rates for girls and all children were lower than statewide rates. The Mat-Su rate for boys was about the same as the statewide rate.

Table 31. Regional Comparison of Rate of Children (Ages 0-4) with Maltreatment Allegations per 1,000 Children, Mat-Su Borough and Alaska, by Gender, 2015

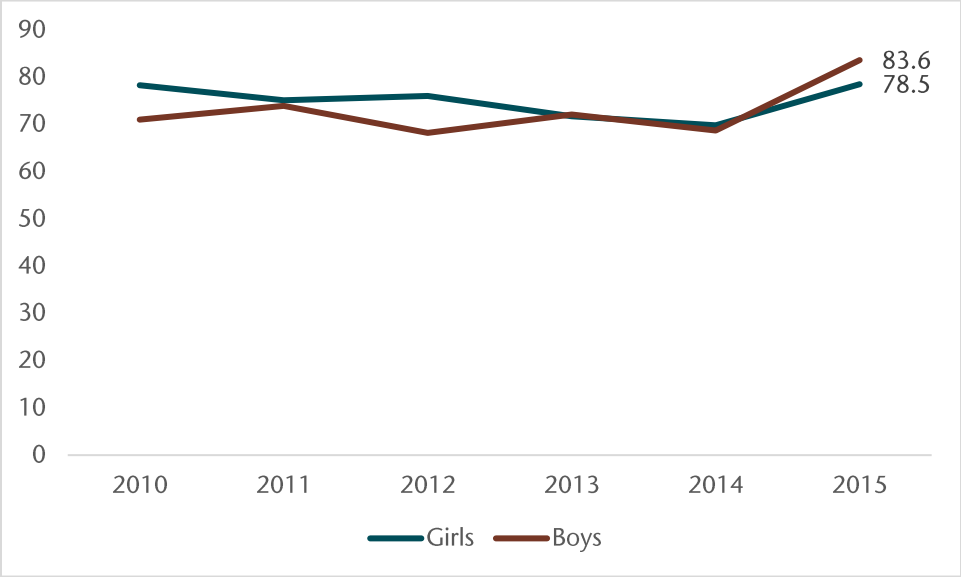
	Mat-Su Rate of Children with Maltreatment Allegations per 1,000 Children	95% Confidence Interval (rate per 1,000 Children)	Statewide Rate of Children with Maltreatment Allegations per 1,000 Children	95% Confidence Interval (rate per 1,000 Children)
Girls	84.1	75.1 - 93.0	103.3	99.6 - 107.0
Boys	101.3	91.7 - 111.0	103.2	99.6 - 106.8
All Children	93.2	86.6 - 99.8	103.9	101.3 - 106.5

Source: Alaska Office of Children's Services, Prepared by SCAN.

CHILDREN AGES 0-17

In 2015, there were 1,037 girls and 1,189 boys (total of 2,240) ages 0-17 with maltreatment allegations. For each population group, the number of children with maltreatment allegations remained steady between 2010 and 2014 and then rose between 2014 and 2015.

Figure 14. Number of Children (Ages 0-17) with Maltreatment Allegations, Mat-Su Borough, by Gender, 2010-2015

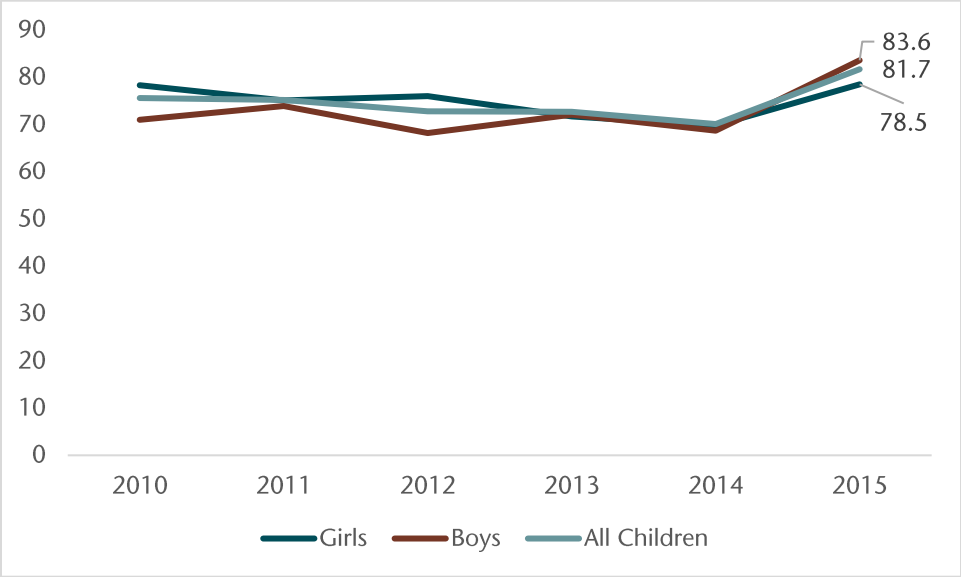


Source: Alaska Office of Children's Services, Prepared by SCAN.

RATE OF CHILDREN WITH MALTREATMENT ALLEGATIONS PER 1,000 CHILDREN

Between 2010 and 2015, the rate of children (ages 0-17) with maltreatment allegations per 1,000 children was steady 78.3 to 78.5 for girls, and rose from 71.0 to 83.6 for boys, and from 75.6 to 81.7 for all children. For all three groups, these increases occurred between 2014 and 2015.

Figure 15. Rate of Children (Ages 0-17) with Maltreatment Allegations per 1,000 Children, Mat-Su Borough, by Gender, 2010-2015



Source: Alaska Office of Children's Services, Prepared by SCAN.

In Mat-Su, rates for girls, boys and all children were lower than statewide rates.

Table 32. Regional Comparison of Rate of Children (Ages 0-17) with Maltreatment Allegations per 1,000 Children, Mat-Su Borough and Alaska, by Gender, 2015

	Mat-Su Rate of Children with Maltreatment Allegations per 1,000 Children	95% Confidence Interval (rate per 1,000 Children)	Statewide Rate of Children with Maltreatment Allegations per 1,000 Children	95% Confidence Interval (rate per 1,000 Children)
Girls	78.5	73.9 – 83.1	93.4	87.7 – 91.4
Boys	83.6	79.0 – 88.1	89.5	91.5 – 95.3
All Children	81.7	78.4 – 84.9	91.8	90.5 – 93.2

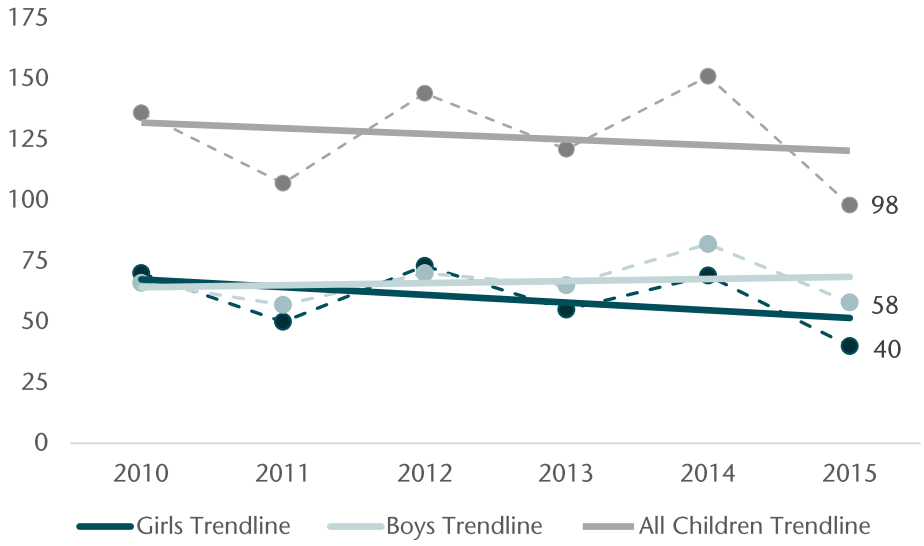
Source: Alaska Office of Children's Services, Prepared by SCAN.

Mat-Su Substantiated Allegations of Maltreatment

Children Ages 0-4

In 2015, there were 40 girls and 58 boys (a total of 98) ages 0-4 in Mat-Su with substantiated maltreatment allegations. While the numbers of substantiated allegations fell for the three groups between 2010 and 2015, they fluctuated heavily during the years in between. Year to year, substantiated rates fluctuate due to changes in OCS policy, interpretations of maltreatment allegations by OCS caseworks, and OCS capacity.

Figure 16. Number of Children (Ages 0-4) with Substantiated Maltreatment Allegations, Mat-Su Borough, by Gender, 2010-2015



Source: Alaska Office of Children's Services, Prepared by SCAN.

Between 2010 and 2015, the number of children with substantiated allegations fluctuated annually without exhibiting an increasing or decreasing trend over time. As a percent of all maltreatment allegations, the number of substantiated allegations showed a fairly flat trend over time.

Table 33. Percent of Children (Ages 0-4) with Allegations with Substantiated Allegations, Mat-Su Borough, 2010-2015

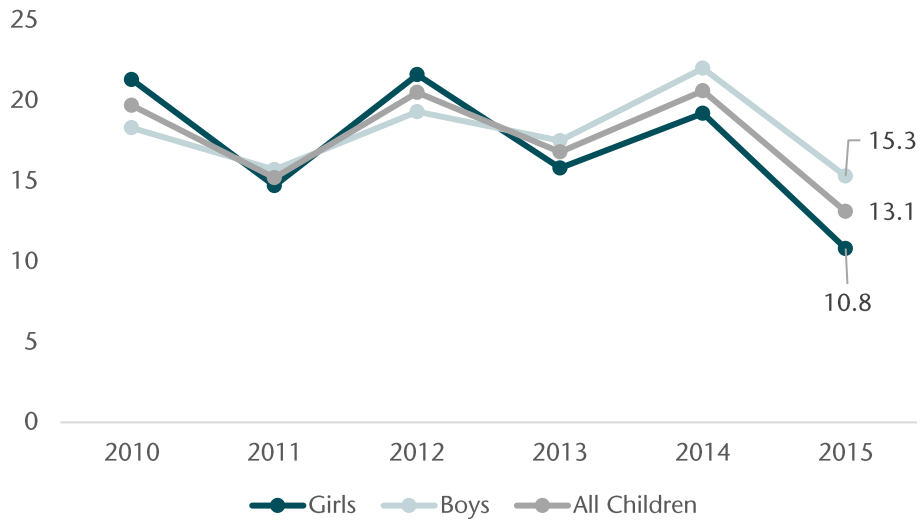
Year	# of Children with Substantiated Allegations	# of Children with Any Allegation	% of Children with Allegations with Substantiated Allegation
2010	136	538	25.3
2011	107	572	18.7
2012	144	561	25.7
2013	121	562	21.5
2014	151	581	26.0
2015	98	697	14.1

Source: Alaska Office of Children's Services, Prepared by SCAN.

RATE OF CHILDREN WITH SUBSTANTIATED MALTREATMENT ALLEGATIONS PER 1,000 CHILDREN

In 2015, the rate of children 0-4 years with substantiated maltreatment allegations per 1,000 children was 10.8 for girls, 15.3 for boys, and 13.1 for all children. Between 2010 and 2015, the rates for all three groups remained flat.

Figure 17. Rate of Children (Ages 0-4) with Substantiated Maltreatment Allegations per 1,000 Children, Mat-Su Borough, by Gender, 2010-2015



Source: Alaska Office of Children's Services, Prepared by SCAN.

In 2015, compared to Alaska, Mat-Su Borough rates of children ages 0-4 with substantiated maltreatment allegations were lower for girls and all children ($p<.05$), but not statistically different for boys.

Table 34. Prevalence of Children (Ages 0-4) with Substantiated Maltreatment Allegations per 1,000 children, Mat-Su Borough and Alaska, by Gender, 2015

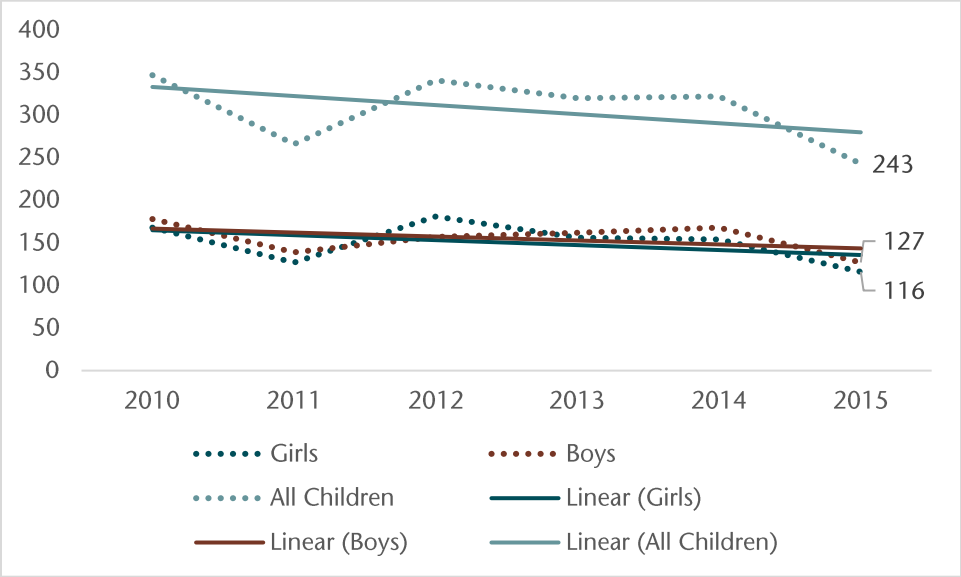
	Prevalence of Mat-Su Children with Substantiated Allegations (per 1,000 Population)	95% Confidence Interval (per 1,000 children)	Prevalence of Alaska Children with Substantiated Allegations per 1,000 Population	95% Confidence Interval (rate per 1,000 children)
Females	10.8	7.5 - 14.1	18.6	17.0 - 20.2
Males	15.3	11.4 - 19.3	18.0	16.4 - 19.6
All Children	13.1	10.5 - 15.7	18.4	17.2 - 19.5

Source: Alaska Office of Children's Services, Prepared by SCAN.

CHILDREN AGES 0-17

In 2015, there were 116 girls and 127 boys (a total of 243) ages 0-17 in Mat-Su with substantiated maltreatment allegations. While the numbers of substantiated allegations fell slightly for the three groups between 2010 and 2015, they fluctuated during the years in between. Year to year, substantiated rates fluctuate due to changes in OCS policy, interpretations of maltreatment allegations by OCS caseworks, and OCS capacity.

Figure 18. Number of Children (Ages 0-17) with Substantiated Maltreatment Allegations, Mat-Su Borough, by Gender, 2010-2015



Source: Alaska Office of Children's Services, Prepared by SCAN.

Between 2010 and 2015, the number of children with substantiated allegations fluctuated annually without exhibiting an increasing or decreasing trend over time. As a percent of all maltreatment allegations, the number of substantiated allegations showed a fairly flat trend over time.

Table 35. Percent of Children (Ages 0-17) with Substantiated Maltreatment Allegations, Mat-Su Borough, 2010-2015

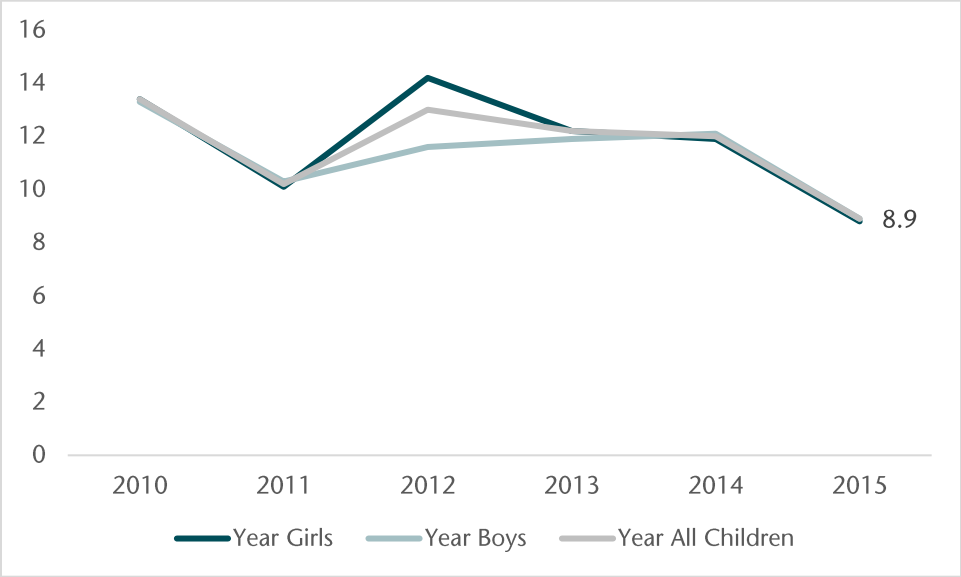
Year	# of Children with Substantiated Allegations	# of Children with Any Allegation	% of Children with Allegations with Substantiated Allegation
2010	347	1,955	17.7
2011	266	1,967	13.5
2012	341	1,917	17.8
2013	320	1,914	16.7
2014	322	1,880	17.1
2015	243	2,240	10.8

Source: Alaska Office of Children's Services, Prepared by SCAN.

RATE OF CHILDREN WITH SUBSTANTIATED MALTREATMENT ALLEGATIONS PER 1,000 CHILDREN

In 2015, the rate of children 0-17 years with substantiated maltreatment allegations per 1,000 children in the Mat-Su was 8.8 for girls, 8.9 for boys, and 8.9 for all children. Between 2010 and 2015, the rates for all three groups are trending down slightly.

Figure 19. Rate of Children (Ages 0-17) with Substantiated Maltreatment Allegations per 1,000 Children, Mat-Su Borough, by Gender, 2010-2015



Source: Alaska Office of Children's Services, Prepared by SCAN.

In 2015, compared to Alaska, Mat-Su Borough rates of children ages 0-17 with substantiated maltreatment allegations were lower for girls, boys, and all children ($p<.05$).

Table 36. Prevalence of Children (Ages 0-17) with Substantiated Maltreatment Allegations per 1,000 children, Mat-Su Borough and Alaska, by Gender, 2015

	Prevalence of Mat-Su Children with Substantiated Allegations (per 1,000 Population)	95% Confidence Interval (per 1,000 children)	Prevalence of Alaska Children with Substantiated Allegations per 1,000 Population	95% Confidence Interval (rate per 1,000 children)
Females	8.8	7.2 – 10.4	12.5	11.8 – 13.2
Males	8.9	7.4 – 10.5	11.4	10.7 – 12.0
All Children	8.9	7.8 – 10.0	12.0	11.5 – 12.4

Source: Alaska Office of Children's Services, Prepared by SCAN.

Potential Lifetime Economic Costs of Child Maltreatment

Estimating the economic cost of child abuse and neglect is complicated. It is well-accepted that child maltreatment is consistently underreported and even reported cases of actual maltreatment may fail to be substantiated. Thus, any cost estimate based on incidence rates will almost certainly be conservative and represent the lower bound of cost. Likewise, many of the known consequences of child maltreatment – reduced life expectancy, decreased quality of life, negative parenting behaviors that lead to intergenerational problems – are difficult to quantify (Fang et al., 2011). Thus, any estimate of cost is unlikely to comprehensively assess the true cost, in economic or human terms, of child maltreatment.

Nevertheless, a study conducted by the CDC estimates the average lifetime cost of non-fatal child maltreatment (defined as physical abuse, sexual abuse, psychological abuse, and neglect) as $210,012 in 2010 dollars (or $228,000 in 2015 dollars) (Fang, Brown, Florence, & Mercy, 2011). This estimate is based on the accumulation

of short-term health care costs, long-term health care costs, loss of earnings due to child maltreatment, child welfare costs, criminal justice costs, and special education costs.

When applied to the 243 children with at least one substantiated report of child abuse and neglect in the Mat-Su in 2015, the total estimated lifetime cost of child maltreatment incurred in 2015 is $55.4 million (in 2015 dollars).

Table 37. Estimated Lifetime Costs of Child Maltreatment in Mat-Su, (2010-2015), 2015$

Year	Age	Number of Children with at least 1 Substantiated Report of Maltreatment	Estimated Lifetime Cost/Person	Total Estimated Lifetime Cost
2010	0-17	347	$228,000	$79,116,000
2011	0-17	266	$228,000	$60,648,000
2012	0-17	341	$228,000	$77,748,000
2013	0-17	320	$228,000	$72,960,000
2014	0-17	322	$228,000	$73,416,000
2015	0-17	243	$228,000	$55,404,000

Source: OCS SCAN, Fang, X., Brown, D. S., Florence, C. S., & Mercy, J. A. (2012). The economic burden of child maltreatment in the United States and implications for prevention. Child abuse & neglect, 36(2), 156-165. McDowell Group calculations.

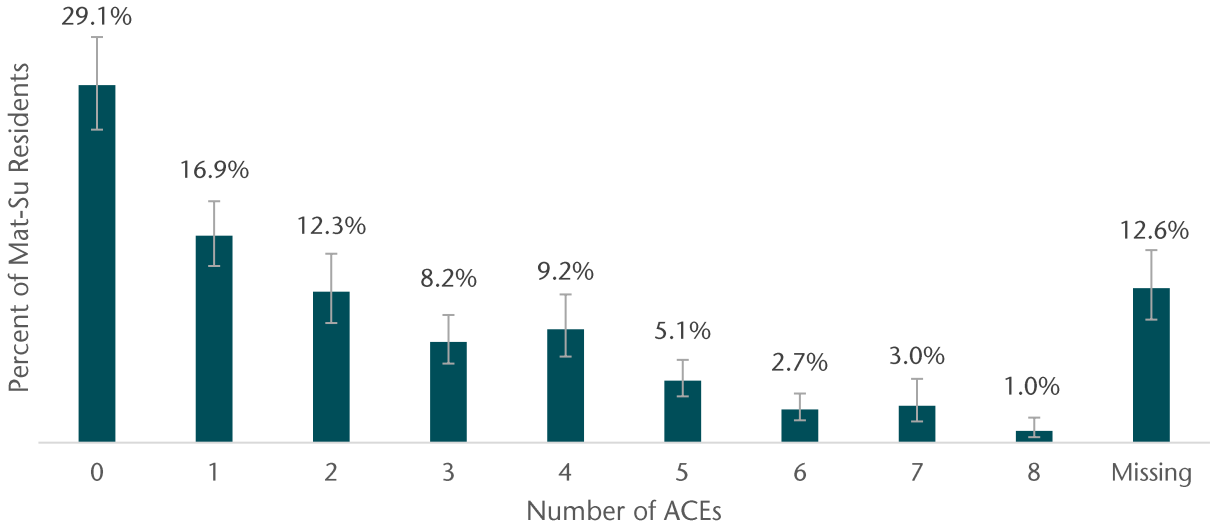
Adverse Childhood Experiences (ACES)

This section of the report summarizes ACEs as reported by Mat-Su adults about their childhood experiences. Appendix A contains a detailed table showing the percentages prevalence, confidence intervals, and number of responses.

Total Score

Three in 10 Mat-Su adults (age 18 or older), an estimated 20,300 people, had no ACEs. Almost 17 percent of Mat-Su adults, or 11,800 individuals, experienced one ACE and about 12 percent of Mat-Su adults, or 8,500 individuals, experienced two ACEs. An estimated 12 percent of the population, about 8,200 individuals, experienced five or more ACEs. When comparing the total ACE scores, Mat-Su did not differ statistically from the rest of Alaska.

Figure 20. Percent of Mat-Su Borough Adults (Age 18+) That Experienced ACEs, 2013-2014



Note: "Missing" refers to surveys in which responses to ACEs questions were either missing or incomplete.
Source: Alaska Behavioral Risk Factor Surveillance System (BRFSS).

Table 38. Prevalence of ACEs in Mat-Su Adults (Age 18+), 2013-2014

# of ACEs	Annual Average % of Mat-Su Adults	95% Confidence Interval (%-%)	Estimated Annual Average # of Mat-Su Adults	Estimated Annual Average # (95% Confidence Interval)
0	29.1	25.5 - 33.0	20,312	17,778 – 23,039
1	16.9	14.4 - 19.7	11,760	10,034 – 13,712
2	12.3	9.7 - 15.4	8,573	6,795 – 10,731
3	8.2	6.4 - 10.4	5,722	4,491 – 7,252
4	9.2	7.0 - 12.1	6,440	4,889 – 8,419
5	5.1	3.8 - 6.7	3,524	2,629 – 4,703
6	2.7	1.8 - 4.0	1,886	1,269 – 2,791
7	3.0	1.7 - 5.2	2,100	1,205 – 3,625
8	1.0	0.4 - 2.0	667	311 – 1,422
Missing/ Incomplete	12.6	10 - 15.7	8,775	6,989 – 10,937

Source: Alaska Behavioral Risk Factor Surveillance System (BRFSS), DOLWD 2013 and 2014 Population Estimates.

Mat-Su's ACE Profile by Type

The table below depicts the prevalence of ACEs and the number of people affected by each ACE in the Mat-Su. The most prevalent ACEs in the Mat-Su are, in order, verbal abuse, divorce, and alcohol abuse. Prevalence rates in Mat-Su suggest about a third of adults have experienced these ACEs. Almost a quarter of adults report physical abuse as a child.

(See table next page.)

Table 39. ACEs Prevalence Rates in Mat-Su, 2013-2014

(Before 18 years of age,...)	Annual Average % of Mat-Su Adults	95% Confidence Interval (%-%)	Estimated Annual Average # of Mat-Su Adults	Estimated Number 95% Confidence Interval
Depression: *did you live with anyone who was mentally ill, depressed or suicidal?*	19.7	16.5 - 23.3	13,706	11,502 - 16,224
Drugs: *did you live with anyone who used illegal street drugs or who abused prescription medications?*	15.5	12.4 - 19.2	10,812	8,663 - 13,371
Alcohol Abuse: *did you live with anyone who was a problem drinker or alcoholic?*	32.3	28.4 - 36.5	22,537	19,789 - 25,473
Divorce: *were your parents separated or divorced?*	34.8	30.8 - 39.0	24,295	21,505 - 27,231
Prison: *did you live with anyone who served time, or was sentenced to serve time in a prison, jail, or other correctional facility?*	12.7	9.8 - 16.4	8,859	6,815 - 11,404
Physical Abuse: *did a parent or adult in your home hit, beat, kick, or physically hurt you in any way? Do not include spanking.*	23.4	20.2 - 27.1	16,343	14,062 - 18,868
Verbal Abuse: *did a parent or adult in your home swear at you, insult you, or put you down?*	36.5	32.4 - 40.8	25,446	22,579 - 28,459
Domestic Violence: *did your parents or adults in your home slap, hit, kick, punch, or beat each other up?*	21.2	17.5 - 25.3	14,766	12,228 - 17,668
Sexual Abuse – Touch You: *did anyone at least 5 years older than you or an adult, ever touch you sexually?*	16.6	13.8 - 19.8	11,565	9,609 - 13,832
Sexual Abuse – Touch Them: *did anyone at least 5 years older than you or an adult try to make you touch them sexually?*	12.5	9.9 - 15.5	8,684	6,927 - 10,812
Sexual Abuse – Forced Sex: *did anyone at least 5 years older than you or an adult force you to have sex?*	9.8	7.4 - 12.8	6,815	5,139 - 8,962
Sexual Abuse – Any: *did you respond yes to any (at least one) of the three sexual abuse questions (touched, touch them, force sex)*	17.8	15.1 - 21	12,444	10,505 - 14,655
Parental Neglect- Food, Clothes, Protection: *do ANY of the following events apply to you: You didn't have enough to eat, you had to wear dirty clothes or you had no one to protect you?*	13.8	10.6 - 17.7	9,605	7,400 - 12,346
Parental Neglect – Love and Appreciation: *did you feel that your parents or adults in your home did not love you or appreciate you?*	19.7	16.0 - 24	13,755	11,174 - 16,761

Note: Data excludes missing or incomplete responses.
Source: Alaska Behavioral Risk Factor Surveillance System (BRFSS).

When asked about experiences before they were 18 years of age, Mat-Su adults reported:

- An estimated 13,700 lived with someone who was mentally ill, depressed or suicidal.
- Almost 11,000 lived with someone who used illegal street drugs or abused prescription medications.
- An estimated 22,500 lived with someone who was a problem drinker or alcoholic.
- Close to 25,000 had parents divorced or separated.
- Close to 9,000 lived with someone who served time or was sentenced to serve time in a prison, jail, or other correctional facility.
- More than 16,000 reported being hit, beat, kicked, or physically hurt by a parent or adult in their home (excluding spanking).
- More than 25,000 were sworn at, insulted, or put down by a parent or adult in their home.

- Almost 15,000, had parents or adults in their home who had slapped, hit, kicked, punched, or beat each other up.
- 11,500 had an adult or someone who was five years older than them touch them sexually.
- More than 8,500, experienced an adult or someone at least five years older make them touch the other person sexually.
- Almost 7,000 were forced to have sex with an adult or someone at least five years older than them.
- About 12,500, experienced any type of sexual abuse including they were touched sexually, they were forced to touch another person sexually, or they were forced to have sex.
- 9,600 experienced parental neglect where they did not have enough to eat, had to wear dirty clothes, or had no one to protect them.
- Almost 14,000 felt that their parents or adults in their home did not love or appreciate them.

A comparison of Mat-Su ACEs to the rest of Alaska can be found in Appendix E.

Prison

Residents ages 18-24 (25.2 percent) were the most likely to have, as a child, lived with someone who had served time in prison, jail, or correctional facility, while those ages 65+ were the least likely (3.6 percent).

Divorce

While almost half of residents ages 18-24 (46.1 percent) and ages 35-44 (48.3 percent) had divorced parents before the age of 18, about one in six (15.7 percent) ages 65+ had divorced parents.

Physical Abuse

Residents ages 35-44 and 45-64 reported the highest percentage of experiencing physical abuse as a child (26.9 and 28.1 percent respectively).

Illegal Drugs

Residents ages 18-24 (32.5 percent) were the most likely to have lived with someone using illegal drugs as a child, more than 15 times more likely than residents ages 65+ (2.0 percent).

Table 40. Prevalence of ACEs in Mat-Su Adults (Age 18+), Statistical Comparisons by Age Group, By Percent, 2013-2014

Age Group	Sexual Abuse - Touch Them (%)	Sexual Abuse - Touch You (%)	Sexual Abuse - Forced Sex (%)	Sexual Abuse – Any (%)	Prison (%)	Divorce (%)	Physical Abuse (%)	Drug Abuse (%)
18-24	2.2	9.6	3.6	9.7	25.2	46.1	18.7	32.5
25-34	9.7	15.1	9.6	15.5	21.3	36.9	18.7	24.8
35-44	19.8	22.4	16.8	28.8	17.4	48.3	26.9	15.8
45-64	15.6	18.5	10.7	22.2	5.5	30.9	28.1	10.7
65+	5.9	10.6	3.1	12.3	3.6	15.7	15.7	2.0
Unknown/ Refused	15.4	20.0	10.4	19.2	35.9	21.0	30.9	4.6

Source: Alaska Behavioral Risk Factor Surveillance System (BRFSS).

By Household Income Level

Sexual Abuse Questions

Mat-Su adults with household incomes of less than $15,000 (23.0 percent) were three times more likely than those earning more than $75,000 (7.5 percent) to have had an adult or anyone five years older try to force them to touch them sexually. Similarly, adults in the lowest income range (41.9 percent) were four times more likely than those in the in the highest income range (10.3 percent) to have experienced an adult or someone five years older trying to touch them sexually. With regards to any form of sexual abuse by an adult or anyone five years older, adults in the lowest income range (42.2 percent) were about three times more likely to be a victim than those in the highest income range (14.6 percent).

Prison

Mat-Su adults with household incomes of less than $15,000 (28.0 percent) were the most likely to have lived with someone who had spent time in prison, jail or correctional facility, more than three times more likely than individuals earning $50,000-$74,999 (8.1 percent) and more than $75,000 (8.6 percent).

Parental Neglect

Almost half (44.8 percent) of adults in the lowest household income bracket felt like their parents or adults in their home did not love or appreciate them; only 17.8 percent of adults in the highest income bracket experienced this feeling.

Domestic Violence

Adults in the lowest household income bracket (38.9 percent) were more than three times as likely as those earning $50,000-$74,999 (12.9 percent) to have witnessed domestic violence between their parents as a child.

Table 41. Prevalence of ACEs Results in Mat-Su Adults (Age 18+), Statistical Comparisons by Household Income, By Percent, 2013-2014

Household Income Range	Sexual Abuse - Touch Them (%)	Sexual Abuse - Touch You (%)	Sexual Abuse – Any (%)	Prison (%)	Parental Neglect - Love and Appreciation (%)	Domestic Violence (%)
<$15,000	23.0	41.9	42.2	28.0	44.8	38.9
$15,000-$24,000	14.1	17.0	19.8	19.3	20.0	35.1
$25,000-$49,999	14.1	19.5	21.8	13.5	18.8	21.0
$50,000-$74,999	14.4	15.6	17.7	8.1	13.5	12.9
$75,000+	7.5	10.3	14.6	8.6	17.8	18.1
Don't Know	16.6	21.4	21.0	19.8	26.9	20.9
Refused	3.5	4.1	4.0	1.4	2.3	3.3

Source: Alaska Behavioral Risk Factor Surveillance System (BRFSS).

BY EDUCATIONAL ATTAINMENT

Sexual Abuse – Touch Them

Adults with the lowest educational attainment, less than high school, were more than three times as likely as their peers with a college degree to have had an adult, or anyone five years older, try to force them to touch them sexually (21.8 percent compared to 6.6 percent, respectively).

Divorce

Those who graduated high school or earned a GED were more likely than their peers with college degrees to have had divorced parents as a child (37.2 percent compared to 23.1 percent, respectively).

Table 42. Prevalence of ACEs Results in Mat-Su Adults (Age 18+), Statistical Comparisons by Educational Attainment, By Percent, 2013-2014

Level of Educational Attainment	Sexual Abuse - Touch Them (%)	Parental Divorce (%)
Less Than High School	21.8	34.0
High School Grad or GED	15.3	37.2
Some College/Tech	13.9	35.7
College Grad	6.6	23.1
<Age 25 or Refused	2.8	45.3

Note: Those less than 25 years of age were excluded as it served as the reference point to have allowed respondents to finish higher education – i.e. a standard reference point when using education as a variable.
Source: Alaska Behavioral Risk Factor Surveillance System (BRFSS).

By Mat-Su Region

Prison

The prevalence of only one ACE varied significantly by Mat-Su region: having lived with a person who had spent time in prison, jail, or a correctional facility. Residents of Palmer (7.0 percent) were the least likely to have had this experience, while the prevalence was twice as high for Wasilla residents (14.7 percent) and residents in the rest of the borough (14.9 percent).

Table 43. Prevalence of ACEs Results in Mat-Su Adults (Age 18+), Statistical Comparisons by Mat-Su Regions, By Percent, 2013-2014

Region	Prison (%)
Palmer	7.0
Wasilla	14.7
Rural	14.9

Source: Alaska Behavioral Risk Factor Surveillance System (BRFSS).

Chapter 3: Social Connectedness in Mat-Su

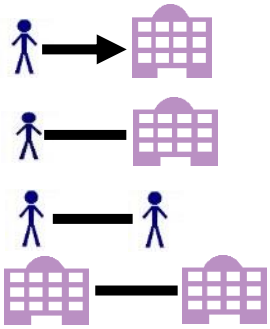
Social connectedness is very important for the development of Parental and Youth Resilience. A key to building parental and youth resilience is the establishment of positive social connections with other people who can provide emotional, informational, and concrete support. Community practices can invite interaction between children, parents, and others that provide them with a meaningful connection to the larger world and support them. Some residents who have experienced trauma, both children and adults, will access formal programs and benefit from specialized interventions to help them heal from ACEs and increase their resiliency in dealing with crises and problems in their lives. Others are not likely to access formal services due to personal beliefs, including fear of stigma, need for privacy, and/or lack of time and resources. For all members of the community, increasing the community's capacity to provide support through informal networks and nontraditional initiatives that are developed and led by community leaders and other residents can be key to them healing and leading fulfilled lives. To effectively increase long-term resilience, Shonkoff and others have theorized the necessity of creating resilience supports throughout the community, over a long period. This requires the combination of many and continuous "informal supports" along with the "formal support" associated with Evidence - Based Programs. Programs cannot do it alone, even if expanded to serve many more people.

This chapter will explore social connectedness in Mat-Su and look at data on how residents view this connectedness.

Social Connectedness

Communities demonstrate a level of "social connectedness" or "social capital." Social connectedness can occur in the following ways:

1. Residents seek support from service organizations
2. Residents volunteer to assist organizations
3. Resident(s) connect with other resident(s) for mutual support
4. Organizations and sectors cooperate and collaborate



Social connectedness includes being connected to people in one's life such as family, neighbors, and coworkers and to more formal groups such as churches or volunteer organizations. Research shows that having a high level of social connectedness can have a preventative effect on mental and physical health problems, along with promoting positive health behaviors across the life span (Mechanic, 2007).

As social connectedness increases, social capital is created. Social capital is the "sum total of benefit that people build up from the web of their relationships." It comes from networks of acquaintances and relationships – through participation in business transactions, community events, clubs, volunteering, church, etc. Like economic capital it is a type of currency that you can "spend." It grows with every interaction and with the new people you add to your network. It flows in both directions, you can earn it through positive interactions, by

helping those in your network such as helping someone with a ride, bringing food when someone is sick, or watching a neighbor's house when they are away (Community Tool Box, 2016). Emotional support provided by social ties enhances psychological well-being, which in turn, reduces the risk of unhealthy behaviors and poor physical and mental health (Kiecolt K.J., 2008; Kiecolt-Glaser, 2002; Umberson & Montez, 2010).

Specific to families, the connection with the community is crucial to decreasing child maltreatment and neglect, and promoting optimal child development. Communities can prevent child maltreatment by creating norms of appropriate parenting behavior, supporting parents under stress, and by providing additional professional and lay resources. Numerous studies have shown that social isolation is associated with a greater risk of child maltreatment (Tomison & Wise, 1999).

Volunteering represents both residents being connected to each other and residents being connected to community organizations and groups. A review of recent research sponsored by the Corporation for National and Community Service demonstrates a strong relationship between volunteering and health – volunteers have lower mortality rates, greater functional ability, and lower rates of depression later in life than those who do not volunteer (Corporation for National & Community Service, 2007). Comparisons of the health benefits of volunteering for different age groups have shown that older volunteers (60 and older) are most likely to receive greater benefits (increased life satisfaction and improvement in perceived health) from volunteering as compared to mid-life volunteers (Li & Ferraro, 2005).

Youth are another population who reap the benefits of volunteering. Research has demonstrated that youth volunteering relates to reduced rates of course failure, suspensions from school, and school dropout, reduction in teen pregnancy, and an improved self-concept and attitudes toward society (Moore & Allen, 1996). Further, bringing youth and seniors together can have advantages for both – decreasing senior isolation and supporting youth. Youth mentoring programs have been shown to have long-term benefits for both mentors and mentees, such as increasing self-esteem for both and lowering high school dropout rates, and improving behavior at home and school for youth (US Government, 2016).

Social Connection in Mat-Su

The 2016 Mat-Su Household Survey, part of the *Mat-Su Community Health Needs Assessment,* measured social connectedness in terms of access to support and giving support. As far as giving support, 50 percent of Mat-Su residents reported they very often or often do favors for people in their community. Seventeen percent said they rarely, or never do, favors. Residents were less likely to do favors for those outside their family. Forty-three percent said they very often or often do these favors, and 25 percent said they rarely or never do. Forty-four percent of Mat-Su residents report volunteering in the last year. Residents report that they reach outside of their circle of friends less often than their family circle. Twenty-nine percent reported very often, or often, helping someone outside their circle of friends; 36 percent said they rarely or never do this. As far as stepping in to help supervise children in their neighborhood, 47 percent of residents said they would report a child skipping school to their parents, 26 percent said they would be somewhat, or very likely, not to contact the parents.

Table 44. Percentage of Mat-Su Residents Who Report Giving Support

Question	Response	Response	Response	Response
How often do you and people in your community do favors for each other?	Very often/often 50%	Sometimes 31%	Rarely/Never 17%	Don't know 2%
In the past 12 months, how often have you helped a person in need outside your family?	Very often/often 43%	Sometimes 30%	Rarely/Never 25%	Don't know 1%
How often do you reach outside your circle of friends to give or receive help?	Very often/often 29%	Sometimes 35%	Rarely/Never 36%	
In the past 12 month, have you volunteered for any local groups?	Yes 44%	No 55%		
If you saw a child from your immediate neighborhood skipping school, how likely would you be to report this to the child's parent or school?	Very likely 41%	Somewhat likely 23%	Somewhat unlikely/very unlikely 26%	Don't know 8%

Source: McDowell Group, 2016 Mat-Su Household Survey.

The number of people that Mat-Su residents can count on appears to be associated with place of residence, life satisfaction, reported health status, and whether they have children in the household. A higher percentage of rural respondents had six or more people they could count on for help with practical problems (48 percent) as compared to urban respondents (37 percent). More respondents with children in the household reported having six or more people they could count on (42 percent) as compared to respondents who did not live with children (32 percent). Similarly, a smaller percentage of respondents from households with children had only 0-1 people they could count on (8 percent) as compared to households without children (11 percent).

Mat-Su data supports the research findings that associate more social connection with better health and life satisfaction. Mat-Su residents who reported a better status of health had more people they could count on. This pattern was also seen with satisfaction with life. Fifty-two percent of those who reported excellent health had six or more people they could count on as compared to only 21 percent of those who reported poor health. Forty-one percent of residents who reported satisfaction with life had six or more people they could count on, compared to 20 percent of those who said they were not satisfied with life.

Table 45. Percentage of Mat-Su Residents Who Report # of People They Can Count on by Place of Residence, Health Status, Satisfaction Status, and Having Children in the Household

Question	Response	Response	Response	Response
What number of people can you count on to help you with a practical problem, such as you need a ride to a medical appointment?	0-1 people	2-5 people	≥6 people	Don't know
All respondents	10%	52%	39%	5%
Urban respondents	10%	48%	37%	5%
Rural respondents	9%	37%	48%	5%
Respondents who report excellent health	7%	34%	52%	6%
Respondents who report very good/good health	9%	46%	40%	4%
Respondents who report fair/poor health	14%	57%	21%	6%
Respondents who report they are satisfied with life	9%	45%	41%	4%
Respondents who report they are not satisfied with life	22%	49%	20%	9%
Children in the household	8%	44%	42%	4%
No children in the household	11%	48%	35%	5%

Source: McDowell Group, 2016 Mat-Su Household Survey.

Mat-Su residents overwhelming reported that they would be very, or somewhat, comfortable asking a neighbor for help in an emergency (84 percent). Additionally, most households with children reported that they were very, or somewhat, comfortable asking for help with their children (77 percent). Although most residents appear to have a support system of two or more people, and felt like they could ask for help in an emergency in their immediate neighborhood or seek help with child care, between 10-13 percent of Mat-Su residents do not appear to have a large amount of support.

Table 46. Percentage of Mat-Su Residents Who Report Asking for Support

Question	Response	Response	Response	Response
If you needed help in an emergency, how comfortable would you be seeking help in your immediate neighborhood?	Very comfortable 45%	Somewhat comfortable 39%	Not comfortable 13%	Don't know 2%
If you needed to care for your children, such as someone to watch your child for a few hours or pick them up from school, how likely would you be to ask for help?	Very or somewhat likely 77%	Somewhat or Very unlikely 19%	Don't know 2%	

Source: McDowell Group, 2016 Mat-Su Household Survey.

The Context of Social Support in Mat-Su

In 2014, 59 in-depth interviews were conducted with Mat-Su residents for the Mat-Su Behavioral Health Environmental Scan. This section will report the findings from a series of questions asked in these interviews about the support that residents received from the community and where they sought support during times of need.

Community residents were asked if they felt they were supported as parents in their community. They were also asked what they felt was done well and what might be done differently to improve this support. Most residents said that they did feel community support, although there were many suggestions as to what might help create a stronger support system within the community for parents and their children. The most common being low cost (or free) activities for children and teens. A few examples of this finding are as follows with a breakdown of residents who responded 'yes' and then residents who responded 'no'.

Some comments from community residents who feel that they are supported in their community were:

"This is a great community. I live in Palmer and we have great schools and great people. This community, you know, is small town, so everybody kind of takes care of everybody, everybody is friendly, you know. I don't worry too much about [my daughter playing outside]. It's a good life. I have no complaints.

"I think we have a lot of early childhood interventions, like options for preschool [children] to go and get checked for childhood illnesses. [Also places like] WIC (Women, Infant, and Children). I think we need more things at the 5th-9th-grade level; we need more for kids in this community at that age. We need more early intervention on prevention of smoking, alcohol use, or even marijuana. There's nothing for kids after school really, so we have a lot of kids just kind of wandering around or going home when parents aren't home. So, there's kind of that time between 2:15 and about 5:00 in the afternoon where kids are just free to do whatever."

"There's outreach programs [that do well to support parents]. The prices of sports [is what the community can do to help] so that lower income people can get their children to participate."

"Getting together and doing fun things is what makes parents feel supported. What more could a community do? I think focusing more on making safe places for teenagers to get together."

Community residents who did not feel that they are supported in their community said:

"I think my church does a lot to support parents, but I don't know that the community in general does. I don't think it's the community's responsibility. But I think programs like the library programs, park programs, things like that are good for supporting the community or good for supporting parents."

"That's a hard one, because I feel supported by friends, but the community as a whole, I think a lot of what's out there, is only available dependent on income. You're either not poor enough or not rich enough and so you're just kind of stuck, stuck in a rut."

"Probably not so much. I think more of the support comes from my religion. I think maybe encouraging different family activities, say maybe for instance like the 4th of July activities. Things like that encourage family time."

Parents in the community were asked what helped them the most during tough times as a parent. Most residents answered: the family, spouse, friends, and/or their faith/church. There was only a couple of responses that did not fall into this category. Some examples of responses were:

"Church has been a number one thing. I have a good church system that, whenever I have tough times, it's just a really good support network."

"Probably just my family for that. But also, the community, in the sense that I feel like if I ever needed help that it is there."

Other responses included:

"My military career. The discipline, not blaming others for my mistakes or the things that are going on. I took more initiative of myself as a person and as a father. "

"Probably my co-workers in school, at the school district."

"I went and saw a counselor for six months at the Mat-Su Behavioral Health Clinic and he helped. It's always nice to get an outsider's perspective on reality, instead of just having people agree with you all the time."

"Activities, just like golf, lifting weights, fishing, just doing things physical."

"Group outings."

Community residents were asked whom they felt comfortable with in seeking support in regard to their mental and emotional problems. Many shared responses of family and friends. Some shared places that they felt safe such as counseling services and church affiliations. These are annotated in the following examples:

"Well, my wife, if she's not that one involved in the problem."

"Usually my friends or even church sometimes. Most of my friends are from the church."

"My neighborhood has a real good support system."

"Oh, all my walking buddies. We just vent."

"Definitely my husband and a few best friends and my parents."

"I have a great church family."

"My case manager or clinician."

"I have a case worker in two areas."

"I had a person I talked to at the Southcentral Foundation."

"My best friend and my counselor."

"Usually my husband."

"I don't usually discuss my personal things with very few people, but I do go to the VA if I have some issues because my medical care is through them and I feel comfortable there."

Community residents who participated in the phone interviews were questioned about their childhood and whether they felt valued and supported as a child. There was a substantial amount of positive feedback along with a few negative responses. Key themes were: the overall family unit/support systems (school, teachers, extended family), parental figures, love, time, positive reinforcement, validation, encouragement, security, and safety.

There were quite a few residents who shared the same response of their mother, father, family unit, extended family, and friends as their primary source of value and support when they were children.

"Attention from my family and friends."

"Spending time with my family."

"My mom and my father."

"Oh, just mother and father's love."

"A cohesive family."

Some residents, who shared their feelings on being validated, positive reinforcement, and involvement as their source of value and support during their childhood years made statements such as:

"Well, my parents always encouraged us kids to get into sports and were always at the events."

"Hugs from my parents, and just validation."

"Well, my mom always said I did some pretty cool stuff when I did pretty cool stuff."

"My parents, parents paying attention, you know, doing things with us, you know, letting us know that we were valued and paying attention to us. I had a good set of parents. [I have] no complaints about that."

A handful shared memories of social systems in the community as being a primary source of their feelings of value and support during childhood years:

"I think one-on-one time with an adult…and my school. I went to a private Christian school and I was very supported by the staff there. It was very much a one-on-one atmosphere. We had very small classrooms [about 5 or less students per class]. I think the whole time I was there, there were fewer than 35-40 students [in the school]. And it really had a good impact on how we viewed [the adults]. They made us feel very loved and supported…never felt fear."

"Doing things in Boy Scouts and having a paper route, that kind of thing."

"My teachers."

"Probably being a part of a small community, stable parents, success at school, all kinds of things."

The same community residents that were questioned about values and support during their childhood years were also asked how they feel they are valued and supported during their adulthood. Themes that remained the same were: family, support networks, love, time, validation, encouragement, and stability. Added themes that emerged were: financials, social structures, healthy relationships, and employment/career success.

Community residents were asked what they thought a family required to be emotionally healthy. The statements came back with a handful of common themes: time, love, communication, support, financial stability, basic needs, and safety. The consensus of what our community believes to be crucial for families to have and maintain emotional health are shown here with the following examples:

Time

"I think that time together, time to play, not just time in the same room in front of the TV, but also time doing things together. I take advantage, though, of those times where, you know, I'm in the same room with them while they're doing homework, while the TV's on, while we're eating dinner, or we're in the car. I try to have conversations and keep it light-hearted. And my girls kind of play with me. They're older, 11 and 13 and they still have that comfort level to be goofy with me. So, I think it's finding things to do, activities to do, spend time together one-on-one, but also making the most of that routine time."

Love/Communication/Support

"Understanding, compassion, support, and just somebody to listen to your problems and then, you know, not necessarily give you advice, but just listen."

"Good communication."

"A lot of patience and just good ability to communicate."

Basic Needs/Financial Stability/Safety/Social Services

"I think that they need adequate money for food."

"I think that they need a significant income."

"Security…the knowledge that you're not just one paycheck or a week away from wondering where you're going to live, where your next meal is coming from."

"It needs security and support. At that time when I was the happiest, I had the most security, and I felt safe."

"A family needs good shelter, which would be, like, a stable environment where the kid can play and grow, which would include having healthy parents, so, like, not drinking around your kid, not smoking around your kid, things like that, so the kids feel safe in their stable environment."

In summary, data collected on levels of social connectedness in Mat-Su reveal a community in which some residents are well connected and can avail themselves of opportunities for support that benefit their families and children. These residents with high levels of social support where more likely to report positive health status and satisfaction with life. A smaller group of residents don't appear to have a robust support system. Residents appear to be more likely to support those within their families and circle of friends than outside these circles. Residents pointed out areas where the community could better support families and these included more recreational opportunities that are affordable and available to all families and safe places for teens to recreate. Overwhelmingly, support as a child and adult was mentioned as being linked to a close family with good communication, compassion, and quality time spent together. Also, a basic level of financial stability contributed to residents feeling supported as an adult. While residents thought that family was very important as a child, there were several residents who mentioned the large role that teachers, schools, clubs and other adults played in helping them feel supported. Adults reported that they seek help with problems they face from a variety of places - family, friends, church, people at work, and professionals like counselors and case workers. This information provides a window into the community-level of support that exists in Mat-Su that can help parents have what they need to make good parenting decisions and support children with their emotional and physical development. The next chapter looks at formal programs and services that focus on the same goals.

Chapter 4: Service Gap Analysis

This chapter will examine three key ingredients necessary to create a system that ensures that children are well-cared-for and safe from the perspective of a "gap analysis." Research and best practices will be presented that describe key practices and programs that help to support children and families and aid in preventing child maltreatment. This assessment will determine if these services and programs exist in Mat-Su and if they meet the current need. This is a snapshot in time view that will give funders, organizations and State and local planners and coalitions a road map to move forward to support Mat-Su in creating a system that keeps children well-cared-for and safe. This assessment will look at three types of support:

1. Community sector support for children and families;
2. Specific programs that exist to meet the needs of children and families; and
3. Efforts in the community to organize and meet the needs of children and families.

The sectors and programs will be organized by life stages for children (preconception/prenatal, early childhood, school-age, youth/young adult) and services for parents. The sectors that will be discussed are listed in the table below.

Table 47. Sectors Interacting with Children and Parents

Sectors that normally interact with children and parents/guardians	Sectors that interact with children and parents/guardians in times of crisis
Health care	Child Welfare
Education	Judicial
Child care	Concrete support in times of need (i.e. food banks, shelters, etc.)
Early Learning	Law Enforcement
Parent Support	Behavioral Health

Not included in this analysis is the Business Sector which intersects with many parents. Possible policies for this sector are discussed in Chapter 6.

In this section, the charts will be color coded according to the level of prevention that the program is focused on, along with whether the organization delivers "trauma informed care." Organizations are considered to provide trauma informed care if they have gone through a formal process to convert their organization to this type of care. The National Council for Community Behavioral Healthcare conducts training for organizations to become trauma informed. They list seven domains for becoming a trauma-informed care organization, including:

- Use respectful screening and assessment process that is routine, competently done, and culturally relevant;
- Provide consumer driven care and services which involve people receiving the services in planning, implementation, and evaluation to improve efforts;
- Have a trauma-informed, educated and responsive workforce;
- Train the workforce on the provision of trauma-informed, evidence-based and emerging best-practices;

- Create a safe and secure environment including examining and changing policies, procedures, and practices that may unintentionally cause distress and re-traumatize;
- Engage in community outreach and partnership building that recognizes that the people served are part of a larger system of care.

Figure 21. Legend Coding for Service Gap Analysis

THE FOLLOWING CHART EXPLAINS THIS CODING USED IN TABLES IN THIS CHAPTER	
Code	**Definition**
1 Primary Prevention	activities are directed at a whole community and are intended to prevent maltreatment before it occurs and promote resilient and thriving children and families
2 Secondary Prevention	activities target families that have high levels of stress and may be at increased risk for child maltreatment, these activities are designed to decrease risk of maltreatment occurring
3 Teritiary Prevention	activities focus on children and families already impacted by child maltreatment. These efforts and are meant to reduce the harm from the trauma and prevent maltreatment from happening again in the future
T Trauma Informed Care	is delivered in a manner that recognizes the history of trauma of the individual and incorporates that history and the presence of trauma symptoms in an approach that addressed the needs of the individual and does not re-traumatize them
N No Specific Prevention Orientation	these services, while they have the potential to incorporate prevention activities do not currently have these activities integrated into their service provision

Preconception/Prenatal Period

PRECONCEPTION/PRENATAL DEVELOPMENT

The early years of life-prior to conception through early childhood-may have the most significant impact on healthy development. Human fetuses develop rapidly. Thus, they are particularly vulnerable to both the positive and negative aspects of their prenatal environment. Long-term health can be closely tied to the mother's health during pregnancy. Exposure to healthy environments and protection from unhealthy ones can prevent stressors in the prenatal environment associated with the onset of physical, mental, emotional, and behavioral issues for the child.

Table 48. Preconception and Prenatal – Medical Sector Gaps Analysis

PRECONCEPTION AND PRENATAL MEDICAL SECTOR GAPS ANALYSIS				
	Service Provider(s)	**Service Type**	**Population Served**	**Funding**
1	2 Nurse Family Home Visiting Programs	Education/support and supplemental prenatal care, well-child check-ups, parenting support	Pregnant first time mothers who are low-income. Alaska Native first time and multiparous mothers Area: All Mat-Su	Federal and State grant funding, SouthCentral Foundation funding
1	Public Health Nursing; Planned Parenthood; Heart Reach Pregnancy Center	Family planning, STD testing including online access, pregnancy options counseling	All Area: Core area and online access	Third party reimbursement, sliding fee scale and free
N	OB-GYN providers (10); 2 Federally Qualified Health Centers	Prenatal Care	All families and individuals Area: Core area and Upper-Su	Third party reimbursement; sliding fee schedule at FQHCs
N	Mat-Su Regional Medical Center	Childbirth classes, delivery, postpartum care, breastfeeding support	All	Third party reimbursement
N	5 Birthing/ Midwifery Centers	Prenatal, delivery, postpartum care, breastfeeding support	All Capacity dependent on location	Third party reimbursement

1 Primary Prevention · 2 Secondary Prevention · 3 Teritiary Prevention · T Trauma Informed Care · N No Specific Prevention Orientation

PRECONCEPTION/PRENATAL PREVENTION

Primary prevention pre-conception care includes access to family planning care. Research shows that women who have an unintended pregnancy (mistimed or unwanted) are more likely to initiate care later and receive less adequate care than women with intended pregnancies.[13] Women with unwanted and mistimed conceptions are also more likely to smoke or drink during pregnancy. Studies have also linked children from an unintended pregnancy to be at a higher risk of child maltreatment (Child Welfare Information Gateway, n.d.). In 1986, the U.S. Surgeon General Kopp stated that "the starting point for effective child abuse programming is pregnancy planning" (Institute of Medicine, Committee on Unintended Pregnancy, 1995). If a pregnant woman receives adequate medical care during her pregnancy, the incidence of a poor outcome for the health of the child and mother is reduced. Receiving this type of care is an important type of primary prevention. Avoiding health issues sometimes experienced during pregnancy-such as flu, stress, domestic violence, anxiety and depression-reduces potential detrimental impacts on the future child's behavioral health. Further, since barrier cells in the brain are not yet developed to protect the child's brain from chemicals, avoiding prenatal substance abuse, such as alcohol, tobacco, recreational drugs, and other pharmaceutical drugs, can prevent a negative impact to the child's development. Additionally, access to safe water and air quality during the prenatal period removes some environmental risks to children for developmental, behavioral, and mental impairments. A woman's medical

[13] Unintended pregnancies include mothers who answered "I didn't want to be pregnant then or at any time in the future" or "I wanted to be pregnant later."

provider should screen for these conditions and situations and provide information and referral services to address these issues.

Preconception/Prenatal Secondary and Tertiary Prevention for pregnant women include programs that address prenatal conditions that can harm the woman and her fetus. These include domestic violence shelters, substance abuse treatment programs for pregnant women, tobacco quit programs, and behavioral health programs. One best practice that can address many of the topics discussed above is the Nurse Family Partnership. This program is designed to promote the health and well-being of young, low-income first-time mothers and their children.

SERVICES IN MAT-SU

There are several options for women in Mat-Su for family planning, STD testing and pregnancy counseling. These options include private providers, a faith-based provider, telehealth, and clinics that have sliding fee schedules. Pregnant women in Mat-Su can access prenatal care with at least 10 private providers and provider groups, several private birthing clinics, federally qualified community health centers in Sutton, Wasilla, Willow and Talkeetna, the Valley Native Primary Care Clinic (for Alaska Native women), and on the Joint Base Elmendorf (for active military families). Federally qualified health centers offer discounted services based on income level. Medical insurance coverage is available for low income pregnant women through Denali Kid Care.

In Mat-Su, specialized **secondary prevention** services for pregnant women include two Nurse Family Partnership home-visiting programs with 100 slots that provide intensive support for women from prenatal through the second birthday of their child. One program is grant-funded and serves low-income, first-time mothers and care must be started during the prenatal period. The other program, primarily funded by a local Tribal Health Organization, Southcentral Foundation, serves Alaska Native women who are first-time mothers or multiparous. The Nurse Family Partnership is a program designed to promote the health and well-being of mothers and their babies. During pregnancy, a nurse meets with an expecting mother in the mother's home to teach about prenatal care and other preparation for the birth. After the child is born, the nurse continues to meet with the mother to guide healthy child development. Throughout all meetings, the nurse provides emotional support, mentoring the mother to continue her own educational and career development and serves as a consistent and reliable positive influence in a mother's life.

There are currently no behavioral health programs that cater specifically to pregnant women **(tertiary prevention)**. Pregnant women who need a safe place to stay due to domestic violence or are homeless can access services which are available to all Mat-Su women (see *Concrete Support in Times of Need* chart). The medical services that are focused on the needs of pregnant women do not have waiting lists, they are primarily located in the core area except for two federally qualified health care centers located in Willow, Talkeetna and Sutton and the home visiting programs that serve the whole region. Delivery services and supports, such as breastfeeding support, are available at Mat-Su Regional Medical Center and at least five private birthing centers in Mat-Su.

GAPS

The following areas for growth in preconception and prenatal services were observed:

- Create teen pregnancy prevention efforts, including family planning

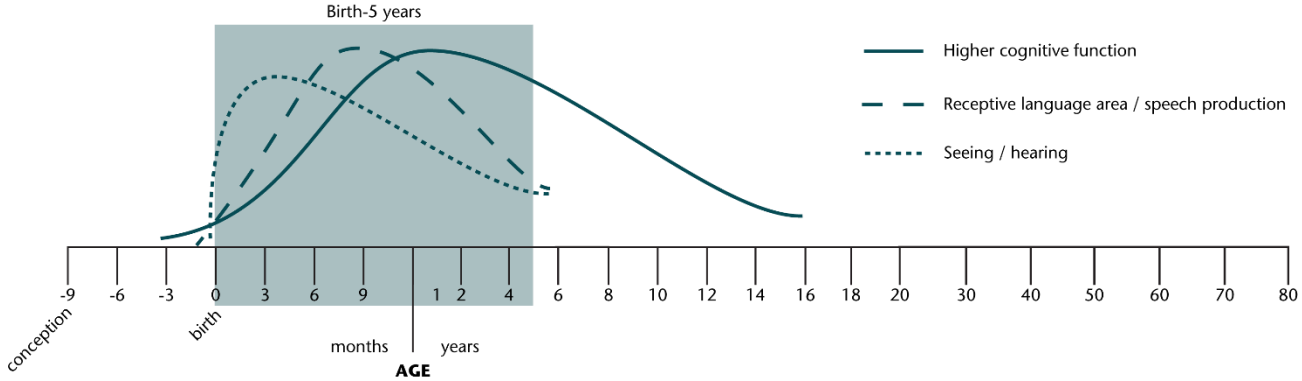
- Develop primary prevention efforts for pregnant women
- Support program for pregnant teens
- Create behavioral health care specifically for pregnant women, including trauma-informed prenatal care

Early Childhood

EARLY CHILDHOOD DEVELOPMENT

Healthy development for children is defined as the ability to grow up having their physical, social, emotional, and educational needs met (Centers for Disease Control and Prevention, 2016). A child's development starts at birth and continues throughout childhood, in fact, the brain keeps growing into the mid-20s. When children feel safe and nurtured, their brains are able to learn better, bond with parents, and engage in healthy relationships with others. Rapid neurodevelopment continues from conception throughout the first years of life, and children's bodies and brains remain highly susceptible to their early environments and relationships. The figure below displays how synapses form in the developing brain; synapses begin to form before birth and peak during the first year of life. This sensitive period is a double-edged sword: a time of great promise but also considerable risk (Shonkoff, 2012).

Figure 22. Synapse Formation in the Developing Brain



Source: Adapted from the National Scientific Council on the Developing Child (2007). The Timing and Quality of Early Experiences Combine to Shape Brain Architecture: Working Paper 5. Available at: http://www.developingchild.net.

The importance of early childhood is significant, not only as a time of risk and potential, but also as a powerful opportunity for prevention and intervention. A child's health is a strong predictor of adult health, and "early childhood developmental interventions…have been shown to greatly ameliorate the effects of social disadvantage on children's physical, mental, and social development; the first 3 to 5 years of life appear to be the most critical" (Braveman, Egerter, and Mockenhaupt, 2011). It is easier to develop into healthy adults when children have safe, stable and nurturing relationships and environments (CDC, 2016; Shonkoff, 2012).

The National Scientific Center on the Developing Child (2016), stresses the following key points about early childhood development:

1. Development is not determined solely by genes; it is a highly interactive process.
2. Infants and young children can be adversely affected when stresses threaten them, their families, and their caregiving environments.
3. Healthy attachments to parents are crucial, but young children also benefit tremendously from strong, caring relationships with other caregivers.

4. Although significant brain development occurs before the age of 3, influential windows are open beyond the age of 3, and adults can learn 'work-arounds' too.

Early childhood is a crucial time when children start to develop social emotional competence. Social emotional competence during the 0-5-year age span is related to forming close and secure adult and peer relationships, and being able to experience, regulate, and express emotions in socially and culturally appropriate ways (Browne, Charlyn, 2014). The National Scientific Council on the Developing Child (2004b) defined social emotional competence as "the ability to identify and understand one's own feelings, to accurately read and comprehend emotional states in others, to manage strong emotions and their expression in a constructive manner, to regulate one's own behavior, to develop empathy for others and to establish and sustain relationships" (National Council on the Developing Child, 2004). Research has shown that the early development of social and emotional competence rivals the importance of cognitive development for school readiness. The importance of this development reaches into adulthood in terms of mastery of social skills that are essential for the formation of lasting friendships, marriage, effective parenting, holding down a job, and contributing to a community in general. Social and emotional competence is linked to learning because it provides a foundation for children to learn. If children cannot self-regulate in the form of controlling and coordinating their thoughts, emotions, and behaviors, and adapt their behavior to get a desired outcome, they will not be able to mind the teacher, get along with other children, or be receptive to learning skills, like reading and math.

Strong relationships with caregivers and stable, safe environments play a pivotal role in building a strong foundation for later growth and learning. Studies show early childhood care reduces special education enrollment, increases high school graduation rates, lessens participation in criminal activity, raises future earnings, and eases reliance on social welfare. Furthermore, early childhood care mitigates adversity that can limit brain development for children born into homes with household dysfunction.

Studies have shown that social and emotional competence is developed during childhood through the following conditions and experiences (National Scientific Council on the Developing Council, 2004):

- Role models such as parents and others who have well-developed social and emotional competence
- Warm and nurturing relationships with an enduring emotional bond with at least one parent or caregiver
- Adults structuring activities to practice skills and role modeling with children
- Consistent, caring, compassionate, and responsive care and interaction with caregivers
- Positive and encouraging messages
- Regular and predictable routines
- A physically safe living environment where basic needs are met
- An environment that encourages developmentally-appropriate play, experiential learning, and promotes vocabulary development, talking, and reading, and encourages children to express emotions.

The bond between caregiver and child is crucial to positive social and emotional development. One researcher framed it as follows: "In order to develop normally, a child requires progressively more complex joint activity with one or more adults who have an irrational emotional relationship with the child. Somebody's got to be crazy about that kid. That's number one. First, last, and always" (National Scientific Council on the Developing Council, 2004). The social and emotional competence of children is intricately linked to that of their parents. A

parent must have these skills themselves to model and create a safe and emotionally supportive environment to raise their child. If a parent grew up in an environment that did not nurture their social and emotional competence they will benefit from programs that address their mental health needs and build self-regulation and executive functioning capacities.

Table 49. Early Childhood – Medical, Childcare and Early Learning Sector Gaps Analysis

EARLY CHILDHOOD – MEDICAL, CHILDCARE AND EARLY LEARNING SECTOR GAPS ANALYSIS				
	Service Provider(s)	**Service Type**	**Population Served**	**Funding**
MEDICAL CARE SECTOR				
1	Public Health Nursing	Immunizations, newborn hearing screenings, well-child exams, school screenings	All children Area: Wasilla, Palmer, Big Lake, Willow, Talkeetna, Trapper Creek, Glennallen and Sutton.	Third party reimbursement and State funding
1	Alaska Native Primary Care Center	Well-child and general medical care	Alaska Native and American Indian children Area: Core area	Federal funding and third party reimbursement
1 T	Federally Qualified Health Centers (3)	Well-child and general medical care; Sunshine Community Health is working towards becoming Trauma-informed	All children Area: Wasilla, Willow, Talkeetna, and Sutton	Third party reimbursement, sliding fee scale for self-pay, Federal and state grants
1	Private pediatricians, family practice, and primary care providers	Well-child and general medical care	All children	Third party reimbursement
1	Ptarmigan Pediatrics	Screening families with the ACE-Q; neurodevelopmental assessment; consultant with Pre-K program	All children Area: Core area	Third-party reimbursement and grant funding
CHILDCARE SECTOR				
N	Licensed childcare centers, group homes, approved relatives	Childcare services	83 providers with 1,913 slots. Most providers are located between Big Lake/Houston and Palmer (including Head Start and Early Head Start)	Private pay and those with CCAP funds. Slots are filled when staffing allows
N	Private childcare	Childcare services	All children	Private pay
EARLY CHILDHOOD LEARNING SECTOR				
1 T	CCS Early Learning	Early Learning	Low-income children – 49 slots for 0-3 years; 200 slots for 3-5 years. Area: Sutton, Meadow Lakes, Wasilla	Federal and State funding
1	MSBSD Preschool	Early Learning	Approximately 400 slots in 2015-2016 school year	Federal and State funding
1	Infant Learning Program and Child find	Developmental screening	Children 0-5 years; Area: Core	Grant and MSBSD funding
1	Home-based -Infant Learning Programs (2)	Early intervention services	Children 0-3 with developmental delays	Medicaid, State and other grants
N	Private Preschools	Early Learning	All children 3-5 years	Private Pay
N	Mat-Su Imagination Library	Free books home-delivered	Every child 0-5 years	Grants and donations
PARENTING SUPPORT SECTOR – SEE PRENATAL/PRECONCEPTION CHART				

1 Primary Prevention; 2 Secondary Prevention; 3 Teritiary Prevention; T Trauma Informed Care; N No Specific Prevention Orientation

PREVENTION DURING EARLY CHILDHOOD

Medical Sector: All children need medical care when they are healthy and sick. Well-child care provides an important opportunity for **primary prevention** when the provider screens and educates parents on developmental milestones, nutrition, immunizations, safety, and child and family emotional well-being. These visits provide an opportunity for prevention, tracking growth and development, and providing parent education (American Academy of Pediatricians, 2016). The American Academy of Pediatrics recommends well-child visits at the following ages: 2-5 days; 1, 2, 4, 6, 9, 12, 24 and 30 months; and every year from 3-18 years.

The American Academy of Pediatrics has launched the **secondary prevention** initiative called *The Resilience Project* that has developed resources for pediatricians and medical home teams to more effectively identify and care for children and adolescents who have been exposed to violence (American Academy of Pediatrics, 2016).

Medical-related Services Mat-Su: There are a total of six pediatric and 44 family medicine providers primarily located in the core area and three federally qualified health clinics (FQHC) in the rural areas –Sutton, Willow and Talkeetna, which offer pediatric and family medical care and have a sliding fee schedule. Additionally, Mat-Su Health Services, offers these services with a sliding fee schedule. The Valley Native Primary Care Center provides pediatric and family medical care to Alaska Native and American Indian beneficiaries.

The All Alaska Pediatric Partnership is also committed to decreasing child abuse and neglect by developing statewide primary prevention strategies to reduce trauma and other forms of child abuse and neglect. The Partnership is working with hospitals to implement an annual curriculum for nurses and physicians relating to identifying possible abuse and neglect and supporting birthing facilities to implement evidence-based **primary prevention** strategies, such as the Triple P - the Positive Parenting Program.

A project supported by the MSHF, which could be considered **secondary prevention**, was launched in 2016. Ptarmigan Pediatrics, a private pediatric group, will house an internship for a child psychologist. Part of the program includes training pediatricians at Ptarmigan and in the community on how to screen for ACEs. Additionally, Ptarmigan will have the psychologist intern do neuropsychological assessments for children who are identified through the screening.

Child Care Sector: Quality child care can be considered **primary prevention** when it contributes to a child's positive development in terms of the child's sense of identity, trust of others, and opportunity to acquire successful learning characteristics. The Child Development Council lists the *10 Components of High Quality Childcare for Infants and Toddlers* (Child Development Council, 2016):

1. Child care Programs that follow appropriate health and safety practices
2. Staff well-trained in early childhood development
3. Age-appropriate environments
4. Small groups with optimal ratios
5. Having a primary caregiver at the center which allows for continuity of care
6. Active and responsive caregiving to support child development
7. Appropriate curriculum, observation, and individualized programming
8. Emerging language and literacy
9. Family involvement and cultural continuity

10. Referrals and connection to comprehensive support services as needed

Therapeutic child care and preschool for children who have been exposed to adverse childhood events and trauma can be part of **secondary and tertiary prevention**. These children are often struggling with emotional and behavioral problems and they are often asked to leave traditional child care settings. This type of child care uses a trauma-informed approach to care and offers treatment from licensed clinical staff. Family therapy is provided, and parents and caregivers are invited to observe their children in a group setting and see the therapeutic interventions and how staff interact with their children.

Child care in Mat-Su: In the spring of 2015, a statewide telephone survey conducted by McDowell Group revealed

- More than half (54 percent) of Mat-Su children under age 6 typically receive some form of early care and learning services.
- Almost all (97 percent) children under age 6 who did not receive early care and learning services were cared for at home.
- One-half (49 percent) of children under age 6 who received early care and learning services in the month prior to the survey were in pre-elementary school or licensed center-based care, 33 percent received care at someone else's home, and 20 percent received care in the child's own home.
- Parents reported that early care and learning services were easy or very easy to find for 67 percent of children under age 6.
- Among households that had trouble finding services for their children under age 6, cost was a barrier for 52 percent, followed by availability/lack of a provider (40 percent), and quality (28 percent) (McDowell Group, 2015).

Several forms of informal and formal child care exist in the Mat-Su Borough. "Informal care" includes care provided by a parent or relatives and friends. "Formal care" is care for which providers are licensed by the state, including preschool offered by Mat-Su Borough School District (MSBSD) and programs such as Early Head Start and Head Start. Data on informal care is limited, but the Child Care Program Office (CCPO) tracks and publishes information on most formal care. Mat-Su has 83 providers approved or licensed by the state, with 1,900 slots (some of these daycare providers may not have all the slots available due to lack of staffing). This includes a Head Start and Early Head Start Program with are described in the next section. The MSBSD preschools have had staff training on ACEs.

Current Mat-Su child care settings also serve children who have experience trauma and whose families are involved with OCS and the foster care system. In 2015, there were 160 children whose families were involved with OCS who received child care for at least one day and there was an average of 13 children who received care per month. These children would benefit from therapeutic childcare and preschool, however, there are none in Mat-Su.

Early Childhood Learning Sector: Preschools can help children develop intellectually and social-emotionally and ensure they are ready for school when kindergarten starts. Longitudinal data shows that MSBSD students who attended preschool retained their academic advantage through second grade when compared to peers who did not attend preschool.

Early Childhood Learning in Mat-Su: MSBSD operates three preschool programs: special education, Title I, and "Widening the Net." In the 2015-2016 school year, MSBSD's special education preschools served 321 children ages 3-5 at 17 locations throughout the borough. These programs serve children with developmental delays, language delays, and other identified disabilities. At the end of the 2015-2016, 100 children age 4 years living in poverty were enrolled in MSBSD Title I preschools in five locations. The "Widening the Net" preschool program, which aims to serve students close to, but not meeting, the developmental delay or income thresholds of special education and Title I preschools, served 80 children age 4. This program was offered at Butte, Goose Bay, John Shaw, Trapper Creek, and Willow elementary schools. During the present school year, 2016-17, the state Widening the Net" funding has decreased, and will diminish each year for the next three years, when it will be eliminated. As the State grant funding for "Widening the Net" is phasing out, it would be ideal to have preschool available to all children in the borough, or at least those with any amount of developmental delay. Additionally, the psychology intern from Ptarmigan Pediatrics is working with MSBSD preschool classrooms at Goose Bay Elementary School to assist teachers with the behavioral health needs of students.

There are several programs that screen young children 0-5 years for developmental delays - the Look at Me Program at MSSCA and the School District's Child Find Program. These programs will refer children who are identified with a delay to appropriate services. The MSBSD runs 17 special education preschool programs, serving over 300 students. The programs are required to serve children who have a 25 percent delay in one areas or a 20 percent delay in two areas. These pre-kindergarten programs all utilize three-core curricula; Second Step, Talking About Touching, and Positive Action. All preschool staff have received education on the Adverse Childhood Experiences study. The Second Step program teaches children enrolled in preschool how to listen, pay attention, control their behavior, and get along with their peers. Teaching all preschool students enrolled in MSBSD preschool programs self-regulation and social-emotional skills helps to ensure students are set up to be successful in kindergarten. The Talking about Touching (TAT) curriculum is currently being taught in all MSBSD preschools. TAT focuses on teaching children basic skills that will help them keep safe from dangerous or abusive situations. The content and method of instruction in the curriculum were developed using current research on child abuse prevention and social learning theory. The curriculum includes personal safety lessons on topics such as automobile and fire safety, getting lost, sexual abuse, and other types of child abuse.

Early Head Start (EHS) and Head Start (HS) programs fall within the category of State-licensed providers. These programs serve: those with family incomes below the federal poverty level, families with a child in foster care, families that are homeless, families that receive public assistance, or children who have experienced trauma, or identified disabilities. The 2014 ACS five-year estimates report 12.9 percent of Mat-Su families lived below the federal poverty level. This percentage applied to the number of children age 0-2 years and 3-4 years provides an estimate of the number of children eligible for EHS and HS: 579 and 386, respectively. CCS Early Learning operates the Early Head Start and Head Start programs in the Mat-Su that serve 49 and 200 children, respectively from three center locations in Wasilla, Meadow Lakes, and Sutton. Accordingly, EHS serves an estimated 8 percent of the eligible population, while HS serves an estimated 51 percent of the eligible population. CCS Early Learning is currently becoming trauma-informed by participating in a nationally known Head Start Trauma Smart Program.

GAPS

The following areas for growth in early childhood services were observed:

- There is a need for more trauma-informed medical providers offering integrated behavioral health and primary care.
- Therapeutic Child Care for children who have experienced trauma and/or have behavioral health challenges.
- A sufficient supply of high-quality child care that is affordable for all income levels. (A detailed analysis of childcare providers is included in Appendix B.)
- More home visiting programs, including those for single fathers.
- More early learning slots in Head Start, Early Head Start, and MSBSD preschools.

Childhood - School-aged Years

SCHOOL AGED CHILDHOOD DEVELOPMENT

The Center for the Study of Social Policy, which developed the Strengthening Families Framework has developed a similar framework focused on youth titled, Youth Thrive. This framework is "a strength-based initiative to examine how all youth can be supported in ways that advance healthy development and well-being, and reduce the likelihood or impact of negative life experiences." The framework is informed by the belief that a healthy adolescence can be fostered through intentional and deliberate processes of providing support, relationships, experiences, and opportunities that promote positive outcomes for youth (Charlyn Harper Brown, 2014)

Youth Thrive is based on the Positive Youth Development Perspective which is strength-based and identifies policies and programs designed to promote positive adolescent development and well-being. The policies and programs are supported across all sectors of the community – school, youth serving agencies, faith organizations, community governance, business, the juvenile justice system, etc. A key premise of the Positive Youth Development Perspective is focusing on the strengths of adolescents and knowing that when these strengths are aligned with resources in the settings that touch youth in their community the yield will be healthy, positive youth development (Charlyn Harper Brown, 2014).

The Positive Youth Development Perspective asserts that there are five Cs of positive youth development:

- **Competence:** A positive view of one's actions in specific areas, including social, academic, cognitive, health and vocational
- **Confidence:** An internal sense of overall positive self-worth and self-efficacy
- **Connection:** Positive bonds with people and institutions in which both parties contribute to the relationship
- **Character:** Respect for societal and cultural norms, possession of standards for correct behaviors, a sense of morality and integrity
- **Caring/Compassion:** A sense of sympathy and empathy for others, and a sense of social justice

Table 50. School-Age Children – Educational and Medical Sector Gaps Analysis

SCHOOL-AGE CHILDREN – EDUCATIONAL, MEDICAL, AND CHILDCARE				
	Service Provider(s)	**Service Type**	**Population Served**	**Funding**
MEDICAL CARE SECTOR – SAME AS FOR EARLY CHILDHOOD – SEE TABLE				
EDUCATION SECTOR				
1	MSBSD Training and Curriculum	Capturing Kids Hearts Safe & Civil Schools	District-wide	MSBSD
1	MSBSD Curriculum	Social Emotional Learning (Positive Action)	Many elementary schools and some middle schools; Talkeetna pilot with BH professionals	MSBSD, MSHF Health School Grants
1	MSBSD	Behavioral health services	Students with IEPs	MSBDS funding
1	MSBSD	Crisis Counseling	Five schools	Federal/MSHF grants
1	Onward and Upward Launch, Excel, and Moonshot Programs	Positive education programming	Limited # of slots for MSBSD students	MSHF, MSBSD, Private funding
1	You Are Not Alone Club; Straight Gay Alliance	Suicide prevention and LGBTQ Programing	Small number of individual schools	Grant funding when available
1	Alaska Military Academy	Education program to assist youth in making positive life changes	At-risk 16-18-year-old youth statewide (20% from Mat-Su)	State and Federal funding
2	Mat-Su Youth Court	Student defendants are processed by student staffed court	9-18 years	State of AK, Private donations
2	MSBSD/DJJ: PACE Program	Online drug/alcohol abuse intervention and aggressive replacement training including Prime for Life	Expelled or suspended students	Department of Corrections
3	Alcohol and Drug Information School – local BH providers	Education to reduce subsequent alcohol/drug offenses	Minors referred by court system	Private Pay
T	MSBSD	Trauma informed training	Five schools	MSBSD and R.O.C.K. Mat-Su

1 Primary Prevention 2 Secondary Prevention 3 Teritiary Prevention T Trauma Informed Care N No Specific Prevention Orientation

Table 51. School-Age Children – Childcare Sector Gaps Analysis

SCHOOL-AGE CHILDREN – EDUCATIONAL, MEDICAL, AND CHILDCARE - CONTINUED				
	Service Provider(s)	**Service Type**	**Population Served**	**Funding**
		AFTER SCHOOL/SUMMER CARE SECTOR		
1	Boys and Girls Club	Before/after school and summer care	All children ages 7-18 years Area: Core	Grants, private donors, fees
1	THRIVE Mat-Su and Alaska Wellness Coalition	Positive Community Norms Media Campaign	Medio outlets	State funding
1	Onward and Upward summer/afterschool courses	Positive education programming	School age children; limited # of courses	MSHF and Private funding
1	THRIVE Mat-Su	Anti-Bullying and Suicide Prevention Training, Peer Helpers, Youth Leadership and Development, Youth Resource Guide; Volunteer mentoring for tutoring at local schools	Select middle and senior high schools	MSBSD, State and local funding
2	Big Brothers, Big Sisters	Youth mentoring	Limited # of slots	Grant and donor funding
3	The Yak	Afterschool care two days per week	Junior and senior high school students Area: Palmer	Private donors
3	Royal Family Kids-Alone	Camps/mentor clubs for foster care children	Foster care children ages 6-12 years; 45-50 slots	Private donors and grants
3	SED: Summer youth behavioral Health Programs (4)	Group therapy, skill building, group support staff, and community outings.	Children who have severe emotional disturbance Ages 5-16 Area: Core	Medicaid
3	Camp Hope	Summer camp for children whose lives have been impacted by substance abuse in their family	Children 7-1 years; limited # of slots	Grant funding

1 Primary Prevention 2 Secondary Prevention 3 Teritiary Prevention T Trauma Informed Care N No Specific Prevention Orientation

PREVENTION DURING SCHOOL-AGED YEARS

Researchers assert that youth who are working on developing the five Cs will make a significant contribution to themselves, their school, community and society. There are 40 developmental assets, identified as building blocks for positive youth development, which can help develop the five Cs. The table below lists these assets (SEARCH Institute, 2016). The Youth Thrive theory of change includes three key concepts: Risk factors, Promotive Factors, and Protective Factors. Risk Factors are conditions of individuals, families, communities or the larger society that increase the possibility of poor outcomes.

Table 52. 40 Developmental Assets for Positive Youth Development

External to the Youth		Internal to the Youth	
1. Family Support	11. Family boundaries	1. Achievement motivation	11. Restraint
2. Positive family communication	12. School boundaries	2. School engagement	12. Planning and decision-making
3. Other adult relationships	13. Neighborhood boundaries	3. Homework completion	13. Interpersonal competence
4. Caring school climate	14. Adult role models	4. Bonding to school	14. Cultural competence
5. Caring neighborhood	15. Positive peer influence	5. Reading for pleasure	15. Resistance skills
6. Parent involvement in schooling	16. High expectations	6. Caring	16. Peaceful conflict resolutions
7. Community values youth	17. Creative activities	7. Equality and social justice	17. Personal power
8. Youth as resources	18. Youth programs	8. Integrity	18. Self-esteem
9. Service to others	19. Religious community	9. Honesty	19. Sense of purpose
10. Safety	20. Time at home	10. Responsibility	20. Positive view of personal future

Protective Factors are similar conditions that mitigate or eliminate risk and Promotive Factors are conditions that actively enhance well-being. Youth Thrive believes that "Youth in general, as well as those at heightened risk for negative outcomes, have a greater likelihood of achieving healthy outcomes because of experiences that support the building of the Youth Thrive Protective and Promotive Factors and the reduction of Risk Factors. This approach can be for all types of prevention, especially **primary prevention.** The table below identifies these factors:

Table 53. Youth Thrive Protective, Promotive, and Risk Factors

Protective and Promotive Factors	Risk Factors
Youth resilience	Stressors
Social connections	Inadequate or negative relationships with family members, adults outside youth's family and peers
Knowledge of adolescent development	Insufficient or inadequate opportunities for positive growth and development
Concrete support in times of need	Unsafe, unstable, inequitable environments
Cognitive and social-emotional competence in youth	

Additionally, social emotional learning is key to promoting protective and promotive factors. The Committee for Children proposes that teaching social emotional learning (SEL) in schools is as important as teaching math or language arts. Children can learn SEL in the classroom in the same way other subjects are taught:

- The teacher explains a concept with words, pictures, video and or audio
- Students practice the concept with skill practice, group discussion, individual writing, or partner work
- The teacher continues reinforcing the concept throughout the week
- The teacher sends information home for students to work on with parents
- The teacher checks for understanding
- The teacher re-teaches where necessary (Committee on Children, 2016).

ACEs can interfere with children's learning, causing them to be anxious, depressed and exhibit bullying and other aggressive behaviors. As children grow older the behaviors that can result from experiencing ACEs include alcohol and drug use, self-harm, suicidal attempts, and other detrimental activities. Schools becoming Trauma-informed is a key practice for **secondary and tertiary prevention**. Children who have or are experiencing trauma act out or withdraw and their behavior can be treated in a traditional disciplinary manner that can risk further traumatizing the child. Often the "acting out" behavior is caused by other conditions in a child's life that

are "triggered" by procedures or situations in the school setting. When a child is "triggered" and acting out they are unable to learn. If a school is "trauma-informed" the instances where students are triggered can be lessened and addressed appropriately.

Since schools are settings that touch almost all children they are ideal places for children to receive supportive services that parents and caregivers may not be able to provide for their children. Children with identified developmental delays, including behavioral health, that relate to their education goals have Individualized Education Plans. Some schools in the lower 48 offer counseling services to students that are not related to IEPS, but work to intervene early when behavioral health issues arise.

SCHOOL-AGED PREVENTION IN MAT-SU

Education Sector in Mat-Su: The MSBSD district employs approximately 2,200 staff members at 46 schools. The schools, which include K-12 grades, range in enrollments from about 20 to more than 1,300 students. **Primary prevention** programs and activities include staff training, curriculum, and intentional programs to create school culture.

School Staff Training: In the 2015-2016 school year, the MSBSD administration provided trainings, which could be considered primary prevention, in some schools on Positive Action, a social emotional learning approach for all age levels; and several trainings on working with children who have experienced trauma and Mandt de-escalation skills. Additionally, a select set of coaches have been trained in the Coaching Greatness approach. Coaching Greatness teaches coaches how to intentionally and consistently define expected behaviors and create a culture that reflects the values of the athletic program while meeting activity goals. Some staff have also received training in Mental Health First Aid for Students.

School Curriculum: The school district has implemented a district-wide curriculum titled Capturing Kids Hearts (CKH) with an aim to transform the campuses into emotionally safe and relationally connected places for students, staff, and parents to come alive with a love for learning.

All MSBSD elementary schools use the Safe & Civil Schools (SCS) principles and procedures. SCS principles and procedures help improve the school climate and culture of MSBSD elementary schools by teaching all students expectations of behavior. Several schools are using social-emotional learning curriculum titled Positive Action (elementary school level) and Parenting with Love and Logic (middle school level). In the Upper Susitna Area, the Sunshine Community Health Center is partnering with four local schools to use a comprehensive counseling model in the school linked to the Positive Action curriculum.

In the MSBSD, school psychologists and local behavioral health organizations provide services in schools to address the needs identified on students' IEPs. When these needs are related to social emotional and behavioral deficits this type of service is considered **secondary and tertiary prevention.** There are five schools that also have counselors to address non-education related behavioral health needs. There are also school clubs that can support students. You Are Not Alone (YANA) is a peer-led youth suicide prevention outreach with a focus on early intervention. YANA includes wristbands with the careline number for youth to wear and give to those who may be struggling, an evidence-based suicide prevention class, and the option for youth to become class presenters and start a You Are Not Alone Club at their school. Additionally, two schools have Gay Straight Alliance groups to support LGBTQ students.

There is a pilot project for five MSBSD schools to become trauma-informed that is being led by R.O.C.K. Mat-Su. The goal is for these schools to undertake a paradigm shift at the staff and organizational level to recognize, understand, and address the learning needs of children impacted by trauma. In these schools, a team will be trained and coached during a year-long process to create this systemic change.

There are several alternative educational programs in Mat-Su for students identified with significant high-risk behaviors or legal infractions, such as the Alcohol and Drug Information School, which is for minors referred by the court system. The Mat-Su Youth Court is a state-sanctioned juvenile justice system where students serve as attorneys, clerks, bailiffs, and judges in cases involving their peers. The courts are assisted by program staff and legal advisors. Cases for each youth court are based on referrals from law enforcement, and allow first-time juvenile offenders who have committed misdemeanors to be held responsible for their actions, be given a form of punishment, but have a clear criminal record upon finishing their sentencing. The three-judge panel hands down sentences, normally consisting of community service hours, essays, apologies, and other sanctions. There are 10 total youth courts in Alaska, including the Mat-Su Youth Court. In 2013, the most recent data available, the Mat-Su Youth Court had 102 cases referred to them, with 81 of these cases proceeding to a court hearing.

Another disciplinary MSBSD program is the Pace Program which provides online learning, intervention for drug/alcohol abuse (Prime for Life) and aggressive replacement training for students who are expelled or suspended. The Alaska Military Academy located on Joint Base Elmendorf Richardson is an accredited special purpose school that runs several programs designed to help Alaskan youth make positive life changes. It is a division of the Alaska Department of Military and Veterans Affairs and serves at youth between the ages of 16 and 18 years. The program is offered free of charge to qualifying students.

The Alaska Job Corps is a no-cost education and career technical training program administered by the U.S. Department of Labor that helps young men and women ages 16 through 24 improve the quality of their lives through career technical and academic training.

After School/Summer Care –Sector in Mat-Su

The 2015 McDowell report on Mat-Su child care revealed that 37 percent of Mat-Su children ages 6 – 12 years use child care services and spend an average of 39 hours per month in these services. The average amount spent per month on this care is $308 and 9 percent of children use the financial assistance program. Approximately 29 percent of parents report being restricted due to lack of child care services for this age group.

Afterschool care is very limited in Mat-Su. The Boys and Girls Club provides low-cost child care that (per their website) "builds on character and leaderships and healthy life styles with a focus on academic success. The Yak is a youth center that is open two days a week and provides a safe place for youth to come after school and play games, do homework and hang-out with friends.

There are various summer programs and camps that serve all children usually at a cost. Summer programming for high risk youth includes the Royal Family Kids camp. There are several behavioral health providers who provide summer programming for children with a Serious Emotional Disturbance diagnosis and who are eligible for Medicaid reimbursement. These programs could be considered **secondary and tertiary prevention**.

Onward and Upward offers a spectrum of prevention program and services in schools, after school, and during summer. The Excel Program provides positive education courses for all types of students; the Launch Program is targeted at youth who are exposed to mid/high-level risk factors who need an extra layer of support and the Moonshot Program is focused on youth with high risk factors referred by a behavioral health professional, agency, or school counselor or administrator. These courses are offered at several schools with a limited number of slots.

THRIVE Mat-Su and the Alaska Wellness Coalition have launched a positive social norms campaign entitled "Be You" in conjunction with other similar coalitions statewide which is focused on decreasing underage drinking. Activities include the release of public service announcements statewide and other local coalition activities.

GAPS

The following areas for growth in school-aged child services were observed:

- Educational Services for School-Age Children
    - Universal social emotional learning curriculum in all schools throughout the academic career and held to the same high standards as all other core subjects of study
    - A fully trauma-informed school district
    - Counseling available in the schools for primary and secondary prevention to address emerging problems
    - Parent support and engagement to encourage social emotional learning for homeschooled children
    - Expanded support for LGBTQ students and their parents
- Youth Asset Development
    - More structured opportunities for youth to be involved in community services and service learning
    - Increase afterschool programs and opportunities for students to learn and be immersed in their community

Young Adulthood Age

YOUNG ADULT DEVELOPMENT

The brain's final stage of crucial development occurs during puberty and early adulthood (MHA, 2016c). During this time, young adults experience numerous transitions at school, at home, at work, and socially. Mental health problems often first present during this time, and most mental, emotional and behavioral disorders emerge before the age of 24 years (Beardslee, Chien and Bell, 2011; Kessler et al., 2005). It is also at this time that youth who have experienced ACEs may be experiencing risk factors, such as substance abuse, high-risk sexual behaviors, depression, eating disorders, and suicide attempts. Additionally, many young adults are still experiencing the concrete effects of household dysfunction that include being homeless and without parental support and guidance.

Table 54. Young Adulthood, Medical, Education, and Social Services Gaps Analysis

YOUNG ADULTHOOD, MEDICAL, EDUCATION, AND SOCIAL SERVICES GAPS ANALYSIS				
	Service Provider(s)	Service Type	Population Served	Funding
MEDICAL CARE SECTOR				
1 T	Burchell High School and local Mat-Su Health Services	Primary care	Alternative high school students Area: Core	Federal and State funding
EDUCATION SECTOR				
1	Mat-Su College Health and Wellness Committee and Dragon Wellness activities	Wellness and Behavioral health activities and counseling	MSC students Area: Core	MSHF Grant
SOCIAL SERVICES SECTOR				
3	My House and community partners	Transitional Housing; BH counseling; Mediation; Assistance with food, clothing, job training.	High risk and homeless youth Area: Core	Grants, Private donors, revenue from non-profit coffee shop

1 Primary Prevention | 2 Secondary Prevention | 3 Teritiary Prevention | T Trauma Informed Care | N No Specific Prevention Orientation

Prevention during Young Adult Years: The prevention concepts described in the Youth Thrive model apply to the young adult age, as well as teenage years. Young adults need the same resilience, social connections, social emotional competence, and concrete supports in times of need as their teenage counterparts.

Young Adult Prevention Services in Mat-Su: Services are limited in Mat-Su for young adults in the areas of **primary and secondary prevention**. A targeted program for **tertiary prevention** is MyHouse, a non-profit organization located in Mat-Su with the mission "to provide safe shelter for homeless youth with a goal of connecting kids to a network of caring individuals and agencies able to assist them in becoming self-sufficient." MyHouse provides youth aged 14-24 years with the following assistance: food, clothing, shower and laundry services, public health care, mediation services, vocational assistance, legal issues and support, and referral for mental health and substance abuse treatment. They also provide transitional housing for homeless young adults. The male house has five beds and the female house has six beds. Each house has a case manager who assists the young adults who are required to work and pay rent while gaining rental experience and life skills. This housing is filled with a waiting list.

Most recently, MyHouse began offering substance abuse treatment in a partnership with the Cook Inlet Tribal Council. This is very important because as the social worker at the agency reports, this population is rarely able to access behavioral health care because they have no insurance or ability to pay for care, difficulties obtaining transportation, and, if there is a wait for services, they are transient and it is difficult for them to be notified by the agency when an appointment is available. Even if the youth (14-24 years) would qualify for Medicaid, they often don't have the necessary family assistance, identification, and vital records to apply. The "other supports" for this population are not in place to allow this group to access BH services. Additionally, providers may be reluctant to provide services to a minor if the parent or guardian has not given permission. The social worker

for MyHouse stated that many of the youth they serve are abandoned by their parents and/or have non-supportive parents from whom they can't get permission.

The BH professional at MyHouse reported numerous barriers due to youth not having parental support and lacking their birth certificates, school records, and other documentation. Children who would qualify for Medicaid are prohibited from getting this coverage because it is difficult and time-consuming to request the necessary records to apply. Since these youths are homeless and transient, they often are not in one place long enough to receive their records when they are sent from the state or schools.

Mat-Su youth who are 18 years old and aging out of the foster care system also may need additional support to be independent, find housing or work, or continue their education. One difficulty in providing this care is that the youth must agree to be in services and accept help. There is currently no provider who is tasked with assisting this population.

Mat-Su does not have a homeless shelter for youth and young adults. Currently, these individuals need to travel to Anchorage to access a Covenant House shelter. This may be difficult for some youth to leave the support system they have here, no matter how weak, to venture to a place where they know no one. Often youth and young adults want to stay connected to their Mat-Su-based school and friends instead of being displaced to Anchorage.

GAPS

The following areas for growth in young adult services were observed:

- More support services and housing for homeless and at risk youth and young adults.
- Immediate access to behavioral health services for homeless youth.
- Support for youth aging out of the foster care system to transition successfully into adulthood.
- An assessment and development of a policy/advocacy agenda to create structural changes in the system to allow young adults facing adversity to thrive.

Sector Analysis

Behavioral Health Sector

Reducing exposure to, and the effects of, ACEs can dramatically affect a child's short, medium and long-term physical, behavioral, and mental health. It is important to have behavioral health services that cater to all children to address trauma and other behavioral health issues as soon as possible and instruct parents in how to support and nurture their children through difficult experiences and resulting emotions and behaviors (**tertiary prevention)**. Data on treatment for mental health and substance abuse disorders are more limited for children and adolescents than for adults. Parents or other care providers may have difficulty identifying behavioral health disorders or helping children and adolescents access the right types of treatment. According to the National Comorbidity Survey Replication (NCS-R), the average time from onset of a mental health disorder, which many first experience during childhood or adolescence, to first receipt of treatment is nearly 10 years. This delay may lead to less effective treatment and poorer outcomes (Wang, Berglund, Olfson, Pincus, Wells, & Kessler, 2005).

In 2015, the MSHF along with McDowell Group and the Western Interstate Commission for Higher Education released a report that included a gap analysis of the behavioral health system that is available to Mat-Su residents. For a complete discussion about behavioral health services for children and adults in Mat-Su see the *Mat-Su Behavioral Health Environmental Scan – Report 2*.

Table 55. Behavioral Health – Child/Youth Behavioral Health Sector Gap Analysis

BEHAVIORAL HEALTH – CHILD/YOUTH BEHAVIORAL HEALTH SECTOR GAP ANALYSIS				
	Service Provider(s)	**Service Type**	**Population Served**	**Funding**
3	Providers (2)	Alcohol and Drug School providers	Wait time 2-3 weeks	Private Pay
3	Providers (11)	Outpatient services for Families	Formal family program has wait times of 4-6 months	Third party reimbursement; Private Pay State funding
3	Providers (4)	Outpatient medication management	Wait time 1-4 weeks	Third party reimbursement; Private Pay; State funding
3 T	General mental healthcare for children – 13 Providers Severe Emotional Disturbance – 6 providers	Outpatient Treatment Several provider organizations becoming trauma-informed	0-3 years (4 providers) Children 4-12 years (9 providers) Youth 13-18 years (11 providers) Waits range from no wait to 20 weeks. 3 providers becoming Trauma-Informed	Third party reimbursement; Private pay; State funding; sliding fee schedules
3 T	Providers (5)	Outpatient Youth Substance Use Disorder Treatment One provider becoming Trauma-informed	No wait time	Third party reimbursement; Private pay; State funding

1 Primary Prevention | 2 Secondary Prevention | 3 Teritiary Prevention | T Trauma Informed Care | N No Specific Prevention Orientation

Source: MSHF Survey of Providers, 2016. Providers are not mutually exclusive – they may be represented in several different categories.

GAPS

The following areas for growth in the behavioral health care sector that supports children and families were observed:

- Early childhood mental health care (0-3 years);
- Behavioral health counselors in the elementary schools;
- Integrated behavioral health and primary care
- Immediately accessible outpatient care for children;
- Crisis prevention and treatment services for children; and
- More family-oriented behavioral health services
- Provisions that if a wait list exists for any of these services that continuous follow-up occurs to ensure that crisis situations, at least, receive some form of services

Child Welfare Sector

The table below lists the primary service providers for child victims of maltreatment. The primary child welfare service providers are the Office of Children's Services (OCS) and the Office of Public Advocacy. OCS is the designated child protection agency for the state of Alaska. The agency's mission is to work "in partnership with

families and communities to support the well-being of Alaska's children and youth." Their website states that "Services will enhance families' capacities to give their children a healthy start, to provide them with safe and permanent homes, to maintain cultural connections and to help them realize their potential" (Office of Children Services, 2015). OCS provides child welfare activities focused on the goal of protecting children from harm. The provision of services includes performing risk assessments, developing case plans, and identifying services for children and families.

Any child involved with OCS is a candidate for referral to behavioral health services; however, they do not all receive services. Many children come in to the foster care system without being assessed for issues until behaviors arise. If there is no known history of trauma, they will probably go into regular foster care and/or with a relative. If they do well in that environment they may not need to be evaluated for behavioral health issues. However, if they start acting out at home or school there may be a decision to have them evaluated and to provide wrap around services or to place them in a higher level of care. Then they must identify if the behaviors are the result of early childhood trauma, prenatal exposure, family violence, etc. If there is a formal diagnosis at that point, there will be funds available for therapeutic services at a higher level of care in a therapeutic foster care setting.

There are 67 OCS employee positions at the Wasilla office – 35 Case Workers who are Protective Service Specialist employees and 32 other positions which include nurses, administrative officers, office assistants, mental health clinicians, etc. As of October 2016, due to vacancies the case loads of direct service workers are much higher than the optimal 15 case number. These workers' caseloads ranged from 43 cases to 51 cases. The frontline OCS workers visit every child and their parents involved with an open case at least once a month and provide referrals and aid where applicable. They conduct permanency planning to maintain the child in his/her own home whenever possible, and when it is not possible, the division will work to promote an alternate permanent home for the child. OCS works with local providers who provide supervised visitation and other services to parents and their children who have an open case. The OCS office in Wasilla has a significant number of staff positions that are open which creates a situation where the workers have large caseloads and face high levels of stress providing services. It is beyond the scope of this report to examine the functioning and outcomes of the OCS child protective and permanency services. However, this is a recommendation to ensure the adequate protection of Mat-Su children.

The Office of Public Advocacy advocates for abused and neglected children in protective proceedings. Guardian ad Litem's advocate for the best interests of abused and neglected children who are involved in the juvenile courts considering each child's age, maturity, culture and ethnicity, and public laws and policies regarding family preservation and timely permanency planning. This office operates the Court Appointed Special Advocate (CASA) programs that recruit, train, and supervise community volunteers to serve as advocates for foster youth. There is a Valley CASA office in Palmer. Every child in state custody has a paid advocate, but the paid advocates have high caseloads, particularly in the larger communities. The child to advocate ratio for a paid advocate can be as high as 100 to 1, while the CASA volunteer ratio average 3 to 1. Another advocacy service funded by the federal government is the Indian Child Welfare Act workers who ensure that the State makes active efforts to prevent removal of an Indian child from his or her parent or Indian custodian and work for reunification.

The Palmer Superior Court, with the support of community partners, is moving to adopt a Safe Babies Court. Abuse and neglect have been linked with serious developmental consequences for infants and toddlers. These

negative developmental consequences can be further perpetuated in a foster care system with infrequent visitation, multiple placement changes, and delays in achieving permanency. However, developmentally appropriate early intervention and child welfare policies can help infants and toddlers overcome the negative developmental consequences that stem from maltreatment. Safe Babies Court Teams aim to: increase awareness among those who work with maltreated infants and toddlers about the negative impact of abuse and neglect on very young children; and, change local systems to improve outcomes and prevent future court involvement in the lives of very young children. When parents are separated from their young children because of judicial intervention for child abuse and neglect, Safe Babies Court Teams Project steps in to take responsibility for the children to mitigate the potential impact on development. This is facilitated through a coordinator that comes to know the children, interacts on their behalf with the judge, and connects them with community resources, such as the care of a pediatrician and Early Head Start. This effort is advised by a community board composed of representatives from ZERO TO THREE, local courts, child and family advocates, non-profits, agencies, etc. The board actively searches for new community resources, evaluates existing resources, and identifies gaps in resources. If possible, the coordinator works to gradually reintegrate parents with their children. If that is not possible, then foster care seeks out a suitable foster family.

The Children's Place is a nonprofit organization that uses the Children Advocacy Centers (CAC) model. The purpose of a CAC is to provide a child-friendly, neutral facility where professionals from many agencies involved in the evaluation, investigation, and treatment of child abuse meet to coordinate and bring their services to children and families impacted by child abuse. The Children's Place provides evaluations for children up to age 18 who live in the Mat-Su Borough and outlying areas. Families and guardians must be pressing charges and seeking an investigation for their child to receive services. Services include: medical exams, resource and referral services for the non-offending parent to set up services, and family advocacy for up to a year post assault. Referrals are accepted from law enforcement (Alaska State Troopers/city police departments/FBI), the Office of Children's Services (OCS), and medical care providers.

There are several agencies that support families who are involved with OCS. These include the Alaska Center for Resource Families and Alaska Attachment and Bonding Associates which provide training, information, and resources to Alaska licensed foster parents, adoptive parents, relative caregivers and guardians. They are a private nonprofit grantee working in collaboration with the OCS, Tribes, and others. Both Chickaloon and Knik Tribes have Indian Child Welfare Workers who assist families with OCS cases involving Alaska Native and American Indian children. The Alaska Family Services Family Support and Preservation Program provides parenting workshops and in-home services designed to improve parenting skills, as well as providing supervised visitation. Additionally, Unified Families provides supervised visitation for OCS involved families. The Alaska Youth and Family Network, an Anchorage-based organization is currently setting up an office in Mat-Su and there are two peer workers who help OCS involved families navigate the behavioral health care system and find other services necessary for their family.

Table 56. Child Welfare Sector Gap Analysis

CHILD WELFARE SECTOR GAP ANALYSIS				
	Service Provider(s)	**Service Type**	**Population Served**	**Funding**
3	Office of Children's Services--Wasilla	Investigations of allegations of child maltreatment and placement of children in safe, permanent homes	All children - Services dependent on staffing – office is currently understaffed	State funding
3	Office of Public Advocacy	Advocates for maltreated children in protective proceedings	All children	Office of Public Advocacy
3 T	Children's Place	A multi-disciplinary team that investigates and supports child abuse victims and non-offending caregivers	Children with an open criminal justice case	Federal, State and Private funds
3	AFS – Family Support and Preservation	Parenting workshops and in-home services to keep children safe including supervised visitation	OCS involved families	State funding
3	Unified Families	Consultant providing supervised visitation	OCS involved families	State funding
3	Alaska Center for Resource Families	Training, support, case management and resources	Licensed foster/adoptive parents	State and private funding
3	AK Attachment and Bonding Associates	Training and advocacy for family attachments and bonding	Adoptive parents/ foster families	AK Attachment and Bonding Associates
3	Indian Child Welfare Act case workers and specialist	Assists in OCS cases to prevent removal of an Indian child from his or her parent or Indian custodian and work for reunification.	Chickaloon and Knik Tribes and Wasilla ICWA specialist	Federal and State funding
3	Alaska Youth and Family Network	Peer-run, peer-delivered services-support groups, navigation, parent coaching	OCS involved families	State and grant funding

1 Primary Prevention; 2 Secondary Prevention; 3 Teritiary Prevention; T Trauma Informed Care; N No Specific Prevention Orientation

GAPS

The following areas for growth the Child Welfare Sectors were observed:

- A full assessment and plan for improvement for the Mat-Su Office of Children Services (OCS), including workforce development and converting to a trauma-informed approach
- A more extensive system for all levels of visitation and family contact for families involved with OCS
- Support for all personnel who work with child maltreatment cases to prevent secondary trauma and support self-care
- Implement a Differential Response Program for low-risk families with a report of harm to the OCS to enhance the child welfare system and increase parents' voluntary engagement in services

Parent Support Sector

The Center for the Study of Social Policy describes the underpinning of strength-based parental support as: "A strength-based approach helps parents feel valued because they are acknowledged as knowledgeable and competent. This type of support is considered **primary prevention**. They develop a sense of self-confidence and self-efficacy because they have the opportunities to build their skills, experience success and provide help to others." Parents can be supported through a variety of means and on a variety of issues. Parents may need advice on parenting issues, as well as concrete services and assistance in times of need. Access to this support

must be accompanied by a quality of service coordination and delivery that is designed to preserve parent's dignity and to promote their and their family's healthy development, resilience and ability to advocate for and receive needed services and resources (Center for the Study of Social Policy, 2013) (Kessler et al., 2005). Further, as described in the prenatal and childhood sections, adults play a crucial role in the behavioral health and well-being of the next generation. Adults with a secure and supportive childhood and adolescence are best equipped to handle the challenges that emerge when they become parents.

Support services for parents in Mat-Su, include statewide and local services, as well as services focused on specific populations such as parents with children with developmental delays. The only **primary prevention** services are a statewide parenting support line sponsored by the Alaska Children's Trust and the HeartReach Pregnancy Center, a faith-based effort, which offers a parenting class focused on what to expect from pregnancy and early childhood. This program uses videos, worksheets, and pamphlets, and parent mentors. There are no other primary prevention efforts targeted on supporting all parents in Mat-Su.

There are at least two organizations in Mat-Su that are targeted at supporting parents of children with developmental delays: Mat-Su Services for Children and Adults and the Mat-Su LINKS Parent Resource Center. Beacon Hill, an Anchorage-based foster care and adoption support center, runs the Safe Families for Children Program in Mat-Su. This **secondary prevention** program is a movement of volunteers showing hospitality and opening their homes to children whose families are going through a crisis. That crisis could be homelessness, medical, substance abuse treatment or other stressors. The goal is to reach a family early on in crisis and connect them with social supports while providing the children a safe place and freeing up the parents to deal with their crisis without exposing the children to further trauma.

Table 57. Parent Support Sector Gaps Analysis

PARENT SUPPORT SECTOR GAPS ANALYSIS				
	Service Provider(s)	**Service Type**	**Population Served**	**Funding**
1	Alaska Children's Trust The Alaska Parent Line	Resource/Referral Parenting Support	General Population Unlimited Area: Mat-Su	Alaska Children's Trust
1	Mat-Su Services for Children and Adults (MSSCA)	Short Term Assistance and Referral Program (STAR) (DD) Resource/Referral	Children with Developmental Delays Area: Core area	Medicaid, United Way, third party reimbursement, sliding fee scale, grants
1	Mat-Su LINKS Community Parent Resource Center	Resource/Referral and training to increase parental knowledge, advocacy, and participation in child's education	Children with Developmental Delays Area: Core area	State/Federal Funding
2	Beacon Hill - Safe Families (Faith-based)	Short-term child hosting to support parents; family coaching	Families experiencing crisis such as unemployment, substance abuse, financial problems, or homelessness.	Private funding
2	Heart Reach Pregnancy Center (Faith-based)	Parenting classes, referrals for adoption to Catholic social services, diaper, formula, clothing distribution	General population Area: located in Wasilla	Private, church and business donors

1 Primary Prevention 2 Secondary Prevention 3 Teritiary Prevention T Trauma Informed Care N No Specific Prevention Orientation

GAPS

The following areas for growth in parent support services were observed:

- More home visiting programs, including those for single fathers
- Expand parent training classes to a wider group of parents and more of them, beyond families at-risk
- Create a voluntary peer parent support program accessible to parents with an open Office of Children's Services case or Child in Need of Aid court case
- Create a community-wide peer parent support program for all parents

Concrete Support in Times of Need Sector

There are basic necessities that every family and child needs to survive – healthy food, safe and quality housing, medical and behavioral health care, income, legal services, etc. Families may need this at any time due to a crisis, losing one's job, a substance abuse condition, divorce, etc. Many people are reluctant to seek services or accept a hand out. Residents should be educated that there are these services, and it is necessary sometimes to seek out help and support. The community culture reinforced by strength-based family and child-serving programs can impress on parents that seeking help is not a sign of weakness or failure as a parent, rather, seeking help is a part of resilience and self-advocacy. The programs that provide concrete support in times of need can provide their services in a way that doesn't increase stress. The Strengthening Families Approach proposes the following tenants related to providing services:

- Trusting relationships between parents and service providers are essential;
- All parents, regardless of their current situation, or past, have assets and competencies within and around them, their family and their community that can be identified and called upon;
- Parents must be active participants and not just passively receive services;
- Provision of service navigation and education on the network of services may be necessary at first before a parent independently negotiates the services system
- There are structural inequities that affect each parent's current conditions that service providers must understand and work to change.

Although a parent may have the skills needed to seek formal help, the services may not be available or easily accessible due to a lack of resources, location of services, services that are poorly coordinated, and unaffordable (Center for the Study of Social Policy, 2013).

Life stress such as financial stress, discrimination, and instable housing can exacerbate unhealthy coping mechanisms and create a dysfunctional home. Formal and informal community supports can be instrumental in assisting with these types of stressors. Research has shown that stable housing for children reduces the chance of exposure to other risk factors such as ACEs and reduces the need for school support. Children with stable housing have lower rates of emotional, behavioral, cognitive, and mental health issues later in life. They are also much less likely to drop out of school. Lack of access to nutritious food (quantity and quality) is linked with negative impacts on mental and Behavioral Health, such as aggression, anxiety, and social withdrawal. Children who grow up in households with adequate financial resources are at a lower risk for mental and behavioral problems later in life.

There are two main income-related, State-sponsored support programs for families – Alaska Family Services (AFS) Family First Work Services and AK Temporary Assistance Program. These programs assist low-income families with temporary support and the development of plans for self-sufficiency. As mentioned earlier in this chapter there are several Federally Qualified Health Centers throughout the borough that provide medical care on a sliding-fee schedule and to families with Medicaid. Further, Denali Kid Care provides Medicaid coverage for income eligible children and families. In 2015, there were 11,084 children covered by this insurance (State of Alaska Health and Human Services).

There are several programs that provide food assistance such as the Women's Infant and Children's Program; the Supplemental Nutrition, Assistance Program; food pantries; and child food programs. Mat-Su shelter programs include one focused on domestic violence, an emergency shelter program for families uses local churches for housing, and Knik House, a temporary housing program for men, women, and single parents. Valley Residential Services and other partners provide a homeless prevention program and seek to house residents in affordable housing.

Finally, the Families in Transition (FIT) Program is a program through the school district focused on supporting families in need. FIT is a part of the MSBSD's Title I Program, which provides services throughout the district to children and youth in transition. The goal of FIT is to promote school stability and academic success for students experiencing homelessness. For the purposes of eligibility for FIT services, homelessness is defined as lacking a fixed, adequate, and regular nighttime residence. This may include a child who is homeless with his or her family or an unaccompanied youth who meets the eligibility criteria. Families are referred to the FIT program through contacts in each school, such as the school nurse and school principal. Families that qualify for FIT may be eligible for: transportation assistance to and from school; remaining in same school for duration of school year; educational assistance, including credit recovery; tutoring programs; and referrals to school sponsored academic support; admission to early childhood programs and referrals to preschool programs; assistance with school enrollment; enrollment in MSBSD's free meal program; referrals to community agencies; access to traditional and non-traditional school supplies; and child and family advocacy. Along with the FIT coordinator, the MSBSD employs two FIT Advocates, one in Burchell High School and one in Palmer Junior Middle School. The family advocates and FIT coordinator work with families to ensure that a lack of basic resources does not become an educational barrier to students.

Table 58. Concrete Support in Times of Need Sector Gap Analysis

CONCRETE SUPPORT IN TIMES OF NEED SECTOR GAP ANALYSIS				
	Service Provider(s)	**Service Type**	**Population Served**	**Funding**
INCOME ASSISTANCE				
2	Alaska Family Services-Family First Work Services	Case management to help families develop plans for self-sufficiency	Low income families Core area office	Federal
2	Division of Public Assistance Temporary Assistance Program	Cash assistance to work towards self-sufficiency	Low income families Core area office	Federal
MEDICAL ASSISTANCE				
2	Federally Qualified Health Centers	Medical and behavioral health care	All residents Talkeetna, Willow, Sutton, Wasilla	Federal, State, private grant
2	Denali Kid Care/Medicaid	Insurance	Low-income residents, children and pregnant women	Federal and State
FOOD AND CLOTHING ASSISTANCE				
2	Blood n Fire Ministries	Food and clothing pantry	All residents Area: Meadow Lakes	Private donors/ grants
2	Frontline Mission	Food, clothing, showers	All residents Area: Wasilla	
2	Division of Public Assistance	WIC Supplemental Food Program Farmer's Market Programs	Low-income residents Core area and Joint-Base Elmendorf (WIC) offices	Federal and State Funds
2	Food pantry and distribution programs	Food for individuals and families and child food programs	Low-income residents Area: Mat-Su	Federal, state, private
DOMESTIC VIOLENCE AND HOMELESSNESS AND HOUSING ASSISTANCE				
2	Family Promise	Emergency shelter (15 beds) in local churches – 30 days with job placement support	Families without BH issues Core area housing Availability varies	Federal and private grants and donors
2	Knik House	Temporary housing for families, men, women, single parents (beds)	Families, men, women, and single parents Often waiting list	Federal, state, private, grants
2	Valley Residential Services	Affordable housing	Low income families and adults Area: Mat-Su	Federal, State, Private funding
2	MSBSD Families in Transition	To support stability for students experiencing homelessness	FIT coordinator and 2 family advocates work with families Area: Mat-Su	Federal Funding
3	MyHouse	Transitional Housing for Young Adults	Limited # of beds Often waiting list	Federal and private funds
3 T	AFS Shelter and WRAP Program	Crisis line, counseling, support, groups, advocacy, and training, shelter (32 beds)	All residents Core area housing	Federal, State and private funds

1 Primary Prevention 2 Secondary Prevention 3 Teritiary Prevention T Trauma Informed Care N No Specific Prevention Orientation

GAPS

The following areas for growth in concrete services in times of needs for families were observed:

- Create a more connected network of concrete support service providers that has a culture of serving families in a way that maintains their dignity and promotes resilience and self-advocacy.

- Increase concrete support in times of need in the following areas
    - More housing options for homeless teens and families
    - Transportation for teens and families to access needed services and work
    - More support services for homeless and at-risk youth and young adults

Community Analysis

Collaborative Groups and Community Organizing

A key ingredient in creating a community system that keeps all children well-cared-for and safe includes community members, professionals, organizations, and other entities working together to solve problems and develop supports and changes in the way sectors operate that support families. Porter et al labels this type of community a "self-healing" community and describes the partners, principles, and process that contribute to success.

Partners are defined as community members, services providers, funders, and external partners, such as subject matter experts. These partners work to create cultural change in the community. The way these partners interact is key and is led by local leaders who work with the whole community to unite many different sectors (i.e. education, health care, and business) toward one purpose. There are key features of these partners that help to ensure success in working together. The Partners:

- Put personal agendas aside and focus on the common good;
- Serve as a core team and have a paid coordinator or facilitator;
- Take advantage of opportunities (state and local policy, funding, for learning)
- Educate themselves and the community on the latest data, research, stories on the issue
- Educate themselves on team management, public, political and funder accountability, data analysis, and translating the meaning of data, evaluation and systems thinking;
- Welcome external partners assisting with financial support and training.

The key principles that drive a successful self-healing community are:

1. Leadership listens and reports back to the most affected community residents
2. Groups continually learn about the latest research and successful practices and use this knowledge to address an issue. Results are reflected upon.
3. Partners are continually reaching out to new sectors and people to work on solutions.
4. The work is informed by the latest research in neuroscience, epigenetics, ACEs and resilience research and best-practices.
5. All solutions are adapted to fit the community in terms of size, culture, etc.
6. All work is strength-based and focused on positive movement and celebrating success.

The characteristics of this type of process that are key to success are:

1. **Leadership expansion** – Through various phases there is an expansion of the number and types of people participating, representing different professional disciplines, and different sectors of the community.

2. **Development of a focused shared understanding** – As community people work on various initiatives, a greater shared understanding emerges on the root causes of problems, what it takes to increase resilience and greater agreement on strategies.
3. **Iterative cycle of learning** – Community members gather periodically to assess progress and examine what group of efforts are complementary and mutually reinforcing, what new efforts are needed.
4. **Results are frequently reviewed** – Data are collected and reviewed to check on desired outcomes of efforts, in a developmental evaluation approach, so that modifications can be made in initiatives, practices and strategies.

Data are used to describe the journey undertaken, which reinforces a common identity and commitment. This often helps attract leaders from different community sectors, makes for greater focus, shared among more partners, leads to more learning, deeper insights from exchange of experiences, which helps implement more effective practices leading to better outcomes. Success in one component often invites success in the next. The four components constitute a self-reinforcing cycle. The following chart, visually presents the four components and the cycle.

Mat-Su is a community with a myriad of coalitions, councils, and groups working in a collaborative way on community issues. A 2013 gathering brought together 16 of these coalitions, and since that gathering there have been several more created. Many of the coalitions and taskforces that exist relate to supporting children and families.

Table 59. Mat-Su Collaborative Groups and Community Organizing Gap Analysis

MAT-SU COLLABORATIVE GROUPS AND COMMUNITY ORGANIZING GAP ANALYSIS		
	Collaborative Focus	**Population Served**
	CHILD, YOUTH, AND FAMILY FOCUSED	
1	Early Childhood Partnership	United Way Mat-Su CCS Early Learning
1	THRIVE Mat-Su	United Way Mat-Su
1	R.O.C.K Mat-Su	Mat-Su Health Foundation
3	Community Justice Coalition	Division of Juvenile Justice and others
3	Domestic Violence/Sexual Assault Task Force	Alaska Family Services
	COMMUNITY ORGANIZING	
1	Valley Christian Coalition – Congregation-Based Community Organizing	Valley Christian Coalition
	COMMUNITY-WIDE EDUCATIONAL CAMPAIGNS	
1	Green Dot Trainings	MyHouse
1	ACE Interface Trainers	R.O.C.K. Mat-Su
3	Mental Health First Aid Training for First Responders	Crisis Intervention Team Coalition

1 Primary Prevention; 2 Secondary Prevention; 3 Teritiary Prevention; T Trauma Informed Care; N No Specific Prevention Orientation

Collaborative Groups

The three groups that are focused on children and parents are the Early Childhood Partnership, THRIVE Mat-Su, and R.O.C.K. Mat-Su. The Early Childhood Partnership hosts the Mat-SuFamilies.org website which is intended to help families in the area find information related to parenting, health, early learning, child care, families, and recreation **(primary prevention)**. The Partnership is focused on engaging families and involving them in young children's learning, fostering community recognition of the importance and value of early childhood educations, providing resources to providers, and early child care teachers. The Partnership sponsored an early childhood educator's conference in 2016 and they award "Golden Apple Awards" annually to outstanding early childhood teacher, daycare facility and champion for kids, as well as the best Family Friendly Business.

THRIVE Mat-Su was started in 2006 by the United Way of Mat-Su. The coalition has a long history of working with other community partners to hold events, such as prescription drug take back days, coordinating youth leadership and youth-led events and sponsoring youth to attend youth trainings and events outside of Mat-Su. The coalition has sponsored Block Parties focused on providing neighborhoods with substance-free parties for all ages. Additionally, they have been intricately involved in collaborating on a youth-focused positive social norms campaign with the Alaska Wellness Coalition.

THRIVE Mat-Su receives both State and Federal funding and uses the Substance Abuse and Mental Health Administration (SAMSHA) Strategic Prevention Framework (SPF) as a planning process for preventing substance use and misuse (**primary prevention**). Their vision is a community where individuals thrive in an environment that supports healthy choices regarding substance abuse and their mission is to lead a data-driven coordinated community response to prevent and reduce youth substance use. They focus on youth ages 12-20 years and track abuse of alcohol, marijuana, prescriptions drugs, and tobacco. To accomplish their mission, they believe that the personal beliefs about alcohol and drugs held by youth and adults must change; that youth should spend more time in safe and supportive spaces; and that it is important to expand the number of positive adult and peer relationships that youth must build youth resilience. Information on THRIVE's history, the logic model and strategic plan can be found in Appendix G.

R.O.C.K. Mat-Su is a cross-sector collaborative which is working to strengthen families so all children are safe, healthy, and thriving and to end child abuse and neglect, and reduce other adverse childhood experiences. R.O.C.K.'s objectives for their **primary prevention** work are based on the Strengthening Families Framework:

- Parents, communities and systems understand child development, parenting and resilience;
- Child and youth develop social and emotional skills;
- Children and families meet their basic needs
- Parents have strong social supports
- Educate and connect families to supports
- Prevent child maltreatment and repeat maltreatment

Formed in 2015, R.O.C.K. Mat-Su is currently working on a set of strategies that include:

- Training and coordinating Mat-Su community members to become ACE Interface trainers;[14]
- Partnering with the Palmer Superior Court and community providers and the Child in Need of Aid court team, and the District Attorney's office to bring a Safe Babies Court to Mat-Su.[15]
- Advocating to increase the availability of supervised visitation for Mat-Su families with children in foster care;
- Partnering with the Mat-Su Borough School District to support an initial cohort of five trauma-informed schools in the 2016-2017 school year;
- Co-sponsoring a trauma-informed organization cohort of five local organizations.

R.O.C.K Mat-Su is similar to the Washington Family Policy Councils and appears to be at the "Thriving" stage of development. A full description of the development of R.O.C.K. and a discussion of the collaborative from the perspective of a "self-healing community" can be found in Appendix H. The collaborative is part of a functioning cross-community learning cohort with the Southern Kenai Peninsula's Mobilizing for Action through Planning and Partnership (MAPP) which is working to become a trauma-informed community with increased family resilience and decreased child maltreatment. R.O.C.K Mat-Su is also part of the Heath Federation of Philadelphia and the Robert Wood Johnson Foundation Mobilizing Action for Resilient Communities (MARC) initiative. MARC is a learning collaborative of 14 communities across the country that are actively engaged in building the movement for a just, healthy and resilient world. The Alaska Children's Trust is the convener of the Alaska Resilience Initiative, which formed in 2012 to advance the dialogue in Alaska on brain architecture, Adverse Childhood Experiences (ACEs), and how communities can prevent ACEs and build resilience. This statewide network is funded as a MARC grantee to work with a local network in the South Kenai Peninsula and R.O.C.K. Mat-Su as pilot community efforts to build a movement in Alaska. As a MARC pilot community R.O.C.K. Mat-Su is helping to: strengthen a statewide network working to identify and implement systems changes; test strategies to reduce child trauma; increase knowledge and awareness of brain architecture; ACEs; resilience and, build trauma-informed systems; communities and organizations; and share our community experience with other Alaskan communities looking to implement a coordinated community response to child maltreatment prevention.

Finally, R.O.C.K. Mat-Su has also leveraged funding through their work with the State of Alaska Early Childhood Comprehensive Systems (ECCS) Program. In FY 2015, and again in 2016, the ECCS program set aside money to fund Collective Impact activities in Mat-Su to: *improve developmental trajectories for infants and young children by fostering safe and nurturing relationships and mitigating the effects of toxic stress and trauma.*

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[14] In 2014, eight Mat-Su residents attended an ACE Interface Train the Trainer training provided by Dr. Anda and Laura Porter, the creators of ACE Interface. Those eight trainers soon became overwhelmed with requests for trainings, requiring a second cohort of trainers. In January of 2016, 32 additional Mat-Su community members participated in an ACE Interface Trainer training. This second cohort of trainers included medical professionals, school staff, tribal partners, early childhood educators, and volunteers representing parenting and homeless youth service providers. Both cohorts of ACE Interface trainers are now working to educate community members on neurodevelopment, the impact of trauma on developing brains and the hope of resilience for those who have experienced trauma. As of April 2016, 30 ACE Interface trainings have been conducted in Mat-Su, with 553 community members trained. Additional primary prevention strategies will be adopted in 2016.

[15] Safe Babies Court Teams aim to: increase awareness among those who work with maltreated infants and toddlers about the negative impact of abuse and neglect on very young children; and, change local systems to improve outcomes and prevent future court involvement in the lives of very young children. The Safe Babies Court Team approach is a community engagement and systems-change model focused on improving how the courts, child welfare agencies, and related child-serving organizations work together, share information, and expedite services for children ages 0 – 3 years old in the child welfare system.

COMMUNITY ORGANIZING

The major community organizing initiative in Mat-Su is sponsored by the Valley Christian Coalition – Congregant-Based Community Organizing initiative. VCC-CBCO has 11 member congregations in the Mat-Su Borough. Three congregations have formed "local organizing ministries" or LOM's. These LOM's are trained to conduct a listening campaign in their church and communities for building relationships, develop leaders and surface local concerns and issues that directly impact the lives of parishioners.

St. David's LOM has conducted over 80 one-to-one visits with families and have surfaced concerns of safety and need for green space in the Williwaw Subdivision in Wasilla (which parishioners are residents), substance abuse (particularly heroin) in the borough and a lack of treatment options, and a need for safe and affordable housing. St. David's held a candidate forum on Oct. 24, 2016, where leaders gave personal testimony regarding these issues in their questions to the candidates. The LOM will follow up with legislators in the coming months to seek solutions.

St. Michael's LOM has conducted their first few rounds of one-to-one visits (30 visits with families to date) and have surfaced issues around "isolation." Seniors and young families are feeling isolated for a variety of reasons and it is too early in the campaign to note a trend or specific form this is taking.

Trinity's LOM is has recently identified their congregation's most critical and immediate concern as affordable housing; after nearly 100 one-to-one visits with families. Several members have become homeless or are in temporary housing since the LOM formed in February 2016. This affects the entire church as they struggle to help meet needs of their parishioners in a small, 60-member church. They are doing research currently and a public meeting is projected for Spring 2017.

Sacred Heart Catholic Church and Catholic Native Ministries will begin the process of forming a local organizing ministry in Spring 2017. To date, VCC-CBCO staff, clergy and congregation members have visited with over 300 families, seniors and individuals living in the greater Palmer and Wasilla areas.

COMMUNITY-WIDE INITIATIVES

There are three community-wide educational initiatives that focus on prevention:

- Green Dot: MyHouse has recently sponsored a training in this violence prevention approach and Alaska Family Services has staff trained, as well. This approach is based on the belief that individual safety is a community responsibility and shifts the lens away from victims/perpetrators and onto bystanders. The overarching goal is to mobilize a force of engaged and proactive bystanders. For more information see https://www.livethegreendot.com/gd_overview.html.
- ACE Interface Trainers: In Mat-Su, over 40 residents have been trained through the ACE Interface Training Program to be able to deliver 1 hour to half day trainings on ACEs and resilience science, and promote understanding and application of the science to improve health and wellbeing across the lifespan. For more information see http://www.aceinterface.com/MTE.html.
- Mental Health First Aid Training: This is an 8-hour course that teaches you how to identify, understand and respond to signs of mental illnesses and substance use disorders. Three types of this training have been offered in Mat-Su. The Crisis Intervention Team Coalition, a coalition of first responders, has made a concerted effort to get all first responders, including law enforcement, emergency medical technicians,

court personnel, and emergency department staff trained. As of October 2016, 120 professionals had been trained. Additionally, as part of a federal AWARE grant, this training has been offered to school personnel. Finally, the United Way and other organizations have sponsored this training for community residents and professionals.

GAPS

The following areas for growth in community initiatives were observed:

- Develop media campaigns and workplace training addressing health promotion, primary prevention, trauma-informed programs, and ACEs.
- Explore a process for Mat-Su coalitions (such as THRIVE Mat-Su, ROCK Mat-Su, Homeless Coalition, etc.) to communicate and possibly leverage efforts. One possible strategy is the creation of a network map of all people, agencies, and programs involved in all initiatives and coalitions.
- Utilize community organizing to identify and unify parent leaders to create community driven solutions to family issues.
- Increase community gatherings in public spaces to reduce parent and family isolation.
- Develop a volunteer hub to connect community residents with other residents with needs and organizations with needs to increase social connectedness in Mat-Su.

There are several System Reform Recommendations that pertain to more than one or all the sectors that were discussed in this chapter that are supported by the information that was presented.

GAPS

The following areas for growth in the "system" were observed:

- Increase access to information and existing programs through a central resource center which is available via phone, internet, and in-person to provide information and referral, and navigation, as needed, to families, referrers, and providers.
- Support the adoption and adaptation of existing national models of prevention to the Alaska and Mat-Su context.
- Take to scale prevention strategies that have proven successful in the community so they are accessible to all families that can benefit from them.
- Adopt a balanced view of prevention, equally emphasizing health promotion and primary prevention, as well as secondary and tertiary prevention.
- Implement trauma-informed policies throughout social service agencies, medical care providers, and schools.

Developing and maintains prevention-oriented organizations, sectors, and initiatives in a community is a complex ever evolving process. State policy and requirements shape the actions of local organizations and state and federal funding is crucial for the formation of most programs and initiatives. The next chapter will examine state policy and funding through a prevention lens.

Chapter 5: State Policy and Funding Assessment

State of Alaska Prevention Policies

The State of Alaska has also adopted some recent prevention policy initiatives as highlighted below.

State Agency Workgroup on Prevention

In 2013, the Council on Domestic Violence and Sexual Assault established the State Agency Workgroup on Prevention with subject matter experts from the Alaska DHSS, Public Safety, and Education and Early Development. The Workgroup:

- Identified opportunities for joint projects, grants and training.
- Recognized areas of common ground across disciplines.
- Clarified unique areas of prevention work that require concentrated focus.

In state fiscal year 2015, the interdisciplinary group developed a document titled: *Investing in Prevention: Working Together in Early Childhood for Healthy Alaskan Children, Families, and Communities*.[16] The document outlines four recommendations for shared prevention priorities and strategies for constructing the foundation for healthy communities. The four priority areas are:

1. Support for quality early childhood programs – Investing in high quality early childhood education is essential to the economic development of Alaska. The State of Alaska's policy supports programs like Head Start, Early Head Start, Parents as Teachers, Pre-Kindergarten, and other quality child care programs.

2. Ensure access to health care including behavioral health care – Comprehensive health care services provide opportunities for preventing and identifying adverse experiences and the resulting poor health outcomes. Children should have regular check-ups with comprehensive screening for developmental delays, social and economic concerns, and exposure to high-risk environments. Pregnant women and new parents should receive screening for depression, domestic violence, and substance abuse. Regular visits should provide information about healthy relationships and the health effects of victimization. Parents should receive anticipatory guidance on child development and information about the effects of interpersonal violence and other adverse experiences on children.

3. Strengthen capacity for social emotional learning (SEL) throughout Alaska's schools – Social-emotional competencies involve skills that enable children to calm themselves when angry, initiate friendships and resolve conflicts respectfully, make ethical and safe choices, and contribute constructively to their community.

4. Maintain and expand prevention efforts that have proven to be effective – Collaborative prevention efforts increase opportunities to leverage funding streams and provide additional infrastructure for collaboration. Successful community-led efforts should be supported with technical assistance and information on practice-informed and evidence-based practices.

[16] http://dhss.alaska.gov/abada/ace-ak/Documents/State_Interagency_Prevention_2015.pdf

Alaska Safe Children's Act

During the 2015 Legislature, a variant of Bree's Law and Erin's Law were combined into the Alaska Safe Children's Act (HB 44). Bree's Law-named after Breeanna Moore, a 20-year old Anchorage resident who was killed by her abusive boyfriend-sought to mandate dating violence education in Alaska's public middle and high schools. Erin's Law, named after Erin Merryn, an advocate for sexual abuse victims who had been sexually abused herself as a young child, mandates sexual-assault prevention education (Kindergarten through 12th Grade).

The Alaska Safe Children's Act was expanded beyond these provisions for dating-violence and sexual-assault prevention education in Alaska's public schools to include provisions for training of school district personnel to recognize and report child abuse, neglect, and sexual abuse of a minor, as well as suicide awareness and prevention training for teachers, administrators, counselors, and specialists who work with students in grades seven through 12.

The Act also created a 10-member Safe Children's Act Task Force that provided recommendations to the Department of Education and Early Development on June 30, 2016, of model curricula for use by school districts, including:

- Suicide prevention training (for school staff), such as Connect Suicide, Youth Mental Health First Aid (currently used in the MSBSD), Alaska Gatekeeper, safe TALK, and others.
- Sexual abuse and sexual assault awareness training and prevention (school staff and students K-12), such as Fourth R Healthy Relationships, Speak Up Be Safe, Safer Smarter Kids, The Great Body Shop, and others.
- Dating violence and abuse awareness training and prevention (school staff and students grades 7-12), such as Safe DATEs, Second Step, The Great Body Shop, Fourth R Healthy Relationships, and others.
- Alcohol and drug-related disabilities training (school staff), such as Green Dot.
- Alcohol and drug abuse education (for students K-12), such as Lifeskills Training, Lions Quest Grades, Positive Action, Project Toward No Drug Abuse, Too Good for Drugs, and others.

The Task Force made other recommendations, including:

- Posting toll-free numbers in schools to report child abuse or neglect
- Development of an eLearning module for teacher training on trauma and ACES, resiliency and communication planning
- Sustainable funding for supporting Alaska Safe Children's Act
- Coordination with agencies within the community that provide domestic violence and sexual assault victim services.[17]

While no cost benefit analysis exists for Alaska's prevention programs, studies conducted in other jurisdictions suggest that preventive interventions provide substantial short-term and longer-term economic benefits that extend beyond the individual patient. Some interventions that occur in life may continue to produce benefits throughout a program participant's lifetime. These benefits can be "measured both in terms of economic costs (such as reduction in crime-related costs) and in positive, quality-of-life terms (such as higher employability)

[17] http://www.alaskachildrenstrust.org/sites/g/files/g1501096/f/201606/ASCATF.pdf

that can consider the long-term contributions a child can make to the community as a fully productive adult" (SAMHSA, 2007).

State of Alaska Grant Funding

Report 2 – The System of Care provides an overview of SFY2015 statewide funding for behavioral health services, including Medicaid, federal block grants, and state-funded grants. Below are highlights of state funding for programs that support early intervention and prevention of behavioral health issues and promote well-being in the Mat-Su Borough.

Department of Health and Social Services

The State of Alaska Department of Health and Social Services makes grants that support early intervention and prevention, and promote well-being. Below is a summary of grants that funded programs in the Mat-Su Borough during State Fiscal Year 2015. In all, approximately $7.6 million, or about 13 percent of DHSS grant program funding statewide (excluding programs funded to support seniors), funneled through the Mat-Su Borough. Mat-Su Borough residents (excluding seniors age 65+) represent 14 percent of Alaska's population. Each Mat-Su resident (under age 65) received $84.90 in behavioral health prevention grant funding. Statewide (not counting the Mat-Su Borough), the average was approximately $86.61 per Alaskan under age 65.

(See tables next pages.)

Table 60. Summary of State of Alaska DHSS Prevention Grant Programs, Mat-Su Borough, SFY 2015

Program	Description	Mat-Su Award
Behavioral Health Community Action Prevention and Intervention		
Alcohol Safety Action Program	Case management for adults and juveniles who have current or pending substance abuse related misdemeanor criminal cases. Services include screening, referral, and monitoring of offenders, to ensure required substance abuse education or treatment programs are completed as prescribed by the courts.	$155,000
Comprehensive Behavioral Health Prevention and Early Intervention Services	Assist and support efforts to reduce and prevent substance use and abuse, suicide and self-destructive behavior; strategies will be comprehensive, integrated prevention and early prevention approaches. Overall, the goal of these grant funds is to "promote healthy communities utilizing effective practices and partnerships to reduce risk factors and the harmful consequences of substance and poor mental health, and to promote protective factors to empower local communities to create population-level change in behavioral health conditions.	$260,960
Rural Human Service System	This program offers grants to rural substance abuse, mental health, BH, and human services agencies, and to urban agencies serving people who have relocated from rural areas.	$148,703*
Substance Abuse Treatment for OCS Engaged Parents	To provide clinical treatment and recovery services to OCS engaged parents.	$225,220
Therapeutic Court	Under the Therapeutic Court Program, agencies provide a range of services integrating behavioral treatment, sanctions, and incentives with case processing.	$150,146
Finance Management Services		
Human Services Community Matching Grants	These funds provide essential human services whose unavailability would subject persons needing the services to serious mental or physical hardship.	$345,223
Juvenile Justice		
Youth Courts	Services include case screening, adjudication, disposition, and case management for non-violent first or second time misdemeanor offenses and/or status offenses.	$55,300
Office of Children's Services		
Children's Advocacy Centers	Children's Advocacy Centers provide a coordinated, child-centered response to child abuse cases, ensuring children are not further victimized by systems designed to protect them.	$236,639
Community-Based Support Services to Promote Safe Children, Strong Families	These services are designed to help families and children who are at risk of out-of-home placement and/or children who are in out-of-home placement needing services to reunify with their families.	$445,000
Early Intervention for Young Children	Establishment or continuation of early childhood mental health consultation systems to early care and learning programs and learning networks.	$200,000*
Early Intervention/Infant Learning Program	Provide early intervention services to families of infants and toddlers with disabilities or developmental delays to ensure improved outcomes and the development of natural supports for children and their families.	$598,000

Program	Description	Mat-Su Award
Office of Children's Services (cont'd)		
Family Support	Community-based services that promote the safety and well-being of children and families. The focus of the program is on primary and secondary prevention for young parents and families with children age birth to 10 years, and families who have a member who experiences a disability.	$51,644
Mentorship for Independent Living	Mentors will work with foster youth both in and out of OCS custody, supporting their individual needs as described in their personalized case plans as they transition out of foster care.	$7,000*
Public Assistance		
Child Care Assistance	Services are provided for low-moderate income eligible families, enabling parents to attain self-sufficiency by subsidizing the cost of child care.	$786,954
Families First Work Services	Services are provided to ATAP applicants and recipients to support them in increasing their self-sufficiency, work readiness, and attaining employment.	$1,337,496
Special Supplemental Nutrition Program for Women, Infants and Children (WIC)	Provides nutrition, assessment services, nutrition education, breastfeeding guidance and support, free supplemental foods that contain key nutrients often lacking in the diets of the target population, and referral for health and social services.	$700,000*
Transportation Services	Provides transportation supports to DPA ATAP clients who need the service to pursue work and other activities that help them toward self-sufficiency.	$75,000
Public Health		
Children's Health Improvement Program Reauthorization Act	Testing measures of quality of care, demonstrating patient care models, and implementing electronic health records, targeting children and youth age 0-18.	$93,750*
Non-Marital Pregnancy Prevention	Project designed to education providers and young men and women about the prevention of non-marital pregnancies using abstinence primary messages as appropriate, targeting young women aged, 15-29 years.	$75,000
Obesity Prevention and Control K-12	Supports high-quality physical education in schools, increased daily physical activity for students, and improve the school nutrition environment.	$150,000
Tobacco Prevention and Control	Programs to prevent initiation of tobacco use among youth, eliminate exposure to secondhand smoke, promote tobacco cessation among youth and adults, & identify and eliminate tobacco-related disparities.	$300,000
Senior and Disabilities Services		
Community Developmental Disabilities	Addresses needs of individuals with developmental disabilities for "habilitation", which is the acquisition and maintenance of skills to live with independence and improved capacity, and to minimize institutionalization and provide care in the local community.	$950,000
Short-Term Assistance	Provides information and assists individuals who experience developmental disabilities and their families in accessing information about existing services, as needed.	$85,000
Traumatic and Acquired Brain Injury Mini-Grant	Mini-grants allow the eligible individual to access medical, dental, and behavioral training services to implement compensatory strategies for cognitive disabilities	$200,000
Total		**$7,632,035**

* Indicates estimated portion expended in the Mat-Su Borough.
Source: DHSS, *Fiscal Year 2015 Operating Grants*.

Table 61. Summary of Per Capita Spending, State of Alaska DHSS Prevention Grant Funding Awards, Alaska and Mat-Su Borough, SFY 2015

Program	Total Grant Value	Mat-Su Portion	Mat-Su Grantee	Rest of State Per Capita Spending	Mat-Su Per Capita Spending	Difference in Per Capita Spending
Behavioral Health						
Alcohol Safety Action Program	$1,281,500	$155,000	Alaska Family Services	$1.97	$1.72	($0.24)
Comprehensive Prevention	$3,814,074	$260,960	Boys & Girls Clubs of Southcentral Alaska (THRIVE)	$6.20	$2.90	($3.30)
Rural Human Services System	$1,838,765	$148,703*	CITC	$2.95	$1.65	($1.30)
Substance Abuse Treatment for OCS Engaged Parents	$225,220	$225,220	Akeela	$0.00	$2.51	$2.51
Therapeutic Court	$685,325	$150,146	Daybreak, Inc.	$0.93	$1.67	$0.74
Finance Services						
Human Services Community Matching Grants	$1,785,300	$345,223	Mat-Su Borough	$2.51	$3.84	$1.33
Juvenile Justice						
Youth Courts	$449,325	$55,300	City of Wasilla	$0.69	$0.62	($0.07)
Office of Children's Services						
Children's Advocacy Centers	$2,938,398	$236,639	Matanuska Community Health Care Inc.	$4.72	$2.63	($2.08)
Community-Based Support Services to Promote Safe Children, Strong Families	$1,866,803	$445,000	Alaska Family Services	$2.48	$4.95	$2.47
Early Intervention for Young Children	$419,900	$200,000*	Anchorage Community Mental Health Services	$0.38	$2.22	$1.84
Early Intervention/Infant Learning Program	$9,469,200	$598,000	Mat-Su Services for Children & Adults	$15.49	$6.65	($8.83)
Family Support	$519,764	$51,644	Alaska Family Services	$0.82	$0.57	($0.24)
Mentorship for Independent Living	$135,000	$7,000*	Big Brothers Big Sisters of Alaska	$0.22	$0.08	($0.15)
Public Assistance						
Child Care Assistance	$3,122,307	$786,954	Alaska Family Services	$4.08	$8.75	$4.68
Families First Work Services	$4,003,406	$1,337,496	Alaska Family Services	$4.65	$14.88	$10.23
Special Supplemental Nutrition Program for Women, Infants and Children (WIC)	$5,740,468	$700,000*	Alaska Family Services	$8.80	$7.79	($1.01)
Transportation Services	$150,000	$75,000	Mat-Su Community Transit	$0.13	$0.83	$0.70

Program	Total Grant Value	Mat-Su Portion	Mat-Su Grantee	Rest of State Per Capita Spending	Mat-Su Per Capita Spending	Difference in Per Capita Spending
Public Health						
Children's Health Improvement Program Reauthorization Act	$228,750	$93,750*	Southcentral Foundation	$0.24	$1.04	$0.81
Non-Marital Pregnancy Prevention	$150,000	$75,000	Co-Occurring Disorders Institute	$0.13	$0.83	$0.70
Obesity Prevention and Control K-12	$1,150,000	$150,000	Mat-Su Borough School District	$1.75	$1.67	($0.08)
Tobacco Prevention and Control	$4,500,000	$300,000	Alaska Family Services	$7.33	$3.34	($3.99)
Senior and Disabilities Services						
Community Developmental Disabilities	$11,555,795	$950,000	Mat-Su Services for Children & Adults	$18.51	$10.57	($7.95)
Short-Term Assistance	$1,020,000	$85,000	Mat-Su Services for Children & Adults	$1.63	$0.95	($0.69)
Traumatic and Acquired Brain Injury Mini-Grant	$200,000	$200,000	Mat-Su Services for Children & Adults	$0.00	$2.22	$2.22
Total	**$57,249,300**	**$7,632,035**		**$86.361**	**$84.90**	**($1.71)**

Note: Based on 2015 population estimates of 89,894 for Mat-Su Borough residents under age 65, and 572,878 for residents under age 65 for the rest of Alaska.
* Indicates estimated portion expended in the Mat-Su Borough.
Source: DHSS, *Fiscal Year 2015 Operating Grants.*

Funding Analysis

By Strategic Level

It is important that prevention efforts address behavioral health (BH) at multiple levels (individual, family, community and system wide). One level is not necessarily better than another; the broader the strategic level the greater the potential for population-wide benefits. The following table indicates the strategic level at which state prevention grant funding is assigned. Most DHSS SFY2015 funding is geared toward supporting individuals under age 65 (48 percent of $3.7 million), followed by families (43 percent or $3.3 million). Only 8 percent of grant funding is applied to community-level approaches, and no funding is aimed at system-level approaches. No DHSS funding is applied to BH prevention in the workplace.

(See table next page.)

Table 62. State of Alaska DHSS Grant Funding by Strategic Level, State Fiscal Year 2015

Program	Individual	Family	Community	System
Alcohol Safety Action Program				
Rural Human Services				
Substance Abuse Treatment for OCS Engaged Parents				
Therapeutic Court				
Human Services Community Matching Grants				
Youth Courts				
Children's Advocacy Centers				
Mentorship for Independent Living				
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)				
Transportation Services				
Children's Health Improvement Program Reauthorization Act				
Non-Marital Pregnancy Prevention				
Community Developmental Disabilities				
Short-Term Assistance				
Traumatic and Acquired Brain Injury Mini-Grant				
Early Intervention for Young Children				
Community-Based Support Services to Promote Children, Strong Families				
Early Intervention / Infant Learning Program				
Family Support				
Child Care Assistance				
Families First Work Services				
Comprehensive Behavioral Health Prevention and Early Intervention Services				
Obesity Prevention and Control K-12				
Tobacco Prevention and Control				
Total DHSS Mat-Su Grant Funding (SFY2015)	**$3,676,981**	**$3,319,094**	**$635,960**	**$0**
Percent of Total Mat-Su Grant Funding	**48%**	**43%**	**8%**	**0%**

Due to rounding, rows may not sum to 100 percent.

By Life Stage

Behavioral health prevention funding specific to the pre-natal life stage was not available in SFY2015. However, primary medical care support (such as Medicaid/Denali KidCare) for pregnant women is available and impacting BH needs of pregnant women. The table below indicates which life stage Alaska prevention grant funding is assigned to (prenatal, early childhood, childhood, adolescence, and adulthood). Most DHSS SFY2015 funding (not including funding for seniors) is for services provided in adulthood (33 percent or $2.5 million), followed by early childhood (28 percent and $2.2 million each life stage). Just under half of all funding (47 percent or $3.6 million) provides support for programs serving people before they reach adulthood.

(See table next page.)

Table 63. State of Alaska DHSS Grant Funding by Life Stage, State Fiscal Year 2015

	Prenatal	Early Childhood		Childhood	Adolescence		Adulthood
Program	**-9 mos.-0**	**0-3**	**3-5**	**6-10**	**10-13**	**14-18**	**19-64**
Comprehensive Behavioral Health Prevention and Early Intervention Services							
Tobacco Prevention and Control							
Traumatic and Acquired Brain Injury Mini-Grant							
Special Supplemental Nutrition Program for Women, Infants, and Children							
Community-Based Support Services to Promote Children, Strong Families							
Children's Advocacy Centers							
Children's Health Improvement Program Reauthorization Act							
Child Care Assistance							
Early Intervention for Young Children							
Early Intervention / Infant Learning Program							
Family Support							
Obesity Prevention and Control K-12							
Youth Courts							
Alcohol Safety Action Program							
Non-Marital Pregnancy Prevention							
Mentorship for Independent Living							
Rural Human Services							
Substance Abuse Treatment for OCS Engaged Parents							
Therapeutic Court							
Human Services Community Matching Grants							
Families First Work Services							
Transportation Services							
Community Developmental Disabilities							
Short-Term Assistance							
Total Mat-Su Grant Funding (SFY2015)	**$0**	**$2,150,740**		**$692,453**	**$771,538**		**$2,508,075**
Percent of Total Mat-Su Grant Funding	**0%**	**35%**		**11%**	**13%**		**41%**

By Level of Prevention

The table indicates which level Alaska prevention grant funding is assigned to (primary, secondary, or tertiary). While not all DHSS SFY2015 funding is aimed specifically at ACEs prevention, about 15 percent (or $1.2 million) is for primary prevention directed at the general population, attempting to prevent maltreatment, or a behavioral health issue before it occurs. Most of DHSS SFY2015 funding (61 percent or $4.7 million) supports secondary prevention aimed at select populations. Tertiary prevention targeting select populations to prevent a recurrence of maltreatment or behavioral health issue makes up the remaining 24 percent (or $1.8 million) of DHSS funding.

(See table next page.)

Table 64. State of Alaska DHSS Grant Funding by Level of Prevention, State Fiscal Year 2015

Program	Primary	Secondary	Tertiary
Comprehensive Behavioral Health Prevention and Early Intervention Services			
Tobacco Prevention and Control			
Children's Health Improvement Program Reauthorization Act			
Early Intervention for Young Children			
Obesity Prevention and Control K-12			
Rural Human Services			
Families First Work Services			
Transportation Services			
Community Developmental Disabilities			
Short-Term Assistance			
Special Supplemental Nutrition Program for Women, Infants, and Children			
Child Care Assistance			
Early Intervention / Infant Learning Program			
Family Support			
Non-Marital Pregnancy Prevention			
Traumatic and Acquired Brain Injury Mini-Grant			
Community-Based Support Services to Promote Children, Strong Families			
Children's Advocacy Centers			
Youth Courts			
Alcohol Safety Action Program			
Mentorship for Independent Living			
Substance Abuse Treatment for OCS Engaged Parents			
Therapeutic Court			
Human Services Community Matching Grants			
Total Mat-Su Grant Funding (SFY2015)	**$1,153,413**	**$4,659,094**	**$1,819,528**
Percent of Total Mat-Su Grant Funding	**15%**	**61%**	**24%**

Department of Public Safety

The Alaska Department of Public Safety's Council on Domestic Violence and Sexual Assault developed a series of statewide prevention programs. None are administered specifically for the Mat-Su Borough, and no Mat-Su agencies are currently members of the Network on Domestic Violence and Sexual Assault.

Table 65. Summary of State of Alaska Department of Public Safety Prevention Programs, Alaska and Mat-Su Borough, SFY 2015

Program	
Council on Domestic Violence and Sexual Assault	
Alaska Men Choose Respect	Serve to strengthen healthy relationships and respect, building skills among men and boys. These grants provide men with an opportunity to become more involved in making Alaska communities safer by partnering with allies in ending violence and promoting respectful relationships.
Girls on the Run	10-12 week after school program for girls in the 3rd through 5th grade that encourages positive emotional, social, mental and physical development.
Compass	Male-mentoring programs (ages 12-18). How to have conversations about healthy masculinity.
Green Dot Alaska	Project aimed at engaging individual community members in preventing power-based violence in our communities.
Lead on! for Peace and Equality	A goal of this program is to shift norms around respect, sexual assault and teen dating violence. The Lead On summit is an annual event that brings youth and adults together for three days in Anchorage where they build leadership skills to promote healthy relationships. In the past, Mat-Su participation has not been well represented.
Stand Up, Speak Up Alaska	Campaign focuses on six key areas: relationship basics; building a peer culture; respecting yourself; leading the way; keep respect going and getting help. It includes mini-grants to support community-based projects. The community-based projects are youth led and promote leadership skills, healthy relationships and respect among their peers. No mini-grants have been issued to the Mat-Su.
Talk Now Talk Often	The campaign is to help Alaskan parents and caregivers increase healthy relationship conversations with teens. A website features conversation cards to help parents better communicate with adolescents and strengthen relationships and connections between youth and adults.
The Fourth R	Relationship-based curriculum for grades 7-9 that is embedded in school-based physical and health education, to promote healthy relationships and reduce interpersonal violence, dating violence and other adolescent risk behaviors. Endorsed by DEED, Department of DPH, DPS. Training and
When I Am An Elder	Part of Stand Up Speak up public service announcements, posters, and materials developed with youth committed to creating a better world and Standing Up and Speaking Up to end violence.
Coaching Boys Into Men	Comprehensive violence prevention curriculum for coaches and their athletes developed by Futures without Violence.

Once partially funded by the Alaska Department of Public Safety, the Drug Abuse Resistance & Education – Resisting Drugs & Violence (D.A.R.E.) program now is dependent on donations, a volunteer board and police officers who receive training and volunteer their time to work in schools. The program is a comprehensive K-12 education program or curricula that seek to address drugs, violence, bullying, Internet safety, and other risky circumstances affecting students.

Mat-Su Borough School District

There are several prevention programs administered to at-risk pre-school and other students of the Mat-Su Borough School District.

Table 66. Summary of MSBSD Prevention Programs, FY 2015

Program	Description	Budget
Ages 3-5		
Early Childhood Special Education Preschool	Students ages 3-5 with Individual Education Programs receive services in an Early Childhood Special Education Preschool at 17 schools.	
Widening the Net Preschool Project	Working with CCS Alaska (Head Start) to identify at-risk children who do not have the opportunity to attend preschool. Located at Butte, Goose Bay, Shaw, Trapper Creek, and Willow Elementary.	
Childfind	Screening for educational and physical needs for children, including social/emotional development.	
Other Students		
Now is the Time/Youth Mental Health First Aid	Federal funds used to hire three counselors to support students at Burchell, Valley Pathways, and Mat-Su Central schools. From October 2015 through March 2016, these counselors have given nearly 2,000 moments of support/contact to students. Contacts include crisis intervention, small group discussion, school-wide events, parental contact, one-on-one counseling, large group discussions, meetings, and class presentation. Additionally, funds are used to train for early detection and response to mental health issues, connect youth and families with mental health services, and implement effective ways to promote behavioral health and prevent mental illness.	Year 1 funding: ~$500,000; Year 2 funding: ~$425,000
Building Bridges to Brighter Futures	The 21st Century Community Learning Centers program supports the Building Bridges to Brighter Futures program provides out-of-school-time opportunities and support for 400 at-risk students in three Title 1 schools. Programs are available at Burchell High, Wasilla Middle, and Iditarod Elementary. The program provides homework help, skill building, and enrichment classes such as dance, robotics, creative writing, child development, and drug and violence prevention. High school students can recover credits through their participation in engaging afterschool classes. The aim of this program is to increase the academic success of all participants; integrate social/emotional, mental health, violence prevention, substance use/abuse, and support services into afterschool activities; and offer STEM opportunities that increase students' interest in science and technology.	$500,000 (July 1, 2014-June 30, 2019)

Chapter 6: "Best Practices" Prevention Policies and Promising Practices

Overview

In a recently released technical package, the Center for Disease Control and Prevention (CDC) outlines recommended strategies to prevent child abuse and neglect (Fortson, Klevens, Merrick, Gilbert, & Alexander, 2016). While the technical package focuses on the issue of child abuse and neglect only, all recommendations are relevant to the broader discussion of prevention of ACEs and other BH issues. Like the preceding approaches to prevention, the recommendations occur at all levels of the social ecology (including individual, family, community, and system) and are designed to reinforce one another. The following table summarizes strategies and tactics. This chapter also describes other strategies and tactics for various domains of policy influence, such as early child care, schools, workplace, community, etc.

Table 67. CDC Recommended Prevention Strategies and Action

Increasing potential for public health impact

Strategy	Action
Strengthen economic supports to families	• Strengthening household financial security • Family-friendly work policies
Change social norms to support parents and positive parenting	• Public engagement and education campaigns • Legislative approaches to reduce corporal punishment
Provide quality care and education in early life	• Preschool enrichment with family engagement • Improved quality of child care through licensing and accreditation
Enhance parenting skills to promote healthy child development	• Early childhood home visitation • Parenting skill and family relationship approaches
Intervene to lessen harms and prevent future risks	• Enhanced primary care • Behavioral parent training programs • Treatment to lessen harms of abuse and neglect exposure • Treatment to prevent problem behavior and later involvement in violence

Source: Adapted from Fortson, B. L., Klevens, J., Merrick, M. T., Gilbert, L. K., & Alexander, S. P. (2016). Preventing child abuse and neglect: A technical package for policy, norm, and programmatic activities. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Transforming the Child Care Workforce

The Institute of Medicine (IOM) and National Research Council (NRC) published 13 recommendations to transform the workforce serving children from 0 to age 8. Their recommendations include suggestions for implementation:

1. Strengthen competency-based qualification requirements for all care and education professionals working with children from 0-8.
2. Develop education pathways to transition to a minimum bachelor's degree requirement for workers.
3. Strengthen practice-based qualifications for workers, including a supervised induction period.
4. Build an interdisciplinary foundation in higher education for child development.
5. Develop and enhance programs fin higher education for care and education professionals.
6. Support consistent quality and coherence of professional training supports for current professionals.
7. Develop a new paradigm for evaluation and assessment of professional practice.
8. Ensure policies and standards that shape professional learning are grounded in science of child development and learning.
9. Improve consistency and quality of for children by strengthening cross-sector coordination.
10. Support workforce development with coherent funding, oversight, and policies.
11. Collaboratively develop and update guidance for processionals working with children from 0-8.
12. Support comprehensive state and local efforts to transform the early child care workforce.
13. Build a better knowledge base to inform workforce development and professional learning services and systems.

Early Child Care Policies

Child care services present one of the greatest opportunities for positively affecting the health and developmental trajectories of infants and children.

(Miller, Sadegh-Nobari, & Lillie-Blanton, 2011).

Improve the child care workforce

Child care providers and early education workers care for children during crucial developmental years, and many children spend significant time in paid care settings. A strong child care workforce helps ensure that all children have access to high-quality care from qualified, nurturing providers in a stable environment.

TACTICS

1. **Increase compensation and improve working conditions for child care providers to attract and retain high-quality personnel.** Child care providers represent some of the lowest paid workers in the labor market, although they care for children during crucial years of development. Workers who care for the youngest children are paid the least (CotDC, 2016).
2. **Create data and information sharing structures that allow a child's information to transfer from care setting to care setting (medical, care, education etc.).** Accurate and timely information sharing helps ensure children have consistent access to the interventions they need, removes burdens from parents, prevents redundant paperwork, and can avoid premature or inaccurate diagnoses (IOM and NRC, 2015).
3. **Support high standards for child care environments grounded in early childhood science.** Research points to distinct effectiveness factors for high-quality child care: a language-rich environment, serve and return interactions, a physically-safe setting, small group sizes, and high ratios of adults to children (CotDC, 2016). A quality rating and improvement system can provide a framework for developing strong early childcare and education systems.

Ensure equitable access to affordable, quality childcare

Affording child care is challenging for many Alaskan families, especially low-income families. Subsidized childcare-through vouchers, lower cost child care, or care transfers to low-income families-helps offset the cost of quality child care (Fortson et al., 2016). The CDC recommends several tactics states can take to increase access to high-quality child care (Fortson et al., 2016).

TACTICS

1. Raise the income threshold for eligibility for financial aid.
2. Expand approved activities to include training, education, job search time, and rest time for parents working alternative shifts.
3. Support graduated phase-out of benefits.
4. Simplify the aid application process.
5. Shorten wait times.
6. Increase the number of providers offering child care during non-standard hours.

Financial Security Policies

Strengthen household financial security

Better physical and behavioral health are closely associated with financial security. Policies that improve the socio-economic conditions of children, parents, and families have the greatest potential to improve health (Frieden, 2010). Families with adequate financial resources experience less stress, greater stability, and are able to consistently meet the basic needs of their children. Increased financial security is linked with numerous and significant life-long benefits: "Interventions that raise a family's purchasing power through cash or in-kind supplements for food, housing expenses, medical services, and child care are associated with better child health, development, and academic achievement outcomes" (Miller, Sadegh-Nobari, & Lillie-Blanton, 2011).

TACTICS

1. Modify how Temporary Assistance for Needy Families (TANF) benefits interact with child support payments. Allowing child support payments to transfer to the custodial parent without reducing TANF benefits, thereby increasing household income (Fortson et al., 2016).
2. Ease access to the Supplemental Nutrition Assistance Program (SNAP). States can make several changes, such as allowing online application, simplifying the household income reporting process, adjusting whether child support counts as income, and determining which disqualifications are imposed (Fortson et al., 2016).
3. Enable families from high-poverty neighborhoods to relocate to more stable, safe communities. States can support assisted housing mobility that places children in better homes while saving on rent through use of the U.S. Housing and Urban Developments Community Development Block Grant (CDBG) and/or Section 8 Housing Choice Voucher funds (Fortson et al., 2016).
4. Consider tax credits for families with children. One example is the federal and state Earned Income Tax Credit (EITC). As the State of Alaska considers implementing a state income tax, tax credits may be relevant policy options in the future.

5. Prioritize programs and policies that alleviate poverty while children are youngest. The Center on the Developing Child advocates for a multi-prong strategy of tax credits, providing parent job training, debt reduction, and supporting financial literacy (2016).

Reduce high risk impacts of economic crises

Economic crises are times of high risk to the mental well-being of the population. As with individuals, societies can be more or less resistant to such stressors. Economic shocks can destabilize public service budgets (as seen in Alaska's current fiscal crisis due to lower revenue from oil production) and this can undermine education and health care systems. However, available data show that legislation for protecting social welfare can increase the resilience of communities to economic shocks and mitigate the BH effects of unemployment and the stress-related consequences of economic downturns (Stuckler, 2009). Good BH coping skills are beneficial in times of hardship. Promoting problem-solving skills may protect against depression and suicidal behavior.

TACTICS

1. Active labor market programs that keep and reintegrate workers in jobs reduce the BH effects of recessions. Programs should include resilience-building BH promotion.
2. Family support programs are effective in reducing family strain which may lead to increases in family violence and child neglect. Family support may include support for the costs of children and other dependents, as well as support for parental leave.
3. Policy action to increase the price of alcohol reduces consumption and the associated harm, as well as reducing deaths from alcohol disorders (WHO, 2011).
4. Improved responsiveness of health services to changes in people's social, employment, and income status, and early recognition of BH problems, suicidal ideas, and heavy drinking will reduce the human toll of a recession. The primary care approach increases access to BH care and focuses on preventing BH problems and detecting them early.
5. Debt relief programs help people who are suffering from the stress of excessive debt. Debt advice helps individuals to improve their financial situation and may also improve their BH.

Workforce Policies

Employment is good for mental health. Most adults are employed, making the workplace an ideal setting to reach a large population with preventive messages or programs offered through the workplace and Employee Assistance Programs.

Job security, sense of control of work, and social support at work are factors promoting the mental health of employees. Stable employment, secure incomes and social capital predict good mental health (WHO, 2011).

Mental illness causes more lost workdays and performance impairment than each of the following: arthritis, asthma, back pain, diabetes, hypertension, and heart disease. A growing number of business leaders recognize that early detection and treatment of mental illness often can prevent a crisis, reduce employers' health costs down the road, as well as minimize impacts to workplace productivity, stress, and retention/employee turnover.

Ensure family-friendly workplaces

Family-friendly workplaces decrease parental stress, reduce financial strain on families, and make it easier for parents to provide necessary care for children.

TACTICS

1. Require paid parental leave. The Mailman School of Public Health at Columbia University recommends parental leave policies that replace at least two-thirds of wages, guarantee job protection, provide a minimum of 14 weeks of leave, extend to both full- and part-time workers, and effectively monitor employer practices to protect against discrimination (Skinner & Ochshorn, 2012).
2. Provide a combination of paid parental leave, paid sick leave, and paid vacation. The CDC recommends a combination of leave to best support families (Fortson et al., 2016). Permit leave to be taken intermittently for other purposes, including caring for children with chronic illnesses and other special health needs (Skinner & Ochshorn, 2012).

PAID FAMILY LEAVE

Universal paid family leave is one of the most recommended and important levers to support long-term well-being. In addition to providing financial support, paid leave reduces stress on parents that weakens children during critical periods of development (in utero and in years following birth) and supports formation of crucial stable, nurturing caregiver relationships.

The United States is the only developed nation that does not mandate paid leave for new parents (Shepherd-Banigan & Bell, 2014). Paid leave for parents is guaranteed in national legislation by 177 nations, and, according to Heymann and Earle, "no other policy has achieved greater global consensus" (2010). America sits along with Liberia, Papua New Guinea, and Swaziland in its limited regulated allowance for family leave (Shepard-Banigan et al., 2014).

A review of OECD countries from 1969 to 2000 found that, on average, countries provide 18.2 weeks of job-protected paid leave (Tanaka, 2000). In many countries, paid parental leave provides support both pre- and post-childbirth (Tanaka, 2005).

Research indicates numerous health, economic and business benefits linked to provision of paid parental leave. Increasing weeks of job-protected paid leave significantly decreases mortality rates during the prenatal, perinatal, neonatal, post-natal and early child periods (Tanaka, 2005). Paid leave also significantly reduces rates of low birth weights. (Tanaka, 2005). When parents have access to paid parental leave, their children are more likely to receive regular medical checkups and immunizations and less likely to have behavioral problems (Berger, Hill, & Waldfogel, 2005). A review by the Mailman School of Public Health at Columbia University describes evidence-based advantages of universal paid family leave programs for companies such as: improving job retention and morale, leveling the competitive playing field, and providing savings for companies already offering employer-paid leave (Skinner & Ochshorn 2012).

3. Support flexible and consistent work schedules (Fortson et al., 2016).

Promote healthy work environments

Behavioral health of employees is a crucial determinant in their overall health and poor mental health and stressors at the workplace can be a contributing factor to a range of illnesses, like hypertension, diabetes, depression, anxiety, and alcohol- or drug-related disorders. In addition, poor mental health can also lead to burn-out amongst employees, seriously affecting their ability to contribute meaningfully in both their professional and personal lives (WHO, 2005).

TACTICS

1. Encourage businesses to make a visible commitment to activity at work, have a health plan that includes Employee Assistance Programs, wellness benefits, and smoke-free/drug-free/alcohol-free workplace and work events (such as worker picnics, Christmas parties) policies (Miller, Simon, & Maleque, 2009).
2. Promote a trauma-informed workforce.
3. Promote employer awareness of mental health issues in the workplace, and support employees accessing needed services.
4. Accessing tools (such as the National Institute for Occupational Safety and Health Generic Job Stress Questionnaire, Work Stress Scale, etc.) to measure work stress allows individuals to assess for themselves the degree of stress faced in their relationships with superiors, bureaucratic constraints, work family conflict, relationship problems with colleagues, performance pressure and poor job prospects or insecurity (Rajgopol, 2010).

Create a stigma-free workplace

The National Mental Health Organization and the National Council for Behavioral Health suggest six tactics to support employees with behavioral health issues.

TACTICS

1. Educate employees about the signs and symptoms of mental health disorders.
2. Encourage employees to talk about stress, workload, family commitments, and other issues.
3. Communicate that mental illnesses are real, common, and treatable.
4. Discourage stigmatizing language, including labels such as “crazy,” “looney,” or “nuts.”
5. Invest in mental health benefits.
6. Help employees transition back to work after they take leave (Meinert, 2014).

Health Policies

Ensure high-quality care during crucial developmental years

> *Good health supports successful learning. Successful learning supports health. Education and health are inseparable. Worldwide, as we promote health, we can see our significant investment in education yield the greatest benefits.*
>
> *Dr. Desmond O'Byrne, WHO*

TACTICS

1. Ensure access to high-quality prenatal care. High-quality prenatal care can help identify threats to health and development and provide access to needed preventive services (CotDC, 2016).
2. Coordinate medical services for all family members. A mother's health influences her child's health before and after birth.
3. Mandate standardized developmental screening in routine primary care visits, in particular during the first three years of life. Developmental screening helps catch issues early and ensure children and parents have access to needed supports. Currently, less than half of pediatric practices in the United States offer routine developmental screening during the first three years of life (CotDC, 2016). The Ages and Stages questionnaire is a robust, research-based tool that engages parents and physicians in evaluations of a child's developmental and social emotional skills.
4. Screen children, teenagers and adults for exposure to ACEs. The Center for Youth Wellness developed a research-based screening tool for practitioner use. It is available free of charge and includes instructional use guides for physicians. The screening tool is included in Appendix D.
5. Develop supportive policies to enable homeless "unaccompanied" youth access to medical, dental, mental health, and substance abuse treatment (Julianelle & Duffield, 2013).

Integrate primary care and behavioral health services

Because of the close association between young children's emotional well-being and the emotional health and functioning of their caregivers (parents), therapeutic assistance to a parent ought to include an automatic assessment of any young children in the family to see how they are experiencing the emotional consequences of their parent's problems.

TACTICS

1. Any physician treating a depressed mother ought to understand the consequences of that diagnosis for her young children and therefore assure that they receive timely examinations and appropriate intervention, as needed." (National Scientific Council on the Developing Child, 9).

Consider legislation to reduce or deter prescription drug abuse

The nation is dealing with a broad spectrum of effects from what is generally considered an epidemic of opioid abuse. For example, there is significant proof that long-term opioid use leads to longer Workers' Compensation claim duration, longer-term disability, higher costs, and higher medical expenses. In response, legislatures have

been working on policies to address causes and consequences of opioid abuse and other prescription drug abuse as well as examining approaches to prevent abuse.

TACTICS

1. Develop laws that deter people from obtaining multiple prescriptions, so called "doctor shopping" laws.
2. Require physical examination before prescribing controlled substances.
3. Examine Workers' Compensation opioid use data to identify physician/provider groups prescribing and/or dispensing inappropriate medications. Other tactics may include, educating injured workers on the dangers of opioids and identifying injured workers on long-term use of medication and developing a collective approach to halt continued use.
4. Recognize essential role of Prescription Drug Monitoring Programs-statewide mechanisms that collect, monitor, and analyze prescribing and dispensing data related to controlled substances.
5. Encourage and enhance treatment and prevention initiatives.
6. Expand use of drug courts.

Education Policies

Schools can help promote the health of staff, families, and community members, as well as the health of students. Schools are an important setting where many people learn and work, care for and respect each other. It is a setting where education and health programs can have their greatest impact because they influence students at such important stages of their lives from early childhood to early adulthood.

TACTICS

1. Ensure school staff have trauma-informed training and access to mental health consultation. "Preschool teachers with access to mental health consultation, for example, are less likely to expel children with behavioral problems from their programs." (National Scientific Council on the Developing Child, 9).
2. Mandate nutritious school lunch and breakfast offering; remove junk food and vending machines.
3. Make daily activity at school a high priority.
4. For homeless unaccompanied youth, develop partnerships between the school district and appropriate housing programs to ensure stability and consistency so youth can attend and stay in school, and graduate, as well as have ability to fully participate in school athletics and other extra-curricular activities, and receive support for school clothing and transportation, cover graduation expenses (such as caps and gowns), and academic support (Julianelle, 2012).

Community and System Policies

Community and system policies have the broadest prevention reach. These policies require accessing and building upon existing infrastructure as a means of advancing project activities, forging strong partnerships and alliances with state and local representation, having mission-focused leadership at the state and local levels, and utilizing data to inform project activities at all stages (Shea & Shern, 2011).

TACTICS

1. Provide funding for community and system level prevention.
2. Increase public awareness of the advances and cost savings of preventive interventions that support health (Hawkins et al., 2015).
3. Establish data tracking and sharing infrastructure. "Implement community-assessment and capacity-building tools that guide communities to systematically assess and prioritize risk and protective factors, and select and implement evidence-based prevention programs that target prioritized factors," (Hawkins et al., 2015).
4. Assess and remediate hazardous housing conditions (Miller, Simon, & Maleque, 2009).
5. Establish funding channels for promising approaches to break through impacts.
6. Guarantee funding for prevention. "Ensure that 10 percent of all public funds spent on young people support effective prevention programs" (Hawkins et al., 2015).
7. Coordinate related programs. "Mental health services covered by the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, Children's Health Insurance Program (CHIP), early intervention (IDEA Part C) or maternal and child health programs should better coordinate with related programs such as child welfare, child care, Early Head Start and Head Start, home visiting, and other programs and settings" (CotDC, 2016).

Establish trauma-informed policies throughout agencies and schools

Trauma-informed care must involve both organizational and clinical practices that recognize the complex impact trauma has on both patients and providers.

(Menschner & Maul, 2016)

Trauma-informed care is a universal precaution approach that is designed to be both preventative and rehabilitative in nature. (Huckshorn & LeBel 2013). Core principles of a trauma-informed approach to care, include patient empowerment, choice, collaboration, safety, and trustworthiness.

TACTICS

1. **Raise public awareness.** Lead education campaigns to encourage sectors that serve children and families to take appropriate action on childhood adversity.
2. **Develop a trauma-informed workforce.** Adopt professional licensing and certification standards for child- and family-serving professionals that include competency on trauma-informed approaches, such as recognizing symptoms of trauma and ways to help with healing.
3. **Recruit and retain a diverse workforce.** Recruit and retain diverse professionals serving children and families, particularly in communities that experience childhood adversity more severely and profoundly.
4. **Increase access to interventions.** Increase funding for and access to evidence-based or promising interventions that help children heal from ACEs and trauma.
5. **Promote early identification coupled with interventions.** Promote ways to identify when a child is exposed to or suffering from effects of ACEs, and ensure that children have access to interventions that help with healing.

6. **Partner in efforts to address the determinants of ACEs.** Advocates for policies, institutional practices and programs that help treat the root causes of ACEs, such as poverty.
7. **Cultivate trauma-informed systems.** Advocate for all child- and family-serving systems and organizations to integrate trauma-informed approaches (Loudenback, 2015).
8. **Integrate screens for ACEs in health care and use trauma-informed approaches in the schools**.
9. **Engage referral sources and partnering organizations**, including health, juvenile justice, child welfare, early childhood and education, as well as within business, nonprofit, and philanthropic communities.

Promising Practices

This section describes examples of and resources for promising practices currently being used in preventive BH care.

The following two examples-one a clinic and the other a coalition-combine to cover care throughout the lifespan. Each approaches prevention with a multi-level strategy, and both are on the leading edge of BH prevention and intervention in the U.S.

Center for Youth Wellness

OVERVIEW

The Center for Youth Wellness is a pediatric clinic that uses a multi-disciplinary, two-generational intervention that emphasizes:

- Assessment / early screening of ACEs for all patients.
- A standard practice of home visits.
- Provision of psychotherapy and psychiatry services.
- Teaching of mindfulness and coping skills to patients and families.
- Educating families and other providers about the impacts of ACEs and toxic stress on health.
- Engaging families at home and in school.
- Providing consistent guidance throughout the practice.
- Modeling self-care.
- Use of wellness coordinators who are responsible for an entire family's care and who coordinate clinic and outside-clinic resources.
- Engaging in community and system-level advocacy, education, and awareness.

RESOURCES / TOOLS

- Multiple documents explaining ACEs
- Policy advocacy brief
- ACEs screening tool and use instructions for practitioners (included in Appendix D)

TAKEAWAYS / PRINCIPLES

- Remove the burden from families to coordinate services.

- Provide wraparound care.
- Screen early for ACEs.
- Advocacy is an important part of clinical practice.
- Clinic takes responsibility for education of families, physicians and the community about ACEs.
- Requires re-conceptualized medicine and primary care to address ACEs.

Camden Coalition

OVERVIEW

The Camden Coalition is a non-profit coalition of health care providers, community partners and advocates that targets super utilizers of the health care system as a means of reducing costs and improving care for all patients. The coalition:

- Coordinates and shares data from multiple service providers with public and practitioners.
- Conducts research to evaluate and improve upon success of interventions.
- Publishes and contributes to research.
- Supports enrolled patients with a team of nurses, social workers, community health workers, and health coaches for an average of 90 days.
- Assigns team members to accompany patients to all appointments and link patients to resources beyond primary care (transportation, housing, and other wrap-around services).
- Guides interventions according to the principles of motivational interviewing, trauma-informed care and empowerment.

RESOURCES / TOOLS

- Camden ARISE
- Health Information Exchange
- COACH Curriculum
- Camden Health Explorer
- Many resources for training care coordinators (flow charts, harm reduction training, etc.)

TAKEAWAYS / PRINCIPLES

- Share data to improve care and identify patient needs
- Research and publish efforts
- Tailor individualized care and treatment plans to each patient
- Identify system failures and address them
- Build relationships with patients
- Re-conceptualize medicine and primary care to address ACEs

Best Practices of Breakthrough Impacts

The Center for Youth Wellness and the Camden Coalition imagine and deliver care in revolutionary ways. Distinguishing practices include:

- Medical clinics conceive of care (boundaries, approach, interventions) very differently than traditional care settings.
- Support systems around children and families are essential.
- Coordination of services is a responsibility of the provider, not the patient.
- Services must expand beyond traditional service boundaries.
- Children, families and patients are supported by a team of people who communicate and share data.
- Home visits are customary.
- Wraparound services are the norm.
- Community and system advocacy, awareness and education are responsibilities of providers.
- The burden of coordinating care and finding services is removed from the child, family or patient.
- All staff are trained in trauma-informed care principles.

Existing Resources

The following section highlights several prevention resources organized by individual, family, community and system level. Each profile includes a brief synopsis of the organization, program or model's work; a list of resources and tools of potential use to the Matanuska-Susitna Borough; and a list of takeaways.

Individual Level

AGES AND STAGES QUESTIONNAIRE

Overview

Ages and Stages (ASQ) is a rigorous, science-based tool for screening infants and young children for developmental delays during the first five years of life. ASQ-3 is a series of 21 questionnaires designed for children of different ages beginning at 1 month through 51/2 years. Each tool explores five developmental areas: communication, gross motor skills, fine motor skills, problem solving, and personal-social skills. ASQ:SE-2 is a series of nine questionnaires that address social-emotional areas of development – self-regulation, compliance, communication, adaptive behaviors, autonomy, affect, and social interaction – from 1 month through 6 years of age. Parents or caregivers can complete the questionnaire independently, or with the support of a provider. The questionnaires are scored by providers, or by computer if completed online. If developmental delays are identified, each questionnaire concludes with referral for interventions.

ASQ is used by child care programs, Head Start / Early Head Start, the Nurse Family Partnership, pediatricians and parents. All screening tools and supportive materials are available for purchase online. Starter kits cost $275. Online subscriptions to questionnaires are also available for service providers or parents.

Resources / Tools

- Thirty questionnaires
- Associated learning activity books
- http://agesandstages.com

Takeaways / Principles

- Consider providing access to ASQ for Mat-Su parents.
- Consider advocating for use of the questionnaires at pediatrician clinics in the borough.
- Consider requiring grant recipients who provide services for children from zero to five to provide access to ASQ.

Family Level

NURSE FAMILY PARTNERSHIP

Overview

The Nurse Family Partnership is a program designed to promote the health and well-being of young, low-income first-time mothers and their children. During pregnancy, a nurse meets with an expecting mother in the mother's home to teach about prenatal care and other preparation for the birth. After the child is born, the nurse continues to meet with the mother to guide healthy child development. Throughout all meetings, the nurse provides emotional support, mentoring the mother to continue her own educational and career development. The nurse provides a consistent and reliable positive influence in a mother's life.

Several randomized control trials have validated the impacts of the program. Demonstrated outcomes include reduced child abuse and neglect, improved cognitive outcomes for children, reduced maternal smoking, and a reduction in the number of subsequent births during a mother's teen years and early twenties.

Resources / Tools

- Proven model
- Existing examples of program implementation both in Alaska and throughout the country

Takeaways / Principles

- Provide *personalized* and *long-term* support to young and vulnerable first-time mothers.
- In addition to mother and child health, target a mother's educational and professional advancement.

VROOM

Overview

Vroom is a free, parent-friendly, science-based resource designed to help parents turn everyday moments into brain-building activities for children from zero to five. Resources are available on Vroom's website, for download and print, and through an app for smartphones and tablets. The materials assume that all parents want to be good parents and need only accessible, non-academic activities to do so.

Resources / Tools

- http://www.joinvroom.org/

Takeaways / Principles

- Brain building activities can take place at any time, even for busy parents.

- Assume parents want to be good parents.
- Make information easy to access and parent-friendly.

LITTLE KIDS BIG QUESTIONS

Overview

This podcast consists of interviews with experts in child development. It educates listeners about child development topics such as self-control in young children, the influence of fathers, and emotion. Podcasts also teach parenting skills, like healthy eating, encouraging good sleeping habits, and setting limits on child behavior.

Resources / Tools

- Easily accessible and distributable information on parenting and child development

Takeaways / Principles

- Make information free and as accessible as possible.

POSITIVE PARENTING PROGRESS (TRIPLE P)

Overview

Triple P is a system that educates about child development and teach parenting skills. The program is especially intended for parents with behavioral problems, parents of children with developmental delays or behavioral problems, and parents at risk for child abuse and neglect. The goal of the program is to foster healthy home environments and positive parent-child relationships, which enhance developmental outcomes for children.

Triple P engages parents through group sessions, individual in-person consultations, telephone consultations, and reading material. Trained practitioners, who must have a graduate degree in education or clinical psychology, teach the Triple P program. Triple P is touted as capable of serving both small-scale and population-level needs.

Resources / Tools

- Demonstrated model that can be tailored to fit Mat-Su
- Existing examples of implementation in other communities

Takeaways / Principles

- Capable of implementation at the community level
- Teaches parenting skills through highly trained and educated professionals

Community Level

HELP ME GROW

Overview

Help Me Grow (HMG) is an information and referral network designed to support parenting, early detection of child developmental challenges, and linkage of families with service providers. It evolved as a simple solution-a call center for parents and families-to a complex problem: developmental issues in children often progress without detection, quality programs exist to support children and families but information is not centralized or easy to access, and the burden often falls on families to navigate a myriad of programs. HMG connects families to services that already exist, but does not provide direct services.

Started in Connecticut, the original concept has expanded to a nationwide effort to bring the HMG system to all states. States choose how to implement HMG, with guidance from the national organization. States are required to identify an organizing entity, expand statewide, and continuously improve quality. The organizing entity must adhere to the four components of HMG:

1. Child health care provider outreach to support early detection and intervention;
2. Community outreach to promote use of HMG and to provide networking opportunities for families and service providers;
3. Centralized telephone access point for connecting children and their families to services and care coordination; and
4. Data collection to understand all aspects of the HMG system, including identification of gaps and barriers.

Help Me Grow Alaska is currently in the planning stage. Five working groups, each comprised of statewide members, will submit recommendations for implementing the program in mid-August 2016. A soft-launch of a pilot program is planned for November 2017. The host organization for the pilot project has yet to be determined. The Mat-Su Health Foundation and the Mat-Su Borough could be strong candidates.

Resources / Tools

- http://www.helpmegrownational.org/index.php

Takeaways / Principles

- Easy access to information is essential.
- Reduce the burden on parents.
- There may be simple solutions to complex information problems.

LEARN & GROW

Overview

Learn & Grow is Alaska's Quality Recognition and Improvement System (QRIS). The goal of a QRIS is to help early care and learning (ECL) programs stay actively engaged in continuous quality improvement. A QRIS also provides families, communities, and policy makers with an understanding of what quality ECL is and the impact it can have on children's development and readiness to learn and succeed in life. A QRIS can also provide parity across ECL programs that might otherwise remain isolated in funding and improve alignment in federal or state policies and quality standards.

Learn & Grow provides a framework along with resources and supports to help ECL programs work toward and achieve quality improvements. ECL programs receive technical assistance, professional development, and quality recognition awards as they advance through levels of quality. Each of the five (5) levels of quality has progressive quality standards in the areas of: (a) administration and leadership; (b) staff qualifications and professional development; (c) relationships and learning environment, and (d) family engagement.

Alaska has been planning for the development and implementation of a QRIS for approximately 10 years. Starting in July 2016, Learn & Grow joins 43 other states that have implemented a QRIS. Learn & Grow will be implemented in two phases. Phase I is available for State of Alaska and Municipality of Anchorage Licensed Child Care Centers, Group Homes, and Homes and it includes the first two of the five (5) Levels of quality. As Learn & Grow advances and as funding allows, Phase II of Learn & Grow will include quality standards across all five (5) Levels and specific quality standards for: Head Start/Early Head Start, State Pre-Kindergarten or School District Pre-Kindergarten, Military Child Care, and Licensed School-Age programs.

Resources / Tools

Learn & Grow offers a free Learn & Grow Level 1 Training for early care and learning programs at https://threadalaska.org/index.cfm/calendar. The training provides information about the resources and supports available to help ECL programs stay actively engaged in continuous quality improvement.

RIGHT DIRECTION

Overview

Right Direction is an educational initiative for the workplace designed to decrease the stigma associated with depression. The initiative encourages employees and their families to seek help when needed and provides employers with support, resources and tools. The Employer Toolkit is a free guide for employers containing a step-by-step implementation plan, approach for presenting the initiative to employer leadership, promotional materials, internal press releases, and other support materials.

Resources / Tools

- Employer Toolkit

Takeaways / Principles

- Promote awareness of mental health issues in the workplace.
- Provide resources to employees and families.

TURNAROUND FOR CHILDREN

Overview

Turnaround for Children is a non-profit organization that works directly with high-poverty schools to help establish environments that support healthy student development and academic achievement. Their work focuses on neuroscience research into the effects of trauma exposure. Turnaround for Children:

- Works with schools to establish a Multi-Tiered System of Support (MTSS).
- Helps schools create student support systems that provide timely, effective services to students.
- Creates a 'Student Support Team' that coordinates and tracks students behavioral, emotional and academic progress.
- Provides professional development and coaching for teachers on the impacts of adversity, managing the effects of trauma in a classroom setting, and creating safe classrooms for kids.
- Partners with school administrators to put positive disciplinary practices in place, foster attachment, and cultivate high expectations for students.
- Establishes partnerships with a community-based mental health agency to facilitate referrals for students.
- Develops tools and strategies to manage the impact of adversity on learning.
- Creates systemic impact by building awareness of root causes of underperformance in schools.
- Engages in policy initiatives at the city, state and federal levels.

Resources / Tools

- Educator Tools
- Professional development for educators and administrators
- Data indicators for measuring student development

Takeaways / Principles

- Trauma affects how students learn.
- Educators and administrators need to understand the effects of trauma on student behavior and development.
- The standard structure of school makes it challenging for students, teachers, and administrators to manage the impacts of trauma.
- Trauma-informed education requires substantive changes in how schools work with children.

STRIVETOGETHER

Overview

StriveTogether began in Ohio and Northern Kentucky as a collaboration between three post-secondary education institutions and three public school districts to further child educational outcomes beginning in early childhood and extending all the way through college. The collaboration adopted the collective impact model, which aligns goals among numerous stakeholders and organizes efforts to increase overall efficacy and reduce redundancy and waste. After experiencing success, StriveTogether began to share its management model, teaching community and stakeholder leaders from other regions how to collaborate.

Resources / Tools

- A support system of 64 partnerships nationwide
- Lessons learned from numerous experiences
- An active community of collaboration through webinars, forums, and workshops

Takeaways / Principles

- Successful implementation in Anchorage (United Way of Anchorage 90 percent by 2020)
- An approach to maximize the use of limited funds and resources

System Level

CROSS-SYSTEM IMPLEMENTATION CENTERS

Overview

Over the past decade, Cross-System Implementation Centers, often referred to as Centers of Excellence (COE), have emerged around the country to improve intervention-delivery and system-wide collaboration for child and family services. COEs are organized centers or partnerships that work with providers, families and children, policy makers, researchers, and other stakeholders. They work across and within systems to promote systems reform (Mettrick, 2015). While the structure of COEs varies, and some are a consortium of partners, most COEs are housed within universities or non-profit organizations.

States and localities often choose to establish a COE in the following three circumstances:

1. Consistency and coordination are needed during significant system development and reform.
2. The state or locality is applying for funding that would significantly change the local system of care and requires a neutral facilitator and convener.
3. A COE is needed to streamline and coordinate implementation of evidenced-based practices within a state or locality.

Although COEs can play multiple roles, most cross-system implementation centers have the following core functions:

- Implementation Support for EBPs/Promising Practices/Service Delivery Models
- Research / Evaluation / Data Linking Capacity
- Partnership Engagement and Collaboration
- Workforce Development Activities
- Policy and Finance Expertise

Takeaways / Principles

- Systems change requires structural change.

BUILD INITIATIVE

Overview

BUILD advises national, state, and community leaders, from both public and private sectors, to develop systems that support early childhood. These systems encompass early childhood services, the programs providing those services, and public policy. A goal of BUILD is to eliminate redundancy and increase coordination to maximize

value. Specifically, the program addresses systems of early learning; family support; health, mental health, and nutrition; and special needs and early intervention.

Resources / Tools

- Community leader advising
- System evaluation services

Takeaways / Principles

- Takes into account the unique context and situation for each client.
- Tests new models

INTERNATIONAL MODELS OF EARLY CHILDHOOD SUPPORT

Overview

International models of early childhood support provide guidelines of best practices and provide significant resources to parents and children. In contrast to the United States, a review of six countries (Canada, Sweden, France, Germany, Japan, and the United Kingdom), place a distinct emphasis on preventive health care for children and their mothers (Chaulk, 1994). Notably, each country did so although all have substantially different financing structures for health care (Chaulk, 1994). Each country prioritizes children's health by creating accessible, comprehensive, preventive services from pregnancy through early schooling years (Chaulk, 1994).

All six countries employ overlapping tactics (Chaulk, 1994):

- Comprehensive, accessible prenatal care is provided free of charge or with financial assistance.
- Pregnant women are encouraged to seek use prenatal care via financial incentives including stipends, bonuses, and grants. The financial incentives are designed to offset costs associated with pregnancy.
- Proof of insurance or cost sharing is not required to access care.
- A variety of providers, both physicians and non-physicians, provide prenatal and childbirth services.
- Maternity and paternity benefits are financially comparable to earned income and extend much longer than benefits in the United States.

On a variety of early childhood indicators, Scandinavian countries outperform the United States. Rates of child abuse notifications are eight times lower in Scandinavia than in the United States; only 5 percent of pregnant mothers begin prenatal care before the end of the fourth month of pregnancy, compared with 85 percent in the United States; infant mortality and birth rates are among the lowest in the world (Tomison & Wise, 1999).

Scandinavian countries provide extensive, integrated early childhood support. In Sweden, Finland and Denmark family support programs provide: pre- and post-natal parent education, pre- and post-pregnancy health checks at maternity health centers, maternal and child health services, and universal daycare service for preschool children (Kahn 1990).

Takeaways / Principles

- Early childhood support is possible under a variety of health care and financial structures.

- Supporting parents and children during crucial developmental years requires substantial investment.
- Indicators suggest those investments reap benefits later in life.

In Summary

The following matrices categorize the practices and programs highlighted above by strategic level and by life stage.

Table 68. Prevention Practices by Level

	Individual	Family	Community	System
Center for Youth Wellness	✓	✓		✓
Camden Coalition	✓		✓	✓
Nurse Family Partnership	✓	✓		
Ages and Stages Questionnaire	✓	✓		
Help Me Grow	✓	✓	✓	
Vroom	✓	✓		
Positive Parenting Progress		✓		
Mental Health Outreach for Mothers	✓			
Cross-System Implementation Centers			✓	✓
Build Initiative				✓
Strive Together				✓

Table 69. Prevention Approaches by Life Stage

	0-5	5-10	Adolescence	Adulthood
Center for Youth Wellness	✓	✓	✓	
Camden Coalition				✓
Nurse Family Partnership	✓			✓
Ages and Stages Questionnaire	✓			
Help Me Grow	✓			
Vroom	✓			
Positive Parenting Progress	✓			✓
Mental Health Outreach for Mothers				✓
Cross-System Implementation Centers	✓	✓	✓	✓
Build Initiative	✓			
Strive Together	✓	✓	✓	

Chapter 7: Recommendations

The following recommendations are based on data and findings included in this report. Recommendations suggest changes at the state and local levels, and involve multiple sectors, professionals, and residents.

As any parent or caregiver knows, it is impossible to provide specific instructions or an easy recipe for raising a child. It is equally difficult to advise a whole community on what is needed to adequately support families so they can have every opportunity to raise safe and well-cared-for children. The key is to have an adequate array of formal family and child support services, imbedded in key sectors that touch families and children, and robust social connections that wrap around the family unit.

This section draws on the latest research and best practices to provide recommendations for creating such a community. Community action in response to these recommendations may be drawn from best practices reported in this scan (see Chapter 6). This section is organized around the Strengthening Families Framework for supporting family resilience through a focus on five evidence-based protective factors. The recommendations that follow are not listed in order of priority; rather, combined they all support the creation of a community that is supportive of children and families, and that works to prevent child maltreatment.

Protective Factor #1:
Social Connections – Parents need people who care for them and their children, who can be good listeners, whom they can turn to for advice and whom they can ask for help in solving problems. These people may include supportive family members, friends, neighbors, co-workers, and other community members.

MAT-SU CHALLENGE: *In Mat-Su, some residents are well-connected and can avail themselves of opportunities for support that benefit their families and children. These residents with high levels of social support are more likely to report positive health status and satisfaction with life. A smaller group of residents do not appear to have a robust support system:*

- *13 percent of Mat-Su residents report not being comfortable going to a neighbor for help in an emergency.*
- *19 percent of residents say they would be somewhat or very unlikely to ask for help with caring for their children, such as someone to watch them for a few hours or pick them up from school.*
- *10 percent of residents say they had none or only 1 person they could count on to help them with a practical problem, like finding a ride to medical appointment.*

Recommendation 1. Create a community where it is easy for all parents to build supportive relationships with other parents, seniors, and other residents. Approaches may include:

- Create a voluntary community-wide peer parent support program for all parents, including those who have an open Office of Children's Services case or Child in Need of Aid court case
- Increase community gatherings in public spaces to reduce parent and family isolation

- Develop a volunteer hub to connect community members with others in need and organizations with needs to increase social connectedness in Mat-Su
- Bring back "Community Schools"[18]

Recommendation 2. Use community-organizing to identify and unify parent leaders to create community driven solutions to family issues.

Protective Factor #2:

Knowledge of Parenting and Child Development – All parents, guardians, and child-care providers have accurate and timely information on child development and age appropriate expectations for children's behavior. Developing brains need proper nutrition, regular sleep, physical activity, a variety of stimulating experiences, and caregivers who respond to their needs in a nurturing way that is necessary to form a secure attachment between the child and the adult.

MAT-SU CHALLENGE: *There is no universal program/process that informs all Mat-Su parents and others about child development, teaches parenting skills or helps parents support and teach each other. At the extreme opposite of developmentally appropriate care – child maltreatment can have huge costs to children throughout their lives, as well as to society. In 2015, 248 Mat-Su children had at least one substantiated report of child abuse and neglect with an estimated lifetime cost of $55.4 million (this is the sum of short-term and long-term health care costs, loss or earnings, child welfare costs, criminal justice costs, and special education costs). The precursor to "knowledge of parenting and child development is making an informed decision on whether to be a parent. In Mat-Su, 7.1 percent of births in 2015 were "unwanted" and 21.1 percent were to mothers who did not want to be pregnant then, wanted to be pregnant later, or never wanted to be pregnant. In 2015, 67 babies were born to teenage mothers.*

Recommendation 3. Ensure widespread access to family planning for all Mat-Su residents, including family planning imbedded in robust teen pregnancy prevention efforts.

Recommendation 4. Support the development of a wide array of parent training classes, support groups and other initiatives to educate all parents on the effects of ACEs, resilience, child development and appropriate parenting skills. Approaches may include:

- Media campaigns and workplace trainings
- Education efforts for pregnant women on what to expect during their child's first year and where to find information on child development and parenting techniques
- Parenting classes and support groups for all parents, including those who are in crisis
- The adoption of Ages and Stages child development questionnaire and teaching approaches for health care providers

[18] Community Schools is a program that has a coordinator who organizes programming in public schools in the evenings, weekends, and during vacations when schools are not normally used. Community schools offer a host of opportunities and supports built on that give students and parents tools they need to learn and grow. Offerings can include a broad range of topics. Examples of programming in Juneau and Sitka include youth basketball league, woodworking, family roller skating, Tai Chi, preserving wild meat and parenting proactively.

Recommendation 5. Promote affordable, high quality childcare, afterschool care, and home-visiting programs that support optimal child development and youth resilience. Approaches may include:

- Improve the child care workforce through training and credentialing
- Support the thread Alaska tracking system for quality care in Mat-Su
- Expand home visiting programs as needed in Mat-Su
- Create therapeutic child care for children who have experienced trauma and/or have behavioral health challenges
- Increase afterschool programming with structured opportunities to increase youth resilience

Protective Factor #3:
Parental Resilience – Parents are resilient when they can handle personal challenges and those of their children, manage adversity, heal from the effects of trauma in their own lives, and thrive, given the characteristics and circumstances of their families. Also, by managing stressors, parents are more able to provide their children with nurturing attention and a secure emotional attachment – which is important for children to develop their own resilience.

MAT-SU CHALLENGE: *Many Mat-Su parents have experienced ACEs. In 2013-14, 12 percent of Mat-Su adults stated that they had experienced two ACEs. A total of 42 percent said they had experienced three or more ACEs. If these individuals have not healed from these ACEs, it may be more difficult for them to handle personal challenges of their own and of their children. Parents need access to counseling services, substance abuse treatment and integrated medical and behavioral health care to care for themselves so they can care for their children. In Mat-Su, there are not enough services for parents in terms of substance abuse detox, residential care, crisis care and crisis prevention services, family behavioral health programs, and integrated behavioral and primary care. Further, many people who are seeking help for themselves and others do not know where to go for support and services.*

Recommendation 6. As mentioned in the first two Behavioral Health Scan reports, filling the gaps in the behavioral health system and increasing access to information and existing programs through a central resource center which is available via phone, internet, and in-person to provide information and referral, and navigation, as needed, to parents, relatives and others seeking to support families.

Recommendation 7. Ensure support for the "whole" parent and child in medical settings with integrated physical and behavioral health care; trauma-informed practices and policy, and universal screening for trauma and referral for social service needs.

Recommendation 8. Ensure family-friendly workplaces with work-related stress reduction strategies, parental leave, employee assistance programs, flexible and consistent work schedules and an environment for addressing behavioral health issues that is stigma-free.

Recommendation 9. Implement trauma-informed policies in workplaces, social service agencies, medical care providers, and schools to support parents and families who are healing from traumatic experiences.

Protective Factor #4:
Social and Emotional Competence of Children – When a young child has positive interactions with others, self-regulates his or her behavior, and effectively communicates his or her feelings, this has a positive impact on that child's relationship with family, other adults and peers, and on the child's ability to learn in school. When the strengths of adolescents are fostered through the intentional and deliberate process of providing supportive relationships, experiences and opportunities, they develop into healthy, responsible adults who have the capacity to give back to their community. While social emotional learning is important for all children, it is crucial for children who have experienced ACEs that may significantly affect their emotional development.

MAT-SU CHALLENGE: *In Mat-Su, the School Climate and Connectedness Survey assesses social emotional competency for students grades 6-12. The index is composed of questions measuring how easy or difficult it is for students to do certain social emotional skills. Areas where Mat-Su youth had difficulties include finishing tasks that are hard for them (38 percent); setting goals (27 percent); doing schoolwork even when they didn't feel like it (46 percent); being prepared for tests (35 percent) and getting through something even when they felt frustrated (44 percent).*

Recommendation 10. Support universal access to early learning and preschool programs to ensure kindergarten readiness around social emotional competency of Mat-Su children (i.e., create more early learning slots in Head Start, Early Head Start and MSBSD preschools).

Recommendation 11. Promote social emotional competency for all Mat-Su school-age children and young adults, including those who have experienced trauma. Approaches may include:

- Social emotional learning integrated into curriculum for all ages at school
- Support for homeschool parents with social emotional learning
- Social emotional supports for youth aging out of the foster care system
- A position within the Mat-Su Borough School District that includes the authority to establish system-wide policies on social emotional competency and implement programs, such as curriculum development and teacher assessment.

Recommendation 12. Fill gaps in the behavioral health continuum of care for children mentioned in Reports 1 and 2 of this Scan, including making counseling available in schools, integrated pediatric primary and behavioral health care; and the development of child-crisis care services.

MAT-SU CHALLENGE: *Parents in Mat-Su face challenges in raising children that include handling their own health and wellness (see parent resilience) as well as providing financially for their households. From 2010-14, there*

Protective Factor #5:
Concrete Supports in Times of Need – To thrive, families' basic needs must be met. Adequate concrete supports, (e.g., housing, income, and transportation) must be in place to provide stability and help for families in need. These services should be provided in a way that ensures parents' dignity and does not increase parental stress. Services should help parents identify their assets and strengths, and become active participants in negotiating their support system and independence.

were 4,581 single-parent family households in Mat-Su. Children in single-parent households are often more likely to experience poverty (female-headed 44.0 percent, male-headed 17.2 percent) as compared to two parent households (6.3 percent). Additionally, children are more likely to live in a household accessing public assistance headed by a single parent (female-headed 47.5 percent or male-headed 27.2 percent) compared to two parent households (15.1 percent). In 2012-13, one in five mothers, or their partners, experienced a cut in pay or work hours before their baby was born. Also, one in four mothers of 3-year-old children report that since their child was born they have had a lot of bills they could not pay. In the 2014-15 school year, approximately 6,151 students (34 percent) were identified as economically disadvantaged, and in 2015/16, 695 students experienced homelessness.

Recommendation 13. Create a more connected, complete network of concrete support service providers who leverage efforts to adequately meet the needs of Mat-Su parents. These providers should promote a culture of serving families in a way that maintains their dignity and promotes resilience and self-advocacy.

System-Related Recommendations

Unlike the recommendations organized by protective factors listed above, the following recommendations focus on promoting collaboration between system components through shared data, communication, tracking, and reporting to ensure the progress continues. These recommendations are developed in response to research conducted for Reports 1-3 of the Behavioral Health Environmental Scan, as well as additional community work conducted by Mat-Su Health Foundation.

Recommendation 14. Adopt a balanced view of prevention, emphasizing health promotion and primary prevention, as well as secondary and tertiary prevention. Promote prevention strategies that have proven successful in the community so they are accessible to all families and all can benefit from them.

Recommendation 15. Promote wellness and resilience data collection. Invest in enhanced development of data infrastructure, data management, and data tools, including training for providers, community groups and other collaboratives who are collecting and using the data.

Recommendation 16. Promote policy change in the following areas:

- Address policy challenges that prevent local law enforcement and the Alaska State Troopers from sharing child maltreatment data with the Surveillance of Child Abuse and Neglect data tracking system.

- Ensure that parents have continuous Medicaid and insurance coverage, even those who have temporarily lost custody of their children. This policy would ensure continuity of behavioral and physical health care and support resilience.
- Conduct an assessment and develop a policy/advocacy agenda that creates structural changes in the system that is inclusive of homeless youth and young adults, as well as those involved with the foster care system, and helps youth to thrive.

Recommendation 17. Prepare a full assessment and plan of improvement for the Mat-Su OCS, including tools or programs to convert policy into practices (such as trauma-informed approaches) and workforce development. Components of this plan should include:

- A more extensive system for all levels of visitation and family contact for families involved with OCS.
- A support program for all personnel who work with child maltreatment cases to prevent secondary trauma and support self-care.
- A Differential Response Program for low-risk families with a report of harm to OCS Services to enhance the child welfare system and increase parents' voluntary engagement in services.
- Peer support groups for parents whose children are in OCS custody.
- Innovative solutions to cross-sector collaboration and information sharing to protect children, and help traumatized children heal and thrive.

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Appendix A: Stressors and Protective Factor Indicators

Table 70. Symbols for Statistical and Non-statistical Comparison for Appendices Tables

Symbol	Comparison Indication
√	Indicates there is a statistical difference between the Mat-Su and the region compared, and the Mat-Su percent is better than the comparison percent.
□	Indicates a statistical difference within this variable.
↔	Indicates there is not a statistical difference or no difference between the Mat-Su and Alaska.
X	Indicates a statistical difference between the Mat-Su and the area compared, and the Mat-Su percent is worse than the comparison percent.
NA	Indicates the data are not available for this comparison.
↑	Indicates that the Mat-Su is higher than the comparison region, but there is not a statistical test.
↓	Indicators that the Mat-Su is lower than the comparison, but there is not a statistical test.

Office of Children Services Data

Table 71. Mat-Su Children (Age 0-4) with Maltreatment Allegations and Substantiated Maltreatment Allegations, by Gender, 2010-2015

		Children with Maltreatment Allegations			Children with Substantiated Maltreatment Allegations		
	Population	# of Children	Rate per 1,000 Children	95% Confidence Interval (rate per 1,000 children)	# of Children	Rate per 1,000 Children	95% Confidence Interval (rate per 1,000 children)
Girls							
2010	3,284	260	79.2	69.9 - 88.4	70	21.3	16.4 - 26.3
2011	3,403	279	82.0	72.8 - 91.2	50	14.7	10.7 - 18.7
2012	3,382	267	78.9	69.9 - 88.0	73	21.6	16.7 - 26.5
2013	3,471	264	76.1	67.2 - 84.9	55	15.8	11.7 – 20.0
2014	3,603	276	76.6	67.9 - 85.3	69	19.2	14.7 - 23.6
2015	3,699	311	84.1	75.1 - 93.0	40	10.8	7.5 - 14.1
Boys							
2010	3,616	270	74.7	66.1 - 83.2	66	18.3	13.9 - 22.6
2011	3,620	286	79.0	70.2 - 87.8	57	15.7	11.7 - 19.8
2012	3,628	288	79.4	70.6 - 88.2	70	19.3	14.8 - 23.8
2013	3,722	291	78.2	69.6 - 86.8	65	17.5	13.3 - 21.7
2014	3,732	298	79.8	71.2 - 88.5	82	22.0	17.3 - 26.7
2015	3,779	383	101.3	91.7 - 111.0	58	15.3	11.4 - 19.3
All Children							
2010	6,900	538	78.0	71.6 - 84.3	136	19.7	16.4 - 23.0
2011	7,023	572	81.4	75.0 - 87.8	107	15.2	12.4 - 18.1
2012	7,010	561	80.0	73.7 - 86.4	144	20.5	17.2 - 23.9
2013	7,193	562	78.1	71.9 - 84.3	121	16.8	13.8 - 19.8
2014	7,335	581	79.2	73.0 - 85.4	151	20.6	17.3 - 23.8
2015	7,478	697	93.2	86.6 - 99.8	98	13.1	10.5 - 15.7

Source: Alaska Office of Children's Services, Prepared by SCAN.

Table 72. Statewide Children (Age 0-4) with Maltreatment Allegations and Substantiated Maltreatment Allegations, by Gender, 2010-2015

		Children with Maltreatment Allegations			Children with Substantiated Maltreatment Allegations		
	Population	# of Children	Rate per 1,000 Children	95% Confidence Interval (rate per 1,000 children)	# of Children	Rate per 1,000 Children	95% Confidence Interval (rate per 1,000 children)
Girls							
2010	26,100	2,542	97.4	93.8 - 101.0	690	26.4	24.5 - 28.4
2011	26,843	2,631	98.0	94.5 - 101.6	555	20.7	19.0 - 22.4
2012	26,557	2,586	97.4	93.8 - 100.9	510	19.2	17.6 - 20.9
2013	26,255	2,577	98.2	94.6 - 101.8	468	17.8	16.2 - 19.4
2014	26,179	2,525	96.5	92.9 - 100.0	471	18.0	16.4 - 19.6
2015	25,973	2,682	103.3	99.6 - 107.0	483	18.6	17.0 - 20.2
Boys							
2010	27,896	2,513	90.1	86.7 - 93.4	676	24.2	22.4 - 26.0
2011	28,496	2,642	92.7	89.3 - 96.1	605	21.2	19.6 - 22.9
2012	28,168	2,648	94.0	90.6 - 97.4	501	17.8	16.2 - 19.3
2013	27,977	2,629	94.0	90.6 - 97.4	508	18.2	16.6 - 19.7
2014	27,253	2,612	95.8	92.3 - 99.3	542	19.9	18.2 - 21.5
2015	27,081	2,795	103.2	99.6 - 106.8	488	18.0	16.4 - 19.6
All Children							
2010	53,996	5,084	94.2	91.7 - 96.6	1,369	25.4	24.0 - 26.7
2011	55,339	5,307	95.9	93.4 - 98.4	1,162	21.0	19.8 - 22.2
2012	54,725	5,262	96.2	93.7 - 98.6	1,013	18.5	17.4 - 19.6
2013	54,232	5,240	96.6	94.1 - 99.1	981	18.1	17.0 - 19.2
2014	53,432	5,173	96.8	94.3 - 99.3	1,017	19.0	17.9 - 20.2
2015	53,054	5,511	103.9	101.3 - 106.5	974	18.4	17.2 - 19.5

Source: Alaska Office of Children's Services, Prepared by SCAN.

Table 73. Mat-Su Children (Age 0-17) with Maltreatment Allegations and Substantiated Maltreatment Allegations, by Gender, 2010-2015

	Population	Children with Maltreatment Allegations			Children with Substantiated Maltreatment Allegations		
		# of Children	Rate per 1,000 Children	95% Confidence Interval (rate per 1,000 children)	# of Children	Rate per 1,000 Children	95% Confidence Interval (rate per 1,000 children)
Girls							
2010	12,499	979	78.3	73.6 - 83.0	168	13.4	11.4 - 15.5
2011	12,634	949	75.1	70.5 - 79.7	127	10.1	8.3 - 11.8
2012	12,765	970	76.0	71.4 - 80.6	181	14.2	12.1 -16.2
2013	12,735	913	71.7	67.2 -76.2	156	12.2	10.3 -14.2
2014	12,978	906	69.8	65.4 - 74.2	154	11.9	10 -13.7
2015	13,205	1,037	78.5	73.9 - 83.1	116	8.8	7.2 -10.4
Boys							
2010	13,369	949	71.0	66.6 - 75.3	178	13.3	11.4 - 15.3
2011	13,507	998	73.9	69.5 - 78.3	139	10.3	8.6 - 12.0
2012	13,584	927	68.2	64.0 - 72.5	157	11.6	9.8 - 13.4
2013	13,585	979	72.1	67.7 - 76.4	162	11.9	10.1 - 13.8
2014	13,858	952	68.7	64.5 - 72.9	168	12.1	10.3 - 13.9
2015	14,223	1,189	83.6	79.0 -88.1	127	8.9	7.4 - 10.5
All Children							
2010	25,868	1,955	75.6	72.4 -78.8	347	13.4	12.0 - 14.8
2011	26,141	1,967	75.2	72.0 -78.4	266	10.2	9.0 - 11.4
2012	26,320	1,917	72.8	69.7 -76.0	341	13.0	11.6 - 14.3
2013	26,320	1,914	72.7	69.6 -75.9	320	12.2	10.8 - 13.5
2014	26,836	1,880	70.1	67.0 -73.1	322	12.0	10.7 - 13.3
2015	27,428	2,240	81.7	78.4 -84.9	243	8.9	7.8 - 10.0

Source: Alaska Office of Children's Services, Prepared by SCAN.

Table 74. Statewide Children (Age 0-17) with Maltreatment Allegations and Substantiated Maltreatment Allegations, by Gender, 2010-2015

		Children with Maltreatment Allegations			Children with Substantiated Maltreatment Allegations		
	Population	# of Children	Rate per 1,000 Children	95% Confidence Interval (rate per 1,000 children)	# of Children	Rate per 1,000 Children	95% Confidence Interval (rate per 1,000 children)
Girls							
2010	91,414	7,564	82.7	81.0 - 84.5	1613	17.6	16.8 - 18.5
2011	91,670	7,989	87.1	85.3 - 89.0	1358	14.8	14.0 - 15.6
2012	91,540	7,784	85.0	83.2 - 86.8	1284	14.0	13.3 - 14.8
2013	91,331	7,815	85.6	83.8 - 87.4	1294	14.2	13.4 - 14.9
2014	90,700	7,899	87.1	85.3 - 88.9	1300	14.3	13.6 - 15.1
2015	90,328	8,440	93.4	91.5 - 95.3	1130	12.5	11.8 - 13.2
Boys							
2010	96,621	7,358	76.2	74.5 - 77.8	1545	16.0	15.2 - 16.8
2011	96,911	7,807	80.6	78.8 - 82.3	1310	13.5	12.8 - 14.2
2012	96,863	7,679	79.3	77.6 - 81.0	1167	12.0	11.4- 12.7
2013	96,968	7770	80.1	78.4 - 81.8	1227	12.7	12.0 - 13.4
2014	96,379	7,969	82.7	80.9 - 84.4	1275	13.2	12.5 - 14.0
2015	95,938	8,591	89.5	87.7 - 91.4	1090	11.4	10.7 - 12.0
All Children							
2010	188,035	15,016	79.9	78.6 - 81.1	3165	16.8	16.3 - 17.4
2011	188,581	15,876	84.2	82.9 - 85.4	2671	14.2	13.6 - 14.7
2012	188,403	15,534	82.5	81.2 - 83.7	2461	13.1	12.5 - 13.6
2013	188,299	15,664	83.2	81.9 - 84.4	2531	13.4	12.9 - 14.0
2014	18,7079	15,958	85.3	84.0 - 86.6	2581	13.8	13.3 - 14.3
2015	186,266	17,107	91.8	90.5 - 93.2	2226	12.0	11.5 - 12.4

Source: Alaska Office of Children's Services, Prepared by SCAN.

Centers for Disease Control and Prevention Behavioral Risk Factor Surveillance System (BRFSS) Data

Table 75. Adverse Childhood Experiences (ACEs) Indicators, Mat-Su, and Rest of Alaska, 2012 and 2013 Combined

Type	Life Stage	Level	Indicator (Before 18 years of age,...)	Mat-Su %~	Mat-Su 95% CI	Estimated Annual Average # of Mat-Su Adults 18+	Mat-Su N *	Mat-Su Total Respondents	Rest of Alaska %~	Rest of Alaska 95% CI	Rest of Alaska N*	Rest of Alaska Total Respondents	Mat-Su Statistically Compared to Rest of Alaska
Stressor	Early Childhood – Early Adulthood	Individual	Verbal Abuse: did a parent or adult in your home ever swear at you, insult you, or put you down?	36.5%	32.4 - 40.8%	25,446	467	1,324	30.0%	28.4 - 31.6%	4,260	7,642	X
Stressor	Early Childhood – Early Adulthood	Individual	Divorce: were your parents separated or divorced?	34.8	30.8 - 39.0	24,295	358	1,324	31.7	30.0 - 33.4	1,855	7,642	↔
Stressor	Early Childhood – Early Adulthood	Individual	Alcohol Abuse: did you live with anyone who was a problem drinker or alcoholic?	32.3	28.4 - 36.5	22,537	359	1,324	28.8	27.3 - 30.5	2,004	7,642	↔
Stressor	Early Childhood – Early Adulthood	Individual	Physical Abuse: did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way? Do not include spanking.	23.4	20.2 - 27.1	16,343	277	1,324	17.6	16.3 - 19.0	1,191	7,642	X
Stressor	Early Childhood – Early Adulthood	Individual	Domestic Violence: did your parents or adults in your home ever slap, hit, kick, punch, or beat each other up?	21.2	17.5 - 25.3	14,766	220	1,324	18.1	16.7 - 19.5	1,173	7,642	↔
Stressor	Early Childhood – Early Adulthood	Individual	Parental Neglect – Love and Appreciation: did you feel that your parents or adults in your home did not love you or appreciate you?	19.7	16.0 - 24.0	13,755	148	705	15.0	13.4 - 16.8	645	3,683	X
Stressor	Early Childhood – Early Adulthood	Individual	Depression: did you live with anyone who was mentally ill, depressed or suicidal?	19.7	16.5 - 23.3	13,706	237	1,324	21.1	19.6 - 22.6	1,308	7,642	↔
Stressor	Early Childhood – Early Adulthood	Individual	Sexual Abuse – Any: Did you respond yes to any (at least one) of the three sexual abuse questions (touched, touch them, force sex)	17.8	15.1 - 21.0	12,444	239	1,324	13.0	11.9 - 14.1	1,105	7,642	X

Note: CI indicates Confidence Interval.
Source: Alaska Behavioral Risk Factor Surveillance System (BRFSS).

Type	Life Stage	Level	Indicator (Before 18 years of age…)	Mat-Su %~	Mat-Su 95% CI	Estimated Annual Average # of Mat-Su Adults 18+	Mat-Su N *	Mat-Su Total Respondents	Rest of Alaska %~	Rest of Alaska 95% CI	Rest of Alaska N*	Rest of Alaska Total Respondents	Mat-Su Statistically Compared to Rest of Alaska
Stressor	Early Childhood – Early Adulthood	Individual	Sexual Abuse – Touch You: did anyone at least 5 years older than you or an adult, ever touch you sexually?	16.6	13.8 - 19.8	11,565	207	1,324	12.5	11.5 - 13.7	644	7,642	X
Stressor	Early Childhood – Early Adulthood	Individual	Drugs: did you live with anyone who used illegal street drugs or who abused prescription medications?	15.5	12.4 - 19.2	10,812	139	1,324	15.0	13.7 - 16.4	828	7,642	↔
Stressor	Early Childhood – Early Adulthood	Individual	Parental Neglect- Food, Clothes, Protection: did ANY of the following events apply to you: You didn't have enough to eat, you had to wear dirty clothes or you had no one to protect you?	13.8	10.6 - 17.7	9,605	84	705	10.7	9.2 - 12.4	394	3,683	↔
Stressor	Early Childhood – Early Adulthood	Individual	Prison: did you live with anyone who served time or was sentenced to serve time in a prison, jail, or other correctional facility?	12.7	9.8 - 16.4	8,859	104	1,324	11.7	10.5 - 13.1	608	7,642	↔
Stressor	Early Childhood – Early Adulthood	Individual	Sexual Abuse – Touch Them: did anyone at least 5 years older than you or an adult try to make you touch them sexually?	12.5	9.9 - 15.5	8,684	142	1,324	9.4	8.4 - 10.4	693	7,642	X
Stressor	Early Childhood – Early Adulthood	Individual	Sexual Abuse – Forced Sex: did anyone at least 5 years older than you or an adult force you to have sex?	9.8	7.4 - 12.8	6,815	96	1,324	6.0	5.3 - 6.9	426	7,642	X

Note: CI indicates Confidence Interval.
Source: Alaska Behavioral Risk Factor Surveillance System (BRFSS).

Childhood Understanding Behaviors Survey (CUBS) Data

Table 76. Selected Indicators from Childhood Understanding Behaviors Survey (CUBS), Percentage of Mothers of Three-Year-Olds, Mat-Su, Rest of Alaska, and Alaska, 2012-2014

Type	Life Stage	Level	Indicator	Mat-Su Mothers with 3-Year Olds %~	Mat-Su Mothers with 3-Year Olds 95% CI	Estimated Annual Average # of Mat-Su Mothers with 3-Year Olds	Estimated # of Mat-Su Mothers with 3-Year Olds Confidence Interval	Mat-Su Mothers with 3-Year Olds N *	Rest of Alaska Mothers with 3-Year Olds %~	Rest of Alaska Mothers with 3-Year Olds 95% CI	Rest of Alaska Mothers with 3-Year Olds N*	Mat-Su Statistically Compared to Rest of Alaska	Alaska Mothers with 3-Year Olds %~	Alaska Mothers with 3-Year Olds 95% CI	Alaska Mothers with 3-Year Olds N*
Protective	Early Childhood	Family	Have you ever delayed or decided not to get vaccine shots or immunizations for your child?	37.7	29.5 - 46.7	550	430 - 681	209	27.3	24.3 - 30.5	1,446	X	28.6	25.8 - 32.0	1,655
Protective	Early Childhood	Family	Did you delay or decide not to get a specific vaccine shot or immunization for your child?	37.0	24.9 - 51.1	212	142 - 292	82	46.3	39.8 - 52.8	378	↔	44.%	38.7 - 50.0	460
Protective	Early Childhood	Family	My child's bedtime is usually the same everyday	89.7	83.3 - 93.8	1,307	1,214 - 1,368	209	84.2	81.5 - 86.5	1,446	↔	85.0	82.6 - 87.0	1,655
Protective	Early Childhood	Community	My child has a caring relationship with at least one other adult other than his or her parents	94.9	89.0 - 97.7	1,382	1,298 - 1,424	209	95.1	93.4 - 96.4	1,446	↔	95.%	93.5 - 96.0	1,655
Stressor	Early Childhood	Family	Respondents who sat down and ate fewer than 3 meals per week with their child	0.8	0.2 - 3.4	12	3 - 50	209	1.7	1.1 - 2.8	1,446	↔	1.6	1.0 - 3.0	1,655
Stressor	Early Childhood	Family	Respondents who read a book or story to their child fewer than 3 days per week	5.7	2.8 - 11.4	85	40 - 167	209	9.9	8.2 - 11.9	1,446	↔	9.5	7.9 - 11.0	1,655
Protective	Early Childhood	Community	My child plays with children outside the family on a regular basis	74.9	66.0 - 82.1	1,242	963 - 1,197	209	79.8	77.1 - 82.3	1,446	↔	79.0	76.4 - 81.0	1,655
Protective	Early Childhood	Community	I know where to go for parenting information or if I have questions or concerns about my child's development	96.6	91.7 - 98.7	1,441	1,368 - 1,473	213	93.5	91.8 - 94.9	1,478	↔	93.7	92.1 - 95.0	1,691
Protective	Early Childhood	Individual	I am confident in my ability to raise and take care of my child	96.7	91.2 - 98.8	1,442	1,361- 1,474	213	96.0	94.5 - 97.1	1,478	↔	96.0	94.6 - 97.0	1,691
Protective	Early Childhood	Community	I feel comfortable asking for help when I need it	84.9	77.1 - 90.3	1,267	1,151 –-1,348	213	84.4	81.8 - 86.6	1,478	↔	84.2	81.8 - 86.0	1,691
Protective	Early Childhood	Individual	I have steps I can take to manage stress	92.8	86.6 - 96.2	1,384	1,292 - 4,308	213	87.2	85.1 - 89.1	1,478	↔	87.8	85.8 - 90.0	1,691

Type	Life Stage	Level	Indicator	Mat-Su Mothers with 3-Year Olds %~	Mat-Su Mothers with 3-Year Olds 95% CI	Estimated Annual Average # of Mat-Su Mothers with 3-Year Olds	Estimated # of Mat-Su Mothers with 3-Year Olds Confidence Interval	Mat-Su Mothers with 3-Year Olds N *	Rest of Alaska Mothers with 3-Year Olds %~	Rest of Alaska Mothers with 3-Year Olds 95% CI	Rest of Alaska Mothers with 3-Year Olds N*	Mat-Su Statistically Compared to Rest of Alaska	Alaska Mothers with 3-Year Olds %~	Alaska Mothers with 3-Year Olds 95% CI	Alaska Mothers with 3-Year Olds N*
Protective	Early Childhood	Community	Do you now have routine child care arrangements for your 3-year old child?	35.5	27.3 - 44.7	518	398 - 1,955	209	46.1	42.7 - 49.4	1,446	X	44.6	41.5 - 48.0	1,655
Protective	Early Childhood	Community	I know someone who would help me if I was sick and needed to be in bed	90.1	82.8 - 94.5	1,344	1,236 - 4,230	213	88.6	86.4 - 90.5	1,478	↔	88.6	86.5 - 90.0	1,691
Protective	Early Childhood	Community	I know someone who would listen to me if I needed to talk	97.5	91.3 - 99.3	1,456	1,363 - 4,448	213	94.1	92.4 - 99.3	1,478	↔	94.4	92.8 - 96.0	1,691
Protective	Early Childhood	Community	I know someone who would loan me money for bills if I needed it	85.6	78.0 - 90.9	1,277	1,164 - 4,069	213	79.2	76.3 - 81.7	1,478	↔	80.1	77.5 - 82.0	1,691
Protective	Early Childhood	Community	I know someone who would take me to the clinic or doctor's office if I needed a ride	93.6	86.7 - 97.1	1,397	1,294 - 4,345	213	92.4	90.6 - 93.9	1,478	↔	92.4	90.6 - 94.0	1,691
Protective	Early Childhood	Family	During the past 12 months, has your child seen a health care worker for routine medical care such as a well-child check-up or physical exam	84.3	77.0 - 89.6	1,228	1,122 - 3,918	209	84.9	82.4 - 87.0	1,446	↔	84.8	82.6 - 87.0	1,655
Protective	Early Childhood	Community	Is there a doctor, nurse, or other health care worker who knows your child well and is familiar with your child's health history?	85.1	77.7 - 90.4	1,241	1,133 - 3,951	209	79.8	77.1 - 82.4	1,446	↔	80.5	77.9 - 83.0	1,655
Stressor	Early Childhood	Family	During the past 12 months, did you husband or partner push, hit, slap, kick, choke or physically hurt you in any other way?	1.4	0.4 - 4.6	21	7 - 204	213	3.3	2.4 - 4.6	1,478	↔	3.0	2.2 - 4.0	1,691
Stressor	Early Childhood	Family	Has your child ever experienced alcoholism or mental health disorder in the family	6.7	3.3 - 13.1	98	49 - 572	209	6.0	4.6 - 7.8	1,446	↔	6.0	4.7 - 8.0	1,655
Stressor	Early Childhood	Family	Has your child ever experienced death in the immediate family	6.4	3.5 - 11.2	93	52 - 489	209	12.7	10.8 - 15.0	1,446	√	12.0	10.2 - 14.0	1,655
Stressor	Early Childhood	Family	Has your child ever experienced being away from either parent for longer than a one-month time period	17.6	11.9 - 25.5	257	173 - 371	209	19.8	17.3 - 22.5	1,446	↔	19.4	17.1 - 22.0	1,655

Type	Life Stage	Level	Indicator	Mat-Su Mothers with 3-Year Olds %~	Mat-Su Mothers with 3-Year Olds 95% CI	Estimated Annual Average # of Mat-Su Mothers with 3-Year Olds	Estimated # of Mat-Su Mothers with 3-Year Olds Confidence Interval	Mat-Su Mothers with 3-Year Olds N *	Rest of Alaska Mothers with 3-Year Olds %~	Rest of Alaska Mothers with 3-Year Olds 95% CI	Rest of Alaska Mothers with 3-Year Olds N*	Mat-Su Statistically Compared to Rest of Alaska	Alaska Mothers with 3-Year Olds %~	Alaska Mothers with 3-Year Olds 95% CI	Alaska Mothers with 3-Year Olds N*
Stressor	Early Childhood	Family	Has your child ever experienced change in household members (including a new sibling)	50.6	41.6 - 59.5	737	607 - 867	209	41.3	38.0 - 44.6	1,446	↔	42.6	39.5 - 46.0	1,655
Stressor	Early Childhood	Family	Has your child ever experienced an overnight stay in hospital (not including right after birth)	7.3	3.9 - 13.2	107	57 - 193	209	12.0	10.0 - 14.2	1,446	↔	11.4	9.6 - 13.0	1,655
Stressor	Early Childhood	Family	Has your child ever experienced seeing violence or physical abuse in person	1.5	0.5 - 4.6	22	7 - 68	209	4.6	3.4 - 6.2	1,446	↔	4.4	3.3 - 6.0	1,655
Stressor	Early Childhood	Family	Has your child ever experienced conflict between parents	20.6	14.5 - 28.5	301	211 - 416	209	25.5	22.6 - 28.6	1,446	↔	24.8	14.5 - 28.5	1,655
Stressor	Early Childhood	Family	Since your 3-year old child was born, have you been homeless?	1.7	0.4 - 7.6	25	5 - 113	213	4.0	2.8 - 5.6	1,478	↔	3.9	2.8 - 6.0	1,691
Stressor	Early Childhood	Family	Since your 3-year old child was born, has someone very close to you died?	20.7	14.5 - 28.7	309	216 - 428	213	25.2	22.5 - 28.1	1,478	↔	24.9	22.4 - 28.0	1,691
Stressor	Early Childhood	Family	Since your 3-year old child was born, have you or your husband/partner been to jail?	3.3	1.2 - 8.8	49	17 - 131	213	7.2	5.8 - 8.9	1,478	↔	6.9	5.6 - 8.0	1,691
Stressor	Early Childhood	Family	Since your 3-year old child was born, has your marital status changed?	15.9	9.9 - 24.4	237	148 - 365	213	14.2	11.9 - 16.9	1,478	↔	14.5	12.3 - 17.0	1,691
Stressor	Early Childhood	Family	Since your 3-year old child was born, has someone very close to you been depressed, mentally ill, or suicidal?	13.5	8.4 - 21.0	201	125 - 313	213	15.2	12.9 - 17.8	1,478	↔	15.1	12.9 - 18.0	1,691
Stressor	Early Childhood	Family	Since your 3-year old child was born, has someone very close to you had a problem with drinking or drugs?	13.0	8.0 - 20.3	194	120 - 303	213	16.0	13.8 - 18.5	1,478	↔	15.6	13.9 - 18.0	1,691
Stressor	Early Childhood	Family	Since your 3-year old child was born, has your husband or partner lost his job?	12.6	7.5 - 20.3	188	112 - 303	213	12.3	10.2 - 14.6	1,478	↔	12.5	10.5 - 15.0	1,691
Stressor	Early Childhood	Family	Since your 3-year old child was born, have you moved to a new address?	49.0	40.2 - 57.8	731	600 - 863	213	49.6	46.3 - 53.0	1,478	↔	49.8	46.7 - 53.0	1,691

Type	Life Stage	Level	Indicator	Mat-Su Mothers with 3-Year Olds %~	Mat-Su Mothers with 3-Year Olds 95% CI	Estimated Annual Average # of Mat-Su Mothers with 3-Year Olds	Estimated # of Mat-Su Mothers with 3-Year Olds Confidence Interval	Mat-Su Mothers with 3-Year Olds N *	Rest of Alaska Mothers with 3-Year Olds %~	Rest of Alaska Mothers with 3-Year Olds 95% CI	Rest of Alaska Mothers with 3-Year Olds N*	Mat-Su Statistically Compared to Rest of Alaska	Alaska Mothers with 3-Year Olds %~	Alaska Mothers with 3-Year Olds 95% CI	Alaska Mothers with 3-Year Olds N*
Stressor	Early Childhood	Family	Since your 3-year old child was born, have you lost your job?	14.0	8.6 - 22.0	208	128 - 328	213	11.6	9.6 - 14.1	1,478	↔	12.2	10.2 - 15.0	1,691
Stressor	Early Childhood	Family	Since your 3-year old child was born, have you had a lot of bills you couldn't pay?	26.6	19.3 - 35.4	396	288 - 528	213	22.1	19.4 - 25.0	1,478	↔	23.0	20.4 - 26.0	1,691
Stressor	Early Childhood	Family	Since your 3-year old child was born, have you been diagnosed with depression?	8.5	4.8 - 14.7	127	71 - 219	213	9.9	7.9 - 12.3	1,478	↔	9.7	7.9 - 12.0	1,691
Protective	Early Childhood	Community	Do you regularly use a childcare center, preschool, Head Start or other center that is not a caregiver's home?**	60.9	45.7 - 74.3%	327	245 - 399	206	47.1	42.1 - 52.1	1,419	↔	48.4	43.6 - 53.0	1,625
Protective	Early Childhood	Community	Do you regularly use child care in your home by a non-relative**	12.5	5.3 - 26.6	67	29 - 143	70	8.3	5.9 - 11.4	673	↔	8.7	6.4 - 12.0	743
Protective	Early Childhood	Community	Do you regularly use child care in your home by a relative**	19.0	9.5 - 34.4	102	51 - 185	70	24.1	20.1 - 28.6	673	↔	23.4	19.7 - 28.0	743
Protective	Early Childhood	Community	Do you regularly use child care in a non-relative's home**	21.6	11.8 - 36.2	116	63 - 194	70	21.6	17.9 - 25.9	673	↔	21.5	18.0 - 26.0	743
Protective	Early Childhood	Community	Do you regularly use child care in a relative's home?**	31.4	19.0 - 47.2	169	102 - 253	70	25.5	21.4 - 30.0	673	↔	26.5	22.5 - 31.0	743
Protective	Early Childhood	Community	Do you regularly use another type of child care?**	2.1	0.3 - 13.0	11	2 - 70	70	2.0	1.2 - 3.4	673	↔	2.0	1.2 - 3.0	743
Stressor	Early Childhood	Community	Is the average cost per month that you pay now for child care for your 3-year-old $600 or more?**	9.5	5.4 - 16.2	142	77 - 209	209	16.7	14.4 - 19.4	1,444	√	15.0	13.5 - 18.0	1,653
Stressor	Early Childhood	Community	Would you prefer to use a form of child care for your child other than what you are using now?**	14.2	6.0 - 30.0	76	32 - 161	70	22.4	18.5 - 26.8	673	↔	21.4	17.8 - 26.0	743
Protective	Early Childhood	Individual	During the past 12 months, did a doctor, nurse or other health care or mental health worker talk to you about depression or how you are feeling emotionally?	35.0	26.8 - 44.1	522	400 - 659	213	29.4	26.4 - 32.6	1,478	↔	30.2	27.3 - 33.0	1,691

Notes: * unweighted denominator data. ~ weighted percentages represent the whole population. CI indicates Confidence Interval. ** indicates mothers who reported currently using childcare regularly.
Source: Alaska Childhood Understanding Behaviors Survey (CUBS).

Pregnancy Risk Assessment Monitoring System (PRAMS) Data

Table 77. Selected Indicators from Pregnancy Risk Assessment Monitoring System, Percentage of Mothers with Newborns, Mat-Su, Rest of Alaska, and U.S. 2012-2013

Type	*Life Stage*	*Level*	*Indicator*	*Mat-Su Mothers with Newborns %~*	Mat-Su Mothers with Newborns 95% CI	Estimated Annual Average # of Mat-Su Mothers with Newborns	Mat-Su Mothers with Newborns N *	Mat-Su Mothers with Newborns Total Respondents	Rest of Alaska Mothers with Newborns %~	Rest of Alaska Mothers with Newborns 95 % CI	Rest of Alaska Mothers with Newborns N*	Rest of Alaska Mothers with Newborns Total Respondents	Mat-Su Statistically Compared to Rest of Alaska	U.S. Mothers with Newborns %	U.S. Mothers with Newborns 95% CI
At any time during the 12 months before you got pregnant with your new baby, did you...															
Protective	Prenatal	Individual	Diet to lose weight?	28.9	22.4 - 36.4	362	72	232	28.6	26.2 - 31.1	510	1,985	↔	28.8	28.0 - 29.5
Protective	Prenatal	Individual	Exercise 3 or more days of the week?	53.9	46.1 - 61.6	681	126	232	53.7	51.0 - 56.3	1,019	1,980	↔	44.3	43.5 - 45.1
Protective	Prenatal	Community	Have your teeth cleaned by a dentist or dental hygienist?	59.3	51.3 - 66.7	744	135	230	59.1	56.5 - 61.7	1,141	1,975	↔	56.4	55.6 - 57.3
Protective	Prenatal	Individual	Regularly take prescription medicines other than birth control?	15.1	10.5 - 21.2	190	47	232	17.9	16.0 - 20.1	364	1,981	↔	19.9	19.3 - 20.6
Protective	Prenatal	Community	Talk to a health care worker about your family medical history?	29.8	23.2 - 37.5	376	72	231	26.7	27.3 - 32.2	614	1,979	↔	27.1	26.4 - 27.8
Protective	Prenatal	Community	Visit a health care worker and get checked for depression or anxiety?	13.5	9.1 - 19.7	171	40	233	15.9	14.0 - 17.9	324	1,983	↔	-	-
Protective	Prenatal	Community	Visit a health care worker and get checked for diabetes?	9.9	6.2 - 15.5	125	31	232	17.6	15.7 - 19.7	359	1,972	X	-	-
Protective	Prenatal	Community	Visit a health care worker and get checked for high blood pressure?	20.6	14.9 - 27.6	256	51	230	24.4	22.2 - 26.7	504	1,972	↔	-	-

Type	Life Stage	Level	Indicator	Mat-Su Mothers with Newborns %~	Mat-Su Mothers with Newborns 95% CI	Estimated Annual Average # of Mat-Su Mothers with Newborns	Mat-Su Mothers with Newborns N *	Mat-Su Mothers with Newborns Total Respondents	Rest of Alaska Mothers with Newborns %~	Rest of Alaska Mothers with Newborns 95 % CI	Rest of Alaska Mothers with Newborns N*	Rest of Alaska Mothers with Newborns Total Respondents	Mat-Su Statistically Compared to Rest of Alaska	U.S. Mothers with Newborns %	U.S. Mothers with Newborns 95% CI
During any of your prenatal visits, did a doctor, nurse, or other health care worker talk with you about...															
Protective	Prenatal	Community	Breastfeeding your baby?	87.4	81.0 - 91.8	1,087	203	232	86.0	84.1 - 87.8	1,677	1,948	↔	83.6	83.0 - 84.2
Protective	Prenatal	Community	Doing tests to screen for birth defects or diseases that run in your family?	89.9	84.5 - 93.6	1,118	203	231	83.5	81.5 - 85.3	1,591	1,937	√	87.3	86.8 - 87.9
Protective	Prenatal	Community	Getting tested for HIV?	66.4	58.6 - 73.4	821	149	228	70.7	68.1 - 73.1	1,384	1,927	↔	75.3	74.6 - 76.0
Protective	Prenatal	Community	How drinking alcohol during pregnancy could affect your baby?	79.1	72.2 - 84.7	984	175	232	73.5	71.1 - 75.9	1,486	1,947	↔	72.3	71.5 - 73.0
Protective	Prenatal	Community	How much weight you should gain during pregnancy?	79.1	72.0 - 84.8	982	180	230	76.8	74.5 - 79.0	1,472	1,949	↔	75.9	74.4 - 77.3
Protective	Prenatal	Community	How smoking during pregnancy could affect your baby?	80.7	73.9 - 86.1	1,003	185	232	72.1	69.5 - 74.5	1,475	1,945	√	70.9	70.1 - 71.6
Protective	Prenatal	Community	How using illegal drugs could affect your baby?	68.8	61.2 - 75.6	847	159	231	61.2	58.5 - 63.8	1,298	1,946	↔	63.8	63.0 - 64.6
Protective	Prenatal	Community	Medicines that are safe to take during your pregnancy?	90.3	84.9 - 93.9	1,122	209	232	86.8	84.9 - 88.5	1,695	1,947	↔	88.2	87.6 - 88.7
Protective	Prenatal	Community	Physical abuse to women by their husbands or partners?	70.9	63.3 - 77.4	872	150	230	59.3	56.6 - 61.9	1,178	1,938	√	51.7	50.9 - 52.6
Protective	Prenatal	Community	The signs and symptoms of preterm labor?	89.4	83.8 - 93.2	1,108	192	229	82.3	80.2 - 84.2	1,554	1,944	√	80.4	79.7 - 81.0
Protective	Prenatal	Community	Using a seat belt during pregnancy?	62.0	54.2 - 69.2	770	130	231	54.6	51.9 - 57.3	1,057	1,927	↔	53.9	53.1 - 54.8
Protective	Prenatal	Community	What to do if you feel depressed during your pregnancy or after your baby is born?	80.0	73.1 - 85.5	994	177	231	76.9	74.6 - 79.1	1,473	1,945	↔	72.2	71.5 - 73.0

Type	Life Stage	Level	Indicator	Mat-Su Mothers with Newborns %~	Mat-Su Mothers with Newborns 95% CI	Estimated Annual Average # of Mat-Su Mothers with Newborns	Mat-Su Mothers with Newborns N *	Mat-Su Mothers with Newborns Total Respondents	Rest of Alaska Mothers with Newborns %~	Rest of Alaska Mothers with Newborns 95 % CI	Rest of Alaska Mothers with Newborns N*	Rest of Alaska Mothers with Newborns Total Respondents	Mat-Su Statistically Compared to Rest of Alaska	U.S. Mothers with Newborns %	U.S. Mothers with Newborns 95% CI
For mothers with a live birth, just before you got pregnant with your new baby...															
Stressor	Prenatal	Family	I didn't want to be pregnant then, or at any time in the future (unwanted pregnancy)	7.1	4.0 - 12.6	89	14	230	4.7	3.7 - 5.9	104	1970	↔	-	-
Stressor	Prenatal	Family	I wanted to be pregnant later, or didn't want to be pregnant then, or at any time in the future (unintended pregnancy)	21.1	15.4 - 28.1	264	58	230	26.9	24.6 - 29.4	516	1970	↔	-	-
During...															
Stressor	Prenatal	Family	The 12 months before you got pregnant with your new baby, did you husband or partner push, hit, slap, kick, choke, or physically hurt you in any other way?	3.8	1.7 - 8.4	47	8	230	2.8	2.1 - 3.8	64	1,967	↔	3.2	2.9 - 3.5
Stressor	Prenatal	Family	Your most recent pregnancy, did you husband or partner push, hit, slap, kick, choke, or physically hurt you in any other way?	2.9	1.1 - 7.6	36	5	231	2.1	1.5 - 2.9	57	1,967	↔	2.0	1.3 - 3.2
In the 12 months before your new baby was born,...															
Stressor	Prenatal	Family	A close family member was sick and had to go into the hospital.	22.4	16.3 - 29.9	276	46	228	20.3	18.2 - 22.5	384	1,967	↔	21.6	21.0 - 22.3
Stressor	Prenatal	Family	I argued with my husband or	19.6	14.0 - 26.7	242	45	231	19.3	17.3 - 21.5	393	1,965	↔	21.9	21.2 - 22.6

Type	Life Stage	Level	Indicator	Mat-Su Mothers with Newborns %~	Mat-Su Mothers with Newborns 95% CI	Estimated Annual Average # of Mat-Su Mothers with Newborns	Mat-Su Mothers with Newborns N *	Mat-Su Mothers with Newborns Total Respondents	Rest of Alaska Mothers with Newborns %~	Rest of Alaska Mothers with Newborns 95 % CI	Rest of Alaska Mothers with Newborns N*	Rest of Alaska Mothers with Newborns Total Respondents	Mat-Su Statistically Compared to Rest of Alaska	U.S. Mothers with Newborns %	U.S. Mothers with Newborns 95% CI
			partner more than usual.												
In the 12 months before your new baby was born,...															
Stressor	Prenatal	Family	I got separated or divorced from my husband or partner.	8.7	5.0 - 14.6	108	22	231	6.7	5.6 - 8.1	161	1,967	↔	6.6	6.2 - 7.0
Stressor	Prenatal	Family	I had problems paying the rent, mortgage, or other bills.	20.9	15.2 - 28.1	256	49	228	15.4	13.6 - 17.5	327	1,962	↔	-	-
Stressor	Prenatal	Individual	I lost my job even though I wanted to go on working.	7.8	4.6 - 13.1	97	23	231	6.9	5.7 - 8.3	160	1,963	↔	9.7	9.2 - 10.2
Stressor	Prenatal	Family	I moved to a new address.	39.4	32.0 - 47.3	488	88	231	37.1	34.5 - 39.7	726	1,968	↔	31.9	31.1 - 32.7
In the 12 months before your new baby was born...															
Stressor	Prenatal	Family	I was apart from my husband or partner due to military deployment or extended work-related travel.	12.3	8.0 - 18.5	151	27	229	16.1	14.1 - 18.3	270	1,966	↔	-	-
Stressor	Prenatal	Family	I was homeless or had to sleep outside, in a car, or in a shelter.	3.6	1.6 - 8.2	45	8	230	2.8	2.1 - 3.8	71	1,972	↔	-	-
Stressor	Prenatal	Family	My husband or partner lost his job.	11.9	7.6 - 18.2	147	24	231	7.9	6.6 - 9.5	169	1,963	↔	11.7	11.1 - 12.2
Stressor	Prenatal	Family	My husband or partner said he didn't want me to be pregnant.	9.2	5.4 - 15.0	113	20	229	6.1	5.0 - 7.6	127	1,964	↔	7.5	7.1 - 7.9
Stressor	Prenatal	Family	My husband, partner, or I had a cut in work hours or pay.	21.4	15.6 - 28.7	265	49	231	13.5	11.8 - 15.5	252	1,962	X	-	-
Stressor	Prenatal	Family	My husband, partner, or I went to jail.	7.0	3.8 - 12.5	87	12	230	3.7	2.9 - 4.6	103	1,968	↔	3.6	3.3 - 3.9

Type	Life Stage	Level	Indicator	Mat-Su Mothers with Newborns %~	Mat-Su Mothers with Newborns 95% CI	Estimated Annual Average # of Mat-Su Mothers with Newborns	Mat-Su Mothers with Newborns N *	Mat-Su Mothers with Newborns Total Respondents	Rest of Alaska Mothers with Newborns %~	Rest of Alaska Mothers with Newborns 95 % CI	Rest of Alaska Mothers with Newborns N*	Rest of Alaska Mothers with Newborns Total Respondents	Mat-Su Statistically Compared to Rest of Alaska	U.S. Mothers with Newborns %	U.S. Mothers with Newborns 95% CI
In the 12 months before your new baby was born...															
Stressor	Prenatal	Family	Someone very close to me died.	17.6	12.2 - 24.8	218	37	230	16.5	14.7 - 18.5	355	1,963	↔	16.3	15.7 - 16.9
Stressor	Prenatal	Family	Someone very close to me had a problem with drinking or drugs.	17.5	12.2 - 24.3	216	39	230	14.6	12.9 - 16.5	323	1,966	↔	11.2	10.7 - 11.7
Since your new baby was born, have you...															
Protective	Early Childhood	Individual	Had a postpartum checkup for yourself?	89.8	83.7 - 93.7	1,117	206	231	86.7	84.8 - 88.3	1,638	1,942	↔	91.0	90.4 - 91.6
Stressor	Early Childhood	Individual	ALWAYS OR OFTEN felt down, depressed, or hopeless?	5.1	2.6 - 9.7	63	16	230	5.7	4.6 - 7.1	129	1,949	↔	-	-
Stressor	Early Childhood	Individual	ALWAYS OR OFTEN had little interest or pleasure in doing things?	6.8	3.8 - 12.0	63	19	230	9.0	7.6 - 10.7	189	1,944	↔	-	-
Since your new baby was born, did a doctor, nurse, or other health care worker talk with you about...															
Protective	Early Childhood	Community	Birth control methods that I can use after giving birth?	87.9	81.6 - 92.2	1,056	197	222	88.5	86.7 - 90.2	1,631	1,854	↔	-	-
Protective	Early Childhood	Individual	Getting to and staying at a healthy weight after delivery?	45.6	37.8 - 53.7	544	100	221	46.1	43.4 - 48.9	868	1,853	↔	-	-
Since your new baby was born, did a doctor, nurse, or other health care worker talk with you about...															
Protective	Early Childhood	Community	Help with or information about breastfeeding?	89.3	83.8 - 93.1	1,073	195	222	86.3	84.4 - 87.9	1,580	1,857	↔	-	-
Protective	Early Childhood	Community	How long to wait before getting pregnant again?	61.6	53.5 - 69.0	740	136	222	59.6	56.9 - 62.3	1,126	1,843	↔	-	-

Type	Life Stage	Level	Indicator	Mat-Su Mothers with Newborns %~	Mat-Su Mothers with Newborns 95% CI	Estimated Annual Average # of Mat-Su Mothers with Newborns	Mat-Su Mothers with Newborns N *	Mat-Su Mothers with Newborns Total Respondents	Rest of Alaska Mothers with Newborns %~	Rest of Alaska Mothers with Newborns 95 % CI	Rest of Alaska Mothers with Newborns N*	Rest of Alaska Mothers with Newborns Total Respondents	Mat-Su Statistically Compared to Rest of Alaska	U.S. Mothers with Newborns %	U.S. Mothers with Newborns 95% CI
Since your new baby was born, did a doctor, nurse, or other health care worker talk with you about...															
Protective	Early Childhood	Individual	Postpartum depression?	88.5	82.3 - 92.8	1,062	192	220	84.9	82.9 - 86.7	1,561	1,851	↔	-	-
Protective	Early Childhood	Community	Resources in my community such as nurse home visitation programs, telephone hotlines, counseling, etc.?	39.9	32.4 - 47.9	475	102	220	51.4	48.7 - 54.1	968	1,856	X	-	-
Protective	Early Childhood	Community	Support groups for new parents?	38.9	31.5 - 46.8	467	97	221	49.1	46.4 - 51.9	934	1,848	X	-	-

Notes: N* is unweighted number of mothers of newborns who said Yes to the indicator. CI indicates Confidence Interval. The U.S. value is based on the weighed mean percentage across participating U.S. states meeting an acceptable response rate threshold. National data is for year 2011.
Source: Pregnancy Risk Assessment Monitoring System (PRAMS) and CDC PRAMStat.

Behavioral Risk Factor Surveillance Survey (BRFSS) Data

Table 78. Selected Indicators from Behavioral Risk Factor Surveillance System Survey, Mat-Su and Alaska, 2013

Type	Life Stage	Indicator	Mat-Su %	Mat-Su 95% CI	Mat-Su N	Mat-Su Estimated Number	Mat-Su Statistically Compared to Alaska	Alaska %	Alaska 95 % CL	Alaska N
Protective	Adulthood	Have you received food assistance from a government program, such as Food Stamps (also known as Quest or SNAP), WIC (Women, Infants and Children Program), Free or Reduced School Lunch or Breakfast?	17.7%	12.7 - 24.2%	83	68,320	↔	15.6%	13.9 - 18.0%	592
Protective	Adulthood	Have you received food assistance from community programs, such as a food bank or food pantry, a church, Meals on Wheels, or Senior Center Meals?	13.4%	8.6 - 20.2%	59	16,996	↔	7.0%	5.8 - 8.0%	293
Protective	Adulthood	In the last 12 months, have you seen a healthcare professional?	71.2%	65.5 - 76.2%	496	12,853	X	71.1%	68.8 - 73.0%	3391

Note: Mat-Su's estimated number of adults is calculated based on DOLWD 2013 population estimates for the Mat-Su Borough. CI indicates Confidence Interval.
Source: Alaska Behavioral Risk Factor Surveillance System (BRFSS).

School Climate and Connectedness Survey (SCCS) Data

Table 79. School Climate and Connectedness Survey (SCCS) Results, Mat-Su and Alaska, School Year 2014-2015

Indicator	Grades	Average Mat-Su	Average Alaska	Mat-Su Compared to Alaska
Parent and Community Involvement Index	6th-12th	3.52	3.56	↓
Caring Adults Index	6th-12th	3.57	3.59	↓
Caring Others Index	3rd-5th	2.54	2.56	↓
Peer Climate Index	6th-12th	3.20	3.18	↑
Respectful Climate Index	6th-12th	3.54	3.54	↔
School Leadership and Student Involvement Index	6th-12th	3.37	3.42	↓
School Safety Index	6th-12th	3.96	3.90	↑
Social and Emotional Learning Index	6th-12th	3.82	3.84	↓
High Expectations Index	6th-12th	4.08	4.10	↓
Percentage of students who heard a message in the past year saying that most do not drink	6th-12th	54%	56%	↓
Attendance rate (percent)	Pre-K-12th	92.3%	93.1%	↓

Notes: Results are averages of categorical responses, and index scores are based upon a model summarizing responses.
Source: Alaska School Climate and Connectedness Survey (SCCS) and DEED.

Table 80. Social and Emotional Learning (SEL) Skills, Grades 6-12, Mat-Su, 2016

Indicator	Mat-Su Percent	Mat-Su Higher or Lower than Statewide Results
Self-Awareness – Self Concept		
Knowing ways I calm myself down.		
Very Difficult	5.2	↑
Difficult	17.3	↑
Easy	45.3	↓
Very Easy	32.3	↓
Knowing what my strength are.		
Very Difficult	3.7	↑
Difficult	15.2	↔
Easy	43.1	↓
Very Easy	38.0	↑
Self-Awareness – Emotions		
Knowing when my feelings are making it hard for me to focus.		
Very Difficult	4.1	↓
Difficult	16.2	↓
Easy	45.8	↓
Very Easy	33.9	↑
Knowing the emotions I feel.		
Very Difficult	5.7	↑
Difficult	17.0	↑
Easy	44.6	↓
Very Easy	32.7	↑
Social Awareness		
Learning from people with different opinions than me.		
Very Difficult	4.2	↑
Difficult	16.9	↓
Easy	53.6	↓
Very Easy	25.2	↑
Knowing what people may be feeling by the look on their face.		
Very Difficult	2.3	↓
Difficult	11.6	↓
Easy	47.6	↓
Very Easy	38.6	↑

Indicator	Mat-Su Percent	Mat-Su Higher or Lower than Statewide Results
Social Awareness (cont'd)		
Knowing when someone needs help.		
Very Difficult	1.4	↓
Difficult	10.6	↓
Easy	52.4	↑
Very Easy	35.6	↑
Self-Management – Emotions		
Getting through something even when I feel frustrated.		
Very Difficult	8.1	↑
Difficult	35.5	↑
Easy	42.0	↓
Very Easy	14.5	↓
Being patient even when I am really excited.		
Very Difficult	8.7	↑
Difficult	26.6	↑
Easy	43.2	↓
Very Easy	21.6	↓
Self-Management – Goals		
Finishing tasks even if they are hard for me.		
Very Difficult	5.8	↑
Difficult	32.3	↑
Easy	45.0	↔
Very Easy	16.9	↓
Setting goals for myself.		
Very Difficult	6.2	↑
Difficult	20.8	↔
Easy	44.5	↑
Very Easy	28.5	↓
Self-Management – School		
Doing schoolwork even when I do not feel like it.		
Very Difficult	12.3	↑
Difficult	34.0	↑
Easy	37.0	↓
Very Easy	16.7	↓

Indicator	Mat-Su Percent	Mat-Su Higher or Lower than Statewide Results
Self-Management – School (continued)		
Being prepared for tests.		
Very Difficult	6.6	↑
Difficult	28.7	↑
Easy	46.7	↓
Very Easy	18.1	↓
Relationship Skills		
Respecting a classmate's opinions during a disagreement.		
Very Difficult	3.8	↑
Difficult	14.7	↓
Easy	54.4	↑
Very Easy	27.1	↓
Getting along with my classmates.		
Very Difficult	3.3	↑
Difficult	11.1	↓
Easy	52.3	↑
Very Easy	33.3	↓
Responsible Decision Making		
Thinking about what might happen before making a decision.		
Very Difficult	4.4	↑
Difficult	18.7	↓
Easy	51.4	↓
Very Easy	25.6	↑
Knowing what is right or wrong.		
Very Difficult	2.0	↑
Difficult	6.4	↓
Easy	40.7	↓
Very Easy	50.9	↑

Notes: Results are averages of categorical responses, and index scores are based upon a model summarizing responses. See Appendix A for additional data information.
Source: Alaska School Climate and Connectedness Survey (SCCS) and Alaska Department of Education and Early Development.

Table 81. Social and Emotional Learning (SEL) Skills, Grades 6-12, Mat-Su and Alaska, 2016

Indicator	Mat-Su Percent	Mat-Su Number	Alaska Percent	Alaska Number
Self-Awareness – Self Concept				
Knowing ways I calm myself down.				
Very Difficult	5.2	288	4.2	1,173
Difficult	17.3	963	15.9	4,472
Easy	45.3	2,518	46.9	13,167
Very Easy	32.3	1,794	33.0	9,258
Knowing what my strength are.				
Very Difficult	3.7	208	3.2	903
Difficult	15.2	843	15.2	4,257
Easy	43.1	2,397	44.0	12,293
Very Easy	38.0	2,115	37.6	10,515
Self-Awareness – Emotions				
Knowing when my feelings are making it hard for me to focus.				
Very Difficult	4.1	230	4.3	1,191
Difficult	16.2	900	17.8	4,983
Easy	45.8	2,546	46.6	13,068
Very Easy	33.9	1,886	31.4	8,795
Knowing the emotions I feel.				
Very Difficult	5.7	319	4.4	1,244
Difficult	17.0	947	16.5	4,620
Easy	44.6	2,479	47.9	13,443
Very Easy	32.7	1,819	31.3	8,786
Social Awareness				
Learning from people with different opinions than me.				
Very Difficult	4.2	234	3.5	963
Difficult	16.9	937	17.3	4,826
Easy	53.6	2,966	54.4	15,177
Very Easy	25.2	1,393	24.9	6,947
Knowing what people may be feeling by the look on their face.				
Very Difficult	2.3	125	2.6	717
Difficult	11.6	641	13.8	3,848
Easy	47.6	2,640	48.1	13,461
Very Easy	38.6	2,139	35.6	9,968
Knowing when someone needs help.				
Very Difficult	1.4	80	1.5	430
Difficult	10.6	588	12.4	3,456
Easy	52.4	2,904	51.9	14,519
Very Easy	35.6	1,972	34.2	9,561
Self-Management – Emotions				
Getting through something even when I feel frustrated.				
Very Difficult	8.1	446	7.3	2,052
Difficult	35.5	1,966	33.8	9,449
Easy	42.0	2,328	42.5	11,886
Very Easy	14.5	802	16.3	4,555

Indicator	Mat-Su Percent	Mat-Su Number	Alaska Percent	Alaska Number
Self-Management – Emotions (continued)				
Being patient even when I am really excited.				
Very Difficult	8.7	480	7.5	2,104
Difficult	26.6	1,476	25.2	7,058
Easy	43.2	2,394	43.7	12,245
Very Easy	21.6	1,197	23.7	6,630
Self-Management – Goals				
Finishing tasks even if they are hard for me.				
Very Difficult	5.8	321	5.3	1,494
Difficult	32.3	1,797	31.4	8,811
Easy	45.0	2,503	45.0	12,596
Very Easy	16.9	940	18.3	5,121
Setting goals for myself.				
Very Difficult	6.2	342	5.0	1,402
Difficult	20.8	1,157	20.8	5,806
Easy	44.5	2,472	43.8	12,254
Very Easy	28.5	1,581	30.4	8,488
Self-Management – School				
Doing schoolwork even when I do not feel like it.				
Very Difficult	12.3	687	9.5	2,659
Difficult	34.0	1,892	30.5	8,541
Easy	37.0	2,062	39.8	11,147
Very Easy	16.7	930	20.3	5,687
Being prepared for tests.				
Very Difficult	6.6	365	6.0	1,686
Difficult	28.7	1,594	28.5	7,979
Easy	46.7	2,591	46.8	13,090
Very Easy	18.1	1,004	18.6	5,198
Relationship Skills				
Respecting a classmate's opinions during a disagreement.				
Very Difficult	3.8	208	3.1	869
Difficult	14.7	815	14.9	4,176
Easy	54.4	3,020	54.2	15,178
Very Easy	27.1	1,505	27.8	7,773
Getting along with my classmates.				
Very Difficult	3.3	183	3.2	881
Difficult	11.1	616	11.5	3,214
Easy	52.3	2,900	50.2	14,040
Very Easy	33.3	1,849	35.2	9,839
Responsible Decision Making				
Thinking about what might happen before making a decision.				
Very Difficult	4.4	242	3.9	1,092
Difficult	18.7	1,035	19.4	5,423
Easy	51.4	2,849	51.7	14,442
Very Easy	25.6	1,416	25.0	6,985

Indicator	Mat-Su Percent	Mat-Su Number	Alaska Percent	Alaska Number
Responsible Decision Making (continued)				
Knowing what is right or wrong.				
Very Difficult	2.0	108	1.9	527
Difficult	6.4	354	7.9	2,191
Easy	40.7	2,253	41.9	11,701
Very Easy	50.9	2,817	48.4	13,499

Source: Alaska School Climate and Connectedness Survey (SCCS) and Alaska Department of Education and Early Development.

Youth Risk Behavior Survey (YRBS) Data

Table 82. Selected Indicators from Youth Risk Behavior Survey (YRBS), High School Students, Traditional and Alternate High Schools, Mat-Su, Alaska, and U.S., School Year 2014-2015

Type	Life Stage	*Indicator*	Type of Student	Mat-Su Students (%)	Mat-Su Students CI	Est. # Mat-Su Students	Mat-Su Students N	Alaska Students (%)	Alaska Students CI	Alaska Students N	Mat-Su Statistically Compared to Alaska	U.S. Students (%)	U.S. Students CI	U.S. Students N
Among students who dates or went out with someone, the percentage of students who had been...														
Stressor	Adolescence and Early Adulthood	Physically hurt on purpose by someone they were dating or going out with one or more times during the past 12 months	Trad.	9.7	6.8 - 13.5	400	425	9.5	7.5 - 12.1	857	↔	9.6	8.8 - 10.6	10,501
Stressor	Adolescence and Early Adulthood	Physically hurt on purpose by someone they were dating or going out with one or more times during the past 12 months	Alt.	16.5	13.3 - 20.2	73	279	17.0	14.2 - 20.3	655	↔	–	-	–
Stressor	Adolescence and Early Adulthood	Forced by someone they were dating or going out with to do sexual things they did not want to during the past 12 months	Trad.	13.1	10.3 - 16.4	540	428	10.1	7.7 - 13.2	860	↔	10.6	9.5 - 11.7	10,180
Stressor	Adolescence and Early Adulthood	Forced by someone they were dating or going out with to do sexual things they did not want to during the past 12 months	Alt.	12.5	9.8 - 15.8	55	278	13.5	11.0 - 16.5	654	↔	–	-	–
Percentage of students who agree or strongly agree that (in) their...														
Protective	Adolescence and Early Adulthood	Community they feel like they matter to people	Trad.	48.5	44.0 - 53.0	1,999	663	52.7	49.6 - 55.8	1,362	↔	–	-	–
Protective	Adolescence and Early Adulthood	Community they feel like they matter to people	Alt.	45.8	42.0 - 49.6	202	379	41.8	38.4 - 45.3	868	↔	–	-	–
Protective	Adolescence and Early Adulthood	School has clear rules and consequences for behavior	Trad.	71.1	66.5 - 75.2	2,930	656	66.1	63.3 - 68.9	1,342	↔	–	-	–
Protective	Adolescence and Early Adulthood	School has clear rules and consequences for behavior	Alt.	82.0	78.9 - 84.7	362	369	76.6	73.6 - 79.3	895	↔	–	-	–
Protective	Adolescence and Early Adulthood	Teachers really care about them and give them a lot of encouragement	Trad.	63.7	59.8 - 67.4	2,625	664	62.1	59.2 - 64.9	1,369	↔	–	-	–
Protective	Adolescence and Early Adulthood	Teachers really care about them and give them a lot of encouragement	Alt.	80.1	77.0 - 82.9	354	378	73.3	70.1 - 76.3	860	√	–	-	–

Type	Life Stage	Indicator	Type of Student	Mat-Su Students (%)	Mat-Su Students CI	Est. # Mat-Su Students	Mat-Su Students N	Alaska Students (%)	Alaska Students CI	Alaska Students N	Mat-Su Statistically Compared to Alaska	U.S. Students (%)	U.S. Students CI	U.S. Students N
Percentage of students who…														
Stressor	Adolescence and Early Adulthood	Did not go to school on at least one of the past 30 days because they felt they would be unsafe at school or on their way to or from school	Trad.	7.8	6.0 - 10.0	321	708	8.8	7.3 - 10.6	1,413	↔	5.6	4.8 - 6.5	15,563
Stressor	Adolescence and Early Adulthood	Did not go to school on at least one of the past 30 days because they felt they would be unsafe at school or on their way to or from school	Alt.	9.8	7.8 - 12.2	43	398	8.3	6.6 - 10.4	903	↔	–	-	–
Protective	Adolescence and Early Adulthood	Feel it is pretty much true or very much true that there is an adult who notices when they are upset about something	Trad.	51.8	48.1 - 55.5	2,135	662	–	-	–	NA	–	-	–
Protective	Adolescence and Early Adulthood	Feel it is pretty much true or very much true that there is an adult who notices when they are upset about something	Alt.	54.7	50.8 - 58.5	242	368	–	-	–	NA	–	-	–
Protective	Adolescence and Early Adulthood	Feel it is pretty much true or very much true that they do fun things at home with parents or other adults	Trad.	57.0	53.6 - 60.3	2,349	656	-	-	–	NA	–	-	–
Protective	Adolescence and Early Adulthood	Feel it is pretty much true or very much true that they do fun things at home with parents or other adults	Alt.	39.3	35.6 - 43.1	174	366	–	-	–	NA	–	-	–
Protective	Adolescence and Early Adulthood	Feel it is pretty much true or very much true that they do interesting activities at school	Trad.	37.2	33.5 - 41.1	1,533	663	–	-	–	NA	–	-	–
Protective	Adolescence and Early Adulthood	Feel it is pretty much true or very much true that they do interesting activities at school	Alt.	40.2	36.5 - 44.0	178	371	–	-	–	NA	–	-	–
Protective	Adolescence and Early Adulthood	Feel it is pretty much true or very much true that they do things at home that make a difference	Trad.	42.6	39.2 - 46.1	1,756	655	–	-	–	NA	–	-	–
Protective	Adolescence and Early Adulthood	Feel it is pretty much true or very much true that they do things at home that make a difference	Alt.	35.6	32.0 - 39.3	157	368	–	-	–	NA	–	-	–
Protective	Adolescence and Early Adulthood	Feel it is pretty much true or very much true that they help make decisions with their family	Trad.	48.6	44.2 - 53.0	2,003	653	–	-	–	NA	–	-	–
Protective	Adolescence and Early Adulthood	Feel it is pretty much true or very much true that they help make decisions with their family	Alt.	43.8	40.0 - 47.6	194	369	–	-	–	NA	–	-	–
Protective	Adolescence and Early Adulthood	Had a least one parent who talked with them about what they were doing in school every day	Trad.	42.3	38.7 - 46.7	1,743	674	39.6	36.6 - 42.7	1,373	↔	-	-	–

Type	Life Stage	Indicator	Type of Student	Mat-Su Students (%)	Mat-Su Students CI	Est. # Mat-Su Students	Mat-Su Students N	Alaska Students (%)	Alaska Students CI	Alaska Students N	Mat-Su Statistically Compared to Alaska	U.S. Students (%)	U.S. Students CI	U.S. Students N
Percentage of students who…														
Protective	Adolescence and Early Adulthood	Had a least one parent who talked with them about what they were doing in school every day	Alt.	28.1	24.8 - 31.6	124	383	23.7	20.9 - 26.7	872	↔	–	-	–
Stressor	Adolescence and Early Adulthood	Had been bullied on school property during the past 12 months	Trad.	22.4	18.3 - 27.2	923	702	22.8	20.4 - 25.4	1,403	↔	20.2	18.8 - 21.7	15,448
Stressor	Adolescence and Early Adulthood	Had been bullied on school property during the past 12 months	Alt.	18.1	15.5 - 21.1	80	394	20.4	17.7 - 23.5	890	↔	–	-	–
Stressor	Adolescence and Early Adulthood	Had been physically forced to have sexual intercourse when they did not want to	Trad.	9.5	7.0 - 12.7	391	696	7.5	6.0 - 9.4	1,399	↔	6.7	5.6 - 8.0	14,896
Stressor	Adolescence and Early Adulthood	Had been physically forced to have sexual intercourse when they did not want to	Alt.	18.7	16.0 - 21.7	83	394	18.9	16.3 - 21.8	890	↔	–	-	–
Stressor	Adolescence and Early Adulthood	Have had serious difficulty concentrating, remembering, or making decisions because of a physical, mental, or emotional problem.	Trad.	26.5	22.2 - 31.3	1,092	674	27.1	23.9 - 30.6	1,368	↔	–	-	–
Stressor	Adolescence and Early Adulthood	Have had serious difficulty concentrating, remembering, or making decisions because of a physical, mental, or emotional problem.	Alt.	38.6	34.9 - 42.4	171	374	37.5	34.2 - 41.0	849	↔	–	-	–
Stressor	Adolescence and Early Adulthood	Missed classes or school without permission during the past 30 days	Trad.	33.8	30.2 -37.7	1,393	679	28.7	25.1 - 32.6	1,383	↔	–	-	–
Stressor	Adolescence and Early Adulthood	Missed classes or school without permission during the past 30 days	Alt.	52.0	48.3 - 55.8	230	382	45.2	41.8 - 48.7	870	↔	–	-	–
Protective	Adolescence and Early Adulthood	Received grades of mostly As and Bs during the past 12 months	Trad.	67.8	62.8 - 72.4	2,794	703	67.8	63.6 - 71.7	1,402	↔	–	-	–
Protective	Adolescence and Early Adulthood	Received grades of mostly As and Bs during the past 12 months	Alt.	44.5	40.9 - 48.2	197	395	43.5	40.1 - 47.0	893	↔	–	-	–
Protective	Adolescence and Early Adulthood	Spend one or more hours helping people without getting paid, or volunteering at school or in the community during an average week	Trad.	50.1	45.0 - 55.2	2,065	668	56.6	53.2 - 59.9	1,378	↔	–	-	–
Protective	Adolescence and Early Adulthood	Spend one or more hours helping people without getting paid, or volunteering at school or in the community during an average week	Alt.	38.6	35.0 - 42.4	171	383	43.3	39.9 - 46.7	869	↔	–	-	–

Type	Life Stage	Indicator	Type of Student	Mat-Su Students (%)	Mat-Su Students CI	Est. # Mat-Su Students	Mat-Su Students N	Alaska Students (%)	Alaska Students CI	Alaska Students N	Mat-Su Statistically Compared to Alaska	U.S. Students (%)	U.S. Students CI	U.S. Students N
Percentage of students who…														
Protective	Adolescence and Early Adulthood	Take part in organized after school, evening, or weekend activities, on one or more days during an average week	Trad.	50.0	46.3 - 53.7	2,061	673	54.9	51.4 - 58.3	1,378	↔	–	-	–
Protective	Adolescence and Early Adulthood	Take part in organized after school, evening, or weekend activities, on one or more days during an average week	Alt.	40.8	37.1 - 44.6	180	381	35.9	32.6 - 39.3	869	↔	–	-	–
Stressor	Adolescence and Early Adulthood	Usually slept with friends, family, or other people because their parents or they lost their home or cannot afford housing in the past 30 days	Trad.	2.6	1.6 -4.0	107	678	3.2	2.4 - 4.4	1,383	↔	–	-	–
Stressor	Adolescence and Early Adulthood	Usually slept with friends, family, or other people because their parents or they lost their home or cannot afford housing in the past 30 days	Alt.	4.5	3.1 - 6.3	20	382	5.4	4.0 - 7.2	874	↔	–	-	–
Stressor	Adolescence and Early Adulthood	Were electronically bullied during the past 12 months	Trad.	20.1	16.9 - 23.8	828	702	17.7	15.7 - 19.9	1,407	↔	15.5	14.5 - 16.6	15,465
Stressor	Adolescence and Early Adulthood	Were electronically bullied during the past 12 months	Alt.	19.8	17.0 - 22.9	88	391	19.8	17.2 - 22.5	891	↔	–	-	–
Stressor	Adolescence and Early Adulthood	Were in a physical fight one or more times during the past 12 months	Trad.	22.2	18.6 - 26.3	915	691	20.1	17.4 - 23.1	1,383	↔	22.6	20.9 - 24.4	13,124
Stressor	Adolescence and Early Adulthood	Were in a physical fight one or more times during the past 12 months	Alt.	33.0	29.6 - 36.5	146	396	29.8	26.8 - 33.0	885	↔	–	-	–
Protective	Adolescence and Early Adulthood	Would feel comfortable seeking help from at least one adult besides their parents if they had an important question affecting their life	Trad.	84.8	81.2 - 87.0	3,495	676	85.7	83.6 - 87.6	1,379	↔	–	-	–
Protective	Adolescence and Early Adulthood	Would feel comfortable seeking help from at least one adult besides their parents if they had an important question affecting their life	Alt.	83.8	80.8 - 86.4	370	378	83.8	81.1 - 86.1	869	↔	–	-	–

Notes: * Mat-Su has a statistically different higher rate of bullying than the United States. CI indicates Confidence Interval.
Source: Youth Risk Behavior Survey (YRBS).

Alaska Department of Education and Early Development

Table 83. Economic Disadvantaged Status and Special Education Students, Mat-Su Borough School District and Alaska Comparison, School Year 2015-2016

Indicators	Mat-Su %	Alaska %	Mat-Su Compared to Alaska	Mat-Su N	Alaska N
% of Students with Economically Disadvantaged Status in School (Pre-K-12th) (School Year 2014-2015)	34.1	46.4	↓	-	55,346
% of special education students of total enrollment	14.8	13.7	↑	2,765	18,390
% special education students - Specific learning disabilities	37.6	38.9	↓	1,040	7,151
% special education students - Speech/language impaired	17.3	16.6	↑	479	3,055
% special education students - Other health impairments	13.6	13.9	↓	376	2,553
% special education students - Developmentally delayed	11.1	11.7	↓	307	2,159
% special education students - Autism	7.1	7.3	↓	196	1,335
% special education students - Emotional disturbance	6.2	3.6	↑	171	665
% special education students - Cognitive impairments	3.0	3.3	↓	82	614
% special education students - Multiple disabilities	2.4	2.6	↓	65	485
% special education students - Hearing impaired	0.8	1.1	↓	22	200
% special education students - Orthopedic impairments	0.4	0.4	↔	12	80
% special education students - Visual impairments	0.4	0.3	↑	10	47
% special education students - Traumatic brain injury	0.2	0.2	↔	5	44
% special education students - Deaf-blindness	0.0	0.0	↓	0	2

Source: DEED.

Appendix B: Child Care and Early Learning Services

Adequate early childhood care improves the outlook and future growth of children and communities. In the first years of life, children undergo rapid brain development that sets the stage for future mental growth[19]. Early childhood care facilitates this development and has far-reaching impacts on children's futures. Studies show early childhood care reduces special education enrollment, increases high school graduation rates, lessens participation in criminal activity, raises future earnings, and eases reliance on social welfare. Furthermore, early childhood care mitigates adversity that can limit brain development for children born into poverty.

Child Care Access in Mat-Su

In the spring of 2015, McDowell Group conducted a statewide telephone survey on early care and learning services. A McDowell Group report, *Early Care and Learning in the Matanuska-Susitna Valley: Survey of Mat-Su Families*, reported survey data specific to households surveyed in the Mat-Su Borough. Drawn from that report, key statistics on early care and learning for children under the age of six in Mat-Su include:

- More than half (54 percent) of children under age 6 typically receive some form of early care and learning services.
- Almost all (97 percent) children under age 6 who did not receive early care and learning services were cared for at home.
- One-half (49 percent) of children under age 6 who received early care and learning services in the month prior to the survey were in pre-elementary school or licensed center-based care, 33 percent received care at someone else's home, and 20 percent received care in the child's own home.
- Early care and learning services were easy or very easy to find for 67 percent of children under age 6.
- Among households that had trouble finding services for their children under age 6, cost was a barrier for 52 percent of children, followed by availability/lack of a provider (40 percent), and quality (28 percent).

Mat-Su Child Care Providers

Several types of informal and formal child care exist in the Mat-Su Borough. "Informal care" includes care provided by a parent or relatives and friends. "Formal care" is care for which providers are licensed by the state, including preschool offered by Mat-Su Borough School District (MSBSD) and programs such as Early Head Start and Head Start. Data on informal care is limited, but the Child Care Program Office (CCPO) tracks and publishes information on most formal care.

In summary, Mat-Su has 83 providers approved or licensed by the state, with the capacity to care for more than 1,900 children. This includes three Early Head Start and three Head Start programs, with capacities to care for 200 and 49 children, respectively. MSBSD operates three types of preschool programs. In the 2015-2016 school

[19] Yoshikawa, H., Weiland, C., Brooks-Gunn, J., Burchinal, M. R., Espinosa, L. M., Gormley, W. T., et al. (2013). *Investing in Our Future: The Evidence Base on Preschool Education.* Foundation for Child Development.

year, the MSBSD's special education preschools served 321, its Title I preschools served 100 children, and its "Widening the Net" preschools served 80 children.

State Recognized Providers

The State's CCPO regulates and licenses child care facilities in Alaska. Approval or licensure qualifies programs to receive funding from the State Child Care Assistance Program (CCAP). There are several types of licensed and approved providers. (Detailed definitions, approved providers, and program rates are included later in this chapter.)

In February 2016, 83 state-licensed providers operated in Mat-Su with a capacity to care for 1,913 children. They provided care for 647 children authorized to receive CCAP funds. Actual enrollment is likely higher than 647 as children not authorized to receive CCAP funds also are cared for by these providers. The State does not track enrollment for children not authorized to receive CCAP funds.

Table 84. Count and Capacity of Licensed and Approved Child Care Providers in Mat-Su, and Number of Children with CCAP Funds Authorization, February 2016

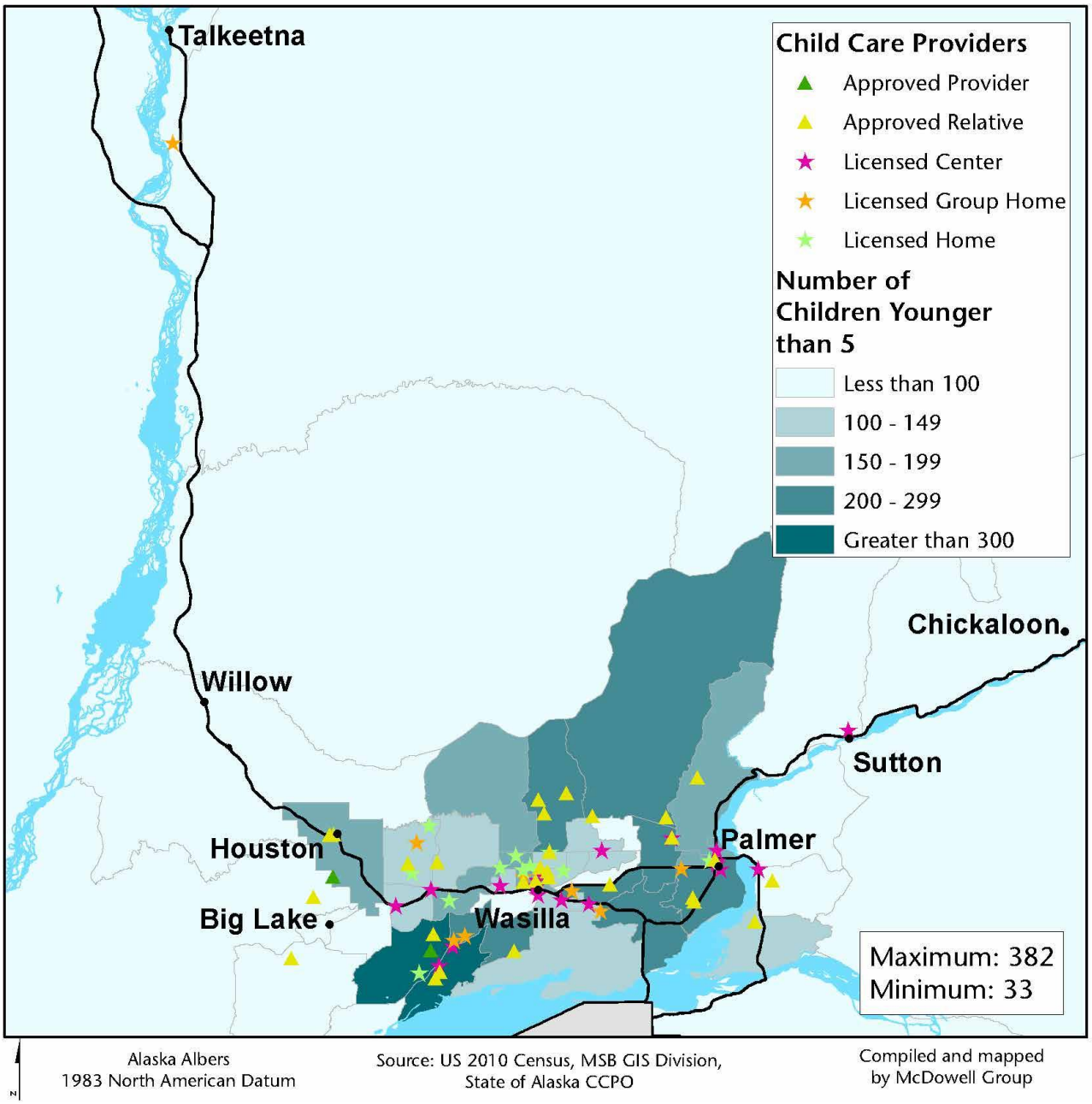
	Number of Providers/Facilities	Child Capacity of Providers	Number of Children in Care with CCAP Funds Authorization
Licensed Centers	20	1,548	512
Licensed Group Homes	8	96	30
Licensed Homes	14	99	29
Approved Provider	4	20*	9
Approved Relative	30	150*	48
PASS I/II/III	7	N/A**	19
Total	**83**	**1,913**	**647**

*Capacity for Approved Providers and Approved Relatives are calculated by McDowell Group. Each of these two provider types can care for a maximum of five children
**There is no set limit for PASS providers; rather, PASS providers care for the number of children in a certain family. See the definition for PASS providers for greater detail.
Source: Alaska Child Care Services Monthly Report, February 2016

Licensed providers operate throughout the borough, as far north as Talkeetna and as east as Sutton. However, nearly all approved and licensed providers concentrate between Big Lake/Houston and Palmer.

(see map on next page)

Figure 23. State-Licensed and Approved Child Care Providers and Population Under Age 5, by Census Block Group, Mat-Su Borough, 2014



Early Head Start (EHS) and Head Start (HS)

Early Head Start (EHS) and Head Start (HS) programs fall within the category of State-licensed providers. A specific demand exists for these programs – those with family incomes below the federal poverty level. The 2014 ACS five-year estimates report 12.9 percent of Mat-Su families live below the federal poverty level. This percentage applied to the number of children age 0-2 and 3-4 provides an estimate of the number of children eligible for EHS and HS: 579 and 386, respectively.

Table 85. Estimated Population Eligible for Early Head Start/Head Start in Mat-Su, 2014

	Population Estimate	Estimated % Living below Federal Poverty Line	Estimated Population Eligible for EHS (ages 0-2) and HS (ages 3-4)
Children age 0-2	4,487	12.9	579
Children age 3-4	2,991	12.9	386
Total Children Under Age 5	**7,478**	**12.9**	**965**

Source: Alaska DOLWD 2015 Population Estimates, ACS 5-year Estimate DP03

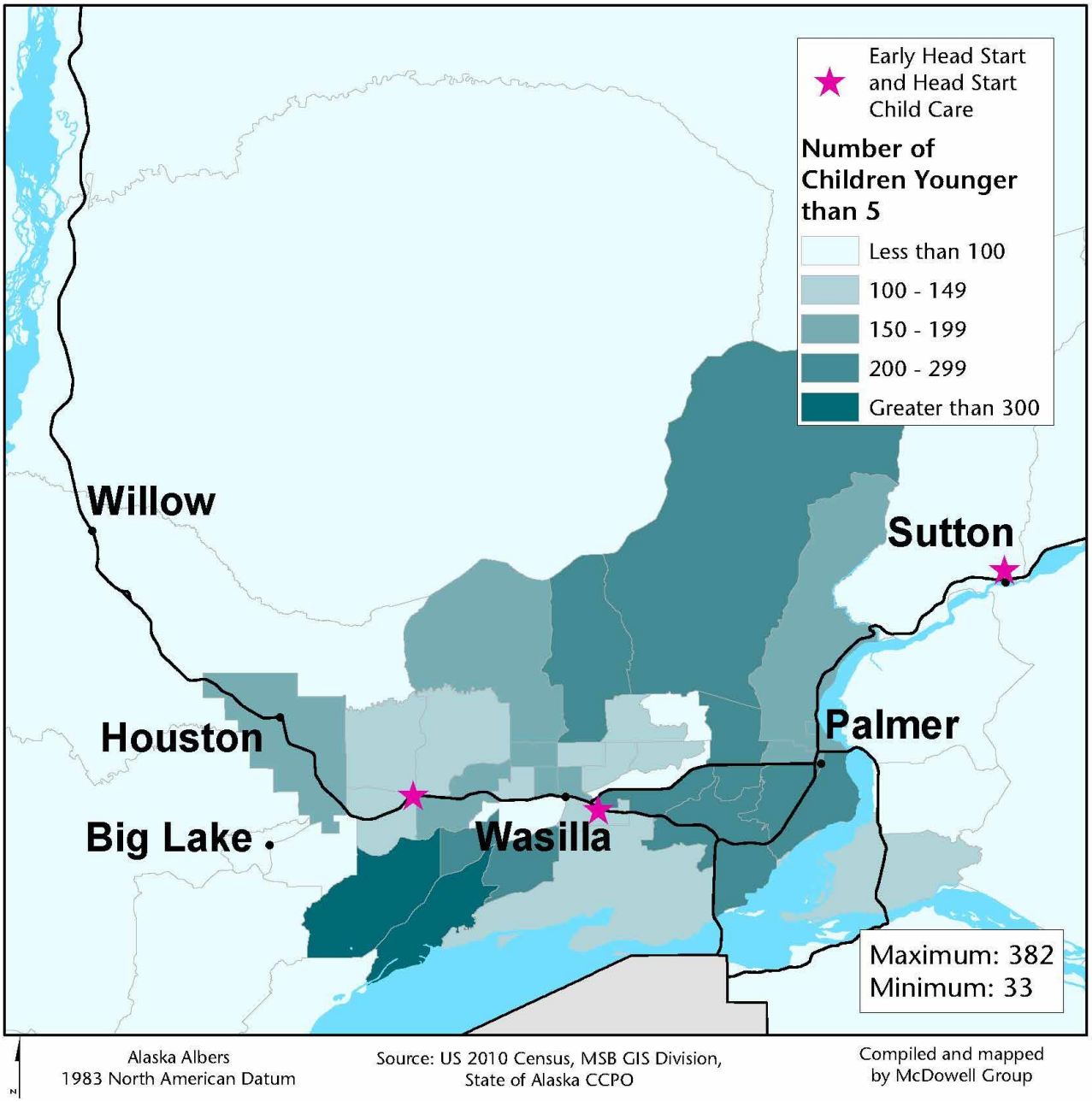
Three EHS and three HS programs operate in Mat-Su, all run by CCS Early Learning. EHS and HS programs are paired together and located in Meadow Lakes, Wasilla, and Sutton. CCS Early Learning's 2016 Community Assessment reports a total Mat-Su enrollment of 49 children in EHS and 200 children in HS. Accordingly, EHS serves an estimated 8 percent of the eligible population, while HS serves an estimated 51 percent of the eligible population.

Table 86. Estimated Population Eligible for Early Head Start/Head Start in Mat-Su, 2014

	Actual Enrollment	Estimated Eligible Population	Estimated Percent of Eligible Population Served
Early Head Start	49	579	8%
Head Start	200	386	51
Total	**249**	**965**	**26%**

Source: AKDOLWD 2015 Population Estimates, ACS 5-year Estimate DP03

Figure 24. Early Head Start and Head Start Facilities and Population Under Age 5, by Census Block Group, Mat-Su Borough, 2014



Mat-Su Borough School District Preschool Programs

MSBSD operates three preschool programs: special education, Title I, and "Widening the Net." In the 2015-2016 school year, MSBSD's special education preschools served 321 children ages 3-5 with developmental delays at 17 locations throughout the borough.[20] At the end of the 2015-2016, 100 children age 4 living in poverty were enrolled in MSBSD Title I preschools. The "Widening the Net" preschool program, which aims to serve students close to, but not meeting, the developmental delay or income thresholds of special education and Title I preschools, served 80 children age 4. This program is offered at Butte, Goose Bay, John Shaw, Trapper Creek,

[20] Including Big Lake, Butte, Cottonwood Creek, Finger Lake, Machetanz, Goose Bay, Iditarod, John Shaw, Larson, Meadow Lakes, Sutton, Swanson, Talkeetna, Tanaina, Trapper Creek, and Willow elementary schools, and Palmer High School.

and Willow elementary schools. As the State grant funding for "Widening the Net" is not expected to be extended, it is likely the program will not continue next school year. The school district also has a program, "Childfind," that includes screening for educational and physical needs for children, including social/emotional development.

Other School District Supports

School Nurses

For the 2015-2016 school year, there were 31.5 FTE registered nurse (RNs) positions in the Matanuska-Susitna Borough School District (MSBSD), with 37 individual RNs filling these positions. There was an average of 487 students per nurse in the district during this time period. In Alaska, there were 183.8 FTE RNs assigned to a caseload (providing direct services to students). If considering nurses assigned to a caseload plus fulfilling floating supplemental assignments that provide care to students, there were 200.7 FTE RNs in the state. Altogether, there were 226 individual nurses filling these positions, for an average of 588 students per nurse. Of note, there are only 15 school districts statewide (out of 54 total) that have registered school nurses; however, since many of these nurses are in the urban communities, 81.1 percent of students enrolled in public schools statewide have access to a registered nurse.

School Counselors

For the 2015-2016 school year, there were 41 FTE school counselors in the MSBSD, for an average of 440 enrolled students per counselor. In Alaska, there were 355 counselors, for an average of 375 students per counselor. Of note, statewide there are 152 schools and 15 school districts with no counselor.

Youth Courts

Youth courts are state-sanctioned juvenile justice systems where students serve as attorneys, clerks, bailiffs, and judges in cases involving their peers. The courts are assisted by program staff and legal advisors. Cases for each youth court on based on referrals from law enforcement, and allow first-time juvenile offenders who have committed misdemeanors to be held responsible for their actions, be given a form of punishment, but have a clear criminal record upon finishing their sentencing. The three-judge panel handing down sentences, normally consisting of community service hours, essays, apologies, and other sanctions.

There are 10 total youth courts in Alaska, including the Mat-Su Youth Court. In 2013, the most recent data available, the Mat-Su Youth Court had 102 cases referred to them, with 81 of these cases advancing to a court hearing.

Definitions of Licensed Child Care Providers

The Child Care Program Office (CCPO) of the Alaska Department of Health and Social Services (DHSS) licenses three types of child care providers: Licensed Center, Licensed Group Home, and Licensed Home. All licensed locations must have an administrator with either college credit in child development, a Child Development Associate credential, or a Montessori certificate. Additional licensure qualifications include a business license,

background check, CPR and first aid certifications, annual trainings, Fire Marshall Approval of Premises, and on-site compliance evaluation.

Licensed Child Care Centers provide care for 13 or more children. They require an administrator aged 21 or older. The threshold ratio of the number of caregivers to children varies according to the ages of the children. The ratios call for one caregiver for every five infants, every six toddlers, every 10 preschool children, and every 14 Kindergarten children.

Licensed Child Care Group Homes provide care for nine to 12 children at one time. They require an administrator aged 21 or older. There must be a minimum of two caregivers with no more than five children under the age of 30 months and no more than four non-ambulatory children.

Licensed Child Care Homes provide care for up to eight children at one time. They require an administrator aged 18 or older. There can be no more than three children under the age of 30 months and no more than two non-ambulatory children.

Approved Child Care Providers

Several types of child care providers are exempt from licensure, though they must be approved by DHSS to participate in the State of Alaska Child Care Assistance Program. These provider types include: Approved Non-relative, Approved Relative, Approved In-home (Pass II/Pass III) Caregivers, and PASS I In–home Child Care Caregivers. Qualifications necessary for approved providers include a business license, background check, approved rates, a disaster preparedness and emergency evacuation plan, and a health inspection of the premises.

Approved Non-relative Child Care Providers operate child care for up to four children unrelated to the provider. Approved Providers may care for no more than a total of five children under age 13, including the provider's own children. No more than two of these children may be under 30 months of age. This category of provider needs to be licensed within 12 months to continue to be eligible for payment through the Child Care Assistance Program.

Approved Relative Child Care Providers care for no more than five children under 13 years of age in the provider's residence, including the provider's own children. This total may include no more than two children under 30 months of age. Eligible children include the caregiver's grandchildren, great-grandchildren, siblings who reside in a separate residence, niece or nephew, and great-niece or nephew. These providers are not required to be licensed to continue to be eligible for payment through the State of Alaska Child Care Assistance Program, though a new application for approval is required every two years.

Approved In-home Child Care Caregivers care for children in the home of a child whose parents receive PASS II or PASS III child care assistance.

Pass I In-Home Child Care Caregivers care for children whose parents receive Alaska Temporary Assistance benefits while seeking work or engaging in educational activities that may lead to employment. Care is conducted in the home of the family receiving PASS I Child Care Assistance. The providers may also include their own children in care, with the permission of the other parents. The providers must meet Division of Public

Assistance child care requirements. PASS I child care assistance is available for children under age 13, up to age 19, if the child has a developmental disability, or ages 13 through 18 if the children are under court supervision and required to be in the care of an adult.

Legally-exempt child care providers are legally exempt from licensing requirements if they care for no more than four children unrelated to them. These providers are eligible for Child Care Assistance funds. The number of such providers in Anchorage is not known.

Table 87. Summary of Child Care Provider Types and Characteristics

Provider Type	Maximum # Children in Care	Maximum # of Infants ≤ 30 Months in Care*	Age of Children Served	Eligible for Child Care Assistance funds? (Y or N)	Administrator Required? (Y or N)
Approved Non-relative	5	2	0-12	Y	N
Approved Relative	5	2	0-12	Y	N
Approved In-Home	**	**	0-12	Y	N
Pass 1 In-Home	**	**	0-12	Y	N
Licensed Center	13+	1:5 caregiver to infant ratio*	0-12	Y	Y
Licensed Home	8	3	0-12	Y	Y
Licensed Group Home	12	2	0-12	Y	Y
Military Center†	NA	NA	0-5	Y	NA
Military Home†	NA	NA	0-12	Y	NA

* Note: Infants refers to children under the age of 30 months except for Licensed Centers, for which infant refers to children under the age of 18 months.
† Multiple efforts were made to obtain additional information about this provider type, but the study team was unable to obtain the information.
** Note: For Approved In-Home and Pass 1 In-Home providers, there is no single limit for the number of children allowed in care. Rather, the only children allowed in care are those of the family receiving Child Care Assistance and, with the family's permission, the children of the caregiver. Likewise, there is no single limit on the number of infants in care, provided they are the children of the family receiving Child Care Assistance.
NA – Not Available

Child Care Assistance Program Rate Schedule

The State of Alaska Child Care Program funds child care for families with financial need. Families are eligible for this program if they are receiving Alaska Temporary Assistance benefits while attempting to find work or if they are transitioning away from Alaska Temporary Assistance benefits while working or in school. Families are obligated to fulfill a copay, ranging from 1 percent to 10 percent of their total income, depending on the size of the family and the family's annual income. Following are the contribution rates set by the State of Alaska.

Table 88. Rate Schedule for State of Alaska Child Care Assistance Program, Mat-Su Borough, 2015

	Full Time	% Full Time Children Charged Above State Rate	Minimum – Maximum Range	Part Time	% Part Time Children Charged Above State Rate	Minimum – Maximum Range
Licensed or Military Center Care						
Infant (0 – 18 months)	$713	31	$713 – $795	$428	26	$428 – $490
Toddler (19 – 36 months)	$670	16	$625 – $795	$402	9	$402 – $450
Preschool Age (37 months – 6 years)	$605	46	$605 – $725	$363	37	$363 – $425
Licensed or Military Group Homes						
Infant	$713	46	$713 – $758	$428	0	$400 – $400
Toddler	$670	41	$640 – $836	$402	0	$400 – $402
Preschool Age	$605	32	$580 – $836	$363	20	$338 – $430
Licensed or Military Home Care						
Infant	$647	50	$647 – $700	$388	29	$288 – $448
Toddler	$600	53	$600 – $700	$360	50	$360 – $445
Preschool Age	$600	32	$600 – $650	$360	43	$360 – $400
Approved or In-Home Care						
Infant	$518	*	*	$311	*	*
Toddler	$492	*	*	$295	*	*
Preschool Age	$440	*	*	$264	*	*

* Data not available for Approved or In-Home care in the CCPO 2015 Alaska Child Care Market Price Survey Report.
Source: Alaska DHSS CCPO, CCPO 2015 Alaska Child Care Market Price Survey Report

The federal government mandates that states conduct surveys every two years to identify child care market prices. These surveys are intended to guide state Child Care Assistance rates. While states are required to perform these surveys, they are not required to update the payment rates. Thus, Alaska's rates are based on a 2009 market survey, even though the state has conducted surveys every two years since.

Appendix C: Additional Prevention Resources

This Appendix provides alternative prevention resources that may be applicable to the Mat-Su context.

The Primary School

Overview

The Primary School combines education, health care, and parent support into one program. It aims to assist children predisposed to a higher prevalence of ACEs: racial minorities and the poor. A holistic approach addresses numerous factors that affect child development. By enrolling children full-time at the age of 3, education is expanded beyond the traditional scope. A partnership with a federally qualified health center ensures children and their families receive health care. The school maintains strong relationships with parents and offers guidance for parenting and child development. The 2016-2017 school year will be the first of instruction for The Primary School, located in Palo Alto, CA.

Resources / Tools

- A model on which to base efforts to assist children with ACEs
- www.theprimaryschool.org

Takeaways / Principles

- Child development is multifactorial; addressing as many factors as possible in one place maximizes the needs that are met and minimizes the likelihood needs are not met
- Actively seek out the families and children more likely to have ACEs; don't wait for problems to develop and grow
- Provide special programs for children with ACEs to reduce educational and health disparity

Safe Babies Court Teams Project

Overview

When parents are separated from their young children as a result of judicial intervention for child abuse and neglect, Safe Babies Court Teams Project steps in to take responsibility for the children to mitigate the potential impact on development. This is facilitated through a coordinator that comes to know the children, interacts on their behalf with the judge, and connects them with community resources, such as the care of a pediatrician and Early Head Start. This effort is advised by a community board composed of representatives from ZERO TO THREE, local courts, child and family advocates, non-profits, agencies etc. The board actively searches for new community resources, evaluates existing resources, and identifies gaps in resources. If possible, the coordinator works to gradually reintegrate parents with their children. If that is not possible, then foster care seeks out a suitable foster family.

Resources / Tools

- ZERO TO THREE helps run programs throughout the country

TAKEAWAYS / PRINCIPLES

- Putting the responsibility for foster care children into the hands of an entire community
- Creating a multidisciplinary team of community stakeholders to oversee the care of foster care children
- Personalized care seeks out the best solutions for each individual

Mental Health Outreach for Mothers (MOMS)

OVERVIEW

Mothers, especially those with low income, face considerable stress and mental strain, affecting their health as well as their ability to care for their child's health and development. The Harvard Center on the Developing Child is collaborating with the State of Connecticut and Frontiers of Innovation to improve the mental health of mothers to enable them to better care for themselves and their children. This will lead to better outcomes for children, families, and communities. Mothers are engaged through Community Mental Health Ambassadors, women who are mothers themselves, live in the same neighborhood as low-income mothers, and are the mothers' peers.

RESOURCES / TOOLS

- Community Mental Health Ambassador

TAKEAWAYS / PRINCIPLES

- Stabilize low-income mothers by improving their mental health
- Approach mothers in need through their peers, by establishing ambassadors already ingrained in the community

USDA Child Care Food Program

OVERVIEW

The USDA reimburses licensed and approved child care providers for providing meals to children ages 12 and younger. To qualify for reimbursement, meals must meet USDA nutrition guidelines. The program offers workshops to educate child care providers about proper nutrition.

RESOURCES / TOOLS

- A federally funded program to provide nutritious food to a community's youth
- The program is already active, but increased awareness could increase usage

TAKEAWAYS / PRINCIPLES

- The program not only provides food, but disseminates information on healthy nutrition.

Single Parent Scholarships

CAPTURE THE DREAM SCHOLARSHIP

The non-profit organization supports disadvantaged youth and families in their career and educational goals. A scholarship fund provides $1,000 scholarship to low-income single parents in the Bay Area.

WOMEN'S INDEPENDENCE SCHOLARSHIP PROGRAM, INC.

The organization aims to empower female victims of domestic violence to achieve economic independence through higher education. Women who have left an abusive relationship and have a need for financial assistance qualify to apply for a scholarship to attend higher education.

ARKANSAS SINGLE PARENT SCHOLARSHIP FUND

With more than half of single parent families possessing incomes below the poverty line, the organization aims to assist these families achieve economic independence by developing themselves through higher education. In addition to financial assistance through scholarship, the program provides personal support to single parents.

Appendix D: ACEs Screening Tool and BRFSS ACEs Module Questions

ACEs Screening Tool

Prior to your 18th birthday:

1. Did a parent or other adult in the household often or very often swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?
   No___If Yes, enter 1 __
2. Did a parent or other adult in the household often or very often push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?
   No___If Yes, enter 1 __
3. Did an adult or person at least 5 years older than you ever touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?
   No___If Yes, enter 1 __
4. Did you often or very often feel that no one in your family loved you or thought you were important or special? or your family didn't look out for each other, feel close to each other, or support each other?
   No___If Yes, enter 1 __
5. Did you often or very often feel that you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   No___If Yes, enter 1 __
6. Were your parents ever separated or divorced?
   No___If Yes, enter 1 __
7. Was your mother or stepmother: often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   No___If Yes, enter 1 __
8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?
   No___If Yes, enter 1 __
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
   No___If Yes, enter 1 __
10. Did a household member go to prison?
    No___If Yes, enter 1 __

Now add up your "Yes" answers. This is your ACE Score.

BRFSS ACEs Module Questions

The following table lists the exact question in the BRFSS Survey. This report presents the data of respondents who indicated having ever experienced the event regardless of frequency.

Table 89. Full ACEs Questions and Corresponding Descriptive Phrase

Descriptive Phrase	Full ACEs Question
Depression	Before 18 years of age, did you live with anyone who was mentally ill, depressed or suicidal?
Drug Abuse	Before 18 years of age, did you live with anyone who used illegal street drugs or who abused prescription medications?
Alcohol Abuse	Before 18 years of age, did you live with anyone who was a problem drinker or alcoholic?
Divorce	Before 18 years of age, were your parents separated or divorced?
Prison	Before 18 years of age, did you live with anyone who served time or was sentenced to serve time in a prison, jail, or other correctional facility?
Physical Abuse	Before age 18, did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way? Do not include spanking.
Verbal Abuse	Before age 18, did a parent or adult in your home ever swear at you, insult you, or put you down?
Domestic Violence	Before 18 years of age, did your parents or adults in your home ever slap, hit, kick, punch, or beat each other up?
Sexual Abuse - Touch You	Before age 18, did anyone at least 5 years older than you or an adult, ever touch you sexually?
Sexual Abuse - Touch Them	Before age 18, did anyone at least 5 years older than you or an adult try to make you touch them sexually?
Sexual Abuse - Forced Sex	Before age 18, did anyone at least 5 years older than you or an adult forced you to have sex?
Sexual Abuse - Any	Did you respond yes to any (at least one) of the three sexual abuse questions (touched, touch them, force sex)
Parental Neglect - Food, Clothes, Protection	Before age 18, did ANY of the following events apply to you: You didn't have enough to eat, you had to wear dirty clothes or you had no one to protect you?
Parental Neglect - Love and Appreciation	Before age 18, did you feel that your parents or adults in your home did not love you or appreciate you?

Appendix E: Mat-Su ACEs Data Comparisons

Mat-Su Compared to the Rest of Alaska

Among the 14 ACEs categories, Mat-Su adults reported higher rates than the rest of Alaska in several categories ($p<.05$). The following sections describe these differences and it is followed by two tables using visual symbols to indicate statistical or non-statistical differences in the data comparisons.

Among Mat-Su adults reporting experiences before age 18:

- 12.5 percent reported someone at least five years older than them or an adult tried to make them touch the other person sexually compared to 9.8 percent for the rest of the state.
- 16.6 percent had someone at least five years older than them or an adult touch them sexually compared to 13.0 percent for the rest of the state.
- 9.8 percent reported someone at least five years older or an adult forced them to have sex compared to 6.5 percent for the rest of the state.
- 17.8 percent reported anyone at least five years older or an adult ever tried to make them touch them sexually, touched you sexually, or forced them to have sex compared to 13.6 percent.
- 23.4 percent experienced a parent or adult in their home hit, beat, kick or physically hurt the survey respondent in any way compared to 18.4 percent for the rest of the state.
- 36.5 percent heard parent or adult in their home swear at them, insult them, or put them down compared to the 30.8 percent for the rest of the state.
- 19.7 percent felt their parents or adults in their home did not love or appreciate them compared to 15.6 percent for the rest of the state.

Mat-Su Sociodemographic Comparisons

To understand if certain populations experienced ACEs differently in the Mat-Su, the analysis explored the following socioeconomic variables: race, gender, age group, household income, educational attainment, and region within the Mat-Su. Only the statistical differences ($p<.05$) are highlighted. The following table uses dots to identify where statistical differences exist. The table presents the ACEs questions sorted by where there were the most differences across the indicator by sociodemographic variable.

Table 90. Prevalence of ACEs in Mat-Su Adults (Age 18+), Statistical Comparisons within Each Demographic Characteristics, 2013-2014

Individual ACEs Question	Gender	Age Group	Income	Education	Region	Race
Sexual Abuse - Touch Them	▯	▯	▯	▯	↔	↔
Sexual Abuse - Touch You	▯	▯	▯	↔	↔	↔
Sexual Abuse - Any	▯	▯	▯	↔	↔	↔
Prison	↔	▯	▯	↔	▯	↔
Sexual Abuse - Forced Sex	▯	▯	↔	↔	↔	↔
Divorce	↔	▯	↔	▯	↔	↔
Parental Neglect - Love and Appreciation	↔	↔	▯	↔	↔	↔
Physical Abuse	↔	▯	↔	↔	↔	↔
Drug Abuse	↔	▯	↔	↔	↔	↔
Alcohol Abuse	▯	↔	↔	↔	↔	↔
Domestic Violence	↔	↔	▯	↔	↔	↔
Depression	↔	↔	↔	↔	↔	↔
Parental Neglect - Food, Clothes, Protection	↔	↔	↔	↔	↔	↔
Verbal Abuse	↔	↔	↔	↔	↔	↔

Source: Alaska Behavioral Risk Factor Surveillance System (BRFSS).

By Gender

Sexual Abuse

Gender differences emerged in the sexual abuse ACE questions. Women reported that an adult or anyone five years older:

- Made them touch them sexually 2.3 times more often (17.4 percent) than men (7.7 percent).
- Touched them sexually nearly three times (2.8) more often (24.8 percent) than men (8.8 percent).
    - Or, one in four women were touched sexually inappropriately.
- Forced them to have sex more often (14.4 percent) than men (5.3 percent).
- Caused any kind of sexual abuse (touch them sexually, touch you sexually, or forced sex) at a percentage three times higher (28.3 percent) than men (10.8 percent).

Alcohol Abuse

Women also reported a higher percentage (39.9 percent) of living with problem drinkers before the age of 18 than men (24.9 percent).

Table 91. Prevalence of ACEs Results in Mat-Su Adults (Age 18+), Statistical Comparisons by Gender, By Percent, 2013-2014

ACE	Female Prevalence (%)	Male Prevalence (%)
Sexual Abuse - Touch Them	17.4	7.7
Sexual Abuse - Touch You	24.8	8.8
Sexual Abuse - Forced Sex	14.4	5.3
Sexual Abuse - Any	28.3	10.8
Alcohol Abuse	39.9	24.9

Source: Alaska Behavioral Risk Factor Surveillance System (BRFSS).

By Age Group

Sexual Abuse

In Mat-Su, eight of the ACEs exhibited differences by age group for the sexual abuse related questions.

- Almost one in five (19.8 percent) residents ages 35-44 were forced to touch an adult, or anyone five years older sexually, whereas only 2.2 percent of residents ages 18-24 were victim to this experience.
- Persons ages 35-44 (22.4 percent) were more than twice as likely as those ages 18-24 (9.6 percent) to have experienced an adult, or anyone five years older, try to touch them sexually.
- About one in six Mat-Su residents (16.8 percent) ages 35-44 experienced an adult, or anyone five years older, try to force them to have sex as a child, compared to 3.6 percent of residents ages 18-24.
- Residents ages 35-44 (28.8 percent) were about three times more likely than residents ages 18-24 (9.7 percent) to have been victim of any form of sexual abuse by an adult, or anyone five years older, as a child.

Appendix F: A Description of Self-Healing Communities

The key properties of self-healing communities that have been identified by Porter et al. are related to **partners, principles, and process.**

Partners are defined as community members, service providers, funders, and external partners such as subject matter experts. These partners work to create cultural change in the community. The way these partners interact is key and is led by local leaders who work with the whole community to unite many different sectors (i.e. education, health care, business, social) toward one purpose. There are key features of these partners that help to ensure success in working together. The Partners:

- Put personal agendas aside and focus on the common good.
- Serve as a core team and have a paid coordinator or facilitator.
- Take advantage of opportunities (state and local policy, funding, for learning).
- Educate themselves and the community on the latest data, research, and stories on the issue.
- Educate themselves on team management, public, political and funder accountability, data analysis, and translating the meaning of data, evaluation and systems thinking.
- Welcome external partners assisting with financial support and training.

The key **principles** that drive a successful self-healing community are:

1. Leadership listens and reports back to the most affected community residents.
2. Groups continually learn about the latest research and successful practices and use this knowledge to address an issue. Results are reflected upon.
3. Partners are continually reaching out to new sectors and people to work on solutions.
4. The work is informed by the latest research in neuroscience, epigenetics, ACEs and resilience and best-practices.
5. All solutions are adapted to fit the community in terms of size, culture, etc.
6. All work is strength-based and focused on positive movement and celebrating success.

Characteristics of this type of **process** that are key to success:

1. **Leadership expansion** – Through various phases, there is an expansion of the number and types of people participating, representing different professional disciplines, and different sectors of the community.
2. **Development of a focused shared understanding** – As community people work on various initiatives, a greater shared understanding emerges on the root causes of problems, what it takes to increase resilience and greater agreement on strategies.
3. **Iterative cycle of learning** – Community members gather periodically to assess progress and examine what group of efforts are complementary and mutually reinforcing, what new efforts are needed.

4. **Results are frequently reviewed** – Data are collected and reviewed to check on desired outcomes of efforts, in a developmental evaluation approach, so that modifications can be made in initiatives, practices and strategies.

Data are used to describe the journey undertaken, which reinforces a common identity and commitment. This often helps attract leaders from different community sectors, makes for greater focus, shared among more partners, leads to more learning, deeper insights from exchange of experiences, which helps implement more effective practices leading to better outcomes. Success in one component often invites success in the next. The four components constitute a self-reinforcing cycle. The following chart visually presents the four components and the cycle.

Figure 25. Components of Process for Self-healing Communities

Examples of Self-Healing Communities

High community capacity levels for being a supportive self-healing community can be associated with higher rates of education outcomes and better mental health and physical health. Much of this evidence comes from an initiative in Washington State called the *Community Public Health and Safety Networks (Networks)*. From 1994 to 2011, the Washington State Family Policy Council (FPC) sponsored 42 Networks statewide. FPC provided small, but continuous, stable funding to the Community Networks every two years, contingent on biennial reports that documented some form of coordinated community prevention efforts that adapted to changing community conditions. Networks needed to focus on three of the following seven social problems: child abuse and neglect; family violence; youth violence; youth substance abuse; dropping out of school; teen pregnancy or youth suicide. Funding contracts were performance-based, encouraging risk-taking in new strategies to achieve best results over the long-term and changing initiatives based on outcomes during each biennium.

This central support allowed each Community Network to fund at least a part-time staff member who:

- Helped implement community board decisions and prevention initiatives
- Based on the staff member's length of experience and training, helped boards think strategically, in a systems way, identifying 'leverage points' (initiatives that would build on each other) thus helping communities develop.

FPC also provided trainings from national experts (at statewide meetings), diffusion of innovations across communities by sharing their experiences and technical assistance involving local visits at the request of any community network board.

Phases for Developing into a Self-healing Community

The FPC communities experienced different stages of development during the funding period that were associate with different levels of change. The phases are described in Table 92.

1. Pre-commitment stage, which includes the network boards establishing their structure and starting to learn about prevention. During this phase, groups began working together to secure funds and receive trainings on key concepts and also the legal structure and requirements of boards.
2. Commitment stage is when the network learns about key prevention data, research, and community empowerment strategies.
3. Shifting/persisting stage, which includes continuing trainings focused on ACEs, system thinking and, collective impact strategies. The collaborative is gaining confidence working together and they generate a shared identity, collective authority, and increased solidarity develops.
4. Thriving stage, includes train-the-trainer, advanced training on resilience and evaluating resilience's effect in buffering the impact of ACEs and the learning system bridges to new groups and a more open leadership focuses on continuous improvement. During this phase, cross sector collaborative initiatives emerge and are implemented.

(See table next page.)

Table 92. Stages of Development for FPC Networks

	Pre-Commitment	Commitment	Persisting	Thriving
Network activities	Established structure and bylaws for network; Started learning about prevention.	Learned about data and research on prevention and community empowerment.	Community and network trainings on ACEs, system thinking and collective impact strategies.	Implemented train the trainer framework for ACEs and resilience.
Outside support	Outside support provided to fund part-time staff; External experts are brought in to provide training on prevention.	Funding support continues to support staff member; State and local data provided; Community data provided; Trainings continue on community empowerment/prevention strategy; technical assistance provided on measurement of community resilience.	Funding of staff continues and trainings on collective impact, ACE research, and monitoring and evaluation.	Funding of staff member continues and training on collective impact; best practices; and monitoring and evaluation.
Community dynamics	Individuals seek outside support for existing services.	Residents and professionals gain shared understanding of issues and motivation to work on them.	Innovative practices develop that are of and for the community.	Learning system bridges to new groups and leaders. Culture continues to change and embrace new resilience concepts
Common understanding	We work together to secure funds.	We will develop capacity using network model.	We are on the right track as a community.	We are continuously learning and improving our system.
Transition to new stage	Funding and technical assistance motivate community to work together.	Data and local stories illuminate issues and motivate collaborative work.	Confidence emerges related to effectiveness of collaborations.	
Role of community network	Distribute funds.	Bring people and ideas together.	Generate shared identity. Collective authority and solidarity develop.	Open leadership, which is focused on continuous improvement, and cross sector, collaborative initiatives emerge and are implemented.

Source: Longhi, Dario and Brown, Marsha, Family Policy Council, Washington, State.

There were 12 communities in Washington State that reached a thriving level of capacity through their networks. The processes that led these communities to reach a thriving stage of development includes components that were identified early on (in 1998) by Community Network representatives (board chairs and staff) at an FPC statewide meeting. They constituted the basis for keeping track of the progress in community capacity every two years from 1998 to 2010.

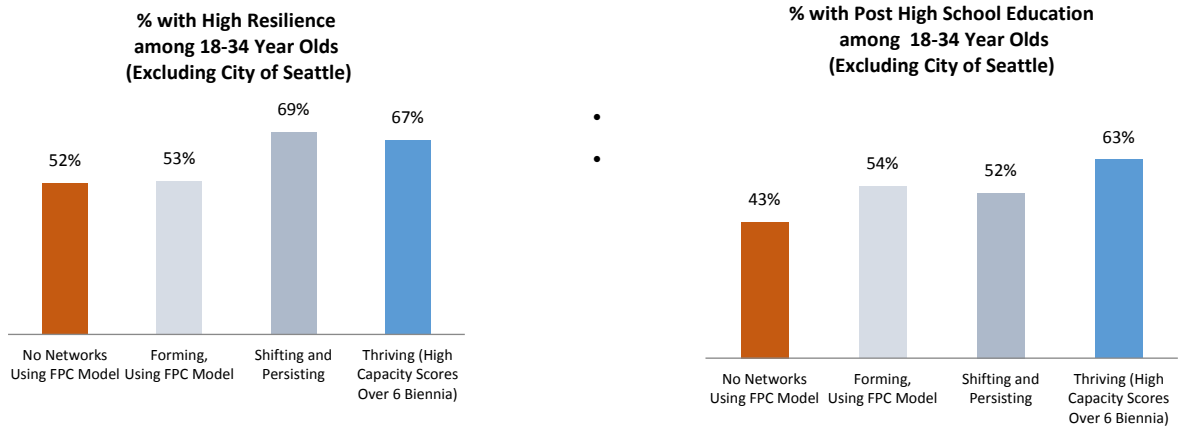
Researchers used common measures of community capacity and a common outcome measure that could incorporate differences in specific goals and efforts across communities.

- For community capacity, an index was created based on the four community capacity attributes, measured every biennium, from 1998 to 2010 - leadership, focus, learning and results (defined as outcome based decision making) - to classify 42 communities in Washington State in the four stages of community capacity already mentioned: Pre-commitment – not using the FPC model, Commitment – forming – starting to use the FPC model, Shifting and Persisting, and Thriving.
- For a common outcome measure, an index of resilience was created based on socio-emotional support, mastery and hope questions in the Behavior Risk Factor Surveillance System survey of adults. This index was chosen because even though prevention activities differed across communities, suited to local conditions and strengths, they were presumably aimed at increasing overall resilience.

Findings from evaluation data on the Networks showed that higher community capacity is related to lower prevalence of ACEs among the youngest generation, age 18 to 34. This is the adult generation most likely affected by the prior 15 years of prevention activities in the FPC community networks in the State of Washington. Researchers found that young adults, age 18 to 34, who lived in communities at higher stages of community capacity had higher resilience and higher levels of education - compared to other young adults living in communities at lower stages of community capacity - independent of ACE levels, socio-economic, demographic and cultural racial/ethnic differences. The charts below demonstrate the relationships between stage of development of the Family Policy Council; they show that as community capacity increases the percentage of 18-34-year-olds with high resilience also increases.

Regarding the outcome of resilience and educational level, a 2012 study found the following results:

Figure 26. Resilience and Education Outcomes



Positive results from one of these communities, Cowlitz County, demonstrated that over the 10 to 15 years there were decreases in births to teen mothers (43 percent decrease); youth suicide and suicide attempts (98 percent decrease); youth arrests (53 percent decrease); high school dropout rates (47 percent decrease). (RWJ)

Cost-benefit Analyses

This systemic, strategic process to address child maltreatment is very cost-effective. It takes advantage of the collective impact of various initiatives over time that build on one another, brought about by a set of formal and informal (volunteer) partners that simply change the way they do 'ordinary business' and create a new supportive culture for the community. In the Washington experience, very impressive results were achieved for a very small investment (Schueller et al. 2009):

- Conservative estimates of **public agency cost savings** were calculated to be about $ 8 for every dollar spent. Costs avoided per year just in child welfare, juvenile justice and in medical expenses for teen mothers added $27.9 million, while per year Family Policy Council costs were $3.5 million.
- The cost/benefit ratio for the taxpayer was much higher, $ 35 per dollar spent, due to the progressive nature of adversity avoided by public services plus loss of tax revenue due to loss of productivity. Benefits amounted to $120 million from 2002 to 2006.

For more information on Self-healing Communities, please see:

- Porter L. Martin K, Anda R. A Transformational Process Model for Improving Intergenerational Health, The Robert Wood Johnson Foundation. June 2016. http://www.rwjf.org/en/library/research/2016/06/self-healing-communities.html

- Hall, J., Porter, L., Longhi, D., Becker-Green, J., & Dreyfus, S. (2012). Reducing Adverse Childhood Experiences (ACE) by Building Community Capacity: A Summary of Washington Family Policy Council Research Findings. Journal of Prevention & Intervention in the Community, 40(4), 325–334. http://doi.org/10.1080/10852352.2012.707463

- Verbitsky-Savitz, N., Hargreaves, M., Penoyer, S., Norberto, M., Coffee-Borden, B., Whitesell, E., Preventing and Mitigating the Effects of ACEs by Building Community Capacity and Resilience: APPI Cross-Site Evaluation Findings. Washington, DC, Mathematica Policy Research. https://www.mathematica-mpr.com/our-publications-and-findings/publications/final-report-preventing-and-mitigating-the-effects-of-aces-by-building-community-capacity.

- Logan-Green, P. Green, S. Nurius, P. Longhi, D. (2014) Distinct Contributions of Adverse Childhood Experiences and Resilience Resources: A Cohort Analysis of Adult Physical and Mental Health. Social Work in Health Care 53: 776-797

- ACEs Connection, A Community-of-Practice Social Network, http://www.acesconnection.com/

- The Community Resilience Cookbook. The Walla Wall Washington Story. http://communityresiliencecookbook.org/tastes-of-success/the-walla-walla-washington-story/

- ACEs Too High Website. https://acestoohigh.com/

Appendix G: History of THRIVE Mat-Su

Vision:
A community where individuals thrive in an environment that supports healthy choices regarding substance use.

Mission:

THRIVE Mat-Su will lead a data-driven coordinated community response to prevent and reduce youth substance use.

A Brief History

2006

- United Way of Mat-Su identifies substance abuse as a critical issue to address to build a healthier community. Substance abuse 3 out of top 10 issues in 2002 & 2005 community health assessments.
- December, Substance Abuse Summit held with key and local stakeholders.
- United Way of Mat-Su Board of Directors pass resolution to commit financial and staff resources to substance abuse initiative for minimum of 10 years.

2007

- March, Community Anti-Drug Coalition formalized. Thirty-five stakeholder groups from community (multiple sectors) sign memorandum of agreement at joint chamber of commerce meeting.
- Coalition sets goal to create coordinated community response with a commitment to have a data-driven purpose.
- Data committee formed to research existing data and identify gaps. Receives grant from Mat-Su Health Foundation (MSHF) for data project.
- December, Request for Proposal (RFP) issued to conduct 5-year retrospective study of existing data on Mat-Su, work with providers to extract meaningful data and conduct survey in schools; no Youth Risk Behavior Survey (YRBS) data available.
- Research on successful coalitions; identifies Community Anti-Drug Abuse Coalitions of America (CADCA) and The Substance Abuse and Mental Health Services Administration (SAMSHA) as resources.
- Coalition adopts Strategic Prevention Framework (SPF).

2008

- March, Data Project awarded to CODI (Co-occurring Disorders Institute)

    - Borrows California Healthy Kids Survey, adapts for Alaska and surveys over 60 percent of 7th, 9th and 11th graders in public, private and homeschool settings.
    - Survey includes misery index and assets with focus on school, home and community connectedness.
- Data and Steering Committee continues to meet monthly to stay involved in Data Project.
- April, Hosted a Town Hall Meeting on underage drinking.
- Coalition and Mat-Su Health Foundation sponsor local documentary about meth addiction, "Ice Crystals."

2009

- Coalition receives funding from Rasmuson Foundation and MSHF to hire Community Impact Coordinator to coordinate Coalition.
- April 2008 Data Report becomes available in Final Report format for Coalition. Steering Committee forms summary of report. Meetings held to re-engage community stakeholders.
- April 21-June 18, seven presentations given for stakeholder groups consisting of treatment providers, healthcare, education (principals, school nurses, and student governments), law enforcement and faith-based organizations with over 120 participants. These meetings help determine and develop potential recommendations, conclusions and priorities for presentation to Steering Committee for adoption and are summarized in the Data Report Summary.
- May, Coalition signs to support the University of Nevada's (Reno) Center for the Application of Substance Abuse Technologies (CASAT) in application for National Institute on Drug Abuse's (NIDA) "Science Education Drug Abuse Partnership Award." Should award be granted, Coalition will act as a control group in 5-year study of coalitions and their impact on substance abuse.
- August 2008 Data Report and Summary available online @ unitedwaymatsu.org.
- August, 4-hour prevention primer presented by the Department of Health and Social Services. Coalition engages community by hosting prevention trainings.
- Community Anti-Drug Abuse Coalitions of America (CADCA) training taking place 2-days prior to Coalition Strategic Planning. CADCA is committed, by charter, to provide this service to every state but had yet to be asked to provide service in Alaska. CADCA representatives fly to Alaska at their cost to facilitate training. Coalition instrumental in securing/planning CADCA statewide training for Alaska, benefits over 300 Alaskans and their communities.
- Coalition contracts with CADCA to coordinate late-September community-wide strategic planning session focusing on problem solving and creating environmental strategies addressing problems Mat-Su communities are facing and build protective factors.
- Changes name to Mat-Su Substance Abuse Prevention Coalition (MSAPC) and develops logo.
- Develops policies and procedures.

2010

- November, Coalition hosts first teleconference consisting of coalition representatives across Alaska.
    - "Alaska Wellness Coalition" formed, will meet quarterly, google list serve created for communications.
- Coalition awards Drug Free Communities (DFC) grant.

- January, Coalition Facebook page created (Find us on FB at THRIVE Mat-Su).
- Coalition (5 adults and 5 youth) invited to Juneau to present data project to Governor Parnell, House and HSS Committee.
- Coalition partners with Mat-Su Borough for Prescription Drug Take Back days.
- Youth-led 3-day event; coordinated events included:
    - National Guard obstacle course.
    - Leadership Development.
    - 56 youth participants.
- March, Action Planning Retreat.
- Coalition sends youth to Lead-On Conference.
- June 26, Youth-led event, Community BBQ at Wonderland Park; coordinated events include:
    - National Guard obstacle course.
    - Live music.
    - Personal testimonies.
    - Over 300 youth attended.
- Alaska Wellness Coalition identifies statewide media project to reduce underage drinking.

2011

- Matanuska-Susitna Borough School District (MSBSD) participates fully in YRBS; commits to ongoing surveys.
- Coalition attends 3-week National Coalition Academy.
- Coalition drafts legislation for ban on K2 Spice.
- Legislature passes ban on K2 Spice.
- Sponsors Tobacco Awareness Program (TAP) and Tobacco Education Group (TEG) programs for MSBSD.
- Sponsors Fetal Alcohol Spectrum Disorder (FASD) workshops.
- Sponsors Mat-Su youth to attend Camp Hope.
- Sponsors youth to attend Alaska Teen Media Institute to produce a Feed the Seed video-commercial aired on 10 different networks!
- Coalition attends Positive Community Norms (PCN) training.
- Sponsors youth-led You Choose Project; over 100 youth volunteer and over 500 attend.

2012

- March 13, Town Hall meeting held.
    - Discussed strategies, planning and updates to the Action Plan for moving into the upcoming year.
    - Plan to include Positive Community Norms (PCN) and a spirit, science, action model within the appropriate areas.
- Members attend training, gain new knowledge.
- Block Parties-neighborhood substance-free parties used for multi-generational outreach to help build connectedness and support.

- Partner with Anchorage Youth Development Coalition to offer several trainings to assist youth serving organizations to build strengths and best practices in several topic areas. Trainings continued throughout the year.
- Coalition receives Department of Behavioral Health (DBH) Prevention and Early Intervention Grant.
- Coalition name changed to THRIVE Mat-Su.

2013

- Elizabeth Ripley passes the Torch of Leadership to Philip Licht after serving as chair for 6 years. Thank you, Elizabeth Ripley!
- THRIVE sponsors 18 school district nurses and counselors for Mental Health and 1st Aid Training.
- THRIVE sponsors Dr. Victor DeNoble to speak at Mat-Su high schools. Dr. DeNoble gives an insider's view into the tobacco industry during talk.
- THRIVE sponsors Positive Community Norms (PCN) training, Mat-Su Youth Courts conference and 4 Neighborhood Night Out Block Parties (to build connectivity between youth and adults).
- THRIVE contracts with McDowell Group for evaluation services for the 2013 Youth Risk Behaviors Survey (YRBS).
- Purchases the domain thrivematsu.org.
- Partners with the State of Alaska Department of Behavioral Health (DBH) for statewide Positive Community Norms (PCN) training held in Anchorage.
- Alaska Wellness Coalition finalizes scope of work for statewide media campaign to reduce underage drinking.

2014

- January, THRIVE Mat-Su successfully adds questions surrounding the youth drinking perception and campaign awareness (have you seen an ad on TV about underage drinking?) for the Positive Community Norms (PCN) Campaign to the 2014 School Climate and Connectedness Survey (SCCS).
- February, holds Strategic Planning Sessions; Gant Chart and Annual Plan developed.
- THRIVE sponsors 25 individuals to attend various trainings, such as, Positive Community Norms, Children of Incarcerated Parents and Mental Health First Aid.
- April, THRIVE Mat-Su provides letters of resolution to the Palmer and Wasilla City Councils in support of the passage of anti-spice ordinances.
- April, THRIVE conducts key informant interviews.
- THRIVE staff begins coordinating The Mat-Su ACEs (Adverse Childhood Experiences) Speakers Bureau for the Mat-Su Valley.
- THRIVE develops Coalition By-Laws.
- October, THRIVE Mat-Su supports Mat-Su Youth-led Town Hall. Approximately 50 attend Town Hall to discuss underage drinking, ACEs and wellness.
- October, Partners with United Way of Mat-Su, Mat-Su Health Foundation and the Mat-Su School District to sponsor ACEs (Adverse Childhood Experiences) Mat-Su Summit. One hundred people, from all sectors, attend event.
- October-December, conducted Community Readiness Assessment.

- November, worked with Youth Risk Behavior Survey (YRBS) to add questions about prescription drug use for the 2015 YRBS.

2015

- THRIVE Mat-Su awarded the Alaska Community Service Award for Health by the Alaska Public Health Association.
- Coalition members attend CADCA Leadership Forum in Washington D.C Activities include workshops and Capitol Hill meetings with Sen. Murkowski, Sen. Sullivan and Congressman Young's office to advocate and inform legislators about successes and areas of concern for the Mat-Su Valley.
- Community meetings held in Palmer, Talkeetna and Wasilla to talk about THRIVE, Alaska State Trooper Amy Nelson presented information about drugs and local resources (services, etc.) given to attendees.
- Coalition members meet with community leaders about the upcoming statewide media campaign on underage drinking, the coalition and community substance abuse resources.
- Data and Evaluation Committee updated Data Indicators and Intermediate Variables.
- Youth Assets Committee conducted Youth Survey; 112 youth provided feedback on community resources, perceptions, communications channels, barriers to participating in youth activities and possible community solutions.
- THRIVE sponsored members to attend the Effects of Trauma & Mental Health Conference.
- Youth Resource List developed by youth.
- THRIVE completed community Strategy Mapping and Portfolio including the continuum of care, evidenced-based strategies, gap analysis, policy and all levels of the social ecology.
- THRIVE supported Title IV statute revisions (laws that govern alcohol sales and enforcement), Smokefree ordinances, and made recommendations for marijuana regulations.
- April - THRIVE sponsored members to attend Early Childhood Mental Health Institute.
- April - THRIVE sponsored youth leadership events at Burchell HS and Houston HS.
- April - Be [You] media campaign launched; Positive Community Norms Media Campaign to reduce underage drinking; 73 percent of Mat-Su Teens Choose Not to Drink.
- May - THRIVE sponsored members to attend the Alaska Tobacco Control Alliance Summit
- "Start the Conversation" folders distributed with parent resources for building stronger families written by youth along with "Conversation Jars."
- May - THRIVE presented to the Advisory Board on Alcoholism and Drug Abuse (ABADA).
- May - Training on "How to Prepare for Policy, System and Environmental Change in Your Community"
- June - THRIVE sponsored Conversations with Jane Stevens (Founder of ACEsTOOHigh and ACEsConnection); training on best practices from each sector on trauma-informed practices and building hope and resilience in our community.
- June - United Way of Mat-Su and THRIVE hosted booth at Colony Days; Information disseminated about Coalition, strategies, conversation starters, ACEs, services available, resource guides and Be [You] materials and engagement.
- June - October-THRIVE sponsored Neighborhood Block Parties to build neighborhood support, connectivity, activism and healthy conditions.
- August - THRIVE Team Building & Member Celebration event.

- September - THRIVE hosted Sue Delucchi Taming the Dragons Seminar, a multi-disciplinary intervention program to help young children ages 0-12 cope after traumatic events.
- September - THRIVE sponsored Legislative Lunch & Learn; presentation on current data, underlying needs and conditions to be addressed, community resources and services available, positive community norms and prevention strategies shared.
- October-December - THRIVE Committees reviewed Annual Plan and developed Strategic Plan and a Work Plan for 2016.

Appendix H: History and Structure of R.O.C.K. Mat-Su

The initial work of the original 18 R.O.C.K. Mat-Su partners in 2014 focused on specific outreach around the issue of child maltreatment prevention. First, partners began convening around child maltreatment prevention, and determined that there was a consensus and urgency to move forward. Also during this phase, several partners participated in a day-long community dialogue on Adverse Childhood Experiences. At this gathering, which was attended by over 100 community members, R.O.C.K. Mat-Su partners presented an ACE Interface training, shared information on what community organizations were doing to be trauma-informed, and announced the intention to create a Collective Impact collaborative to promote family resilience and reduce child maltreatment in Mat-Su.

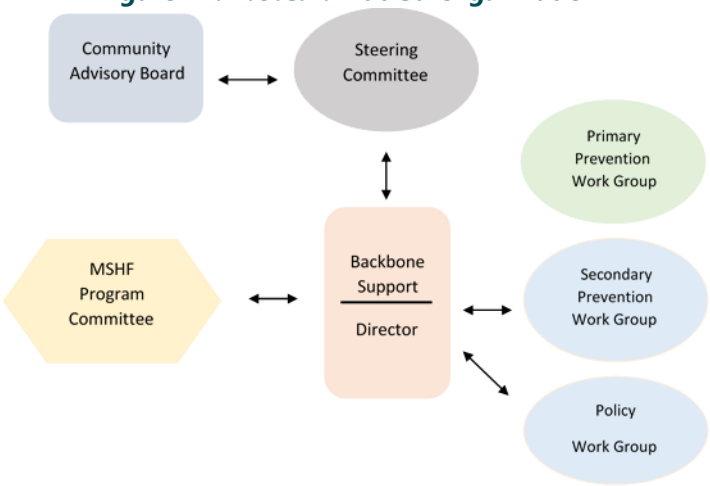
R.O.C.K. Mat-Su's primary prevention goal focuses on increasing family resilience for all Mat-Su families. The objectives for this goal are structured around the Strengthening Families protective factors. R.O.C.K. Mat-Su's secondary and tertiary prevention goal focuses on preventing at risk families from experiencing child maltreatment and reducing the number of Mat-Su youth who experience re-victimization. The table below outlines R.O.C.K. Mat-Su Goals.

Table 93. R.O.C.K. Mat-Su Goals

Strengthen families so all children are safe, healthy, and thriving:
• Parents and communities and systems understand child development, parenting, and resilience
• Children and youth develop social and emotional skills
• Children and families meet their basic needs
• Parents of strong social supports
End child abuse and neglect and reduce other adverse childhood experiences
• Educate and connect families to supports
• Prevent child maltreatment and repeat maltreatment
• Connect families to substance abuse and mental health services

R.O.C.K. Mat-Su is structured such that the collaborative operates with the oversight of a Community Advisory Board, at the direction of a Steering Committee, and under the governance of the MSHF Program Committee. The work of the R.O.C.K. Mat-Su collaborative is conducted by three working groups: Primary Prevention, Secondary Prevention, and Policy.

Figure 27. R.O.C.K. Mat-Su Organization



The collaborative uses a consensus model of decision-making and partner engagement in all aspects of its work. For example, partners determine collectively which activities will be undertaken, then plan and manage the implementation of activities; partners share responsibility for community presentations on the work of the collective with R.O.C.K. Mat-Su staff; and partners work together to set the strategic plan for the collaborative.

In 2015, the R.O.C.K. collaborative focused on the following activities:

- mapped the landscape of available child maltreatment and family resilience data for Mat-Su,
- created a structure for the collaborative;
- established guidelines for working together;.
- held regularly scheduled R.O.C.K meetings;
- identified an organization to house the director and other staff;
- took two multi-day cohort learning trips for education on best-practices on child maltreatment prevention and family support;
- held two day-long community meetings to educate on collective impact, ACEs and resilience, report progress-to-date, and to obtain feedback (100 attendees each meeting).

In 2016, R.O.C.K. Mat-Su:

- contracted with a developmental evaluator to ensure fidelity to the Collective Impact Approach and to establish a real-time form of feedback to the collaborative;
- took a multi-day cohort learning trip on collective impact, as well as held lunch-and-learns in Mat-Su with invited experts as speakers;
- provided funding to train 32 Mat-Su community members to become ACE Interface trainers;[21]

[21] In 2014, eight Mat-Su residents attended an ACE Interface Train the Trainer training provided by Dr. Anda and Laura Porter, the creators of ACE Interface. Those eight trainers soon became overwhelmed with requests for trainings, requiring a second cohort of trainers. In January of 2016, 32 additional Mat-Su community members participated in an ACE Interface Trainer training. This second cohort of trainers included medical professionals, school staff, tribal partners, early childhood educators, and volunteers representing parenting and homeless youth service providers. Both cohorts of ACE Interface trainers are now working to educate community members on neurodevelopment, the impact of trauma on developing brains and the hope of resilience for those who have experienced trauma. As of April 2016, 30 ACE Interface trainings have been conducted in Mat-Su, with 553 community members trained. Additional primary prevention strategies will be adopted in 2016.

- Partnered with the Palmer Superior Court and community providers and the Child in Need of Aid court team, and the District Attorney's office to bring a Safe Babies Court training to Mat-Su. This initiative is being led by the Palmer Superior Court.[22]
- Advocating to increase the availability of supervised visitation for Mat-Su families with children in foster care.
- Partnering with the Mat-Su Borough School District to support an initial cohort of trauma-informed schools in the 2016-2017 school year (4 schools in cohort).
- Co-sponsoring a trauma-informed organization cohort with a kick-off training in September (5 Mat-Su organizations in cohort) – the head of the local child advocacy center is the lead.
- Collaborated with the Alaska Children's Trust to host four community showings of the Paper Tigers documentary, which tells the story of the creation of a trauma-informed school in Walla Walla, Washington (150 attendees).
- Partnered with CCS Early Learning to hold a Go Blue Rally to raise awareness of Child Abuse Prevention Month (25 attendees).

Mat-Su appears to be at the "Thriving" stage of development according to the stages developed through the experience of the Washington State Family Policy Council. The collaborative has established a clear structure with a core group and a paid director; the partners continue to participate in cohort learning experience on the collective impact structure and research and best practices; there is a core of ACEs trainers in Mat-Su to educate the community on ACEs and resilience; new groups and leaders where brought in in 2016 to participate in achieving collective goals (Safe Babies Court initiative); and the collaborative has shared leadership for the cross sector initiatives that emerge.

The following table assesses two aspects of this collaborative effort with the framework proposed by Porter et al. – Partners and Principles. R.O.C.K. Mat-Su appears to be addressing number 2-5 of the key principles on an ongoing basis. While the first key principle, "leadership listens and reports back to the most affected community residents is built into the structure of the collaborative", the Community Advisory Board has yet to be established. The sixth key principle, "all work is strength-based and focused on positive movement and celebrating success" is addressed HOW?

As far as the guidelines on the partners working together it appears that the collaborative is addressing these components. Partners have been working on establishing the collaborative through a focus on the common good. There is a core team and a paid director. The Mat-Su Health Foundation, a community philanthropic foundation that co-owns the local hospital is staffing the collaborative and has committed to five years of continuous funding. Additionally, as noted in the activities conducted during 2015 and 2016, the R.O.C.K. team is educated themselves on data, best practices, and collective impact.

[22] Safe Babies Court Teams aim to: increase awareness among those who work with maltreated infants and toddlers about the negative impact of abuse and neglect on very young children; and, change local systems to improve outcomes and prevent future court involvement in the lives of very young children. The Safe Babies Court Team approach is a community engagement and systems-change model focused on improving how the courts, child welfare agencies, and related child-serving organizations work together, share information, and expedite services for children ages 0 – 3 years old in the child welfare system.

Table 94. Key Principles and Partner Activity Related to R.O.C.K. Mat-Su

Key Principles	R.O.C.K. Mat-Su	Partner Activity	R.O.C.K. Mat-Su
Leadership listens and reports back to the most affected community residents	Build into framework – still to be implemented	Put personal agendas aside and focus on common good.	Ongoing
Groups that learn about the latest research and successful practices and use this knowledge to address an issue. Results are reflected upon.	Ongoing	Serve as a core team and have a paid coordinator or facilitator.	Yes
Continuous reaching out to new sectors and people to work on solutions	Ongoing	Take advantage of opportunities (state and local policy, funding, for learning).	Yes
Informed by neuroscience, epigenetics, ACEs and resilience research	Ongoing	Educate themselves and the community on the latest data, research, stories on the issue.	Yes
Solutions are adapted to fit the community	Ongoing	Educate themselves on team management, public, political and funder accountability, data analysis, and translating the meaning of data, evaluation and systems thinking.	Training conducted on Collective Impact
All work is strength-based and focused on positive movement and celebrating success	Strength-based focus; can expand celebrating success	Welcome external partners assisting with financial support and training.	Yes

The collaborative is taking advantage of funding and learning opportunities as evidenced by being part of a functioning cross-community learning cohort with the Southern Kenai Peninsula's Mobilizing for Action through Planning and Partnership, (MAPP) which is working to become a trauma-informed community with increased family resilience and decreased child maltreatment. R.O.C.K. Mat-Su and MAPP of Southern Kenai Peninsula share information and learn from each other. Most recently they cosponsored the National Council of Behavioral Health to conduct a trauma-informed organization training for organizations from the two communities.

Another opportunity that R.O.C.K. has seized is related to a national effort by the Health Federation of Philadelphia and the Robert Wood Johnson Foundation called Mobilizing Action for Resilient Communities (MARC) funding in 2015. MARC is a learning collaborative of 14 communities across the country that are actively engaged in building the movement for a just, healthy and resilient world. The Alaska Children's Trust is the convener of the Alaska Resilience Initiative, which formed in 2012 to advance the dialogue in Alaska on brain architecture, ACEs, and how communities can prevent ACEs and build resilience. This statewide network is funded as a MARC grantee to work with a local network in the South Kenai Peninsula and R.O.C.K. Mat-Su as pilot community efforts to build a movement in Alaska. As a MARC pilot community R.O.C.K. Mat-Su is helping to: strengthen a statewide network working to identify and implement systems changes; test strategies to reduce child trauma, increase knowledge and awareness of brain architecture, ACEs, resilience and, build trauma-informed systems, communities and organizations; and share our community experience with other Alaskan communities looking to implement a coordinated community response to child maltreatment prevention. As a participant in the MARC learning community R.O.C.K. Mat-Su has access to a wide array of technical assistance provided by leading national experts in maltreatment prevention and the promotion of resilience. R.O.C.K. staff has also connected with individuals in other communities across the country who are undertaking similar strategies.

Finally, R.O.C.K. Mat-Su has also leveraged funding through their work with the State of Alaska Early Childhood Comprehensive Systems (ECCS) Program. In FY 2015, and again in 2016, the ECCS program set aside money to fund Collective Impact activities in Mat-Su *to improve developmental trajectories for infants and young children by fostering safe and nurturing relationships and mitigating the effects of toxic stress and trauma.* The grant awards for R.O.C.K. Mat-Su partners totaled $20,000 in FY 2015 and $35,106 in FY 2016, for a total of $55,106 in leveraged funds in two years.

The growth of the different efforts by the initiative is evidence of leadership expansion. A local judge is leading up the Safe Babies Court initiative, the local child advocacy center director is leading the Trauma-Informed Organization cohort learning effort; and a school administrator and staff are leading the Trauma-informed Schools' effort. Ongoing cohort learning experiences help to develop a focused shared understanding for the R.O.C.K. Steering Committee and work groups