APPENDIX: PREVALENCE ESTIMATES

Introduction

The term "prevalence" refers to the proportion of a population with a particular characteristic at a given time or over a given span of time. Prevalence differs from the term "incidence" in that prevalence includes all new and preexisting cases, whereas incidence is limited to just new cases. This appendix provides prevalence estimates (population counts and percentages) for the Alaska Mental Health Trust's (the Trust) beneficiary population. This includes Alaskans who experience one or more of the following conditions:

1. Mental illness (any mental illness, serious mental illness, and serious emotional disturbance).
2. Alzheimer's disease and related dementia.
3. Traumatic brain injuries.
4. Intellectual and developmental disabilities.
5. Substance use disorders.

Limitations

Currently there is no comprehensive reporting mechanism to measure the prevalence of the Trust's entire beneficiary population in Alaska. Prevalence must instead be estimated using various secondary data sources, including a combination of population surveys, journal articles, and reports. Many of these sources come with important caveats and limitations which require additional consideration and caution when interpreting the estimates reported in this appendix.

For example, estimates of individuals with any or serious mental illness and individuals with alcohol or substance use disorders, are estimated using the Substance Abuse and Mental Health Services Administration's National Survey on Drug Use and Health (NSDUH). The NSDUH is an annual survey of the U.S. civilian, noninstitutionalized population ages 12 years or older. However, these results are based on self-reported data and are likely subject to underreporting, social desirability bias, detection and coverage restrictions, and other limitations. The NSDUH also does not sample all individuals who would likely fall under the Trust's purview, such as those experiencing homelessness who do not use shelters, active-duty military members, and

residents of nursing homes, long-term care hospitals, jails, and mental institutions. These sampling limitations may result in a significant underestimate of the true prevalence of these populations.

Other prevalence estimate data sources are based on point-in-time estimates from studies or reports whose snapshots may now be significantly out of date, or did not include Alaska-specific estimates. For example, the prevalence of Alaskans with traumatic brain injuries is based on a national average from a Centers for Disease Control and Prevention report released in 1999, using data collected between 1996 and 1997. These estimates would not reflect Alaska's current population or its unique demographic composition, cultural history, or public health concerns, especially in rural areas with limited screening, diagnostic, and treatment options.

Concerns with data quality and reliability led the Alaska Department of Health (DOH) and Trust to recommend temporarily removing potentially unreliable prevalence estimates from the 2020 Alaska Scorecard when it was revised to align with Strengthening the System: Comprehensive Integrated Mental Health Program Plan 2020- 2024 (Strengthening the System). During this time, the DOH and the Trust investigated alternative data sources or the feasibility of developing a more accurate methodology for estimating the Trust's beneficiary(s) population. It was concluded that no single survey or administrative data could adequately and consistently measure the broad spectrum of health challenges covered by the statutory definition of the Trust's beneficiaries. Thus, a long-term, tiered strategy is necessary to remedy, but not wholly solve, the prevalence estimate data limitations.

A long-term, tiered approach to prevalence surveillance would not be possible without significant investment, coordination, planning, and implementation strategies spanning several years that would require support from several State Departments, including the DOH and the Trust. This could include methods such as 1) a collegiate literature review for other secondary data sources, 2) the development of a passive surveillance system that works to make all beneficiary conditions reportable, 3) a household or provider survey with regular data collection that also captures populations normally unable or unlikely to respond, 4) the creation of an All-Payer Claims database.

Recognizing the limitations of the current prevalence estimation methodology, and accounting for the long-term tiered strategy to sponsor a robust but likely imperfect solution, it was decided to continue using existing methods to estimate prevalence despite known limitations. Please be aware that the estimates provided in this appendix may be statistically unreliable and should be used with caution. Refer to the individual sections for additional information about each prevalence estimate.

PREVALENCE ESTIMATES 2023
Beneficiaries of the Trust Population Prevalence Estimates

POPULATION	ESTIMATE	PERCENTAGE
PREVALENCE		
P1. Alaskans with any mental illness in the past year (ages 18+)	138,347	25.0%
P2. Alaskans with serious mental illness in the past year (ages 18+)	37,332	6.8%
P3. Alaskans with serious emotional disturbance (ages 5 to 17)	8,184	6.0%
P4. Alaskans with Alzheimer's disease (ages 65+)	9,500	9.0%
P5. Alaskans with traumatic brain injuries	14,731	2.0%
P6. Alaskans with developmental disabilities (ages 3 to 17)	27,681	17.8%
P7. Alaskans with alcohol use disorder in the past year (ages 12 to 17)	2,328	3.7%
P8. Alaskans with alcohol use disorder in the past year (ages 18+)	69,561	12.6%
P9. Alaskans with substance use disorder in the past year (ages 12-17)	7,183	11.5%
P10. Alaskans with substance use disorder in the past year (ages 18+)	134,689	24.3%

PREVALENCE
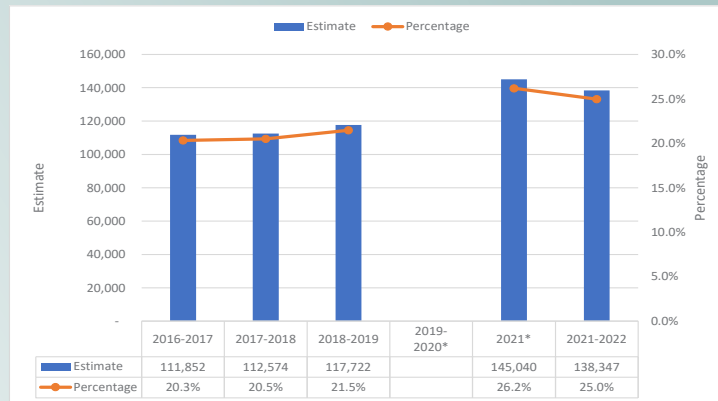## P1: Alaskans with any mental illness in the past year (ages 18+)

Definition

Any mental illness (AMI) is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder. AMI can vary in impact, ranging from no impairment to mild, moderate, and even severe impairment.

Method

Prevalence population percentage data come from the Substance Abuse and Mental Health Services Administration (SAMHSA), National Survey on Drug Use and Health (NSDUH). NSDUH reported population count data, which are rounded to the nearest thousand persons, are substituted with calculated population count data, which are calculated by multiplying the reported population percentage by population estimates from the Alaska Department of Labor and Workforce Development (DOLWD). This allows the calculation of slightly more precise population count data than are reported directly in the NSDUH.

	2016-2017	2017-2018	2018-2019	2019-2020*	2021*	2021-2022
Estimate	111,852	112,574	117,722		145,040	138,347
Percentage	20.3%	20.5%	21.5%		26.2%	25.0%

Population: Alaska (Ages 18+)

Data Source:

- National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia).

Population Source:

- Alaska Department of Labor and Workforce Development.

*Note:

- State estimates for 2019-2020 are not available due to methodological concerns with combining 2019-2020 data. Changes to survey methodology following the COVID-19 pandemic in 2020 resulted in estimates that cannot be compared with earlier surveys. Due to major survey revisions in 2021-2022, data for this indicator are no longer comparable to earlier results.

Additional Notes

NSDUH data from 2018-2019 and earlier are assessed by the Mental Health Surveillance Study (MHSS) Structured Clinical Interview for the Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition - Research Version - Axis I Disorders (MHSS-SCID), which is based on the Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition (DSM-IV).

Data since 2021 are assessed by the DSM-IV. To protect the safety of field staff and survey participants during the COVID-19 pandemic, SAMHSA suspended in-person NSDUH data collection on March 16, 2020. To reduce the impact of the COVID-19 pandemic on NSDUH data, SAMHSA approved the addition of web-based data collection in Quarter 4 of 2020. State estimates for 2019-2020 are not available due to methodological concerns with combining 2019 and 2020 data. NSDUH state estimates are typically based on two years of combined data. However, 2021 estimates are only based on a single year of preliminary data. Changes to survey methodology in 2021 mean the data cannot be combined with previous years and results are not comparable with earlier data.

Sources:

- Substance Abuse and Mental Health Services Administration (SAMHSA)

P2: Alaskans with serious mental illness in the past year (ages 18+)
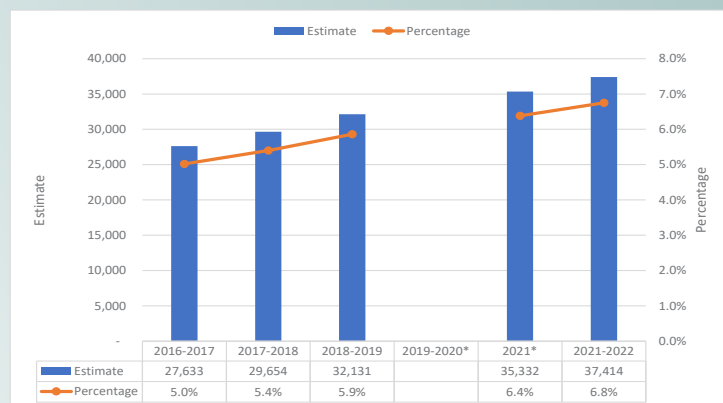
Definition

Serious mental illness (SMI) is a subset of any mental illness (AMI) defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder that results in serious functional impairment which substantially interferes with or limits one or more major life activities.

Method

Prevalence population percentage data come from the Substance Abuse and Mental Health Services Administration (SAMHSA), National Survey on Drug Use and Health (NSDUH). NSDUH reported population count data, which are rounded to the nearest thousand persons, are substituted with calculated population count data, which are calculated by multiplying the reported population percentage by population estimates from the Alaska Department of Labor and Workforce Development (DOLWD). This allows calculation of slightly more precise population count data than are reported directly in the NSDUH.

	2016-2017	2017-2018	2018-2019	2019-2020*	2021*	2021-2022
Estimate	27,633	29,654	32,131		35,332	37,414
Percentage	5.0%	5.4%	5.9%		6.4%	6.8%

Population: Alaska (Ages 18+)

Data Source:

- National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia).

Population Source:

- Alaska Department of Labor and Workforce Development.

*Note:

- State estimates for 2019-2020 are not available due to methodological concerns with combining 2019-2020 data. Changes to survey methodology following the COVID-19 pandemic in 2020 resulted in estimates that cannot be compared with earlier surveys. Due to major survey revisions in 2021-2022, data for this indicator are no longer comparable to earlier results.

Additional Notes

NSDUH data from 2018-2019 and earlier are assessed by the Mental Health Surveillance Study (MHSS) Structured Clinical Interview for the Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition - Research Version - Axis I Disorders (MHSS-SCID), which is based

on the Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition (DSM-IV).

Data since 2021 are assessed by the DSM-IV. To protect the safety of field staff and survey participants during the COVID-19 pandemic, SAMHSA suspended in-person NSDUH data collection on March 16, 2020. To reduce the impact of the COVID-19 pandemic on NSDUH data, SAMHSA approved the addition of web-based data collection in Quarter 4 of 2020. State estimates for 2019-2020 are not available due to methodological concerns with combining 2019 and 2020 data. NSDUH state estimates are typically based on two years of combined data. However, 2021 estimates are only based on a single year of preliminary data. Changes to survey methodology starting in 2021 mean the data cannot be combined with previous years and results are not comparable with earlier data.

Sources:
- [Substance Abuse and Mental Health Services Administration (SAMHSA)](#)

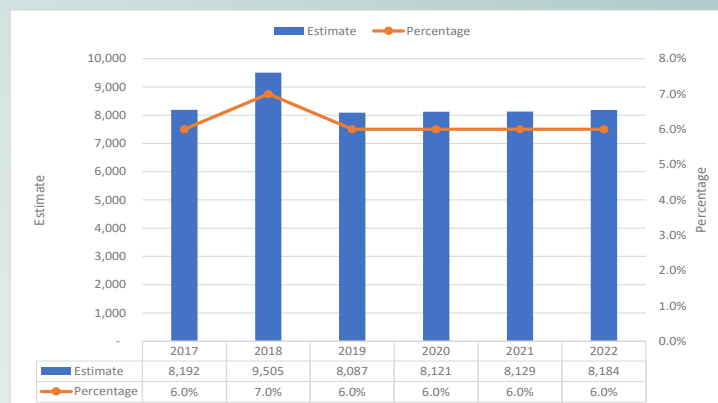# P3: Alaskans with serious emotional disturbance (ages 5 to 17)

Definition

Serious emotional disturbance (SED) is used to refer to children and youth who have had a diagnosable mental, behavioral, or emotional disorder in the past year, which resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities.

Method

Prevalence population percentage data are calculated based on a methodology recommended by the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services

	2017	2018	2019	2020	2021	2022
Estimate	8,192	9,505	8,087	8,121	8,129	8,184
Percentage	6.0%	7.0%	6.0%	6.0%	6.0%	6.0%

Population: Alaska (Ages 5 to 17)

Data Source:

- United States Substance Abuse and Mental Health Services Administration. Center for Mental Health Services. Estimation Methodology for Children With a Serious Emotional Disturbance (SED). Federal Register. 62(193).
- United States Census Bureau. Small Area Income and Poverty Estimates. Ages 5 to 17 in Families Poverty Rate.

Population Source:

- Alaska Department of Labor and Workforce Development.

(CMHS). This methodology is documented in Center for Mental Health Services (1997). Population percentages are assigned based on the child poverty rate, with each of the 50 U.S. states and District of Columbia proportionally divided into low, medium, and high poverty-level categories based on their relative poverty rankings and assigned a corresponding SED prevalence population percentage. Poverty rate estimates come from the Census Bureau's Small Area Income and Poverty Estimates (SAIPE) for children in families aged 5-17 years. Assuming a level of functioning (LOF) of 50, low-poverty states are assigned a population percentage of 6%, medium-poverty states are assigned 7%, and high-poverty states are assigned 8%, with each percentage representing the mid-point of ranges originally recommended by CMHS.

Population count data are calculated by multiplying the reported population percentage by population estimates from the Alaska Department of Labor and Workforce Development (DOLWD).

Additional Notes

There are several important limitations with this methodology. First, the estimated SED population percentage ranges were "based on the findings from many modest-sized studies which varied not only in population but often in instruments that were used (particularly for measurement of impairment), methods that were used to collect the data, and even the diagnostic system that was used". Second, " there are only two studies that include youngsters under the age of nine, and these studies are not adequate to provide a base for any estimate of the prevalence of serious emotional disturbance for children under the age of nine". Although the original ranges were intended for children between 9 to 17 years, the current publicly available SAIPE estimates include children (in families only) aged 5 to 17 years. Third, "the data are also inadequate to determine prevalence estimates for children of different racial and ethnic backgrounds. Several of the studies included youngsters of color in their sample and two studies were done exclusively on Hispanic youngsters in Puerto Rico... However, the sample sizes are too small and not sufficiently representative of African-American, Hispanic, Asian American, or native American populations to permit estimates to be made". Fourth, "with the absence of any large national studies, it is not possible to determine whether rates differ in urban versus rural areas, or different regions of the country". Lastly, because ranges are assigned based on relative rankings of U.S. child poverty rates, this does not account for absolute changes in nationwide poverty. Furthermore, relatively small differences in poverty rates between states can result in areas with otherwise similar levels being assigned different ranges.

Sources:
- Agnew:: Beck LLC, Hornby Zeller Associated, Inc. (2016). Alaska Behavioral Health Systems Assessment Final Report.
- Costello , E.J., Messer, S.C., Bird, H.R., Cohen, P., Reinherz, H.Z. (1998). The prevalence of serious emotional disturbance: a re-analysis of community studies. Journal of Child and Family Studies, 7(4): 411-432.

P4: Alaskans with Alzheimer's disease dementia (ages 65+)

Definition

Alzheimer's disease dementia (AD), the most common form of dementia, involves the parts of the brain that control thought, memory, and language. It is a progressive disease starting with mild memory loss and can eventually lead to loss of the ability to carry on a conversation and respond to the environment, affecting a person's ability to carry out activities of daily living.
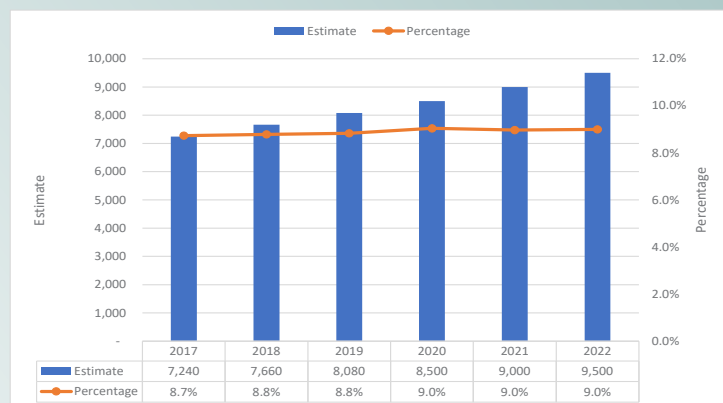
Method

Prevalence population count estimates (in thousands) come from state-level projections reported by Weuve, et al. (2015). These estimates are based on an analysis of AD incidence and mortality data from the Chicago Health and Aging Project (CHAP) which are projected to each state's population in five-year intervals through 2025, with adjustments for state-specific characteristics. Simple linear interpolation is used to derive yearly counts between each reported five-year estimate. Population percentage data are calculated by dividing the reported population count by population estimates from the Alaska Department of Labor and Workforce Development (DOLWD).

Additional Notes

These estimates are derived from AD incidence and mortality data from the CHAP, a longitudinal, population-based study of older adults (60% Black and 40% White) living in a

	2017	2018	2019	2020	2021	2022
Estimate	7,240	7,660	8,080	8,500	9,000	9,500
Percentage	8.7%	8.8%	8.8%	9.0%	9.0%	9.0%

Population: Alaska (Ages 65+)

Data Source:

- Weuve J, et al. (2015). Prevalence of Alzheimer Disease in US States. Epidemiology. 25(1).

Population Source:

- Alaska Department of Labor and Workforce Development.

geographically defined area of Chicago. Although state-level estimates attempt to account for each state's unique age structure, mortality patterns, and other demographic characteristics, the authors caution that " Even within age–sex–race– education strata, the experience of the CHAP population might not generalize to state-specific populations or to different points in time".

Previous scorecard population count estimates were taken from the Alzheimer's Association's Alzheimer's Facts & Figures report which were also generated based data from Weuve et al. (2015). However, as of the 2021 Facts & Figures report, yearly estimates are no longer provided and are instead interpolated directly here. Updated projections will no longer be available after 2025.

Sources:
- Alzheimer's Association
- Chicago Health and Aging Project

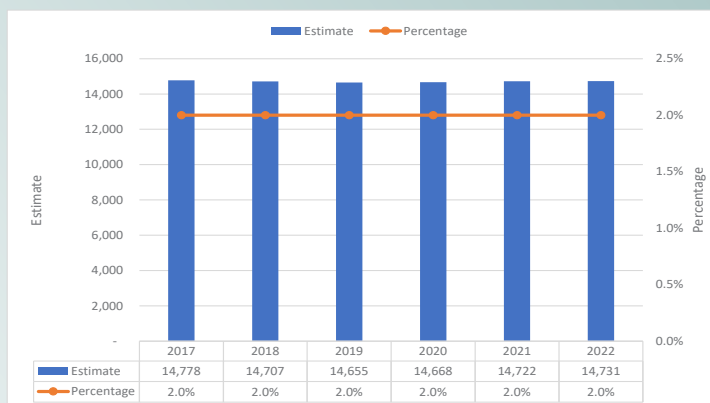# P5: Alaskans with traumatic brain injuries

Definition

A traumatic brain injury (TBI) is an injury caused by a bump, blow or jolt to the head or a penetrating head injury that disrupts the normal function of the brain. Effects of TBI may include impaired thinking, memory, sensation, or emotional functioning.

Method

Prevalence population percentage estimates come from a national-level estimate published by the Centers for Disease Control and Prevention (CDC) (1999). These estimates are based on a model that estimated the number of persons alive in 1996 who had ever had a TBI that required hospitalization and resulted in long-term disability. CDC estimated that 5.3 million U.S. citizens (2% of the population) are living with a disability as a result of a TBI. Population count data are calculated by multiplying the reported population percentage by population estimates from the Alaska Department of Labor and Workforce Development (DOLWD).

	2017	2018	2019	2020	2021	2022
Estimate	14,778	14,707	14,655	14,668	14,722	14,731
Percentage	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

Population: Alaska

Data Source:

- Centers for Disease Control and Prevention (1999). Traumatic Brain Injury in the United States: A Report to Congress.

Population Source:

- Alaska Department of Labor and Workforce Development.

Additional Notes

CDC's estimates are based on a model that incorporated data on the incidence of TBI, severity of injury, and likelihood of disability given a specific level of injury severity. The report notes that their "model does not account for disability among people who visited emergency

departments or outpatient clinics with a TBI but were not admitted to the hospital" and cautions that the reported estimate of 2% "may be low". Due to the lack of projected data, the prevalence estimates reported here assume that this percentage has remained unchanged since publication, which is unlikely. The lack of state-level estimates also make these estimates impossible to generalize to the Alaska-specific population. A follow-up report, Centers for Disease Control (2015), provided no new prevalence estimates and stated that "[c]urrently, ongoing surveillance of TBI-related disability does not exist", warning that data gaps have resulted in the following limitations: "no true national-level estimates; no 12-month prevalence estimate of TBI-related disability; an inability to examine state-level variation; no recent estimates; an inability to monitor trends; and an inability to examine variation in TBI-related disability by important demographic subgroups such as race/ethnicity or military status".

Recent morbidity and mortality incidence data for Alaska suggests that the prevalence estimates reported here are now likely a significant underestimate. According to an analysis done by the Alaska Native Tribal Health Consortium (2019), from 2012-2016, about 1 out of every 5 reported injuries in Alaska included a brain injury. Research by Newell (2023) found that from 2016-2021, Alaska also had the highest TBI-related mortality rate in the nation, at 34.7 deaths per 100,000 population (over twice the national average).

Sources:

- Alaska Department of Health, Division of Senior and Disabilities Services. Traumatic and Acquired Brain Injury Program.
- Alaska Department of Health, Chronic Disease Prevention and Health Promotion. Injury Prevention Program.
- University of Alaska Anchorage Center for Human Development. The Alaska Traumatic Brain Injury Planning Grant Needs and Resources Assessment, June 2001 – January 2003 and Alaska Brain Injury Network.
- Centers for Disease Control and Prevention (2015). Report to Congress on Traumatic Brain Injury in the United States: Epidemiology and Rehabilitation
- Newell, K. (2023). Traumatic Brain Injury in Alaska. State of Alaska Epidemiology Bulletin. 23(2).
- Strayer H, Blake I, Stevens I, Provost E. (2019). Alaska Native Injury Atlas: Third Edition. Anchorage, Alaska Native Tribal Health Consortium Injury Prevention Program and Alaska Native Epidemiology Center.
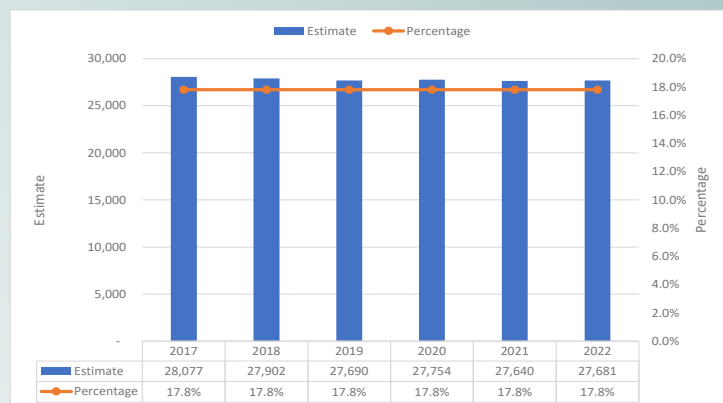
Definition

Developmental disabilities are defined as a group of lifelong conditions due to an impairment in physical, learning, language, or behavior areas. Developmental disabilities as defined here include attention-deficit/hyperactivity disorder, autism spectrum disorder, blindness, cerebral palsy, moderate to profound hearing loss, learning disability, intellectual disability, seizures, stuttering or stammering, and other developmental delays.

	2017	2018	2019	2020	2021	2022
Estimate	28,077	27,902	27,690	27,754	27,640	27,681
Percentage	17.8%	17.8%	17.8%	17.8%	17.8%	17.8%

Population: Alaska and U.S. (All ages and 3-17 years)

Data Source:

- Zablotsky, B. et al. (2019). Prevalence and Trends of Developmental Disabilities Among Children in the United States: 2009–2017. Pediatrics 144(4).

Population Source:

- Alaska Department of Labor and Workforce Development.

Method

Prevalence population percentage estimates come from national-level estimates reported by Zablostsky, et al. (2019). These estimates are based on data from the 2009 to 2017 National Health Interview Survey (NHIS) and includes parents who reported receiving physician or other health care professional diagnoses of developmental disabilities for a child aged 3 to 17 years. The authors estimated that 17.8% of children in this age range were living with one or more developmental disabilities. Population count data are calculated by multiplying the reported population percentage by population estimates from the Alaska Department of Labor and Workforce Development (DOLWD).

Additional Notes

According to Zablostsky et al. (2019), average prevalence for any developmental disability increased from 16.2% between 2009-2011 to 17.8% between 2015-2017 (a 9.5% increase). Due to the lack of projected data, the prevalence estimates reported here assume that this percentage has remained unchanged since publication, which is unlikely. The lack of state-level

estimates also make these estimates impossible to generalize to the Alaska-specific population. The authors caution that their results are subject to the following limitations. "First, in some instances, statistical trend tests may have been underpowered because of smaller sample sizes (eg, rural residents). Second, the reliance on parent report could result in the misreporting of children's diagnoses because these reports may also be subject to recall biases, particularly among parents of older children. Thirdly, there was no mechanism in place to validate parent-reported diagnoses either through clinical evaluation or educational records... Finally, as parents are reporting on a lifetime diagnosis, it is likely that some children included in the current analysis no longer have a diagnosable developmental disability"

Previous scorecard population percentage estimates were taken from earlier research by Larson, et al. (2001), also based NHIS data from 1994 and 1995. This study estimated a non-age specific population percentage for developmental disabilities (including intellectual disabilities, then referred to as "mental retardation") of 1.5%. This study has been replaced with Zablostsky et al. (2019) to better align with more recent definitions of developmental disability and to draw from the latest available NHIS data.

Sources:

- Larson SA, et al. (2001). Prevalence of Mental Retardation and Developmental Disabilities: Estimates from the 1994/1995 National Health Interview Survey Disability Supplements. American Journal on Mental Retardation. 106(3).
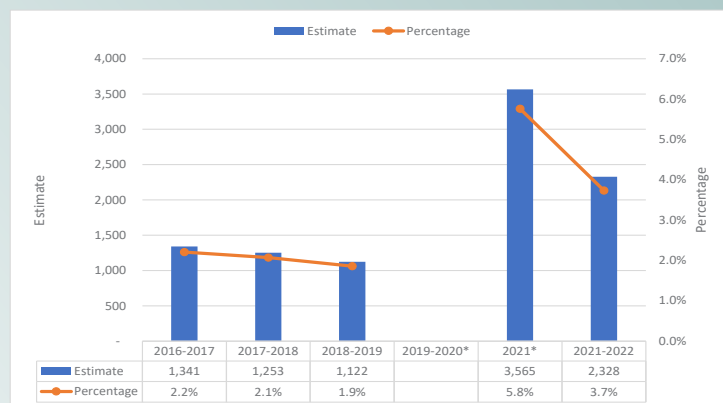
Definition

Alcohol use disorder (AUD) is defined as meeting criteria for alcohol dependence or abuse. Abuse criteria include finding that drinking is interfering with taking care of home or family, having legal problems because of drinking, and continuing to drink even though it was causing trouble with family or friends. Dependence criteria include having withdrawal symptoms when the effects of alcohol are wearing off, wanting to cut down or stop drinking and not being able to, and finding you need to drink more to get the effect you want.

	2016-2017	2017-2018	2018-2019	2019-2020*	2021*	2021-2022
Estimate	1,341	1,253	1,122		3,565	2,328
Percentage	2.2%	2.1%	1.9%		5.8%	3.7%

Population: Alaska (Ages 12-17)

Data Source:

- National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia).

Population Source:

- Alaska Department of Labor and Workforce Development.

*Note:

- State estimates for 2019-2020 are not available due to methodological concerns with combining 2019-2020 data. Changes to survey methodology following the COVID-19 pandemic in 2020 resulted in estimates that cannot be compared with earlier surveys. Due to major survey revisions in 2021-2022, data for this indicator are no longer comparable to earlier results.

Method

Prevalence population percentage data come from the Substance Abuse and Mental Health Services Administration (SAMHSA), National Survey on Drug Use and Health (NSDUH). NSDUH reported population count data, which are rounded to the nearest thousand persons, are substituted with calculated population count data, which are calculated by multiplying the reported population percentage by population estimates from the Alaska Department of Labor and Workforce Development (DOLWD). This allows calculation of slightly more precise population count data than are reported directly in the NSDUH.

Additional Notes

NSDUH data from 2018-2019 and earlier are assessed by the Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition (DSM-IV). Data since 2021 are assessed by the DSM-V. To protect the safety of field staff and survey participants during the COVID-19 pandemic, SAMHSA suspended in-person NSDUH data collection on March 16, 2020. To reduce the impact of the COVID-19 pandemic on NSDUH data, SAMHSA approved the addition of web-based data collection in Quarter 4 of 2020. State estimates for 2019-2020 are not available due to methodological concerns with combining 2019 and 2020 data. NSDUH state estimates are typically based on two years of combined data. However, 2021 estimates are only based on a single year of preliminary data. Changes to survey methodology in 2021 mean the data cannot be combined with previous years and results are not comparable with earlier data

Sources:

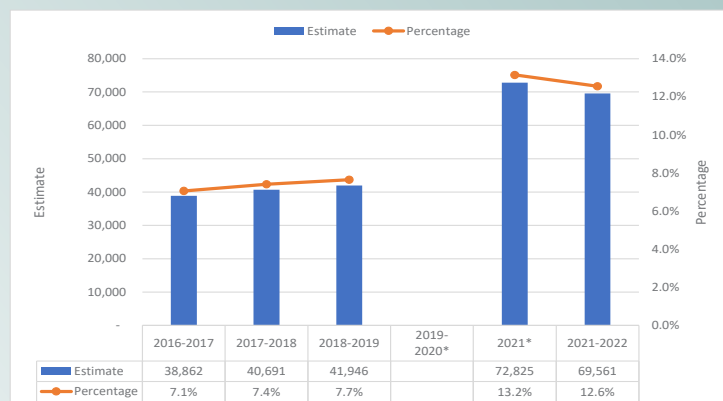- [Substance Abuse and Mental Health Services Administration (SAMHSA)](#)

Definition

Alcohol use disorder (AUD) is defined as meeting criteria for alcohol dependence or abuse. Abuse criteria include finding that drinking is interfering with taking care of home or family, having legal problems because of drinking, and continuing to drink even though it was causing trouble with family or friends. Dependence criteria include having withdrawal symptoms when the effects of alcohol are wearing off, wanting to cut down or stop drinking and not being able to, and finding you need to drink more to get the effect you want.

	2016-2017	2017-2018	2018-2019	2019-2020*	2021*	2021-2022
Estimate	38,862	40,691	41,946		72,825	69,561
Percentage	7.1%	7.4%	7.7%		13.2%	12.6%

Population: Alaska (Ages 18+)

Data Source:

- National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia).

Population Source:

- Alaska Department of Labor and Workforce Development.

*Note:

- State estimates for 2019-2020 are not available due to methodological concerns with combining 2019-2020 data. Changes to survey methodology following the COVID-19 pandemic in 2020 resulted in estimates that cannot be compared with earlier surveys. Due to major survey revisions in 2021-2022, data for this indicator are no longer comparable to earlier results.

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Additional Notes

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Sources:

- Substance Abuse and Mental Health Services Administration (SAMHSA)

P9: Alaskans with substance use disorder in the past year (ages 12-17)
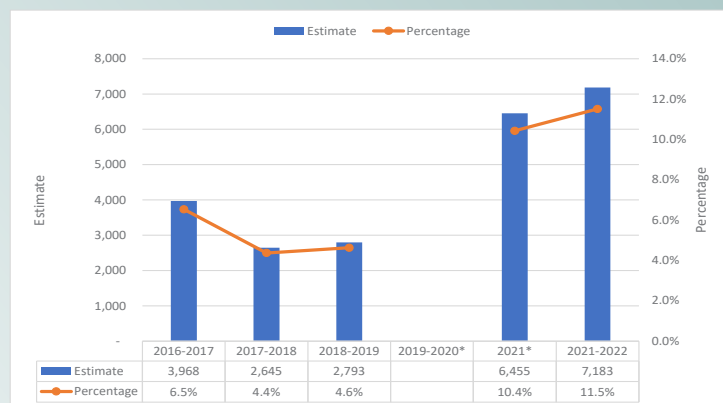
Definition

Substance use disorders (SUDs) are characterized by impairment caused by the recurrent use of alcohol or other drugs (or both), including health problems, disability, and failure to meet major responsibilities at work, school, or home. Drugs include marijuana, cocaine (including crack), heroin, hallucinogens, inhalants, methamphetamine, and any use of prescription stimulants, tranquilizers or sedatives (e.g., benzodiazepines), and pain relievers.

Method

Prevalence population percentage data come from the Substance Abuse and Mental Health Services Administration (SAMHSA),

	2016-2017	2017-2018	2018-2019	2019-2020*	2021*	2021-2022
Estimate	3,968	2,645	2,793		6,455	7,183
Percentage	6.5%	4.4%	4.6%		10.4%	11.5%

Population: Alaska (Ages 12-17)

Data Source:

- National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia).

Population Source:

- Alaska Department of Labor and Workforce Development.

*Note:

- State estimates for 2019-2020 are not available due to methodological concerns with combining 2019-2020 data. Changes to survey methodology following the COVID-19 pandemic in 2020 resulted in estimates that cannot be compared with earlier surveys. Due to major survey revisions in 2021-2022, data for this indicator are no longer comparable to earlier results.

National Survey on Drug Use and Health (NSDUH). NSDUH reported population count data, which are rounded to the nearest thousand persons, are substituted with calculated population count data, which are calculated by multiplying the reported population percentage by population estimates from the Alaska Department of Labor and Workforce Development (DOLWD). This allows calculation of slightly more precise population count data than are reported directly in the NSDUH.

Additional Notes

NSDUH data from 2018-2019 and earlier are assessed by the Diagnostic and Statistical Manual

of Mental Disorders - Fourth Edition (DSM-IV). Data since 2021 are assessed by the DSM-V. To protect the safety of field staff and survey participants during the COVID-19 pandemic, SAMHSA suspended in-person NSDUH data collection on March 16, 2020. To reduce the impact of the COVID-19 pandemic on NSDUH data, SAMHSA approved the addition of web-based data collection in Quarter 4 of 2020. State estimates for 2019-2020 are not available due to methodological concerns with combining 2019 and 2020 data. NSDUH state estimates are typically based on two years of combined data. However, 2021 estimates are only based on a single year of preliminary data. Changes to survey methodology in 2021 mean the data cannot be combined with previous years and results are not comparable with earlier data.

Sources:
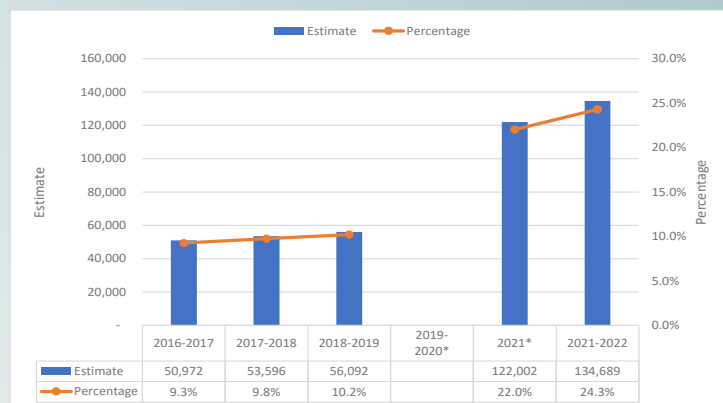- Substance Abuse and Mental Health Services Administration (SAMHSA)

Definition

Substance use disorders (SUDs) are characterized by impairment caused by the recurrent use of alcohol or other drugs (or both), including health problems, disability, and failure to meet major responsibilities at work, school, or home. Drugs include marijuana, cocaine (including crack), heroin, hallucinogens, inhalants, methamphetamine, and any use of prescription stimulants, tranquilizers or sedatives (e.g., benzodiazepines), and pain relievers.

Method

Prevalence population percentage data come from the Substance Abuse and Mental Health Services Administration (SAMHSA), National Survey on Drug Use and Health (NSDUH). NSDUH reported population count data, which are rounded to the nearest thousand persons, are substituted with calculated population count data, which are calculated by multiplying the reported population percentage by population estimates from the Alaska Department of Labor and Workforce Development (DOLWD). This allows calculation of slightly more precise population count data than are reported directly in the NSDUH.

Additional Notes

NSDUH data from 2018-2019 and earlier are assessed by the Diagnostic and Statistical Manual

	2016-2017	2017-2018	2018-2019	2019-2020*	2021*	2021-2022
Estimate	50,972	53,596	56,092		122,002	134,689
Percentage	9.3%	9.8%	10.2%		22.0%	24.3%

Population: Alaska (Ages 18+)

Data Source:

- National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia).

Population Source:

- Alaska Department of Labor and Workforce Development.

*Note:

- State estimates for 2019-2020 are not available due to methodological concerns with combining 2019-2020 data. Changes to survey methodology following the COVID-19 pandemic in 2020 resulted in estimates that cannot be compared with earlier surveys. Due to major survey revisions in 2021-2022, data for this indicator are no longer comparable to earlier results.

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Sources:

- [Substance Abuse and Mental Health Services Administration (SAMHSA)](#)