# 2023 Alaska Scorecard

## Key Issues Impacting Alaska Mental Health Trust Beneficiaries

Trust
Alaska Mental Health Trust Authority

The Alaska Scorecard has been revised to align with Strengthening the System: Comprehensive Integrated Mental Health Program Plan 2020-2024 (Strengthening the System). The Scorecard is a data measurement tool that examines the population health outcomes of Alaskans receiving care and services as described in Strengthening the System. Historically, the Scorecard measured the desired outcomes of the previous Comprehensive Plan: Moving Forward 2006-2011; it was published annually from 2008 until 2019 with indicators corresponding with Moving Forward. The Scorecard was revised in 2020 to include both new indicators and new narratives that are consistent with Strengthening the System. The revised scorecard was formatted to be consistent with the use of the Results-Based Accountability Framework (RBA). Key sections include:

- **Alaska Scorecard 2023:** this section provides the latest U.S. (if available) and Alaska data for each indicator, compared to averaged (typically the initial three reporting periods' data for that indicator, unless otherwise noted) baseline Alaska data available from the start of the 2020 Scorecard's revision. Changes from baseline estimates are not tested for statistical significance.
- **Story Behind the Baseline:** this section takes stock of both the positive and negative forces that impact an indicator, as well as what is working to address it and what is not. It also includes a look at what the population or information being measured revealed prior to planned solutions (as described in the indicator) and includes information on research and causes.
- **What Works:** this section offers a brief explanation of what works to affect measurable improvements in the indicator. This includes information, research, and solutions along with some no- to low-cost strategies to mitigate the challenges the indicator highlights.

The Scorecard remains a concentrated document detailing the key issues impacting Alaska Mental Health Trust beneficiaries and was researched and produced by a group of leaders and planners representing the Alaska Department of Health, the Alaska Mental Health Trust Authority, boards and commissions, and other related state agencies. Trust beneficiaries are Alaskans who experience mental illness, developmental and intellectual disabilities, substance use disorders, Alzheimer's disease and related dementia, and traumatic brain injuries.

Due to the COVID-19 pandemic, some data sources experienced disruptions that impacted the availability or reliability of estimates for certain indicators. Some indicators may contain gaps where no data were available or where data is not directly comparable to previous years due to reporting issues. Every effort was made to ensure that the data contained in this report are up to date and accurate at the time of publication. The Scorecard work group will continue to monitor indicators for data quality issues. For more information, please visit the Comprehensive Integrated Mental Health Program Plan.

# CONTENTS

ALASKA SCORECARD 2023 ..... 04

EARLY CHILDHOOD ..... 06

HEALTHCARE ..... 18

ECONOMIC AND SOCIAL WELL-BEING ..... 22

SUBSTANCE USE DISORDER PREVENTION ..... 33

SUICIDE PREVENTION ..... 42

PROTECTING VULNERABLE ALASKANS ..... 50

SERVICES IN THE LEAST RESTRICTIVE ENVIRONMENT ..... 59

SERVICES IN INSTITUTIONAL ENVIRONMENTS ..... 65

WORKFORCE, DATA, AND FUNDING ..... 77

APPENDIX: PREVALENCE ESTIMATES ..... 84

# ALASKA SCORECARD 2023

## Key Issues Impacting Alaska Mental Health Trust Beneficiaries

| INDICATOR | LATEST U.S. DATA | LATEST ALASKA DATA | AVG. BASELINE ALASKA DATA | CHANGE FROM AVG. BASELINE |
|---|---|---|---|---|
| **EARLY CHILDHOOD** | | | | |
| 1. Percentage of children who received a developmental screening using a parent-completed screening tool in the past year (ages 9 months to 35 months) | 34.4% (2022) | 42.3% (2022*) | 43.6% (2016-2019) | -1.3% |
| 2. Percentage of incoming students who regulate their feelings and impulses 80% of the time or more (grades K-1) | * | 46.1% (2022-2023) | 47.3% (2017-2020) | -1.2% |
| 3. Percentage of women who recently delivered a live birth who have a strong social support system during the postpartum period | * | 76.6% (2021) | 74.7% (2017-2019) | +1.9% |
| 4. Mean index score of (12) indicators associated with child health and well-being that are present at birth | * | 9.5 (2022) | 9.8 (2017-2019) | -0.3 |
| **HEALTHCARE** | | | | |
| 5. Percentage of population without health insurance | 8.0% (2022) | 11.0% (2022) | 12.8% (2017-2019) | -1.8% |
| 6. Rate of non-fatal fall injuries (rate per 100,000; ages 65+) | 3,276.7 (2021) | 4,595.3 (2022) | 4,398.6 (2017-2019) | +196.7 |
| **ECONOMIC AND SOCIAL WELL-BEING** | | | | |
| 7. Percentage of rental occupied households that exceed 50 percent of household income dedicated to housing | 24.8% (2022) | 18.5% (2022) | 18.2% (2017-2019) | +0.3% |
| 8. Rate of chronic homelessness (rate per 100,000) | 38.3 (2022) | 78.2 (2022) | 34.8 (2017-2019) | +43.4 |
| 9. Percentage of Alaskans who experience a disability that are employed | 44.5% (2022) | 50.4% (2022) | 43.9% (2017-2019) | +6.5% |
| 10. Percentage of Alaskans living above 125% of the federal poverty level | 84.8 (2022) | 87.8% (2022) | 83.1% (2017-2019) | +4.7% |
| **SUBSTANCE USE DISORDER PREVENTION** | | | | |
| 11. Percentage of Alaskans needing but not receiving treatment at a specialty facility for substance use in the past year (ages 12+) | 6.8% (2021) | 10.0% (2021) | 8.6% (2016-2019) | +1.4% |
| 12. Percentage of Alaskans who received mental health services in the past year (ages 18+) | 21.8% (2022) | 22.0% (2022) | 14.7% (2016-2019) | +7.3% |
| 13. Rate of alcohol-induced mortality (rate per 100,000; age-adjusted) | 13.6 (2022) | 36.2 (2022) | 23.4 (2017-2019) | +12.8 |
| **SUICIDE PREVENTION** | | | | |
| 14. Rate of intentional self-harm/suicide attempt emergency department visits (rate per 100,000; age-adjusted) | 46.8 (2021) | 125.8 (2022*) | 131.1 (2017-2019) | -5.3 |
| 15. Rate of intentional self-harm/suicide deaths (rate per 100,000; age adjusted) | 14.2 (2022) | 27.7 (2022) | 27.2 (2017-2019) | +0.5 |
| 16. Rate of intentional self-harm/suicide deaths (rate per 100,000; ages 15-24) | 13.6 (2022) | 46.2 (2022) | 49.5 (2017-2019) | -3.3 |

**KEY:**

- ***Asterisk (*):*** *No U.S. data available at time of publication*
- ***Calendar year (yyyy):*** *data represents calendar year*
- ***Fiscal year (FYyyyy):*** *data represents fiscal year (July-June)*
- ***Combined year (yyyy-yyyy):*** *data represents year range*

| INDICATOR | LATEST U.S. DATA | LATEST ALASKA DATA | AVG. BASELINE ALASKA DATA | CHANGE FROM AVG. BASELINE |
|---|---|---|---|---|
| **PROTECTING VULNERABLE ALASKANS** | | | | |
| 17. Rate of child maltreatment, substantiated cases, unique victims (rate per 1,000; ages 0 to 17) | 7.7 (2022) | 14.6 (2022) | 15.4 (2017-2019) | -0.8 |
| 18. Percentage change in youth who accessed home-based family treatment services (ages 0 to 24) | * | 47.8% (2023) | 119.1% (2022-2023) | -47.0% |
| 19. Founded reports of harm to adults (rate per 1,000; ages 18+) | * | 1.1 (FY2023) | 1.4 (FY2018-2020) | -0.3 |
| **SERVICES IN THE LEAST RESTRICTIVE ENVIRONMENT** | | | | |
| 20. Percentage of Alaskans who meet criteria for an institutional level of care who were served by a home and community based waiver | * | 84.1% (FY2023) | 83.5% (FY2018-2019 | +0.6 |
| 21. Percentage of criminal defendant referrals admitted to a therapeutic court | * | 57.1% (FY2023) | 57.2% (FY2018-2020) | -0.1% |
| 22. Percentage of all juvenile justice referrals that were diverted from formal court action | * | 41.5% (FY2023) | 41.3% (FY2018-2020) | +0.2% |
| **SERVICES IN INSTITUTIONAL ENVIRONMENTS** | | | | |
| 23. Percentage of inpatient readmissions within 30 days to non-military hospitals for a behavioral or neurodevelopmental diagnosis (ages 12 to 17) | * | 7.3% (2022) | 7.3% (2017-2018) | 0.0% |
| 24. Percentage of inpatient readmissions within 30 days to non-military hospitals for a behavioral or neurodevelopmental diagnosis (ages 18+) | * | 12.8% (2022) | 11.3% (2017-2019) | +1.5% |
| 25. Percentage of Alaskans who meet criteria for an institutional level of care who were served in nursing homes and Intermediate Care Facilities for Individuals with Intellectual and Developmental Disabilities (ICF/IDD) | * | 18.2% (FY2023) | 18.1% (FY2018-2020) | +0.1% |
| 26. Percentage of juveniles in a Division of Juvenile Justice facility with an identified behavioral health or neurobehavioral condition in a secure treatment unit | * | 97.6% (FY2023) | 97.0% (FY2018-2020) | +0.6% |
| 27. Percentage of incarcerated individuals diagnosed with a psychotic disorder or schizophrenia who received intensive clinical and case management reentry services | * | 73.8% (FY2023) | 82.7% (FY2019-2020) | -8.9% |
| **WORKFORCE, DATA, AND FUNDING** | | | | |
| 28. Percentage change in SHARP health practitioner contracts (current calendar year compared to previous 5 year average) | * | 57% (2023) | 12% (2018-2020) | +45% |
| 29. Percentage change of unduplicated participants served by Alaska Training Cooperative training events | * | 30.6% (FY2023) | -1.5% (FY2018-2020) | +32.1% |
| 30. Medicaid expenses as a percentage of state's budget | 29.6% (FY2023) | 14.0% (FY2023) | 19.9% (FY2018-2020) | -5.9% |

**KEY:**

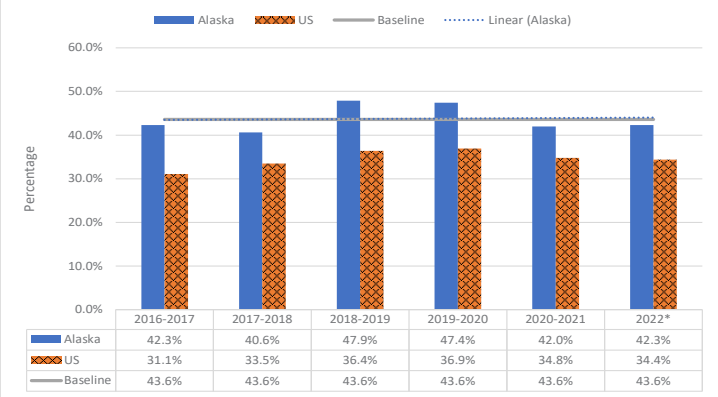
- ***Asterisk (*):*** *No U.S. data available at time of publication*
- ***Calendar year (yyyy):*** *data represents calendar year*
- ***Fiscal year (FYyyyy):*** *data represents fiscal year (July-June)*
- ***Combined year (yyyy-yyyy):*** *data represents year range*

# EARLY CHILDHOOD

## INDICATOR 1: Percentage of children who received a developmental screening using a parent-completed screening tool in the past year (ages 9 months to 35 months)

### Story Behind the Baseline

Early identification of developmental and behavioral health concerns is critical to the well-being and improved outcomes of children and their families. Developmental screening has been proven as an effective strategy for identifying infants and young children who may benefit from early intervention services. Such screenings are also a way to identify areas in which a child's development differs from same-age norms so healthcare professionals can determine if further evaluation is needed. Studies have shown that early intervention can significantly improve outcomes for children with developmental delays and their families. Failure to screen can lead to delays in further evaluation, diagnosis, and treatment, as well as burden families with unnecessary stress and uncertainty, making interventions less effective and more costly.




| | 2016-2017 | 2017-2018 | 2018-2019 | 2019-2020 | 2020-2021 | 2022* |
|---|---|---|---|---|---|---|
| Alaska | 42.3% | 40.6% | 47.9% | 47.4% | 42.0% | 42.3% |
| US | 31.1% | 33.5% | 36.4% | 36.9% | 34.8% | 34.4% |
| Baseline | 43.6% | 43.6% | 43.6% | 43.6% | 43.6% | 43.6% |

**Population: Alaska and U.S. (Ages 9 Months to 35 Months)**

**Data Source:**

- National Survey of Children's Health, Health Resources and Services Administration, Maternal and Child Health Bureau

***Note:**

- Due to imputation and weighting changes, 2022 estimates are not comparable to prior survey years.

In addition, autism-specific screening is recommended at ages 18 and 24 months, and social-emotional screening is recommended at regular intervals. Alaska's Medicaid program has adopted the American Academy of Pediatrics (AAP) Bright Futures Recommendations for Preventive Pediatric Healthcare, which includes a recommendation for developmental

screening in infancy and early childhood.

Data for this measure is from the National Survey of Children's Health (NSCH) and shows rates of parent-reported standardized screening in Alaska as higher than the national average. The measure uses age-appropriate questions to verify whether young children received standardized developmental, behavioral, and social screening using a parent-reported, standardized screening tool or instrument. Parent respondents for all children between 9 months and 35 months old were asked if, during the last 12 months, a healthcare provider offered a questionnaire about specific concerns or observations about their child's development, communication, or social behaviors.

Alaska's Early Childhood Comprehensive Systems and Maternal Child Health programs have coordinated efforts over the past several years to better coordinate and improve developmental screening rates. Help Me Grow Alaska (HMG-AK) emerged from a public-private partnership between the Department of Health (DOH) and the All Alaska Pediatric Partnership (AAPP) to establish centralized screening access and streamline data and referrals. Expansion of these efforts will continue to increase early identification and intervention supports for Alaska's youngest children.

## What Works?

According to the Centers for Disease Control and Prevention (CDC), early detection and subsequent actions are central for referral to treatment and care for the estimated 15% of children with a developmental disability. Children who receive early interventions (services for children with disabilities from birth up to five years, as defined by U.S. federal law) often experience improved long-term outcomes. The AAP recommends that all children should be screened for developmental delays during their regular well-child visits at 9, 18, and 24 or 30 months.

Developmental screening is a standardized set of questions about different aspects of a child's abilities including language, movement, thinking, behavior, and emotions. Going through the process of a developmental screening can be both fun and educational for parents and caregivers and can contribute to a family's protective factors. Many tools use activities that children already engage in or view as games to assess milestones. When done with a health or education provider and a parent or caregiver, the screening tools and processes can give ideas for new activities for caregivers to try with their children, as well as help caregivers understand the types of skills the child may be developing at each new stage.

HMG-AK works closely with pediatricians, early interventionists, and behavioral health providers to promote healthy child development. HMG-AK is a centralized resource that offers

free training and technical assistance on developmental screening and the use of standardized tools for health, child care, and other community providers. HMG-AK offers free developmental screening and resource referrals directly to families and caregivers seeking information and supports.

**Sources:**

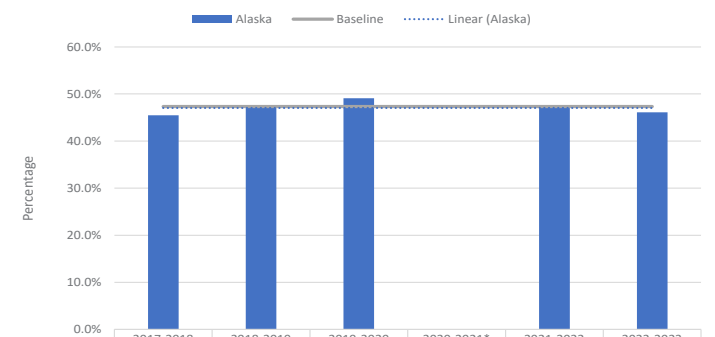
- National Survey of Children's Health, Health Resources and Services Administration, Maternal and Child Health Bureau
- Alaska Infant Learning Program
- American Academy of Pediatrics
- Help Me Grow Alaska Report - Developmental Screening in Alaska: Status | Leadership | Data | Structure - Challenges and Opportunities, March 2020
- Early Childhood Technical Assistance Center

EARLY CHILDHOOD

# INDICATOR 2: Percentage of incoming students who regulate their feelings and impulses 80% of the time or more (grades K-1)

## Story Behind the Baseline

Life skills, also known as Social and emotional learning (SEL), are an integral part of education and human development. Life skill learning is the process through which all young people and adults acquire and apply the knowledge, skills, and attitudes to develop healthy identities, manage emotions, and achieve personal and collective goals.
Life skills also help people feel and show empathy for others, establish and maintain supportive relationships, and make responsible and caring decisions.




| | 2017-2018 | 2018-2019 | 2019-2020 | 2020-2021* | 2021-2022 | 2022-2023 |
|---|---|---|---|---|---|---|
| Alaska | 45.5% | 47.4% | 49.1% | | 47.1% | 46.1% |
| Baseline | 47.3% | 47.3% | 47.3% | 47.3% | 47.3% | 47.3% |

**Population: Alaska Statewide (Grades K-1)**

**Data Source:**

- Alaska Department of Education & Early Development - Developmental Profile Results Domain 2 Goal 4

**Data Source Contact:**

- Kristen Spencer, Education Specialist II
  Section IEE Special Education
  Department of Education & Early Development
  Email: kristen.spencer@alaska.gov

***Note:**

- Due to the COVID-19 pandemic and statewide school facility closures, all statewide assessments (PEAKS, DLM, and ACCESS) were canceled in the spring of 2020. Data for 2020-2021 are not available.

Young children who enter kindergarten with strong foundational life skills, including regulation of feelings and impulses, tend to have higher academic and better lifelong health outcomes. Children who have experienced trauma, or whose families have not had access to needed supports, may have difficulty regulating their emotions when compared to peers of the same age. This difficulty is due to the effects of trauma on the brains of infants and young children, as well-documented through the Adverse Childhood Experiences (ACEs) study and decades of subsequent research. Lack of impulse control and social skills can negatively impact learning opportunities in the classroom and interpersonal relationships, leading to lower academic achievement and lifelong health and employment outcomes.

The Alaska Developmental Profile (ADP) is a tool used by school districts statewide to assess

the developmental skill levels of all incoming students in kindergarten. The purpose of the assessment is to identify, record, and summarize the skills and behaviors students demonstrate upon entry to school, based on teacher observations. Student skills and behaviors are defined by whether students are consistently demonstrating skill in the five domains from Alaska's Early Learning Guidelines, including life skills. The ADP assesses a child's ability to regulate feelings and impulses and offers insight into the level of Alaskan students' life skills through a reliable tool used in all Alaska school districts.

Data from the ADP is being incorporated into the Alaska Longitudinal Child Abuse and Neglect Linkage Project (ALCANLink), which will allow further analysis of early childhood experiences and skills, including life skills, on early lifelong educational and health outcomes. Trends analyzed through ALCANLink currently include the likelihood of a child's involvement in special education, child welfare, and other state-funded and operated services. Findings have the potential to drive education and health policy for children and families for improved population outcomes and lower public cost.

## What Works?

A large body of research has demonstrated the critical importance of the first three years of a child's life. The experiences and interactions children have in these early years significantly affect brain development and help to establish the foundation for future learning. Warm and responsive interactions can create a nurturing and stable environment that enables the development of secure attachments between children and their caregivers—both those within and beyond their families. These attachments support children as they develop a sense of self and begin to understand their emotions, and as they lay the foundation for establishing successful relationships at later ages. Early learning programs, and the people who work in them, play a critical role in supporting children's development, along with their primary caregivers. Furthermore, this crucial development must be supported from infancy when brain development is at its peak. Waiting until children enter preschool or kindergarten to introduce these vital interventions is simply too late.

Life skills are highlighted in early childhood home visiting programs, such as Nurse Family Partnership, Parents as Teachers, and Early Head Start, which can have a profound impact on a young child's ability to learn self-regulation and has the advantage of being a "two-generational approach," an approach that also promotes positive parenting skills and caregiver relationships. Additionally, high-quality early care and learning environments for infants and young children, coupled with infant and early childhood mental health supports, can have a positive impact on a child's life skills prior to kindergarten.

Well-executed life skill education practices, in a variety of home- and center-based

environments, have the potential to move whole groups of children toward better academic and social outcomes. High-quality life skill education practices are especially beneficial for vulnerable children and those who have experienced trauma.

**Sources:**

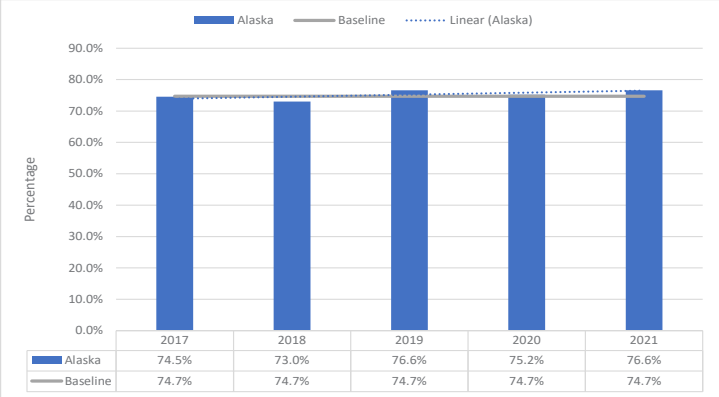

- Coalition for Evidence-Based Policy, "Social Programs That Work: Prenatal/Early Childhood"
- Hirokazu Yoshikawa and others, "Investing In Our Future: The Evidence Base on Preschool Education" (Ann Arbor, MI: Society for Research in Child Development; New York: Foundation for Child Development, 2013)
- Alaska Association for Infant and Early Childhood Mental Health
- CLEAR Trauma Informed Schools White Paper - A Selected Review of Trauma-Informed School Practice and Alignment with Educational Practice, Christopher Blodgett, Ph.D., Joyce Dorado, Ph.D.
- The Collaborative for Academic, Social, and Emotional Learning
- Harvard University Center on the Developing Child, "In Brief: The Science of Early Childhood Development, 2007
- The Heckman Curve

EARLY CHILDHOOD

# INDICATOR 3: Percentage of women who recently delivered a live birth who have a strong social support system during the postpartum period

## Story Behind the Baseline

Research shows that social support is a major buffer of postpartum depression and can improve outcomes for infants, young children, and their families. The presence of social supports, as reported by mothers after giving birth, can help predict early childhood experiences and provide an opportunity to increase individual and community-level supports at a critical developmental period. Culturally, social connections in Alaska are of particular significance. Tribal communities, which carry a greater burden of negative health outcomes, experience social connections as interwoven with other protective factors through the sharing of resources, responsibilities, cultural knowledge, and connections to ancestors and the land.




| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| Alaska | 74.5% | 73.0% | 76.6% | 75.2% | 76.6% |
| Baseline | 74.7% | 74.7% | 74.7% | 74.7% | 74.7% |

**Population: Alaska Statewide**

**Data Sources:**

- Alaska Division of Public Health, Women's Children's and Family Health Section, Pregnancy Risk and Monitoring System

**Data Source Contact:**

- Kathy Perham-Hester, MS, MPH
  Alaska PRAMS Coordinator Section of Women's, Children's and Family Health Division of Public Health Alaska Department of Health
  Email: kathy.perham-hester@alaska.gov

In 2020, Alaska's Pregnancy Risk Assessment Monitoring System (PRAMS) reported that approximately three-quarters (75.2%) of postpartum women state that they have access to all five social support items of inquiry. The questions asked about supports available after delivering their baby, including financial support (someone to loan her $50), physical support

(someone to help if she were sick and needed to be in bed; someone to take care of her baby), and emotional support (someone to talk with about her problems; someone to help if she was tired and feeling frustrated with her new baby). Affirmative responses to all these questions indicated a strong social support system and increased protective factors, which can predict more positive health outcomes for children and families.

## What Works?

The presence of protective factors, such as safe, stable, and nurturing relationships, can often mitigate the consequences of Adverse Childhood Experiences (ACEs). Individuals, families, and communities can all influence the development of many protective factors throughout a child's life that can impact their development. During childhood, particularly the critical postpartum period, caregiver social supports are especially valuable to help prevent and buffer the impact of ACEs.

The State of Alaska and many community partners across the state promote the Strengthening Families approach to improve social supports and increase protective factors to improve outcomes for families and children. Strengthening Families is a research-informed approach to increase family strengths, enhance child development, and reduce the likelihood of child abuse and neglect. The approach is based on engaging families, programs, and communities in building five key protective factors:

1. Parental resilience
2. Social connections
3. Knowledge of parenting and child development
4. Concrete support in times of need
5. Social and emotional competence of children

The Centers for Disease Control and Prevention (CDC) recommends implementing strategies to prevent ACEs from occurring and to mitigate their effects. Research from the Alaska Longitudinal Child Abuse and Neglect Linkage (ALCANLink) project identified that the number of prebirth challenges experienced by the household is strongly associated with the accumulation of childhood ACEs. Addressing and reducing these household challenges during the prebirth period is critical for ACE prevention. The presence of protective factors, particularly safe, stable, and nurturing relationships, can help prevent or mitigate the consequences of ACEs. Individuals, families, and communities can all influence the development of many protective factors throughout a child's life that can impact their development. During childhood, particularly the critical postpartum period, caregiver social supports are especially valuable to help prevent and buffer the impact of ACEs.

**Sources:**

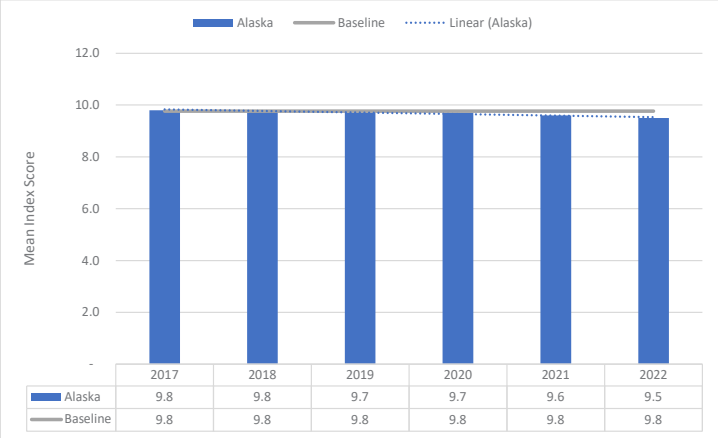
- Alaska Pregnancy Risk Assessment Monitoring System
- Centers for Disease Control And Prevention Pregnancy Risk Assessment Monitoring System
- Center for the Study of Social Policy: Strengthening Families Framework
- CDC Violence Prevention
- ALCANLink Publications

EARLY CHILDHOOD

# INDICATOR 4: Mean index score of (12) indicators associated with child health and well-being that are present at birth

## Story Behind the Baseline

Ensuring families are supported prebirth and immediately post-birth can provide human, social, and material supports that lay a strong foundation for protective factors shown to positively impact outcomes and resilience through their lifetime. Certain human, social, and material supports are considered "assets," i.e., resources that promote resiliency.




| | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 |
|---|---|---|---|---|---|---|
| Alaska | 9.8 | 9.8 | 9.7 | 9.7 | 9.6 | 9.5 |
| Baseline | 9.8 | 9.8 | 9.8 | 9.8 | 9.8 | 9.8 |

**Population: Alaska Statewide**

**Data Sources:**

- Alaska Division of Public Health, Health Analytics and Vital Records Section

**Data Source Contact:**

- Research Unit, Health Analytics and Vital Records;
  Division of Public Health, Department of Health
  Email: healthanalytics@alaska.gov

At birth, infant's brains are not fully developed; they are built throughout childhood as experiences and interactions to create a foundation for the rest of their life. Adverse Childhood Experiences (ACEs) are stressful or traumatic experiences during childhood, including abuse, neglect, witnessing domestic violence, or growing up with a caregiver struggling with substance misuse, mental illness, or incarceration. New research is investigating the relationship between a family's social challenges before giving birth and the later accumulation of ACEs in their children. Some of the prebirth household challenges include situations such as financial challenges, housing stability, violence, someone close to the mother suffering from substance misuse, incarceration of a parent, divorce, mental health challenges, and other concerns. While every child should ideally have the opportunity to grow up in a strong and thriving family environment, this is not always the case.

Information registered at birth can be used to document assets (resources) available to each

Alaskan newborn. Specifically, Alaska's mean index score is comprised of 12 variables. The score for each birth is calculated by counting the number of criteria met (1 point for each criteria), including:

1. Legal parentage established at birth.
2. Born to non-teenage (both parents >= 20 years old).
3. Born to parents with at least a high school diploma or GED.
4. Healthy birth weight (>=2,500 grams).
5. Absence of congenital anomalies, abnormalities, or complications at birth (excluding induction or augmentation of labor, epidural use, and non-vertex births).
6. Absence of transmissible (mother-to-child) infections.
7. Access to and receipt of timely prenatal care (within three months of the start of pregnancy).
8. Receipt of Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) nutrition services (among deliveries not paid using Medicaid).
9. Ability to afford and access healthcare (delivery not paid for out-of-pocket or with an unknown payment source).
10. Born to a parent with a college education.
11. Breastfeeding initiated at the time of discharge.
12. No prenatal exposure to tobacco use.

Assets and conditions at birth do not predetermine a child's future, as shown when high-quality early intervention services are accessed. Thoughtful supports and services may be required to ensure that children with fewer assets find themselves on equal footing with their peers. Monitoring the distribution of assets among newborns in different communities can help ensure investments are intentional and equitable, as well as responsible and fiscally sound.

## What Works?

Just as the accumulation of certain prebirth household challenges are strongly associated with the accumulation of childhood ACEs and chronic health conditions, the positive effects of prebirth supports in a woman's life may help predict improved health for a mother and her child. Improving social determinants of health during the prebirth period and beyond may serve as a primary point of ACEs prevention. Many evidence-based, multidisciplinary intervention strategies can and should be implemented in the prebirth period to strengthen

the household unit before the introduction of a new child. Addressing ACEs should focus on improving economic capacity, supporting early childhood programs, teaching parenting skills, ensuring treatment availability and use, and normalizing positive parenting behavior. Healthcare providers should consider engaging in a continuum of prevention across the lifespan and assess household challenges at multiple time points, partnering with agencies or programs providing resources to address identified challenges impacting their lives.

**Sources:**

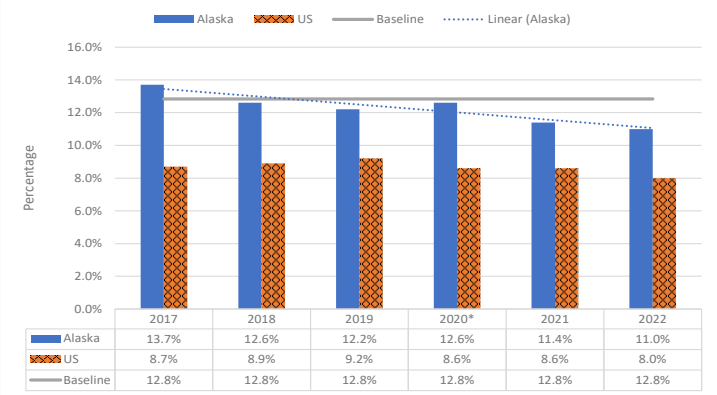
- Alaska Division of Public Health, Women's Children's and Family Health Section, Maternal and Child Health Epidemiology Unit
- Strong Start Index
- Children's Data Network

# HEALTHCARE

## INDICATOR 5: Percentage of population without health insurance

### Story Behind the Baseline

Without access to coverage for healthcare services, which include behavioral health in all geographic areas, there is an increased risk of Alaska's population having poor physical and mental health outcomes. A common goal across the healthcare industry is for all Alaskans to have adequate health insurance and access to healthcare services. Even with access to health insurance, barriers continue to exist in receiving services statewide. There are often long wait times for the first appointment for a new patient, and many primary care providers have stopped accepting new patients on Medicare or Medicaid. Extended wait times often lead to a patient not accessing care or seeking care in a more expensive setting, such as an emergency room, or they recover from the acute illness without being examined or receiving a diagnosis. The location of services in Alaska also presents a barrier as air travel is often necessary in order to seek proper healthcare. Telehealth appointments can offer a range of necessary services; however, barriers such as the




| | 2017 | 2018 | 2019 | 2020* | 2021 | 2022 |
|---|---|---|---|---|---|---|
| Alaska | 13.7% | 12.6% | 12.2% | 12.6% | 11.4% | 11.0% |
| US | 8.7% | 8.9% | 9.2% | 8.6% | 8.6% | 8.0% |
| Baseline | 12.8% | 12.8% | 12.8% | 12.8% | 12.8% | 12.8% |

**Population: Alaska and U.S.**

**Data Source:**

- United States Census Bureau, American Community Survey, Table S2701
- United States Census Bureau, Current Population Survey, Annual Social and Economic Supplement Table H-01

***Note:**

- Due to the COVID-19 pandemic, American Community Survey data for this indicator were not released for 2020. Estimates are substituted with Current Population Survey Annual Social and Economic Supplement data, and are similar, but not directly comparable to other years.

type of services offered and available technology limit telehealth capacity.

## What Works?

Alaskans must be healthy if the state is to thrive. When a population is healthy, more people attend work and school, participate in their communities, engage in traditional cultural practices, and care for their families. Uninsured rates decreased between 2013 and 2018 following the introduction of the Affordable Care Act. In many states across the nation, state health departments have partnered with federally qualified health centers (FQHCs) and rural health clinics (RHCs). These facilities can be accessed by patients with or without insurance and offer a sliding scale fee schedule to those without health insurance.

**Sources:**

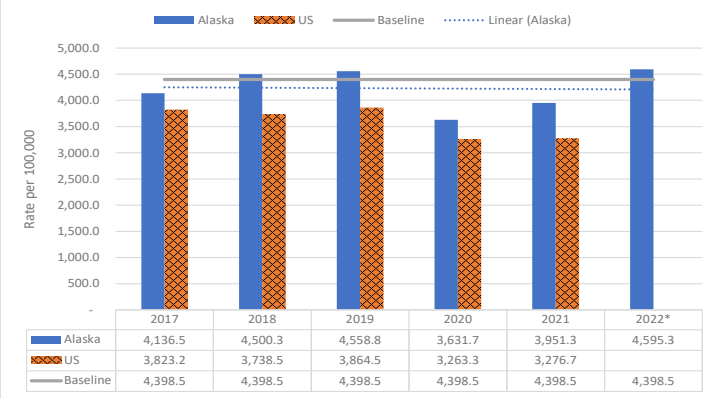
- United States Census Bureau, American Community Survey, Table S2701
- United States Census Bureau, Current Population Survey, Annual Social and Economic Supplement Table H-01v
- U.S. Census Bureau American Current Population Survey,
- Alaska Medicaid Dashboard
- Healthy Alaskans
- Alaska Healthcare Transformation Project
- Alaska Medicaid Redesign

HEALTHCARE

# INDICATOR 6: Rate of non-fatal fall injuries (rate per 100,000; ages 65+)

## Story Behind the Baseline

Among Alaska residents ages 65 and over, falls are the leading cause of serious injury and loss of independence. Falls are also the most common cause of traumatic brain injury and are an especially serious risk for older adults. When an older adult sustains a serious traumatic brain injury in a fall, the injury may result in long-term cognitive changes, reduced ability to function, and changes in emotional health. In addition to traumatic brain injury, falls can cause broken bones, including wrist, arm, ankle, and hip fractures. Many people who fall, even if they are not injured, become afraid of falling. This fear may cause a person to cut down on their regular everyday activities. When a person is less active, they become weaker and increase their chances of falling.




| | 2017 | 2018 | 2019 | 2020 | 2021 | 2022* |
|---|---|---|---|---|---|---|
| Alaska | 4,136.5 | 4,500.3 | 4,558.8 | 3,631.7 | 3,951.3 | 4,595.3 |
| US | 3,823.2 | 3,738.5 | 3,864.5 | 3,263.3 | 3,276.7 | |
| Baseline | 4,398.5 | 4,398.5 | 4,398.5 | 4,398.5 | 4,398.5 | 4,398.5 |

**Population: Alaska and U.S. (Ages 65+)**

**Data Sources:**

- Alaska Division of Public Health, Health Analytics and Vital Records Section
- Center for Disease Control and Prevention, CDC WISQARS

**Data Source Contact:**

- Research Unit, Health Analytics and Vital Records; Division of Public Health, Department of Health
  Email: healthanalytics@alaska.gov

***Note:**

- U.S. data not available at the time of publication.

Risk factors for falls in older adults include lower body weakness, vitamin D deficiency, difficulties with walking and balance, vision problems, environmental hazards such as ice, uneven steps, clutter that can be tripped over, and the use of drugs and alcohol.

## What Works?

Regardless of age group, higher percentages of older adults who reported no physical activity in the past month or reported difficulty with one or more functional characteristics (difficulty walking up or down stairs, dressing and bathing, and performing errands alone) reported

falls and fall-related injuries. These risk factors are frequently modifiable, suggesting that regardless of age, many falls might be prevented. In 2012, the Centers for Disease Control and Prevention (CDC) created the Stopping Elderly Accidents, Deaths & Injuries (STEADI) initiative. STEADI offers tools and resources for healthcare providers to screen their older patients for fall risk, assess modifiable fall risk factors, and to intervene with evidence-based fall prevention interventions. These include medication management, vision screening, home modifications, referral to effective, community-based fall prevention programs, and referral to physical therapists who can address problems with gait, strength, and balance.

There are several evidence-based fall prevention programs that can be implemented by community-based organizations to decrease the number of falls experienced by older Alaskans. Currently, the Alaska Division of Senior and Disabilities Services administers funds allocated through the Older Americans Act. These funds are designated for the implementation of evidence-based fall prevention activities specifically for older adults, as well as fall prevention programs implemented by the Division of Public Health.

As the proportion of older adults living in the United States continues to grow, so too will the number of falls and fall-related injuries; however, many of these falls are preventable. To help keep older adults living independently and injury-free, reducing fall risk and fall-related injuries is essential.

**Sources:**

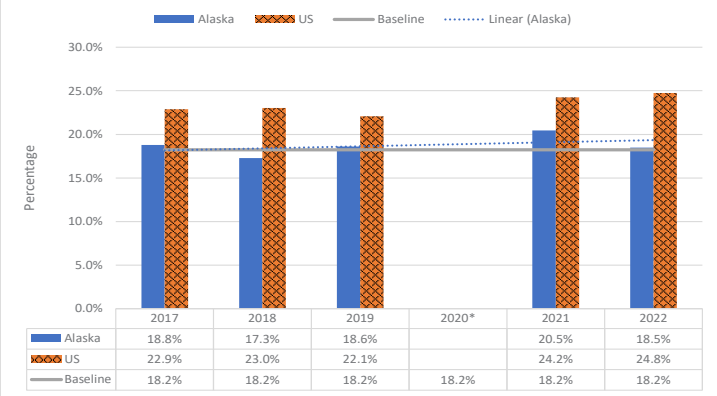

- Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web–based Injury Statistics Query and Reporting System (WISQARS)
- Ambrose AF, Paul G, Hausdorff JM. Risk Factors for Falls Among Older Adults: A Review of the Literature. Maturitas 2013; 75:51–61.
- Vellas BJ, Wayne SJ, Romero LJ, Baumgartner RN, Garry PJ. Fear of Falling and Restriction of Mobility in Elderly Fallers. Age and Aging 1997;26:189–193.
- CDC Home and Recreational Safety Preventing Falls: A Guide to Implementing Effective Community Based Fall Prevention Programs

# ECONOMIC AND SOCIAL WELL-BEING

## INDICATOR 7: Percentage of rental occupied households that exceed 50 percent of household income dedicated to housing

### Story Behind the Baseline

Having a safe place to call home and an income to meet one's basic needs are vital components to living a meaningful life. Limited availability of affordable housing is a problem in Alaska and nationwide. There is a shortage of rental homes available to Alaskan families at or below the poverty line, or at 30% of the area median income. Thus, there is a severe cost burden associated with housing in Alaska. Housing and Urban Development (HUD) has long considered severe shelter burden as greater than paying 50% or more of one's income on rent. When people are forced to spend more than 50% of their income on housing, they must make sacrifices on other important spending such as healthcare, healthy food, and education. Severely shelter-burdened families are at high risk for eviction caused by not being able to pay rent. In addition to the monetary cost of eviction for both the tenant and landlord, the record of having been evicted from rental housing makes re-housing difficult. It is crucial that public health partners work with housing organizations to reduce the severe rental burden for beneficiaries and improve the health of all Alaskans.




| | 2017 | 2018 | 2019 | 2020* | 2021 | 2022 |
|---|---|---|---|---|---|---|
| Alaska | 18.8% | 17.3% | 18.6% | | 20.5% | 18.5% |
| US | 22.9% | 23.0% | 22.1% | | 24.2% | 24.8% |
| Baseline | 18.2% | 18.2% | 18.2% | 18.2% | 18.2% | 18.2% |

**Population: Alaska and U.S.**

**Data Source:**

- United States Census Bureau, American Community Survey, Table B25074

***Note:**

- Due to the COVID-19 pandemic, 2020 results from the American Community Survey (ACS) for this indicator are not available.

## What Works?

Making mortgages accessible to Alaskans has been at the core of Alaska Housing and Finance Corporation (AHFC). Over the years, responsibilities of AHFC have expanded to include affordable housing programs, energy efficiency, older adults housing, and more. AHFC is a self-supporting public corporation with offices in 16 communities statewide. AHFC has contributed more than $2 billion to the state in the form of direct dividends for the General Fund, which is the state's funding source for all services and programs. The General Fund provides funds to the state for building and equipment improvements, bonding for projects such as university student housing, purchasing state assets, and maintenance of state-owned property.

In addition to funding for housing, the following steps can be taken to reduce shelter burden:

- Measuring the shelter burden of households to identify those at risk for housing insecurity due to high shelter burden.
- Identifying existing housing resources available.
- Developing partnerships to maximize opportunities.

Additionally, identifying barriers that may be preventing beneficiaries from effectively utilizing existing programs and collaborating with housing partners is another way to ensure that beneficiaries can overcome any challenges for securing housing.

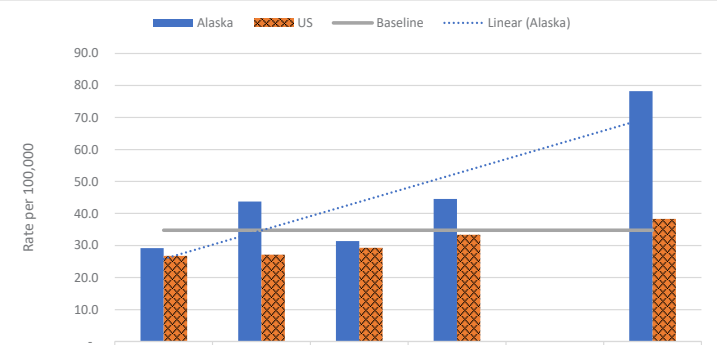
It is also vital that renters and future homeowners are prepared for the responsibility of owning or renting. This preparation is best achieved by providing counseling and education to promote building and maintaining positive rental relationships and support. Furthermore, providing intervention for both tenants and the landlord at a point of crisis, in order to prevent eviction and promote long-term housing stability, is crucial.

As housing is so closely linked to employment and other basic needs, it is also critical to improve and maintain access to employment opportunities, education, and supports to enhance long-term economic self-sufficiency in order to overcome shelter burden.

# INDICATOR 8: Rate of chronic homelessness (rate per 100,000)

## Story Behind the Baseline

Persons experiencing homelessness are at an elevated risk for many adverse medical conditions, as well as premature death. These persons represent a diverse population facing a range of adverse situations, resulting in unstable living situations. In some cases, medical conditions or traumatic events, like domestic violence and/or sexual assault, mental illness, substance use disorder, or disability for example, can increase the likelihood an individual will experience homelessness. In other cases, families are faced with a loss of income or limited job opportunities, overcrowded living spaces, and shrinking public assistance programs, coupled with a lack of affordable housing in their community.




| | 2017 | 2018 | 2019 | 2020 | 2021* | 2022 |
|---|---|---|---|---|---|---|
| Alaska | 29.1 | 43.7 | 31.4 | 44.6 | | 78.2 |
| US | 26.8 | 27.1 | 29.3 | 33.3 | | 38.3 |
| Baseline | 34.8 | 34.8 | 34.8 | 34.8 | 34.8 | 34.8 |

**Population: Alaska and U.S.**

**Data Source:**

- United States Department of Housing and Urban Development, Annual Homeless Assessment Report

***Note:**

- Due to the COVID-19 pandemic, 2021 results from the Annual Homeless Assessment Report were based on sheltered chronically homeless only. Results for this indicator would not be comparable to other years and are not reported.

A smaller number of Alaskans face the more serious challenge of chronic homelessness. Chronic homelessness is defined as a homeless individual or head of household with a disability that meets the Department of Housing and Urban Development (HUD) definition of a disability who (a) lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; (b) and in general have been homeless and living in one of these places continuously for at least 12 months or on at least four separate occasions in the last three years. Alaskans who experience chronic homelessness are among the most at-risk for adverse health conditions.

Many stakeholders are working together to reduce the experience of homelessness as a cornerstone of improving the health and well-being of Alaskan communities.

In Alaska, about 1,907 people were estimated to have experienced homelessness in any capacity during the 2018 calendar year. Most persons experiencing homelessness are sheltered, meaning they are served by an emergency shelter, transitional housing, or have access to housing vouchers. Across Alaska, housing and sheltering services are extremely limited, especially in rural areas. Overall, there are not enough non-domestic violence shelter beds available to meet the needs of persons experiencing homelessness. Furthermore, there is not an adequate amount of rapid re-housing services available to support their needs. According to the 2018 Housing Inventory Count, 15 of the 29 census areas in Alaska have no year-round emergency shelter, transitional housing, rapid re-housing, or permanent supportive housing facilities.

## What Works?

Reducing the factors that lead to people being in vulnerable housing situations is the best way to reduce the number of persons experiencing homelessness in Alaska. One strategy is to implement supportive housing: affordable housing paired with tenancy supports and services that may be permanent for some populations and transitional or time-limited for others. Research shows supportive housing helps people with disabilities live stably in the community, reduces their use of costly systems such as emergency healthcare and corrections, and can help them engage in health and behavioral care services.

Rapid re-housing programs are a nationwide best practice and connect families and individuals to permanent housing using time-limited financial assistance and other supportive services to help with the transition. These programs are very limited in the state. Supportive housing and rapid re-housing programs are more effective at solving homelessness when a Housing First approach is taken, removing barriers and pre-conditions to be housed, such as sobriety or enrollment in services.

Preventing homelessness, much like preventing injury or illness, not only provides better outcomes for individuals, but is the most effective, efficient, and economical approach to addressing homelessness. Homelessness prevention programs are used to prevent eviction, provide utility assistance, fix a car that is needed for employment, and meet other critical needs to ensure a person can continue their existing tenancy.

Through the Homelessness Assistance Program (HAP), funds are awarded competitively to agencies in Alaska to provide emergency or transitional housing and/or services to prevent homelessness or rapidly re-house those who have been displaced.

The Special Needs Housing Grant (SNHG) provides funds through competitive grants to nonprofit service providers and housing developers for construction and operation of housing for Alaska's special needs populations, primarily beneficiaries of the Alaska Mental Health Trust Authority. This can include transitional housing, often used for recovery and reentry from incarceration, as well as permanent supportive housing.

**Sources:**

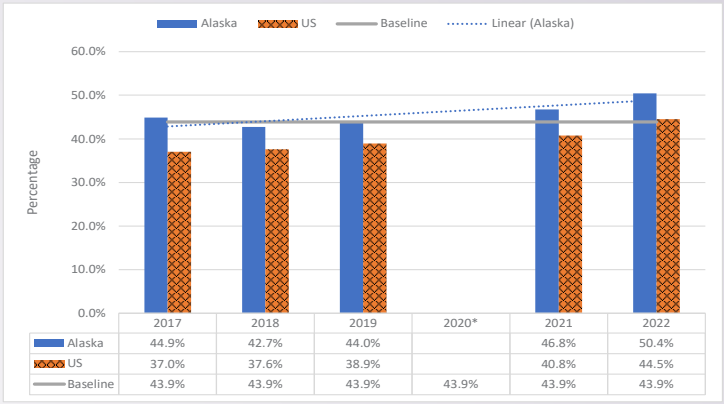
- Alaska Homeless Information Center
- United States Interagency Council on Homelessness. Alaska Homelessness Statistics
- National Alliance to End Homelessness, Housing First

ECONOMIC AND SOCIAL WELL-BEING

# INDICATOR 9: Percentage of Alaskans who experience a disability that are employed

## Story Behind the Baseline

The employment disparity between working-age Alaskans who experience disabilities, and the general population, continues to be wide. Improving employment outcomes for individuals with disabilities has the potential to reduce reliance on publicly funded services, as well as increase self-sufficiency. Alaska has diverse forms of employment, including subsistence activities, seasonal employment, and self-employment. Primary barriers to employment include situational (such as lack of transportation or support services needed for employment), risk of benefits loss (Medicaid and Social Security), as well as employer perceptions. A 2018 survey of Alaska human resource professionals showed perceptions that Alaskan employers largely find the idea of employing people with disabilities uncomfortable.




| | 2017 | 2018 | 2019 | 2020* | 2021 | 2022 |
|---|---|---|---|---|---|---|
| Alaska | 44.9% | 42.7% | 44.0% | | 46.8% | 50.4% |
| US | 37.0% | 37.6% | 38.9% | | 40.8% | 44.5% |
| Baseline | 43.9% | 43.9% | 43.9% | 43.9% | 43.9% | 43.9% |

**Population: Alaskans and U.S. Residents Who Experience Disabilities (Ages 18 to 64)**

**Data Source:**

- United States Census Bureau, American Community Survey, Table B18120

***Note:**

- Due to the COVID-19 pandemic, 2020 results from the American Community Survey (ACS) for this indicator were not reported.

## What Works?

In 2014, Alaska enacted the Employment First Bill (HB 211) making Alaska an Employment First State. This ensures that the first and preferred outcome for publicly funded services is integrated employment in the community with competitive wages. In 2018, Alaska repealed the state's sub-minimum wage regulation, only the third state in the nation to do so.

Working alongside people without disabilities, for minimum wage and above, have been

important factors to successful, long-term employment outcomes for people with disabilities.

Employment services, including supported employment, provide individuals with assistance to acquire and maintain the skills necessary for employment. Successful long-term employment is strongly influenced by a myriad of situational dynamics, including access to safe and affordable housing and healthcare, appropriate vocational training and support, and financial literacy training, as well as understanding the impact of employment on public benefits, and being aware of applicable employment safety net programs. Many individuals and families are afraid of losing vital benefits, such as Medicaid and Social Security. Educating individuals and families on the interplay of benefits and work is critical to successful employment outcomes. Additionally, the transition from school to adulthood is a pivotal time for people with disabilities regarding employment outcomes. Internships, apprenticeships, and Individual Placements and Supports programs are successful strategies for employing people with disabilities.

In early 2021, Alaska Governor Mike Dunleavy initiated the formation of the Alaska Work Matters Task Force under the umbrella of the Governor's Council on Disabilities and Special Education (GCDSE) and the Alaska Mental Health Trust Authority. The directors of the state Division of Vocational Rehabilitation (DVR) and the GCDSE were named as chair and co-chair, and 22 additional individuals representing state agencies and boards, Tribal Vocational Rehabilitation, Mental Health Trust beneficiaries, employers, and educators were selected to participate.

The purpose of the Task Force was to review and analyze existing policies, practices, and procedures, barriers, and workforce utilization data regarding the employment of people with disabilities in the State of Alaska, and prepare a report that includes recommendations that should be adopted by the Governor and applicable departments, agencies, and commissions of the executive branch, and policy options for consideration by the legislative branch to expand and improve employment opportunities and outcomes for individuals with disabilities. Twenty-two recommendations and sixty-eight action steps were identified by the Task Force and are described in detail in the full report.

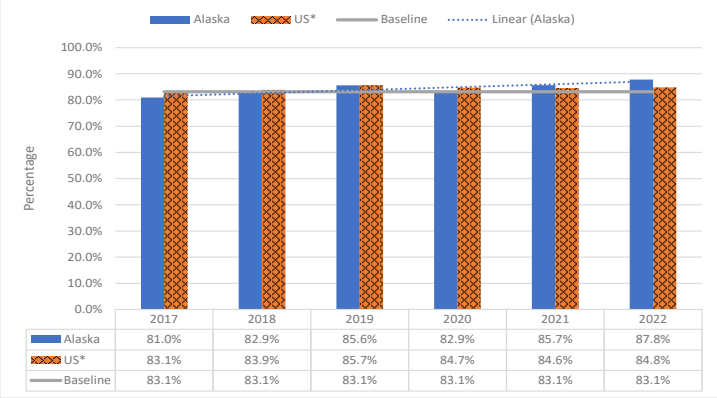
**Sources:**

- United States Census Bureau, American Community Survey, Table B18120
- Annual Disability Statistics Compendium
- Statedata.info. (2020). Population Data from the American Community Survey (Post 2007), Any Disability. Alaska, U.S. Total: Percent of Working-Age People Who Are Employed
- Statedata.info. (2020). Population Data from the American Community Survey (Post 2007), No Disability. Alaska, U.S. Total: Percent of Working-Age People Who Are Employed
- Alaskan Employer Perspectives on Hiring Individuals with Disabilities

# INDICATOR 10: Percentage of Alaskans living above 125% of the federal poverty level

## Story Behind the Baseline

Social determinants of health are conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of-life risks and outcomes. Economic stability is a social determinant of health. Economic stability is the connection between one's financial resources - income, cost of living, and socioeconomic status - and their health. This area includes key issues such as poverty, employment, food security, and housing stability. Poverty limits access to basic needs services for beneficiaries: housing, education, healthcare, and mental healthcare. Financial stressors can make mental health care even harder to access, compounding the risk of experiencing a serious mental health crisis.




| | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 |
|---|---|---|---|---|---|---|
| Alaska | 81.0% | 82.9% | 85.6% | 82.9% | 85.7% | 87.8% |
| US* | 83.1% | 83.9% | 85.7% | 84.7% | 84.6% | 84.8% |
| Baseline | 83.1% | 83.1% | 83.1% | 83.1% | 83.1% | 83.1% |

**Population: Alaska and U.S.**

**Data Source:**

- United States Census Bureau, Current Population Survey, Annual Social and Economic Supplement Microdata

***Note**:

- The Department of Health and Human Services acknowledges high cost of living in Alaska and Hawaii with an adjustment called the "poverty guidelines" which are applied to programmatic eligibility criteria. Alaska is 125% of the Federal poverty level and the U.S. is 100%. Alaska and U.S. estimates shown both represent 125% of the U.S. poverty level.

In 2021, 85.7% of Alaskans lived above 125% of the federal poverty line. However, there is a large difference in rates between Alaskans with disabilities and the general population. This is due in part to the wide disparity in employment and wage between working-age Alaskans with disabilities and the general population. Improving employment and wage outcomes for individuals with disabilities has the potential to reduce reliance on publicly funded services and increase self-sufficiency. The high rates of poverty for Alaskans with disabilities are especially concerning. Lack of resources limits individuals' ability to obtain health insurance, pay for medical care, afford healthy food or safe housing, and access other basic goods and services.

People experiencing disabilities are also more likely to experience material hardships, such as food insecurity, inability to pay rent, mortgage, and utilities, or barriers to access needed medical care, than people without disabilities at the same income levels. Lack of reliable, accessible transportation and difficulty finding affordable accessible housing are examples of some of the challenges they face.

## What Works?

Connecting people to basic needs services, including reducing administrative barriers or hurdles to ensure services are functioning properly, has been shown to reduce poverty. Strategies shown to help include: Social Security Disability Insurance/Supplemental Security Income, healthcare "safety net" programs such as Medicaid, Children's Health Insurance Program, as well as other programs, such as minimum wage requirements, Supplemental Nutrition Assistance Program, and Temporary Assistance for Needy Families. Additionally, job placement and development programs, such as Head Start and those that provide assistance linking people with jobs, aim to reduce poverty by increasing social functioning and self-sufficiency.

Nationwide, more than 65% of the 17.9 million working-age adults with disabilities participate in at least one safety net or income support program. Strategies that have been shown to assist vulnerable subpopulations include affordable child care, care coordination for those in transition, and ABLE accounts (Achieving a Better Life Experience). ABLE accounts help people maintain a safety net without losing benefits. Investing in affordable, accessible housing will enable more people with disabilities to obtain safe and stable housing and live independently. Finally, increasing access to reliable transportation will enable more people with disabilities to explore employment opportunities they may not otherwise seek due to the current lack of transportation options.

Healthy Alaskans 2030, the state's health improvement plan, outlines two strategies related to improving the economic well-being of Alaskans:

1. Improve wages and benefits for the Alaskan workforce so individuals and families have the income needed to meet the costs of daily living.
2. Reduce the number of unemployed and underemployed in households that fall below the poverty level.

**Sources:**

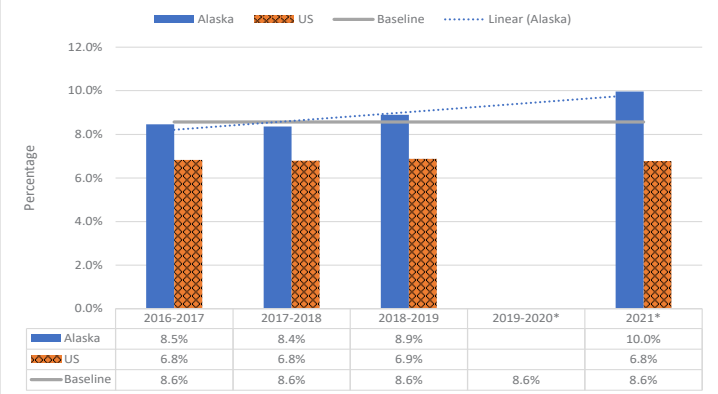
- U.S. Department of Health and Human Services, Healthy People 2030 Economic Stability
- Complete Health Indicator Report of Poverty - All Persons At Or Above Poverty Threshold (HA2020 Leading Health Indicator: 24)
- Disability Is a Cause and Consequence of Poverty
- National Council on Disability: Highlighting Disability / Poverty Connection, NCD Urges Congress to Alter Federal Policies that Disadvantage People with Disabilities

# SUBSTANCE USE DISORDER PREVENTION

## INDICATOR 11: Percentage of Alaskans needing but not receiving treatment at a specialty facility for substance use in the past year (ages 12+)

### Story Behind the Baseline

Historically, Alaska has struggled to deliver a continuum of care that meets the needs of Alaskans struggling with substance use and mental health disorders. A robust continuum of care that delivers services in the right place, and at the right time, is a priority area that will reduce the impact of behavioral health conditions that Alaskans face. Alaskans have, for many years, needed both substance misuse and mental health services above national averages.




| | 2016-2017 | 2017-2018 | 2018-2019 | 2019-2020* | 2021* |
|---|---|---|---|---|---|
| Alaska | 8.5% | 8.4% | 8.9% | | 10.0% |
| US | 6.8% | 6.8% | 6.9% | | 6.8% |
| Baseline | 8.6% | 8.6% | 8.6% | 8.6% | 8.6% |

**Population: Alaska and U.S. (Ages 12+)**

**Data Source:**

- National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia), Table 26

***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 and are no longer available after 2021. This indicator will be deprecated and replaced with an alternative in a future Scorecard.

Alaska has the 10th highest prevalence rate of adult binge drinking in the country. In 2021, Alaska had the second highest age-adjusted rate in the U.S. of alcohol-induced mortality. According to the 2020-2024 Alaska's Child and Family Services Plan, over 70% of all OCS families are impacted by substance use/misuse and equally as many are impacted by mental health concerns.

## What Works?

Alaskans with substance use disorders and mental health needs should have access to the full continuum of care, from prevention and early intervention to treatment and recovery services, that increase the likelihood of long-term recovery.

The Division of Behavioral Health, Prevention & Early Intervention provides grant funding throughout the state, serving both urban and rural service areas. The Comprehensive Behavioral Health Prevention and Early Intervention (CBHPEI) grant focuses on population-based strategies, the prevention of substance misuse and suicide, and the promotion of comprehensive wellness across Alaska with an "upstream" approach. Prevention efforts are community driven and coalition led, with stakeholders representing the diversity of the community or service area. This grant also funded the development of a Statewide Alcohol Prevention Alliance to address underage drinking and adult binge and heavy drinking. Core strategic components include community-based interventions, health equity and mass-reach health communication, promoting Screening, Brief Intervention and Referral to Treatment (SBIRT), surveillance, and evaluation.

A new array of services is available through the Alaska Medicaid 1115 Behavioral Health Demonstration Waiver (1115 Waiver). The 1115 Waiver creates a data-driven, integrated behavioral health system of care for children, youth, and adults with serious mental illness, severe emotional disturbance, and/or substance use disorders. These services include residential treatment for substance use disorder, partial hospitalization program services for substance use disorder and behavioral health, adult mental health residential services, mobile outreach and crisis response services, withdrawal management, and medications for addiction treatment. The 1115 Waiver seeks to increase services for at-risk families to support the healthy development of children and adults through increased outreach, prevention, and early intervention supports.

Ensuring Alaskans have access to the full continuum of care, from early intervention all the way through acute care and treatment and recovery, will be crucial to improving the health outcomes for residents. Moving upstream by increasing prevention and early intervention services will lead to cost savings and improved care for Alaskans.

**Sources:**

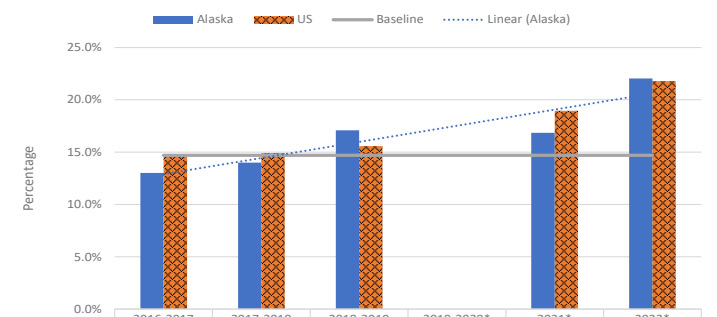
- State of Alaska, Department of Health, Division of Behavioral Health, Alaska Substance Use Disorder and Behavioral Health Program (SUD-BHP) 1115 Evaluation Design FY19-FY24
- Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: Alaska, Volume 6: Indicators as measured through the 2019 National Survey on Drug Use and Health and the National Survey of Substance Abuse Treatment Services. HHS Publication No. SMA–20–Baro–19–AK. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2020
- Healthy Alaskans
- 2020-2024 Alaska's Child and Family Services Plan

SUBSTANCE USE DISORDER PREVENTION

# INDICATOR 12: Percentage of Alaskans who received mental health services in the past year (ages 18+)

## Story Behind the Baseline

Historically, Alaska has struggled with delivering a continuum of care that meets the mental health needs of Alaskans. A robust continuum of care that delivers services in the right place, and at the right time, is a priority to reduce the impact of behavioral health conditions that Alaskans face.




| | 2016-2017 | 2017-2018 | 2018-2019 | 2019-2020* | 2021* | 2022* |
|---|---|---|---|---|---|---|
| Alaska | 13.0% | 14.0% | 17.1% | | 16.9% | 22.0% |
| US | 14.6% | 14.9% | 15.6% | | 19.0% | 21.8% |
| Baseline | 14.7% | 14.7% | 14.7% | 14.7% | 14.7% | 14.7% |

**Population: Alaska and U.S. (Ages 18+)**

**Data Source:**

- National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia), Table 29

***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.

According to the 2018-2019 National Survey on Drug Use and Health (NSDUH), 21.47% of Alaskan adults reported experiencing a mental illness in the past year. From 2017–2019, among adults 18 and older, the annual average prevalence of past-year mental health service use among those with any mental illness (AMI) in Alaska was 38.9%. Data from the 2018 Behavioral Risk Factor Surveillance Survey (BRFSS) shows that 11.3% of Alaskans reported frequent mental distress (14 or more days per month of poor mental health) and Alaska's 2019 suicide rate of 28.7 per 100,000 was almost twice the national rate of 14.5 per 100,000.

In addition to elevated rates for many substance misuse and mental health concerns, Alaskans face special challenges related to geography, population, weather, and size, which make it difficult to effectively provide services. Access to services varies widely depending on clients' needs, their location, and their ability to pay. Many of Alaska's remote communities

are medically under-served for both primary care and mental health services. Many of these communities are located hundreds of miles from a regional medical center and individuals travel long distances for services. Urban areas and rural towns have more access to mental health professionals, yet Alaska still struggles with retention and recruitment of behavioral health professionals. Furthermore, significant economic disparities are prevalent in Alaska, and social determinants of health play a large role in behavioral health outcomes.

## What Works?

Alaskans with behavioral health conditions need a full continuum of care, from prevention and early intervention to treatment and recovery services, that increase the likelihood of long-term recovery. Risk and protective factors (conditions in people's lives that make them more or less likely to use alcohol, tobacco, or illicit drugs, or experience a mental health crisis), play an important role in successful prevention strategies. Successful prevention decreases risk factors and enhances protective factors. Using a shared risk and protective factor approach can be an effective prevention strategy and allows prevention efforts to have a greater reach across multiple areas of concern. Focusing on reducing risk factors while increasing protective factors will have the largest impact on many behavioral health challenges, including substance misuse, depression, violence, and suicide.

The Division of Behavioral Health, Prevention & Early Intervention provides grant funding throughout the state, serving both urban and rural service areas. The Comprehensive Behavioral Health Prevention and Early Intervention (CBHPEI) grant focuses on population-based strategies, the prevention of substance misuse and suicide, and the promotion of comprehensive wellness across Alaska, with an "upstream" approach. Prevention efforts are community driven and coalition led, with stakeholders representing the diversity of the community or service area.

A new array of services is available through the Alaska Medicaid 1115 Behavioral Health Demonstration Waiver (1115 Waiver). The 1115 Waiver creates a data-driven, integrated behavioral health system of care for children, youth, and adults with serious mental illness, severe emotional disturbance, and/or substance use disorders. These services include residential treatment for substance use disorder, partial hospitalization program services for substance use disorder and behavioral health, adult mental health residential services, and mobile outreach and crisis response services. The 1115 Waiver seeks to increase services for at-risk families in order to support the healthy development of children and adults through increased outreach, prevention, and early intervention supports.

Alaska's current healthcare system needs changes that empower patients and healthcare providers. Alaska's SHARP Program is the statewide support-for-service effort that provides

partial financial support to healthcare practitioners in medical, dental, and behavioral health disciplines. It is a public-private partnership working to improve the recruitment, retention, and distribution of health professionals for Alaska.

Ensuring Alaskans have access to the full continuum of care, from early intervention all the way through acute care and treatment and recovery, will be crucial to improving the health outcomes for residents. Moving upstream by increasing prevention and early intervention services will lead to cost savings and improved care for Alaskans.

**Sources:**

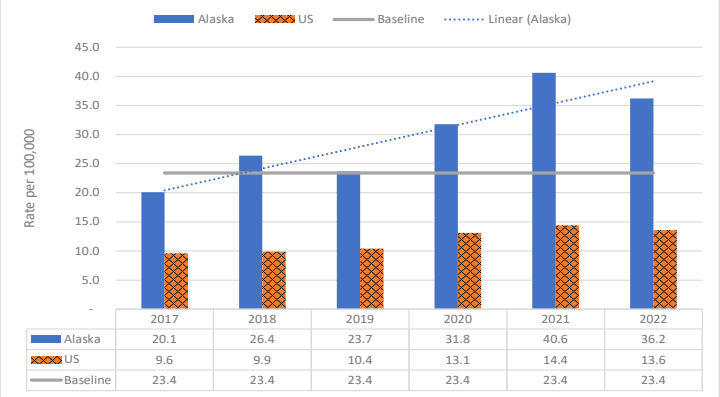
- State of Alaska, Department of Health, Division of Behavioral Health, Alaska Substance Use Disorder and Behavioral Health Program (SUD-BHP) 1115 Evaluation Design FY19-FY24
- Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: Alaska, Volume 6: Indicators as measured through the 2019 National Survey on Drug Use and Health and the National Survey of Substance Abuse Treatment Services. HHS Publication No. SMA–20–Baro–19–AK. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2020.
- National Survey on Drug Use and Health: Comparison of 2017-2018 and 2018-2019 Population Percentages (50 States and the District of Columbia)
- Alaska's SHARP Program
- Healthy Alaskans

SUBSTANCE USE DISORDER PREVENTION

# INDICATOR 13: Rate of alcohol-induced mortality (rate per 100,000; age-adjusted)

## Story Behind the Baseline

Alcohol-induced mortality includes deaths from causes such as degeneration of the nervous system due to alcohol, alcoholic liver disease, gastritis, myopathy, pancreatitis, poisoning, and more. It does not include accidents, homicides, and other causes indirectly related to alcohol use.




| | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 |
|---|---|---|---|---|---|---|
| Alaska | 20.1 | 26.4 | 23.7 | 31.8 | 40.6 | 36.2 |
| US | 9.6 | 9.9 | 10.4 | 13.1 | 14.4 | 13.6 |
| Baseline | 23.4 | 23.4 | 23.4 | 23.4 | 23.4 | 23.4 |

**Population: Alaska and U.S.**

**Data Sources:**

- Alaska Division of Public Health, Health Analytics and Vital Records Section
- Center for Disease Control and Prevention, WONDER Online Database

**Data Source Contact:**

- Research Unit, Health Analytics and Vital Records;
  Division of Public Health, Department of Health
  Email: healthanalytics@alaska.gov

Alcohol misuse and alcohol use disorders negatively impacts the health of the individual, family, and the larger community. According to the 2018 Report on the Economic Costs of Alcohol Misuse in Alaska, the 2018 combined estimated direct costs of substance-use disorders – to state and local governments, employers, and residents of Alaska – totaled $3.45 billion. Approximately $2.39 billion (69% of total costs) were due to alcohol misuse.

Alaskans who misuse alcohol are more vulnerable to the progression of an addiction and often experience barriers to accessing treatment. These barriers can include a lack of available treatment options, lack of insurance or funds to pay for services, long waitlists, past criminal convictions, stigma, and lack of access to transportation, housing, and employment. People with co-occurring disorders (a substance use disorder combined with another disorder, such as mental illness or a developmental disability) often experience greater symptom severity that requires specialized interventions which may not be available in their community.

Alcohol use is strongly associated with a wide range of serious long-term health effects,

including chronic liver disease and cirrhosis, diseases of the heart, and some cancers. All of these conditions are leading causes of death, both in Alaska and nationwide. Alaska experiences higher rates of alcohol-attributable mortality than most other states and the U.S. as a whole. In 2015, it was reported that Alaska's alcohol-attributable mortality rate was the third highest in the nation, and alcohol-attributable causes accounted for more deaths during 2010–2016 than methamphetamine and opioid-attributable causes combined. From 2012–2016, the age-adjusted rate of alcohol-induced deaths in Alaska was nearly double the national rate (18.6 per 100,000 persons compared to 9.8 per 100,000 persons).

Services for alcohol misuse in Alaska are funded through a variety of means, including Medicaid reimbursement, private insurance, state-funded grant dollars to community nonprofits, tribal organizations, and local government providers. State-funded Behavioral Health Treatment and Recovery grants pay for withdrawal management, outpatient treatment, and residential treatment services to low-income youth and adults with moderate to severe behavioral health disorders. Behavioral health treatment providers report that resources have not kept pace with the actual costs associated with serving the growing number of Alaskans who need addiction services. Due to ongoing flat-funding and state grant reductions for behavioral health services, providers have been facing an aging infrastructure, an inability to recruit and retain treatment professionals, attrition of staff, and an increased demand from a statewide addiction epidemic.

## What Works?

Alaskans who experience substance use disorders need a full continuum of care, from prevention and early intervention to treatment and recovery services, that increase the likelihood of long-term recovery. These services can include, but are not limited to, substance use prevention and early intervention, outpatient treatment, ambulatory withdrawal management, Medication Assisted Treatment (MAT), crisis stabilization, peer support and reentry services, and long-term recovery supports.

Alaska's Medicaid 1115 Behavioral Health Demonstration Waiver (1115 Waiver) was approved by the Centers for Medicare and Medicaid Services (CMS) in 2019. Through the 1115 Waiver, a new array of services is available. The 1115 Waiver creates a data-driven, integrated behavioral health system of care for children, youth, and adults with serious mental illness, severe emotional disturbance, and/or substance use disorders. These services include, but are not limited to, residential treatment for substance use disorder, partial hospitalization program services for substance use disorder and behavioral health, adult mental health residential services, mobile outreach and crisis response services, withdrawal management, and medications for addiction treatment. The 1115 Waiver ensures that Medicaid recipients will have options across the full continuum of care, from early intervention all the way through

acute care.

The Alaska Division of Behavioral Health, Prevention & Early Intervention provides grant funding throughout the state, serving both urban and rural service areas. The Comprehensive Behavioral Health Prevention and Early Intervention (CBHPEI) grant focuses on population-based strategies, the prevention of substance misuse and suicide, and the promotion of comprehensive wellness across Alaska with an "upstream" approach. Prevention efforts are community driven and coalition led, with stakeholders representing the diversity of the community or service area. This grant also funded the development of a Statewide Alcohol Prevention Alliance to address underage drinking and adult binge and heavy drinking. Core strategic components include community-based interventions, health equity and mass-reach health communication, promoting Screening, Brief Intervention and Referral to Treatment (SBIRT), surveillance, and evaluation.

Ensuring Alaskans have access to the full continuum of care, from early intervention all the way through acute care and treatment and recovery, is crucial to improving the health outcomes for residents. Moving upstream by increasing prevention and early intervention services will lead to cost savings and improved care for Alaskans.

**Sources:**

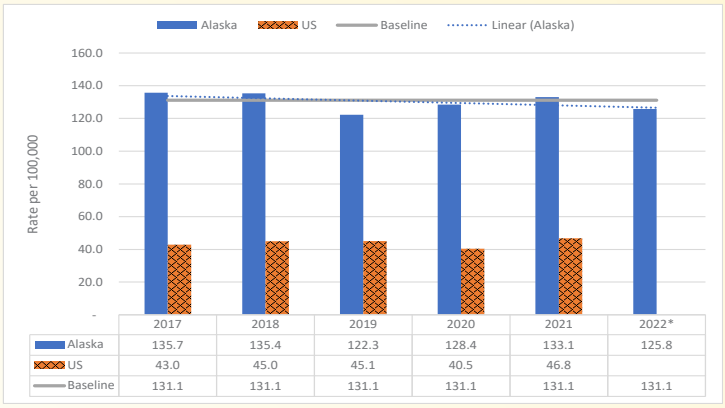
- Alaska Epidemiology Bulletin. "Health Impacts of Alcohol Misuse in Alaska". Volume 20, No 2, May 7, 2018
- The Economic Costs of Alcohol Misuse in Alaska Summary
- The Economic Costs of Alcohol Misuse in Alaska Full Report
- Alaska Trauma Registry, the Alaska Department of Education and Early Development, and the Alaska Birth Defects Registry
- 2019 State of Alaska Epidemiologic Profile on Substance Use, Abuse, and Dependency
- Alaska Behavioral Health Provider Service Standards & Administrative Procedures For SUD Provider Services

# SUICIDE PREVENTION

## INDICATOR 14: Rate of intentional self-harm/suicide attempt emergency department visits (rate per 100,000; age-adjusted)

### Story Behind the Baseline

Suicide impacts all Alaskans, no matter their age. Suicide is one of the leading causes of death for youth and young adults, and they are attempting suicide at higher rates than any other age group in Alaska. Every year, many more people think about or attempt suicide than die by suicide. In addition to the number of people who are injured or die, suicide also affects the health of others and the community. When people die by suicide, their family and friends can experience shock, trauma, anger, guilt, and depression. The economic toll of suicide on society is also immense. Suicide and suicide attempts cost the nation almost $70 billion per year in lifetime medical and work-loss costs alone. While the presence of a mental health condition may contribute to increased suicide risk, it is important to note that the majority of people who live with mental health




| | 2017 | 2018 | 2019 | 2020 | 2021 | 2022* |
|---|---|---|---|---|---|---|
| Alaska | 135.7 | 135.4 | 122.3 | 128.4 | 133.1 | 125.8 |
| US | 43.0 | 45.0 | 45.1 | 40.5 | 46.8 | |
| Baseline | 131.1 | 131.1 | 131.1 | 131.1 | 131.1 | 131.1 |

**Population: Alaska and U.S.**

**Data Sources:**

- Alaska Division of Public Health, Health Analytics and Vital Records Section
- Center for Disease Control and Prevention, CDC WISQARS

**Data Source Contact:**

- Research Unit, Health Analytics and Vital Records;
  Division of Public Health, Department of Health
  Email: healthanalytics@alaska.gov

***Note:**

- U.S. data not available at the time of publication.

conditions will not die by suicide. Research tells us that nine out of ten people who attempt suicide and survive will not go on to die by suicide at a later date.

Many people are impacted by knowing someone who dies by suicide or who experiences suicidal thoughts. Several life factors can increase the risk for suicide, while some life factors protect against it. For example, suicide risk is higher among people who have experienced violence, including child abuse, bullying, or sexual violence. Childhood trauma and historical trauma, often referred to as Adverse Childhood Experiences (ACEs), puts certain individuals at a higher risk of suicide. Protective factors, like family and community support or "connectedness," and easy access to healthcare can decrease the risk for suicidal thoughts and behavior.

According to the Substance Abuse and Mental Health Services Administration (SAMHSA) Behavioral Health Barometer: Alaska, Volume 6, the annual average percentage of serious thoughts of suicide among young adults, ages 18 to 25 in Alaska, in the past year increased between 2008–2010 and 2017–2019 from 5.9% to 17.4%. During 2017–2019, the annual average prevalence of past-year serious thoughts of suicide in Alaska was 17.4% (or 12,000), higher than both the regional average (13.4%) and the national average (11.1%). In Alaska, emergency department data shows that individuals who die by suicide most commonly use a firearm. This data also shows that while women are attempting suicide at a higher rate, men die by suicide at a much higher rate than women. Additionally, women are attempting suicide at a higher rate and at different times during the year than their male counterparts.

## What Works?

Suicide has no single determining cause and it cannot be prevented by any single strategy. Instead, suicide occurs in response to multiple biological, psychological, interpersonal, environmental, and societal influences that interact with one another, often over time. The social-ecological model is a useful framework for viewing and understanding suicide risk and protective factors across four levels of focus: individual, relationship, community, and societal. The relevance of each risk factor can vary by age, race, gender, sexual orientation, residential geography, and socio-cultural and economic status.

Utilizing data can help support upstream prevention and intervention strategies targeted toward vulnerable populations identified through evaluating suicide attempt data. Evidence-based interventions should be chosen to specifically address the unique needs of Alaskans, taking into account homelessness, geographical barriers to accessing healthcare services, stigma, and cultural differences. It is important to have a comprehensive suicide prevention system that addresses not only risk factors representative of those who have died by suicide but also, those who are attempting or struggling with ideation. Early detection and adequate

treatment are key to reducing suicide risk. Staying connected to others and taking care of overall health are all ways to support mental health.

Access to behavioral healthcare services and resources are improving within Alaska. The launch of 988 and crisis services has expanded the crisis continuum of care. Utilizing best practices for crisis care in Alaska has been a collaborative effort involving many state partners. The 1115 Medicaid Demonstration Waiver created new billable crisis services to support this work.

Implementation of the Zero Suicide framework, a systematic framework for comprehensive suicide care in healthcare settings, is an important commitment for patient safety. This framework includes universal screening for suicide risk, collaborative and connected care, and supported transitions through care settings. Zero Suicide work is active in Alaska with initiatives led by the Department of Health and tribal entities aimed at improving suicide care practices in Alaska's healthcare system. Mobile crisis units are active in Anchorage, Fairbanks, and Juneau, and the Restore Hope in Linkage to Care Collaboration grant is working to connect individuals to services and treatments. There are active efforts to develop mobile crisis outreach within Alaska, with some teams operating within larger communities in the state.

Both upstream and primary prevention efforts are needed to reduce suicide in Alaska and should have a strong focus on adolescents, young adults, seniors/elders, and American Indian/Alaska Native people. Strong state leadership, dedicated program efforts, collaboration, and long-term sustainable resources are needed to address suicide in Alaska and the “web of causality” that impacts the health and well-being of Alaskans.

**Sources:**

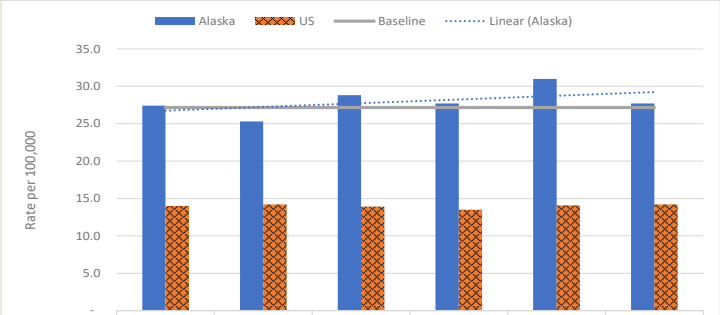

- CDC Division of Violence Prevention. Preventing Suicide: A Technical Package of Policy, Programs, and Practices
- CDC Violence Prevention: Preventing Suicide
- American Foundation for Suicide Prevention
- Statewide Suicide Prevention Council
- Healthy Alaskans

SUICIDE PREVENTION

# INDICATOR 15: Rate of intentional self-harm/suicide deaths (rate per 100,000; age adjusted)

## Story Behind the Baseline

Suicide is preventable. According to the American Foundation for Suicide Prevention, there is no single cause for suicide. Suicide most often occurs when stressors and health issues converge to create an experience of hopelessness and despair. Depression is the most common condition associated with suicide, and it is often undiagnosed or untreated. Conditions like depression, anxiety, and substance use problems, especially when unaddressed, increase the risk for suicide, yet it's important to note that most people who actively manage their mental health conditions go on to engage in life. Efforts to reduce suicide focus on mending the support system through the entire continuum of wellness promotion, suicide prevention, crisis intervention, and postvention programs.
If every Alaskan learned about suicide and the risks and protective factors involved, they would be better prepared to prevent suicide in families and communities.




| | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 |
|---|---|---|---|---|---|---|
| Alaska | 27.4 | 25.3 | 28.8 | 27.7 | 31.0 | 27.7 |
| US | 14.0 | 14.2 | 13.9 | 13.5 | 14.1 | 14.2 |
| Baseline | 27.2 | 27.2 | 27.2 | 27.2 | 27.2 | 27.2 |

**Population: Alaska and U.S.**

**Data Sources:**

- Alaska Division of Public Health, Health Analytics and Vital Records Section
- Center for Disease Control and Prevention, CDC Wonder Data

**Data Source Contact:**

- Research Unit, Health Analytics and Vital Records;
  Division of Public Health, Department of Health
  Email: healthanalytics@alaska.gov

## What Works?

Providers of healthcare services to Alaskans should prioritize screening and early identification of warning signs and risk factors for suicide. Evidence-based

interventions should be chosen to specifically address the special needs of Alaskans – including homelessness, geographical barriers to accessing healthcare services, stigma, and cultural differences. Use of telemedicine should be encouraged and reimbursed so that Alaskans in rural communities have better access to mental health and substance use disorder treatment services. Clinical intervention should focus on suicide specific psychotherapies, as they have demonstrated greater efficacy in reducing suicide than treatment as usual. Restriction of lethal means and effective postvention supports are also key to reducing suicide.

Implementation of the Zero Suicide framework, a systematic framework for comprehensive suicide care in healthcare settings, is an important commitment for patient safety. This framework includes universal screening for suicide risk, collaborative and connected care, and supported transitions through care settings. Zero Suicide work is active in Alaska with initiatives led by the Department of Health and tribal entities aimed at improving suicide care practices in Alaska's healthcare system. Mobile crisis units are active in Anchorage, Fairbanks, and Juneau, and the Restore Hope in Linkage to Care Collaboration grant is working to connect individuals to services and treatments. There are active efforts to develop mobile crisis outreach within Alaska, with some teams operating within larger communities in the state.

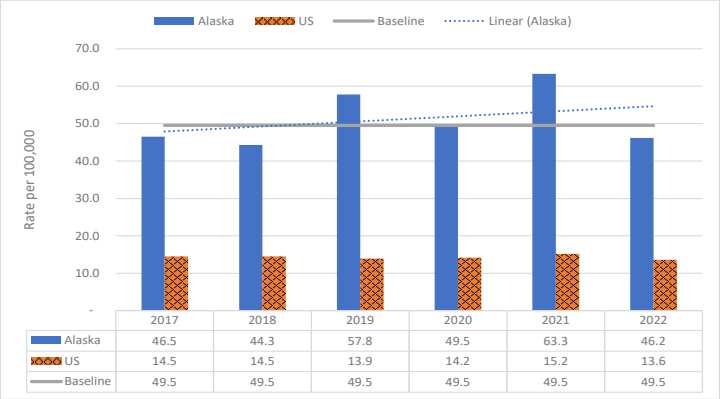
**Sources:**


- CDC Division of Violence Prevention. Preventing Suicide: A Technical Package of Policy, Programs, and Practices
- CDC Violence Prevention: Preventing Suicide
- American Foundation for Suicide Prevention
- Statewide Suicide Prevention Council
- CDC Division of Violence Prevention the Relationship Between Bullying and Suicide: What We Know and What it Means for Schools
- Healthy Alaskans

SUICIDE PREVENTION

# INDICATOR 16: Rate of intentional self-harm/suicide deaths (rate per 100,000; ages 15-24)

## Story Behind the Baseline




| | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 |
|---|---|---|---|---|---|---|
| Alaska | 46.5 | 44.3 | 57.8 | 49.5 | 63.3 | 46.2 |
| US | 14.5 | 14.5 | 13.9 | 14.2 | 15.2 | 13.6 |
| Baseline | 49.5 | 49.5 | 49.5 | 49.5 | 49.5 | 49.5 |

**Population: Alaska and U.S. (Ages 15 to 24)**

**Data Sources:**

- Alaska Division of Public Health, Health Analytics and Vital Records Section
- Center for Disease Control and Prevention, CDC Wonder Data

**Data Source Contact:**

- Research Unit, Health Analytics and Vital Records;
  Division of Public Health, Department of Health
  Email: healthanalytics@alaska.gov

Alaska experiences some of the highest rates of youth and young adult suicide in the nation. Suicide is consistently a leading cause of death for Alaska's young people, frequently rising above mortality rates for accidents and homicides. Furthermore, mental health and suicide related crisis amongst Alaska's youth appear to be increasing. In 2021, suicidal ideation accounted for a quarter of all discharge diagnoses for child and adolescent emergency department treatment episodes within Alaska. This is a 6% increase from the previous year (Alaska's Health Facilities Data Reporting, 2022). Suicide intervention for youth can be especially challenging to access, with limited in-state options for inpatient psychiatric care and rural and geographical barriers to accessing outpatient behavioral health services.

Results from the 2019 Youth Risk Behavior Survey (YRBS) show the percentage of adolescents feeling sad and hopeless is on the rise (1 out of 3). The percentage of students attempting suicide during the past year nearly doubled, from 10.7% in 2007 to 19.7% in 2019. In fact, this measure increased significantly even from 2017 (12.1%). In 2021, suicide was the leading cause of death for youth and young adults, ages 15 to 24 in Alaska, with 63.3 deaths per 100,000. Alaska Native and American Indian people (AN/AI) continue to experience social and economic inequities that contribute to suicide risk.

## What Works?

Programs, services, and opportunities in schools help increase protective factors impacting adolescent depression and suicide. These protective factors include supportive adults and connections, student activities that promote feeling valued, social-emotional competence and self-regulation skills, attending a school with a positive climate, participating in quality after-school activities and structured meaningful activities, a sense of cultural identity and connection, and regular physical activity.

Statewide education on how to talk about and recognize the signs of suicide enables all Alaskans to work together to prevent and mitigate risk factors contributing to suicide. Risk factors include ACEs, easy access to firearms, use of substances (alcohol and/or other drugs), prior suicide attempts, and exposure to violence.

Funding provided through the Statewide Suicide Prevention Council for the Suicide Awareness, Prevention & Postvention (SAPP) program to the Alaska Department of Education and Early Development (DEED) supports online trainings for Alaskan educators and direct grants to school districts that help implement suicide prevention programming throughout the state.

The Division of Behavioral Health, Prevention & Early Intervention provides grant funding throughout the state, serving both urban and rural service areas. The Comprehensive Behavioral Health Prevention and Early Intervention (CBHPEI) grant focuses on population-based strategies, the prevention of substance misuse and suicide, and the promotion of comprehensive wellness across Alaska, with an "upstream" approach. Prevention efforts are community driven and coalition led, with stakeholders representing the diversity of the community or service area.

DEED also provides statewide support by having staff that can respond to district requests for support during a crisis (for example: mental health, suicide prevention, crisis counseling support, and technical assistance). While DEED offers a collection of professional development resources to all districts, by far the largest and most popular are the online suicide prevention courses created since fiscal year 2016 (FY16) with SAPP funding. To date, 37,000 courses have been completed.

Improving and maintaining access to behavioral healthcare services and resources, including 988, community-based crisis interventions (e.g., 1115 Waiver, Crisis Now model), and safer suicide care practices in all healthcare settings is critical for community intervention. Promoting and expanding Zero Suicide efforts throughout Alaska will improve the

identification of those experiencing suicidal thoughts and behaviors and ensure subsequent safe and supported suicide care.

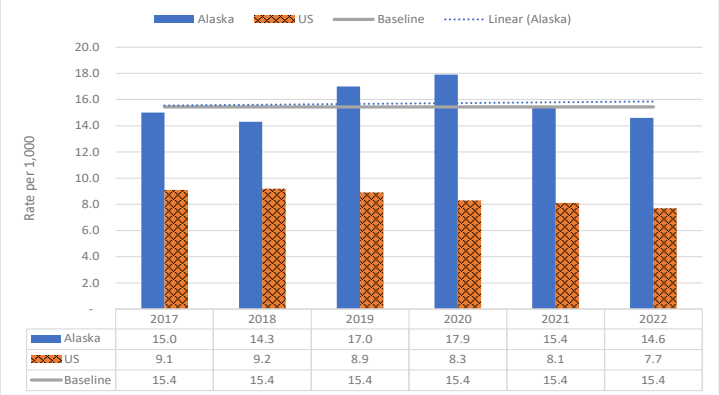
**Sources:**

- State of Alaska Epidemiology Adolescent Suicide Death, AKVDRS Update- Alaska 2016-2019
- CDC Division of Violence Prevention. Preventing Suicide: A Technical Package of Policy, Programs, and Practices
- CDC Violence Prevention: Preventing Suicide
- American Foundation for Suicide Prevention
- Statewide Suicide Prevention Council
- CDC Division of Violence Prevention the Relationship Between Bullying and Suicide: What We Know and What it Means for Schools
- Healthy Alaskans
- Childhood Abuse, Household Dysfunction, and the Risk of Attempted Suicide: Findings From the Adverse Childhood Experiences Study

# PROTECTING VULNERABLE ALASKANS

## INDICATOR 17: Rate of child maltreatment, substantiated cases, unique victims (rate per 1,000; ages 0 to 17)

### Story Behind the Baseline




| | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 |
|---|---|---|---|---|---|---|
| Alaska | 15.0 | 14.3 | 17.0 | 17.9 | 15.4 | 14.6 |
| US | 9.1 | 9.2 | 8.9 | 8.3 | 8.1 | 7.7 |
| Baseline | 15.4 | 15.4 | 15.4 | 15.4 | 15.4 | 15.4 |

**Population: Alaska and U.S. (Ages 0 to 17)**

**Data Source:**

- U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. Child Maltreatment

When children lack safe, supportive family and community environments, they are at risk of impaired development and long-term health problems. According to the data from the National Child Abuse and Neglect Data System (NCANDS), which collects and analyzes data submitted voluntarily by states, Alaska's 2020 rate of child maltreatment was the 2nd highest in the nation (behind Maine), at 18.0 children per 1,000. Caution should be used in interpreting this figure of substantiated (proven) cases of child maltreatment. Although the differences among state rates may reflect actual abuse or neglect, this data can also be impacted by state-to-state variation in statutory jurisdiction, agency screening processes and definitions, and the ability of states to receive, respond to, and document investigations.

The term "Adverse Childhood Experiences" (ACEs) refers to categories of childhood trauma, such as abuse (physical, sexual, and emotional) and household dysfunction including divorce, witnessing domestic violence or living with someone who went to jail or prison, or had substance misuse or mental health problems. These experiences are major risk factors for

the leading causes of illness and death, as well as poor quality of life in the U.S. The number of exposures to these traumas in childhood, known as an "ACEs score," is highly correlated with poor health, social, and economic outcomes in adulthood.

Vulnerable Alaskans, both children and adults, need both supportive and protective services. State and local public awareness campaigns, training programs, and multi-disciplinary teams are essential when providing these supportive services. In addition to improving the systems for responding to children and adults experiencing or at risk of abuse or neglect, it is vital that we focus on preventing such individuals from ever entering the system by supporting healthy, resilient families, and healing intergenerational trauma. Concerns for the safety of Alaska's children and vulnerable adults are reported by neighbors, teachers, nurses, treatment providers, and others to the Office of Children's Services (OCS) and Adult Protective Services (APS).

## What Works?

Increased access to preventive care is an ongoing and a key strategy to preventing abuse, neglect, self-neglect, and exploitation. The Family First Preservation Act, passed in 2018, provided a needed restructuring of federal funding to place a focus on preventing child maltreatment. This act allows states to fund early intervention efforts so that families may receive the assistance and support they need before safety concerns rise to the level of removing the child from the home. Plans of Safe Care, a component of this act, provides screening and case management services to families directly after the birth of a child. These forms of early intervention help maintain family units as well as community and cultural connection by preventing the removal of children from their family units. The Department of Health (DOH) is streamlining and diversifying the types of behavioral health services available under the Alaska Medicaid 1115 Behavioral Health Demonstration Waiver (1115 Waiver).

The Strengthening Families Protective Factors Framework (SFPFF) is a strength-based, research-informed approach to helping families prevent child abuse and neglect. SFPFF is particularly well-suited for Alaska because of its adaptability across cultures. It is embraced by numerous nonprofit and tribal social service organizations throughout the state, helping to shape a shared understanding that children and families are most likely to be safe and healthy when key protective factors are robust in their lives, and when there are trusting, long-term relationships between service providers and families. The five protective factors that are related to the prevention of child maltreatment are:

1. Parental resilience
2. Social connections
3. Knowledge of parenting and child development
4. Concrete support in times of need
5. Children's healthy social and emotional development

While OCS has a limited role in directly promoting protective factors, the office refers families to public health partners who offer a more robust continuum of care. OCS continues to encourage these prevention efforts by asking agencies and communities to make their services individualized and strength-based, culturally sensitive/competent, and trauma-informed. A recent initiative, "Circles of Support," aims to strengthen families and prevent children from being placed out of their homes. Supervised visitation and supervised exchange programs, such as Family First on the Kenai Peninsula, can prevent families from being more deeply involved with OCS. Reducing the use of institutional-based care for children and families with complex mental, emotional, and behavioral needs can also be mitigated through methods like the "wraparound" approach, which focuses on strength-based, individualized care.

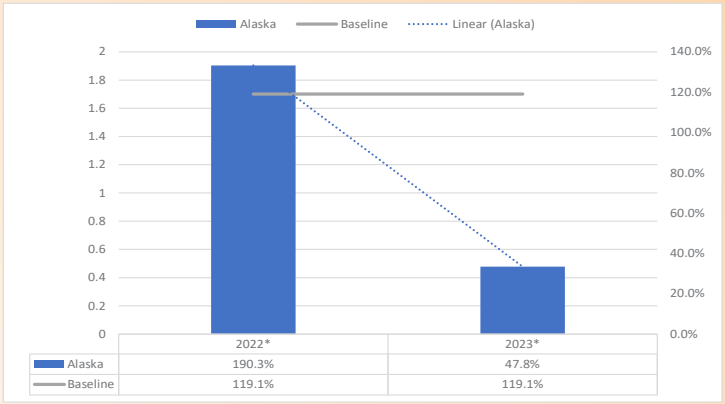
**Sources:**


- U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. Child Maltreatment
- Centers for Disease Control and Prevention, Violence Prevention, Adverse Childhood Experiences
- Alaska Mental Health Board and Advisory Board on Alcoholism and Drug Abuse. Adverse Childhood Experiences in Alaska
- Wraparound Milwaukee

# INDICATOR 18: Percentage change in youth who accessed home-based family treatment services (ages 0 to 24)

## Story Behind the Baseline

Compared to the national average, children in Alaska were 77.4% more likely to be abused in 2020. Alaska also has high rates of repeat child maltreatment, making Alaskan children more likely to encounter the child welfare or juvenile justice system. 1 in every 12 births experience a first substantiated report to the Alaska Office of Children's Services (OCS) before age seven.




**Population : Alaska (ages 0-24)**

**Data Source:**

- Alaska Division of Behavioral Health, Systems and Policy Section

**Data Source Contact:**

- Lynnea Lenamond, Research Analyst
  Division of Behavioral Health, Systems Policy Section, Department of Health
  Email: lynnea.lenamond@alaska.gov

***Note:**

- 2022 is the first full year of indicator data. The 2022-2023 average will serve as the averaged baseline for this indicator until a 3-year average is available.

For those children at risk of coming into the child welfare system, there have been very limited community prevention and early intervention services, which are managed separately from the treatment system. Children and adolescents in the child welfare system are often cared for in Residential Psychiatric Treatment Centers (RPTCs), or inpatient hospital services, sometimes in combination with support services. There are a growing number of children (whether in parental or state custody) being placed in out-of-state or out-of-region facilities, making family reunification efforts challenging. Furthermore, there are very few step-up/step-down services available within the child's own home or community, which are designed to prevent repeated maltreatment.

Specific to this indicator and the Alaska Medicaid 1115 Behavioral Health Demonstration Waiver (1115 Waiver), home-based family treatment (HBFT) is designed to be a community-based early intervention service. These interventions include treatment and wraparound

services that are provided in the home to reduce the need for inpatient hospitalization and residential services for children and adolescents. Services include family therapy, individual therapy, crisis intervention, medication services, parenting education, conflict resolution, anger management, and ongoing monitoring for safety and stability in the home. HBFT services are available for youth who are at risk of an out-of home placement or at risk of developing a mental health or substance use disorder, determined by a screening. A diagnosis by a clinician is not required in order to receive level 1 HBFT services. This supports easier access to care and provides a wider net for people who can become eligible for services. HBFT is a new and expanding service within Alaska that has the capacity to dramatically alter the landscape of community-based intervention services for Alaska's at-risk youth. At this time, Alaska is seeing a steady growth in HBFT services being provided to children ages 0-4 years, and 5-17 years. Expansion to rural service areas is still needed.

Alaska's unique geography, diverse population, lack of infrastructure, struggling economy, and limited healthcare resources make it challenging to provide a person-centered and culturally-responsive system. However, the family-centered and interdisciplinary approach outlined in HBFT could fill this desperate need if the service continues to expand.

## What Works?

The goal of the 1115 Waiver is to create a data-driven, integrated behavioral health system of care for children, youth, and adults with serious mental illness, severe emotional disturbance, and/or substance use disorders. The 1115 Waiver also seeks to increase services for at-risk families in order to support the healthy development of children and adults through increased outreach and prevention, and early intervention supports.

The federal Family First Prevention and Services Act (FFPSA) made substantial changes to federal child welfare financing and is focused on investing in prevention and prioritizing family-based placement. The act rolls out an open-ended entitlement for reimbursement of eligible state expenditures on evidence-based programs and services for children that are at imminent risk of entering the foster care system. It also allows federal reimbursement for evidenced-based programs for in-home parent, skill-based programs that include parenting skills training, parent education, and individual and family counseling, among other services.

Behavioral health challenges often stem from childhood trauma and other adverse experiences and have downstream effects on entire families that translate to higher costs associated with

subsequent acute care and chronic health needs. The 1115 Waiver and the FFPSA promote timely access to a more robust continuum of services, which is key to supporting children who need behavioral health services (or children whose family members need services) in their homes with the goal of preventing out-of-home placement whenever possible. These additional services will provide an important vehicle for strengthening the support system for these young people in hopes of anticipating and preventing crises and reducing the need for out-of-home placements over time.

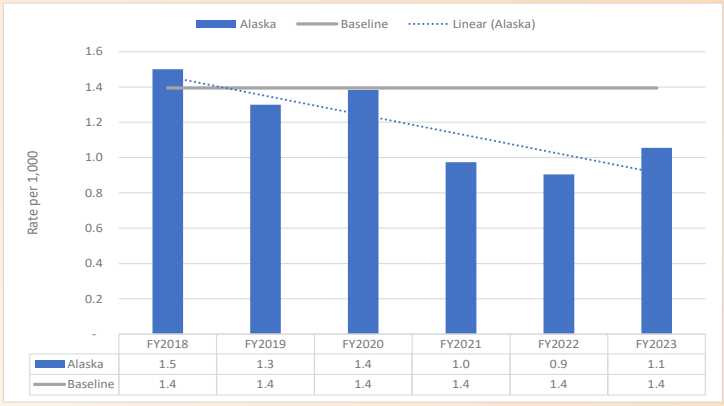
**Sources:**


- State of Alaska, Department of Health, Division of Behavioral Health, Alaska Substance Use Disorder and Behavioral Health Program (SUD-BHP) 1115 Evaluation Design FY19-FY24
- Alaska's 1115 Behavioral Health Medicaid Waiver
- Parrish, J.W., Shanahan, M.E., Schnitzer, P.G. et al. Quantifying Sources of Bias in Longitudinal Data Linkage Studies of Child Abuse and Neglect: Measuring Impact of Outcome Specification, Linkage Error, and Partial Cohort Follow-Pp. Inj. Epidemiol. 4, 23 (2017)
- Alaska Behavioral Health Provider Standards and Administrative Manual for Behavioral Health Provider Services

# INDICATOR 19: Founded reports of harm to adults (rate per 1,000; ages 18+)

## Story Behind the Baseline

Protective services are intended to prevent or alleviate harm resulting from undue influence, abandonment, exploitation, neglect and self-neglect, and are provided to a vulnerable adult or child who needs protection.




| | FY2018 | FY2019 | FY2020 | FY2021 | FY2022 | FY2023 |
|---|---|---|---|---|---|---|
| Alaska | 1.5 | 1.3 | 1.4 | 1.0 | 0.9 | 1.1 |
| Baseline | 1.4 | 1.4 | 1.4 | 1.4 | 1.4 | 1.4 |

**Population: Alaska Statewide (Ages 18+)**

**Data Source:**

- Division of Senior and Disability Services, Department of Health

**Data Source Contact:**

- Anastasiya Podunovich, Research Analyst
  Division of Senior and Disability Services, Department of Health
  Email: jake.bozzini@alaska.gov

Approximately 1 in 10 Americans ages 60 and older have experienced some form of abuse. Some estimates project that as many as 5 million older adults are abused each year. One study estimated that only 1 in 14 cases of abuse are reported to authorities. A study that reviewed news-feed articles collected daily by the National Adult Protective Services Association (NAPSA) through an initiative funded by the National Center on Elder Abuse found that instances of fraud perpetrated by strangers comprised 51% of news articles related to elder financial abuse, followed by family, friends, and neighbors (34%), the business sector (12%), and Medicare and Medicaid fraud (4%). Nearly 60% of perpetrators were men, mostly between the ages of 30 and 59. The news-feed tracked media reports of all types of elder abuse through Google and Yahoo alerts over a three-month period. Seniors who experienced abuse have a 300% higher risk of death when compared to those who have not been mistreated. While likely underreported, estimates of financial abuse and fraud costs to older Americans range from $2.9 billion to $36.5 billion, annually; yet financial exploitation is self-reported at higher rates than emotional, physical, and sexual abuse or neglect.

Social isolation and cognitive impairment, such as dementia or Alzheimer's disease, are two factors that increase the risk of someone experiencing abuse. Recent studies show that nearly

half of those with dementia experienced abuse or neglect. Interpersonal violence also occurs at disproportionately higher rates among adults with disabilities.

Adult Protective Services (APS) and the Long Term Care Ombudsman (LTCO) are two agencies that work together to protect Alaska's vulnerable populations. APS helps to prevent or stop harm occurring against vulnerable adults and takes reports of harm through a centralized reporting system. In addition to investigation of reports, APS makes recommendations for protective placement, guardianship/conservatorship counseling or mediation, links to community resources, and training and designation of local community resources to provide services. The LTCO protects vulnerable seniors by visiting long-term care facilities and investigating complaints.

## What Works?

Social support has been acknowledged as a potentially beneficial intervention. Efforts to enhance social supports of vulnerable adults have the dual benefit of building mental health resilience in response to extreme stressors and lowering the risk of interpersonal violence against the older adult members of our society. One example of a social support intervention is a community-based elder abuse intervention program called "Eliciting Change in At-Risk Elders." The program assists suspected victims of elder abuse and self-neglect through a partnership with local law enforcement. This program involves building alliances with the elder and family members, connecting the elder to supportive services that reduce risk of further abuse, and utilizing motivational interview-style skills to help elders overcome ambivalence regarding making difficult life changes.

Given the complex nature of abuse, inter-professional teams, also referred to as "multidisciplinary teams", have been identified as a possible intervention strategy since no single discipline or sector alone has the resources or expertise needed to address the issue. These teams consist of physicians who are social workers, law enforcement personnel, attorneys, and other community participants who are working together in a coordinated fashion. Education about vulnerable adult abuse is another important way to intervene at the community level. Altering attitudes towards abuse may impact a person's behavior toward vulnerable Alaskans.

Interventions continue to evolve with regard to reporting and data collection of abuse incidents. APS systems play a critical role in addressing the abuse, neglect, self-neglect, and financial exploitation of adults. Historically, there has been no federal "home" for APS, nor a designated federal appropriation for this critically important service. Instead, states and local agencies have developed a wide variety of APS practices resulting in significant variations between, and sometimes within, states. In an effort to support APS agencies and enhance

response, the Administration on Community Living (ACL) has been developing guidelines intended to assist states in developing efficient and effective APS systems.

The LTCO office protects the rights, safety, and welfare of individuals residing in assisted living and nursing homes across the state. The LTCO trains community volunteers to visit nursing facilities and assisted living homes. While visiting, they monitor the residents' conditions in the homes, listen to them, work with the home to resolve problems, and alert LTCO staff when they cannot resolve problems or when residents are at risk of harm.

**Sources:**

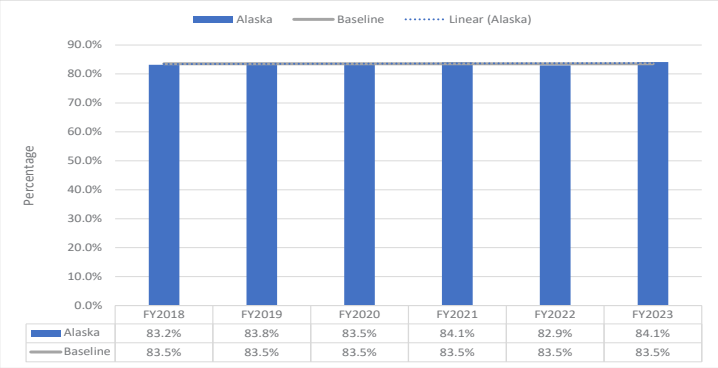
- National Council on Aging
- National Center on Elder Abuse
- Alaska Adult Protective Services
- The Office of the Long Term Care Ombudsman

# SERVICES IN THE LEAST RESTRICTIVE ENVIRONMENT

## INDICATOR 20: Percentage of Alaskans who meet criteria for an institutional level of care who were served by a home and community based waiver

### Story Behind the Baseline

Least restrictive practices in home communities are paramount for Trust beneficiaries to be able to live meaningfully as contributing members of such communities. Receiving local services preserves existing natural supports and allows for the development of additional supports, making it the desired first choice. Long-term services and supports offer a wide range of services to help people with disabilities who need support to live more independently by assisting with personal and healthcare needs and activities of daily living, such as eating, bathing, grooming, and other related activities.




| | FY2018 | FY2019 | FY2020 | FY2021 | FY2022 | FY2023 |
|---|---|---|---|---|---|---|
| Alaska | 83.2% | 83.8% | 83.5% | 84.1% | 82.9% | 84.1% |
| Baseline | 83.5% | 83.5% | 83.5% | 83.5% | 83.5% | 83.5% |

**Population: Alaska Statewide**

**Data Source:**

- Medicaid Management Information System via COGNOS

**Data Source Contacts:**

- Anastasiya Podunovich, Research Analyst
  Division of Senior and Disability Services, Department of Health
  Email: anastasiya.podunovich@alaska.gov

Medicaid home and community-based waivers (HCBW) allow Alaskans with disabilities to avoid institutional care, such as nursing homes, by contracting with HCBW provider agencies. The Division of Senior and Disabilities Services (DSDS) reported on the FY22 Continuum of Care report: individuals who receive HCBW and Intellectual & Developmental Disabilities (IDD) waiver services cost an average of $87,744 per person receiving services. By comparison,

if these individuals with an intellectual disability were in an intermediate care facility, at the average cost of $116,181 per person annually, it would cost $28,437 more per year for each individual. If these individuals were in a nursing home, at the average cost of $159,367 per person annually, it would cost $71,623 more per year for per each individual. Currently, the costs of home and community-based services (HCBS) are much lower because they can serve more people with the same amount of money, ensuring sustainability of services. Services provided in a least restrictive environment ultimately leads to more meaningful lives for beneficiaries, as well as cost efficiencies for state government.

## What Works?

Increased access to enhanced and timely treatment options within a robust continuum of care is necessary. To increase statewide service access and capacity, more providers, including care coordinators, service providers (such as direct service professionals), and rural providers of all types, would help reduce waitlists for services that have already been approved. Furthermore, additional providers and resources are necessary to review eligibility for individuals on an intellectual and developmental disabilities waitlist.

Ensuring that person-centered planning is taking place allows individuals to choose where they would like their care delivered, so they may remain in their home community and maintain as much independence as possible. Supporting a beneficiary's caregivers, family, and/or friends with services such as transportation, respite, and chore services utilization allows the beneficiary and their support people to remain in their home communities.

**Source:**

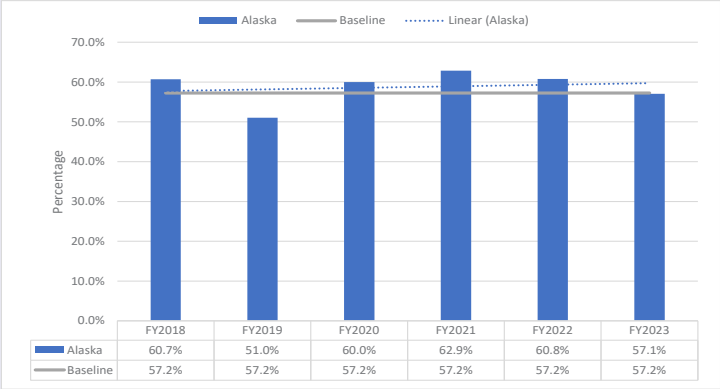
- State of Alaska Home and Community-Based Waiver Programs

SERVICES IN THE LEAST RESTRICTIVE ENVIRONMENT

# INDICATOR 21: Percentage of criminal defendant referrals admitted to a therapeutic court

## Story Behind the Baseline

Therapeutic courts in Alaska support participants' abstinence from drugs and alcohol and promote self-sufficiency while beneficiaries remain in the community and rebuild their lives. Mental health courts are specialized therapeutic courts that employ a problem-solving approach to criminal case processing for eligible beneficiaries with the goal of reducing the high numbers of beneficiaries in Alaska's criminal justice system.




| | FY2018 | FY2019 | FY2020 | FY2021 | FY2022 | FY2023 |
|---|---|---|---|---|---|---|
| Alaska | 60.7% | 51.0% | 60.0% | 62.9% | 60.8% | 57.1% |
| Baseline | 57.2% | 57.2% | 57.2% | 57.2% | 57.2% | 57.2% |

**Population: Alaska Statewide**

**Data Source:**

- Alaska's Automated Information Management System (AKAIMS)- Therapeutic Court Module

**Data Source Contacts:**

- Michelle Bartley, Therapeutic Courts Program Administrator
  Alaska Court System
  Email mbartley@akcourts.gov
- Emily Engrisch, Administrative Program Manager
  Alaska Court System
  Email: eengrisch@akcourts.gov

Therapeutic courts have been working since 1998 to reduce recidivism and provide ready access to treatment for offenders with substance use and mental health disorders. Their mission is to have a positive impact on the community by increasing public safety and reducing the cost associated with rearrest, criminal case processing, confinement, and jail overcrowding. On an individual level, therapeutic courts aim to break the cycle of criminality of people who experience drug and alcohol addiction and enhance their long-term reintegration into the community. All therapeutic courts carryout a self-evaluation every year to measure their performance against goals and objectives aligned with national best practice standards. Additionally, court teams and stakeholders meet regularly to discuss issues that are barriers to meeting these goals.

Prior to fiscal year 2020 (FY20), therapeutic courts revised eligibility criteria so that referral numbers could be maintained despite the criminal justice reforms contained in Senate Bill 91 (SB 91) – a lower legal exposure meant fewer people were interested in an intensive 12 to 18-month program. The repeal of SB 91 came into effect at the beginning of FY20 and this, combined with the previous push for referrals, led to a higher percentage of people being admitted into therapeutic courts in FY20 despite complications caused by the COVID-19 pandemic.

Much of FY20 was impacted by COVID-19. As the pandemic intensified, therapeutic courts made a concerted effort to keep up the number of referrals and, via social media and virtual meeting platforms, kept participants engaged in treatment to ensure continued program progress. FY22 saw a slight drop in the percentage of admissions relative to FY21, with the court backlog in cases and holding no trials because of the pandemic. There was also a high turnover in state prosecuting and defense attorneys. Newer attorneys were still learning about eligibility criteria, and the plea agreements being negotiated did not always meet therapeutic court program requirements, leading to fewer admissions to the courts.

The number of referrals substantially increased in FY23, signifying that project coordinators have been identifying potential applicants to try and increase court utilization. However, the percentage of referrals following through to admission decreased relative to FY22. Therapeutic court administration is exploring the multiple reasons for the reduction in admissions which vary among court types (drug/DUI, mental health, family, Veterans) as well as from location to location. Staff are working with individual courts to address the various factors involved.

## What Works?

Therapeutic court participants require robust and readily available behavioral health services. The therapeutic court administration has developed contractual relationships with local substance use disorder treatment providers to support ready access; however, mental health services within the communities remain limited and beneficiaries do not always have immediate access to mental health services.

Access to the behavioral health continuum of care in Alaska continues to be problematic

for beneficiaries due to a workforce shortage. The Alaska Medicaid 1115 Behavioral Health Demonstration Waiver (1115 Waiver) has helped local behavioral health service providers to increase capacity and coordination through the use of the Administrative Services Organization.

**Sources:**

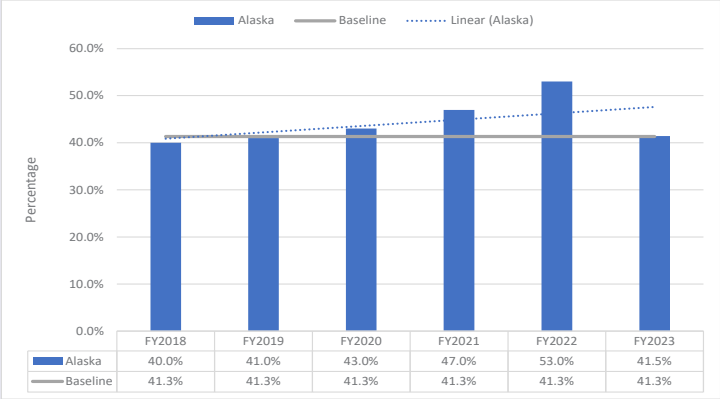
- Alaska Therapeutic Courts
- Therapeutic Courts in the Alaska Court System

SERVICES IN THE LEAST RESTRICTIVE ENVIRONMENT

# INDICATOR 22: Percentage of all juvenile justice referrals that were diverted from formal court action

## Story Behind the Baseline

Research has demonstrated that introducing low-risk youth into formal interventions with the juvenile justice system can unintentionally increase the likelihood of continued delinquent behavior due to the exposure to higher-risk youth; therefore, it is important that youth are diverted from the formal juvenile justice system and are provided less restrictive interventions when appropriate. It is also important that appropriate behavioral and neurobehavioral interventions are provided to youth and families as a part of the diversion process.




| | FY2018 | FY2019 | FY2020 | FY2021 | FY2022 | FY2023 |
|---|---|---|---|---|---|---|
| Alaska | 40.0% | 41.0% | 43.0% | 47.0% | 53.0% | 41.5% |
| Baseline | 41.3% | 41.3% | 41.3% | 41.3% | 41.3% | 41.3% |

**Population: Alaska Statewide**

**Data Source:**

- Division of Juvenile Justice, Department of Health

**Data Source Contacts:**

- Bridget Grieme, Data Processing Manager
  Division of Juvenile Justice, Department of Health
  Email: bridget.grieme@alaska.gov

For a number of years, the Division of Juvenile Justice (DJJ) has consistently diverted anywhere between 30% to 35% of all cases referred from law enforcement. Probation officers receiving these referrals have the discretion to work with youth, parents, victims, and communities to identify appropriate alternative sanctions other than formal court intervention, detention, and/or institutional treatment. Probation officers can recommend community work service, restitution, letters of apology, victim/offender mediation, behavioral health assessments, and other informal interventions to both hold youth accountable for their actions and provide interventions to increase competency development. The DJJ also uses more formal mechanisms for diversion such as informal probation, youth courts, tribal diversion, and other structured interventions available in communities throughout Alaska. The DJJ continues to utilize such interventions to appropriately divert youth from formal court intervention.

Secure juvenile facilities in Alaska are often a default system for ensuring behavioral and neurobehavioral interventions are provided to youth Trust beneficiaries. A correctional setting is not the best environment for youth to receive these services. To ensure adequate services are available and provided in a less restrictive manner, the cooperation of community providers is essential.

## What Works?

According to the Annie E. Casey Foundation, the most recent data collected from the Office of Juvenile Justice Delinquency and Prevention shows that 41% of juveniles involved with the juvenile justice system nationwide were diverted. The purposes of diversion programs are numerous and include cost-savings, reductions in recidivism and re-offending, avoidance of labeling, least-restrictive intervention, an increase in outcomes for youth, and an attempt to reduce disproportionality. Studies have shown that low-risk youth are 45% less likely to re-offend when diverted from formal court; this also accounts for a reduction in recidivism rates. The cost-savings to the community, DJJ, victims, and the youths' families are sizable.

A 2014 study by the McDowell group, specific to the Youth Court Division programs of Alaska, reported that: "Excluding the benefit to the State of Alaska and to individuals who move away from Anchorage, the quantifiable average annual benefit to the Anchorage community alone from youth court operations is $198,800 in savings in the cost of crime plus $80,450 in the value of adult and youth volunteer time and defendant community-service time, for a total annual benefit of $279,250." Tribal diversion programs also account for cost-savings and better outcomes for youth. In Alaska, there are currently 25 tribes participating in the tribal diversion programs.

**Sources:**


- Alaska Department of Health – Division of Juvenile Justice
  System Change Summary; January 2021
- Council of Juvenile Correctional Administrators Community-Based Mental Health Services; August 2017
- Alaska Department of Health- Division of Juvenile Justice
  System Improvement Summary For 2015 State of Alaska Crime Summit; February 2015

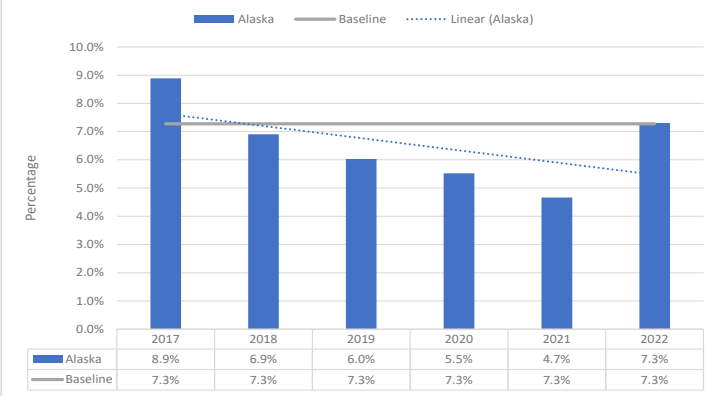
# SERVICES IN INSTITUTIONAL ENVIRONMENTS

## INDICATOR 23: Percentage of inpatient readmissions within 30 days to non-military hospitals for a behavioral or neurodevelopmental diagnosis (ages 12 to 17)

### Story Behind the Baseline

Alaska youth with complex backgrounds, including childhood and historical trauma, can experience escalated behaviors and, as a result, are led to seek services in a psychiatric setting, sometimes out of state. At times, these psychiatric settings are not the most appropriate or do not have the capacity to serve them. Unfortunately, youth often transition from one state system to another, are placed in different homes and schools, and lack consistent providers.

It is common for youth sent to out-of-state psychiatric treatment centers to present with the following risk factors: family history of substance misuse and mental illness, multiple traumas, one or more comorbidities, education as a psychosocial risk factor, a school suspension, or an individualized education plan (IEP).




| | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 |
|---|---|---|---|---|---|---|
| Alaska | 8.9% | 6.9% | 6.0% | 5.5% | 4.7% | 7.3% |
| Baseline | 7.3% | 7.3% | 7.3% | 7.3% | 7.3% | 7.3% |

**Population: Alaska Readmissions Statewide (Ages 12 to 17)**

**Data Sources:**

- Alaska Division of Public Health, Health Analytics and Vital Records Section, Health Facilities Data Reporting

**Data Source Contact:**

- Research Unit, Health Analytics and Vital Records; Division of Public Health, Department of Health
  Email: healthanalytics@alaska.gov

In Alaska, youth receive acute crisis services from psychiatric institutional settings which include the Alaska Psychiatric Institute (API), the State's Designated Evaluation and Stabilization or Designated Evaluation and Treatment (DES/DET) facilities, and private hospitals. Furthermore, youth can receive sub-acute services from group homes, therapeutic treatment foster homes, independent living, or a behavioral rehabilitation facility.

Efficient and effective care coordination and discharge planning between the various providers, including state services systems, have historically been problematic. Utilization and capacity for each component of the continuum of care seems to fluctuate based on advocacy, funding, or variables as simple as awareness of available resources. Out-of-home placement may result in a loss of connection with family, culture, and home community. It is important that professionals work to mitigate these consequences as much as possible.

## What Works?

For youth with complex behavioral needs to transition from an institutional setting to the community of their choice in a timely and coordinated manner, a collaborative team of compassionate, trauma-informed professionals focused on effective delivery of person-centered care is considered critical. Specific programming and services that will assist in prevention of admission and readmission include: The Alaska Medicaid 1115 Behavioral Health Demonstration Waiver (1115 Waiver), Crisis Now model, and programs such as the Complex Behavior Collaborative and the Family Services Training Center through the Division of Behavioral Health.

To best serve Alaskan youth with behavioral health needs, enhanced strategies are needed, such as building in-state capacity for lower levels of care and for nonresidential care; expanding care coordination across all levels of care; improving reporting mechanisms to monitor system access; measuring outcomes and service utilization; developing partnerships with communities and in-state providers to organize the resources and assistance needed to serve children experiencing severe disturbances and their families; and implementing strategies to develop and maintain a skilled in-state workforce.

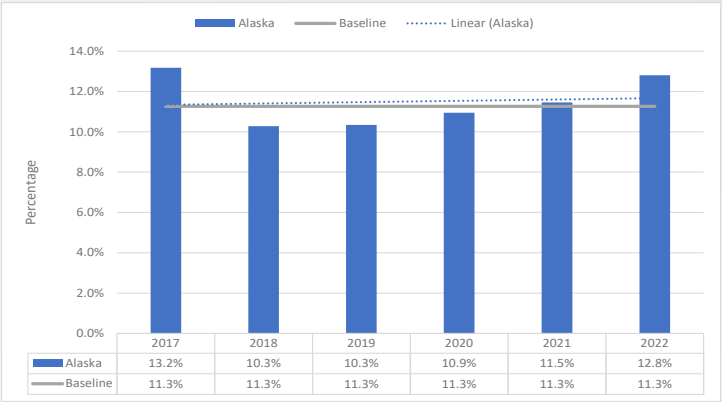
**Sources:**


- Alaska Medicaid Redesign Quality and Cost Effectiveness Targets Report, August 2017
- Alaska Medicaid Redesign Quality and Cost Effectiveness Targets Stakeholder Workgroup – DOH Office of the Commissioner
- Out-of-Home Care Conference Powerpoint
- Alaska's 1115 Behavioral Health Medicaid Waiver
- Recovery Innovations Crisis Now Consultation Report
- Bring the Kids Home

# INDICATOR 24: Percentage of inpatient readmissions within 30 days to non-military hospitals for a behavioral or neurodevelopmental diagnosis (ages 18+)

## Story Behind the Baseline

Community-based behavioral health services and supports are the best model for preventing behavioral health crises, but most Alaskan communities lack the full continuum of care needed. Due to the lack of community-based behavioral health services, both urban and rural areas rely heavily on law enforcement, emergency responders, and hospital emergency rooms to serve people in crisis. Many patients presenting to emergency departments with behavioral health conditions have an alcohol or drug-related diagnosis, other comorbidities, and/or complex social needs in addition to their medical needs. Law enforcement officers are faced with challenging situations when beneficiaries with behavioral and/or medical needs are also charged with crimes, often resulting in the Department of Corrections acting as a provider of psychiatric care without the proper supports.




| | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 |
|---|---|---|---|---|---|---|
| Alaska | 13.2% | 10.3% | 10.3% | 10.9% | 11.5% | 12.8% |
| Baseline | 11.3% | 11.3% | 11.3% | 11.3% | 11.3% | 11.3% |

**Population: Alaska Readmissions Statewide (Ages 18+)**

**Data Sources:**

- Alaska Division of Public Health, Health Analytics and Vital Records Section, Health Facilities Data Reporting

**Data Source Contact:**

- Research Unit, Health Analytics and Vital Records; Division of Public Health, Department of Health
  Email: healthanalytics@alaska.gov

Without strong preventive and treatment services embedded in Alaskan communities, Trust beneficiaries experience high levels of placement within psychiatric institutional settings. In Alaska, these settings include the Alaska Psychiatric Institute (API) and the state's Designated Evaluation and Stabilization or Designated Evaluation and Treatment (DES/DET) facilities.

The number of Alaskans needing mental health services is growing (mirroring national trends) and the state cannot recruit or retain an adequate number of mental health and substance use disorder treatment providers to match. Consequently, API and Alaska's DES/DET institutions are in high demand, understaffed, and are often over capacity. Alaska has experienced an increase in patients who must wait in emergency room boarding for six days or longer for evaluation, and patients needing long-term inpatient treatment may have to travel out of state.

## What Works?

Prevention and early intervention of psychiatric patients reduces the strain on institutions and improves the quality of care. Implementation of Mental Health First Aid Training is an early intervention tool, which focuses on how to identify, understand, and respond to signs of mental illness or substance use disorders. States nationwide, including Alaska, are also implementing Crisis Intervention Team (CIT) training for law enforcement, preparing officers to recognize a mental health crisis, triage the person in need to the proper medical services, and emphasize treatment rather than incarceration when possible.

State policy is another strategy to improve access to behavioral health services along with a strong continuum of care. In Alaska, the Medicaid 1115 Behavioral Health Demonstration Waiver (1115 Waiver) emphasizes early interventions, community-based outpatient services, inpatient residential treatment when appropriate, and enhanced peer recovery supports to improve care and reduce the risk of readmission. By expanding reimbursement options for providers working along the entire continuum of care, the 1115 Waiver strategy also works to reduce the burden on acute end-of-care facilities like API.

Alaska and states across the nation are also adopting tiered crisis stabilization systems as part of strengthening institutional care. Crisis Now is an example of a model being implemented in Alaska and deploys three core elements:

1. A statewide crisis call center to coordinate services.
2. Mobile crisis teams that travel to individuals in crisis.
3. Crisis response centers to stabilize patients whose needs extend beyond the call center or crisis team.

There are several strategies to improve care and coordination for an Alaskan returning from an institutional setting, such as a warm hand-off back to the individual's local community provider. Additional strategies could include reducing the current delay in psychiatric evaluations, creating procedures to enable off-site evaluations of persons waiting for an inpatient bed, and bolstering capacity for longer-term treatments. Adding staff capacity to manage psychiatric evaluations issued by courts, track available beds, and coordinate between the Department of Health and other departments may reduce burdens on the institutions

providing care to patients. Discharge planning with a multi-agency team is key. For example, some patients may need assistance finding safe housing, transportation to follow-up appointments, and appropriate peer support services. Strong discharge planning also ensures that providers at DES/DET facilities can focus on treating the patient's medical needs.

**Sources:**

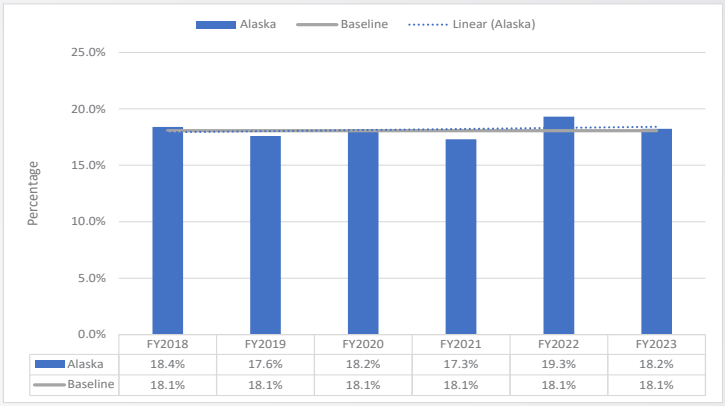
- Alaska Medicaid Redesign Quality and Cost Effectiveness Targets Report, August 2017
- Alaska Medicaid Redesign Quality and Cost Effectiveness Targets Stakeholder Workgroup – DOH Office of the Commissioner
- Out-of-Home Care Conference Powerpoint
- Alaska Behavioral Health Reform 1115 Waiver Concept Paper
- Alaska's 1115 Behavioral Health Medicaid Waiver
- Recovery Innovations Crisis Now Consultation Report

SERVICES IN INSTITUTIONAL ENVIRONMENTS

# INDICATOR 25: Percentage of Alaskans who meet criteria for an institutional level of care who were served in nursing homes and Intermediate Care Facilities for Individuals with Intellectual and Developmental Disabilities (ICF/IDD)

## Story Behind the Baseline

Alaskans with intellectual disabilities experience high levels of placement within institutional settings, which may result in a loss of connection with their culture and home community. Nursing homes are residential facilities that provide a high level of long-term personal or nursing care for persons who are unable to care for themselves. The Division of Senior and Disabilities Services (DSDS) reported on the FY22 Continuum of Care report that there were 1,062 individuals in nursing homes in Alaska. The average cost per person per year residing in a nursing home is $159,367 compared to $80,376 for Alaskans residing in their community being served by an Adults with Physical and Developmental Disabilities waiver, or $87,744 for an Intellectual and Developmental Disabilities waiver. Discharging individuals from a nursing home back to their home is challenging if home-based services are not available or in place, especially with individuals with behavioral or complex needs.




| | FY2018 | FY2019 | FY2020 | FY2021 | FY2022 | FY2023 |
|---|---|---|---|---|---|---|
| Alaska | 18.4% | 17.6% | 18.2% | 17.3% | 19.3% | 18.2% |
| Baseline | 18.1% | 18.1% | 18.1% | 18.1% | 18.1% | 18.1% |

**Population: Alaska Statewide**

**Data Source:**

- Medicaid Management Information System via COGNOS

**Data Source Contacts:**

- Anastasiya Podunovich, Research Analyst
  Division of Senior and Disability Services, Department of Health
  Email: anastasiya.podunovich@alaska.gov

Home and community-based waivers (HCBW) provide an opportunity for Alaskans experiencing disabilities to avoid institutional care such as nursing homes, which helps them to remain in their home community and pursue as much independence as possible. DSDS contracts with provider agencies statewide to help people with daily activities such as eating, bathing, dressing, finding and keeping employment, and connecting with friends and

neighbors. To serve Alaskans with complex behavioral needs, increased opportunities and access to community supports are needed. Currently, Alaska does not have any Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IDD) in the state and very few individuals with developmental disabilities are served in nursing homes.

## What Works?

The key component for Alaskans to remain in, or return to, their community from a residential setting is local home and community-based services (HCBS). Examples of HCBS providers include direct service professionals and personal care services providers. Additionally, subsidized housing options are needed to give individuals the opportunity to stay in their own home with supports less restrictive than nursing home placements and let individuals pursue as much independence as possible at the lowest cost to the state. Furthermore, to prevent individuals from being admitted to a nursing home or to aid in discharge, access to assisted living facilities is imperative for safe transitions.

One program that has been shown to work in Alaska is the Complex Behavior Collaborative (CBC). The CBC helps providers meet the needs of Medicaid clients with complex needs who are often aggressive, assaultive, and difficult to support. The CBC program offers consultation and training to providers and clients' natural supports, including family members.

**Sources:**

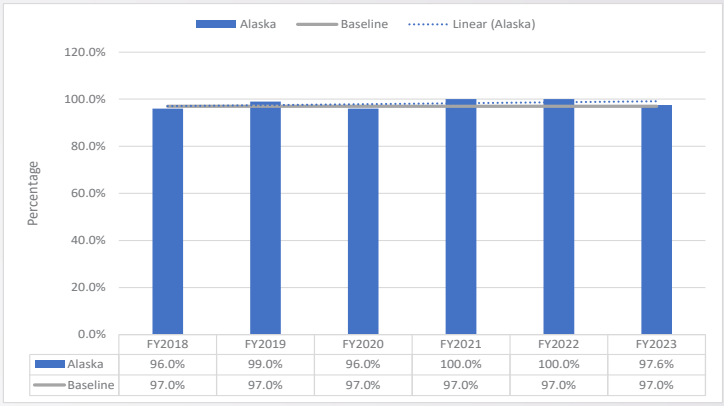
- State of Alaska Home and Community-Based Waiver Programs
- State of Alaska Continuum of Care – Senior and Disabilities Services: Data Source: State of Alaska Automated Budget System, Final Auth 20 Report, COGNOS

SERVICES IN INSTITUTIONAL ENVIRONMENTS

# INDICATOR 26: Percentage of juveniles in a Division of Juvenile Justice facility with an identified behavioral health or neurobehavioral condition in a secure treatment unit

## Story Behind the Baseline

The number of youths entering secure treatment services with the Division of Juvenile Justice (DJJ) have continued to increase for the last several years. Since 2006, the DJJ has collected data on the number of youths with an assessed behavioral health disorder. This data illustrates the story that it is imperative to provide clinical services and targeted behavioral health interventions to ensure the well-being of individuals, families, and communities after youth are released from a secure facility.




| | FY2018 | FY2019 | FY2020 | FY2021 | FY2022 | FY2023 |
|---|---|---|---|---|---|---|
| Alaska | 96.0% | 99.0% | 96.0% | 100.0% | 100.0% | 97.6% |
| Baseline | 97.0% | 97.0% | 97.0% | 97.0% | 97.0% | 97.0% |

**Population: Alaska Statewide Juveniles**

**Data Source:**

- Alaska Division of Juvenile Justice

**Data Source Contacts:**

- Bridget Grieme, Information System Coordinator
  Division of Juvenile Justice, Department of Health
  Email: bridget.grieme@alaska.gov

Targeting interventions to best meet the needs of delinquent youth has been effective in reducing the likelihood of re-offense. Through a grant awarded by the Office of Juvenile Justice & Delinquency Prevention (OJJDP), the DJJ is currently reviewing best practice programming options that have been recently implemented in partner states that are aimed at effectively supporting youth with mental health diagnoses as well as violent offenders. This grant enables the DJJ to examine more specialized services for youth in secure facilities, specifically targeting improved mental health and behavioral health interventions, further allowing the DJJ to review internal assessments and screening processes to ensure that youth services are aligned.

## What Works?

Currently being developed within the DJJ is a neurobehavioral program that focuses on individual treatment needs based on one's developmental age and brain differences. Often

times youth who experience neurobehavioral disorders have a lower IQ or struggle with cognitive processing. Thus, Cognitive Behavioral Therapy (which is generally the model used in the division's secure treatment programs) is often not effective. This new programming will allow staff, including mental health clinicians, to focus on understanding how an individual's brain works differently and apply interventions accordingly.

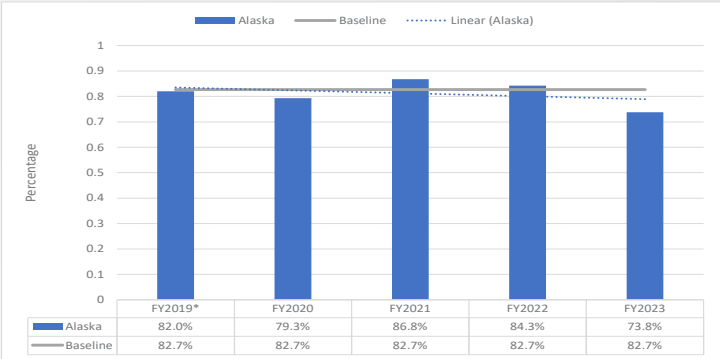
In 2015, in order to improve the youth reentry process, the DJJ began providing transitional services for juveniles using the nationally recognized Intensive Aftercare Program model, facilitating the difficult transition from long-term confinement to juveniles' home communities. This model continues to exist and includes reentry work to incorporate a continuum of care for youth to address their mental and behavioral health needs upon release into the community. The intensive reentry services within the DJJ have been a contributing factor in reducing the recidivism rates of youth leaving DJJ secure facilities.

**Sources:**


- Alaska Department of Health – Division of Juvenile Justice System Change Summary, 2018
- Alaska Department of Health – Division of Juvenile Justice System Improvement Summary, February 2015
- The National Reentry Resource Center Core Principles for Reducing Recidivism and Improving Other Outcomes for Youth in the Juvenile Justice System, 2014

# INDICATOR 27: Percentage of incarcerated individuals diagnosed with a psychotic disorder or schizophrenia who received intensive clinical and case management reentry services

## Story Behind the Baseline




| | FY2019* | FY2020 | FY2021 | FY2022 | FY2023 |
|---|---|---|---|---|---|
| Alaska | 82.0% | 79.3% | 86.8% | 84.3% | 73.8% |
| Baseline | 82.7% | 82.7% | 82.7% | 82.7% | 82.7% |

**Population: Alaska Statewide**

**Data Source:**

- Alaska Department of Corrections, APIC & IDP+ Program Management Tracking Systems

**Data Source Contact**

- Adam Rutherford, Chief Mental Health Officer
  Health & Rehabilitation Services, Department of Corrections
  Email: adam.rutherford@alaska.gov

***Note:**

- FY2019 is the first full year of indicator data. The FY2019-FY2021 average will serve as the averaged baseline for this indicator.

The Department of Corrections (DOC) is one of the largest behavioral health providers in Alaska. The DOC provides services to individuals who are experiencing mental illness, developmental disabilities, chronic alcohol or drug addiction, Alzheimer's disease and related dementia, and traumatic brain injuries (herein referred to as "beneficiaries"). Beneficiaries experience high levels of placement within institutional settings like the DOC. Between July 1, 2008 (beginning of SFY 2009) and June 30, 2012 (end of SFY 2012), 60,247 unique individuals entered, exited, or resided in an Alaska Department of Corrections facility — of which 30.4% (or 18,323) were identified as beneficiaries. Of the 30.4% of the population that were identified as beneficiaries, approximately 22.3% of them were diagnosed with a psychotic disorder or schizophrenia. Some beneficiaries may have both disorders; thus, this percentage may be overestimated. Because of the potential overestimate of those that were eligible for specialized reentry services, it is possible that the percentage of those served is higher.

The DOC has specialized reentry services focused on meeting the needs of beneficiaries diagnosed with a mental illness, substance use disorder, or those who are dually diagnosed. The DOC recognizes that mentally ill offenders recidivate at more than twice the rate of non-mentally ill offenders, and it is the DOC's goal to reduce clinical relapse, reduce legal recidivism, and increase successful reentry for this vulnerable demographic. The DOC has two specialized

release programs designed to aid in transitioning and maintaining seriously mentally ill offenders in the community.

- **IDP+:** The Institutional Discharge Project Plus (IDP+) program is designed to aid offenders on felony probation or parole who have been diagnosed with a severe and persistent mental illness in transitioning into and maintaining a place in the community. IDP+ clinicians maintain regular contact with treatment providers, probation staff, and offenders for the purpose of monitoring stability and treatment compliance in the community.
- **APIC:** The primary goal of the Assess, Plan, Identify, and Coordinate (APIC) evidence-based program is to assist eligible beneficiaries with severe mental illness and/or cognitive disorders to access and remain engaged in community-based services following incarceration. The participant's active engagement with these services is critical and contributes to the overall reduction of recidivism. These reentry programs focus on the most acute population and the services are provided by the DOC's mental health clinicians.

These specialized reentry programs do not reflect those beneficiaries who were not enrolled in the above-mentioned programs. It is important to note that the indicator data only reflects persons with a psychotic disorder or schizophrenia diagnosis, even though both APIC and IDP+ have broader eligibility criteria as described above. Thus, it is likely that a slightly larger percentage of offenders receive release planning services upon release. Furthermore, the DOC's facility-based mental health clinicians provide reentry support regardless of program enrollment.

## What Works?

The Substance Abuse and Mental Health Services Administration (SAMHSA) has developed Guidelines for Successful Transition of People with Mental or Substance Use Disorders from Jail and Prison. Upon release from jail or prison, many people with mental or substance use disorders continue to lack access to services and, too often, become enmeshed in a cycle of costly justice system involvement. In this implementation guide, SAMHSA outlines various strategies that have been adopted to assist with reentry for those individuals diagnosed with a mental illness or substance use disorder. The model outlined in SAMHSA's implementation guide is the APIC model, which the DOC has implemented with the targeted population discussed above, but the APIC model has much broader implications that have proven to reduce recidivism.

Trust beneficiaries, inclusive of those with severe and persistent mental illness, require their communities to have robust community treatment and support services that are

readily accessible. This can be challenging for Alaskan communities due to population size, location, and workforce challenges. Most Trust beneficiaries are Medicaid eligible and access their physical and behavioral healthcare from Medicaid providers or the tribal health system. In 2015, the Department of Health (DOH) initiated a multi-year effort to reform and redesign the state's Medicaid system, create cost efficiencies, improve access to services, and achieve improved Alaskan health outcomes.

To reach these goals, DOH implemented Alaska's Medicaid 1115 Behavioral Health Demonstration Waiver (1115 Waiver) in 2020. The 1115 Waiver redesigned community services aimed at improving access to the integrated behavioral health system of care for children, youth, and adults with serious mental illness, severe emotional disturbance, and/or substance use disorders. It ensures that Medicaid recipients, including those returning to communities from incarceration, will have options across the full continuum of care; however, there will always be a portion of Alaskans reentering the community from a correctional setting that will be unable to access these resources and will continue to require support and services that aid them in successful reentry.

Having resources to expand the APIC model to a broader portion of beneficiaries exiting the DOC, and ensuring collaboration between state agencies and community providers, could have a significant impact on the success of beneficiaries. When state, tribal, and community-based systems identify a beneficiary's treatment needs and supports, communicate that information effectively across systems, provide ongoing case management and monitoring, collaborate with one another to promote beneficiary success, and design and support community-based treatment and service systems, beneficiaries reentering communities from incarceration will have a solid foundation from which to succeed. The DOC, DOH, and other key stakeholders will continue working together to improve Alaska's reentry programs so beneficiaries can be successful, criminal recidivism is reduced, and public safety is increased. Future improvements being explored include virtual in-reach options, increased reentry services in rural communities, increased peer supports, and increased release planning, including identification options for releasing inmates.

**Sources:**

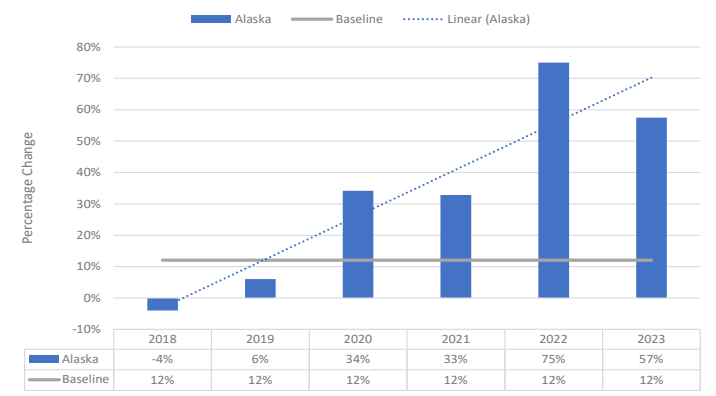

- Assess, Plan, Identify, Coordinate (APIC): Number of Beneficiaries Served in APIC FY08 - FY13. Data Source: FY08-FY13 MHTAAR Status Reports
- Hornby H., Rubin M., & Zeller, D. (2014). Trust Beneficiaries in Alaska's Department of Corrections
- DOH & DOC Recidivism Reduction Joint Annual Report Fiscal Year 2023
- Substance Abuse and Mental Health Services Administration. Guidelines for Successful Transition of People with Mental or Substance Use Disorders from Jail and Prison: Implementation Guide. (SMA)-16-4998. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2017
- Alaska's 1115 Behavioral Health Medicaid Waiver

# WORKFORCE, DATA, AND FUNDING

## INDICATOR 28: Percentage change in SHARP health practitioner contracts (current calendar year compared to previous 5 year average)

### Story Behind the Baseline

Healthcare is one of the leading industries in the state. Unfortunately, Alaska has a workforce shortage across many health and behavioral health-related disciplines and has difficulty meeting the healthcare industry's demand. Without a capable and competent workforce, the continuum of services and care is at risk of not being able to meet the needs of the most vulnerable Alaskans. Key workforce development strategies include increasing the availability of growth opportunities for local professionals through primary and secondary education, training, support-for-services programs (like loan repayment), recruitment, and retention. The latest iteration of Alaska's direct incentive and loan repayment program for healthcare workers, referred to as SHARP-3, builds on previous success and broadens the types of occupations, practice settings, and locations available to health professionals. Tracking the number of SHARP contracts across all SHARP iterations over time provides a glimpse into the health and sustainability of this key recruitment and retention effort.




| | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|---|
| Alaska | -4% | 6% | 34% | 33% | 75% | 57% |
| Baseline | 12% | 12% | 12% | 12% | 12% | 12% |

**Population: Alaska Statewide**

**Data Sources:**

- Alaska Division of Public Health, Section of Rural and Community Health Systems, Office of Healthcare Access, SHARP

**Data Source Contact:**

- Katie Yaniec, SHARP Program Coordinator
  Division of Public Health, Department of Health
  Email: sharp.inquiry@alaska.gov

Mirroring national trends, Alaska's older adult population and their complex care needs are expected to increase. This growth will be felt by healthcare entities, especially those who employ healthcare professionals, like home health aides who work directly with older adults. Additionally, there is continued emphasis in Alaska on home and community-based service (HCBS) professions, such as direct support professionals. Legislation also shapes the workforce landscape by increasing the number and variety of health professionals needed to accommodate Alaskan communities. For example, the growing emphasis on early intervention and crisis stabilization will create a significant number of peer support specialist positions statewide.

A large portion of healthcare jobs in Alaska are entry-level and can lead to long-term, stable, and attractive careers if offered within a supportive environment. Ensuring adequate pay and benefits, access to professional development and advancement, and connecting workers to emotional and administrative supports are key components of retaining a strong healthcare workforce and reducing turnover.

## What Works?

Alaska provides accelerated training and certification programs to harness local talent. In addition to funneling healthcare workers from both in and out of state, Pre-Apprenticeship Training in Healthcare (PATH) Academies — funded by the Alaska Department of Labor — offer three-week intensive courses where graduates earn certifications to become direct support professionals (DSPs). In January 2021, the Alaska Commission for Behavioral Health Certification Board began certifying peers with lived experience. Peers will have the opportunity to be certified as a peer support professional in a variety of different levels and certification types.

Due to Alaska's size and cultural diversity, workforce recruitment and retention efforts must draw on the cultural expertise of locals, especially in rural Alaska. Some state education resources, like the University of Alaska Fairbanks' Rural Human Services Program, offers a culturally informed training path for rural residents to earn a certificate and start working full-time. In other states with large rural populations, promising low-cost models for addressing workforce shortages include legislative initiatives to collect statewide survey data from behavioral health providers to inform policy decisions and using distance technology to host regular mentoring sessions between high school and college-aged youth and health professionals.

Technology can assist with finding placements for healthcare workers. One example is Health TIE's DSP Hire app that aims to mitigate administrative barriers for hiring DSPs. The app simultaneously helps employers find DSPs in their region and simplifies the application process

for the professional. The app also connects DSPs to peers working in the field and provides instant access to training. Alaska can also increase workforce capacity through technology to account for a shortage in-state. For example, Motivo is an online clinical supervision platform used in Alaska to help therapists earn licensure.

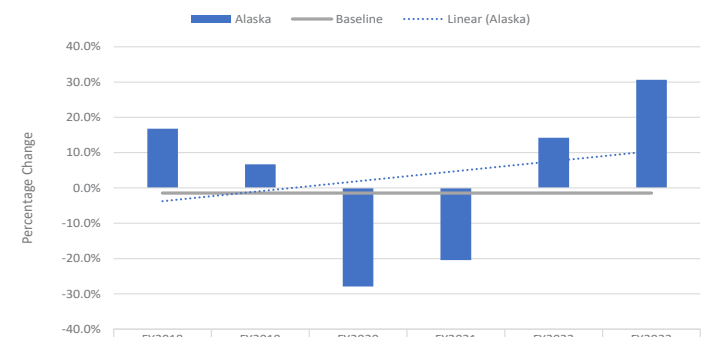
**Sources:**


- Altschul, D. B., Bonham, C. A., Faulkner, M. J., Pearson, A. W. F., Reno, J., Lindstrom, W, et al. (2018). State Legislative Approach to Enumerating Behavioral Health Workforce Shortages: Lessons Learned in New Mexico. American Journal of Preventive Medicine, 54(6), S220-S229.
- Keeler, H., Sjuts, T., Niitsu, K., Watanabe-Galloway, S., Mackie, P. F. E., & Liu, H. (2018). Virtual Mentorship Network to Address the Rural Shortage of Mental Health Providers. American Journal of Preventive Medicine, 54(6), S290-S295.

# INDICATOR 29: Percentage change of unduplicated participants served by Alaska Training Cooperative training events

## Story Behind the Baseline

Training and professional development opportunities are an important component of building a capable and competent workforce in Alaska. For the healthcare workforce to deliver culturally and linguistically appropriate care across Alaska, providers need access to a wealth of enhanced training options whether they work in an urban or remote community. Factors that affect access to training include changing revenue and funding resources and major events like COVID-19, which increased the state's reliance on telehealth and distance learning opportunities.




| | FY2018 | FY2019 | FY2020 | FY2021 | FY2022 | FY2023 |
|---|---|---|---|---|---|---|
| Alaska | 16.8% | 6.7% | -27.9% | -20.4% | 14.2% | 30.6% |
| Baseline | -1.5% | -1.5% | -1.5% | -1.5% | -1.5% | -1.5% |

**Population: Alaska Statewide**

**Data Source:**

- University of Alaska Anchorage, Center for Human Development, Alaska Training Cooperative

**Data Source Contact:**

- Center for Human Development
  Email: info@alaskachd.org

## What Works?

Building a web-based hub for training and professional development promotes ease of access for users and consolidates resources for those delivering training. The Alaska Training Cooperative (AKTC), administered by the University of Alaska Anchorage College of Health's Center for Human Development, is responsible for providing non-academic trainings, professional development, and continuing education to Alaska's behavioral health and long-term care, community and home-based professionals who serve Trust beneficiaries. The AKTC delivers enhanced training methods such as distance-delivered, blended, and in-person formats that accommodate professionals across the state. Access to increased opportunities for distance-delivered training options instead of in-person offerings saves the healthcare workforce money, resources, and time. As state policies continue to change how providers

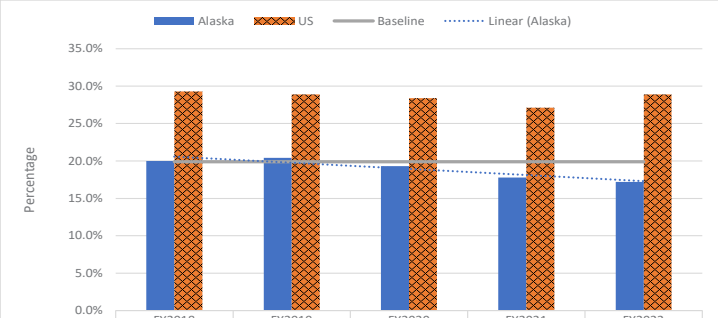
operate, the AKTC offers relevant trainings to ensure that the workforce is prepared to adapt to an evolving healthcare landscape.

**Source:**

- The Alaska Training Cooperative

# INDICATOR 30: Medicaid expenses as a percentage of state's budget

## Story Behind the Baseline




| | FY2018 | FY2019 | FY2020 | FY2021 | FY2022 |
|---|---|---|---|---|---|
| Alaska | 20.0% | 20.4% | 19.3% | 17.8% | 17.2% |
| US | 29.3% | 28.9% | 28.4% | 27.1% | 28.9% |
| Baseline | 19.9% | 19.9% | 19.9% | 19.9% | 19.9% |

**Population: Alaska**

**Data Source:**

- National Association of State Budget Officers, National State Expenditure Report

Through Medicaid, the Department of Health (DOH) provides essential healthcare coverage for low-income Alaskans. Medicaid is a valuable component of healthcare delivery for beneficiaries in Alaska, including older adults and people who experience disabilities. Medicaid plays a critical role in the state's ability to address its opioid epidemic. Medicaid reimbursement to behavioral health treatment providers ensures they can serve low or no income Alaskans, thus increasing opportunities for treatment, recovery, and positive health outcomes. Almost three-quarters of Medicaid spending in the state goes toward acute care, and about one-quarter to long-term care. Compared to the U.S., Alaska shows a lower percentage of state budget spending on Medicaid due to federal match.

Alaska's 1115 Behavioral Health Medicaid Waiver provides an integrated behavioral health system of care for all eligible Alaskans. This waiver allowed for more behavioral health and substance misuse services to be reimbursable by Medicaid, which has increased access to services. Behavioral health is the leading condition treated, resulting in improved access to care for beneficiaries. Additional Medicaid waiver programs allow Alaska to offer Medicaid services outside of institutional care settings, which is particularly important in Alaska as many remote and rural communities lack institutional settings. Home and community-based services (HCBS) offer non-institutional treatment options and allow beneficiaries to remain in their home or community.

## What Works?

Medicaid waivers allow states the flexibility to offer programs and services for increased quality of care and to achieve cost savings through innovative programs that reduce the need for institutional care. For example, Alaska's 1115 Waiver is a significant effort that supports the development of missing components of the care continuum.

Additionally, DOH offers varying waiver options, such as the 1915(k) option, which provides enhanced personal care services for individuals who meet nursing facility level of care criteria. They also provide services under the 1915(c) intellectual development disorder waiver to provide more HCBS at a lower level. Utilizing waiver programs captures federal funding reimbursement at a higher rate for these services than for regular personal care services, allowing DOH to capture additional savings of state general fund dollars.

In Alaska, the implementation of care coordination agreements (CCAs) between tribal and non-tribal providers allows the state to claim the enhanced federal match for services provided to an Alaska Native Medicaid enrollee by a non-tribal provider. Alaska is leading the nation in refinancing claims at this level and provides national leadership in this area. Another care coordination strategy is to streamline care for Medicaid recipients with excessive hospital emergency department utilization through individualized case management services and referrals to specialists and social service supports. Other cost-saving factors include managing fraud, waste, and abuse in the Medicaid system.

Partnerships across public health and Medicaid sections can improve Medicaid service delivery. For example, DOH explored costs of a Continuum of Coverage for low-income Alaskans that would ease transitions between public health coverage programs and private market coverage. The Centers for Disease Control and Prevention (CDC) provides guidance on how state public health agencies can partner with Medicaid staff to implement evidence-based prevention interventions.

**Sources:**

- Kaiser Family Foundation, Medicaid in Alaska
- Understanding Public Health's Role in CDC's 6 | 18 Initiative: A Primer for Medicaid Partners: Technical Assistance Tool

# 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

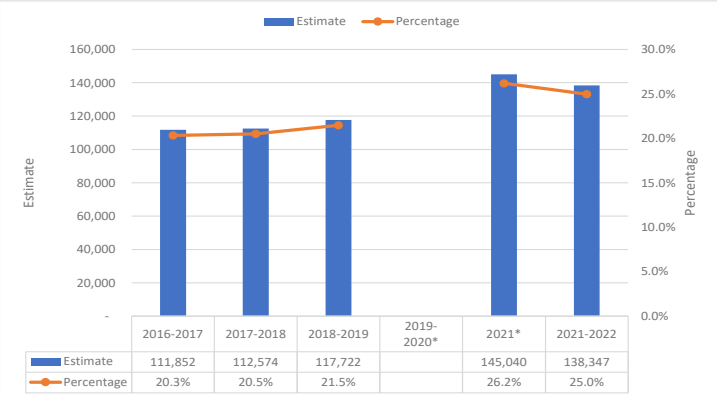
# P1: Alaskans with any mental illness in the past year (ages 18+)

## 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:**

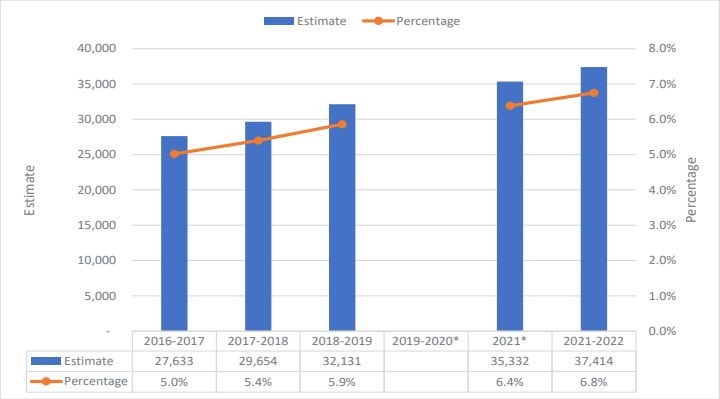
- Substance Abuse and Mental Health Services Administration (SAMHSA)

PREVALENCE

# 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.




| | 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.

## 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 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:**

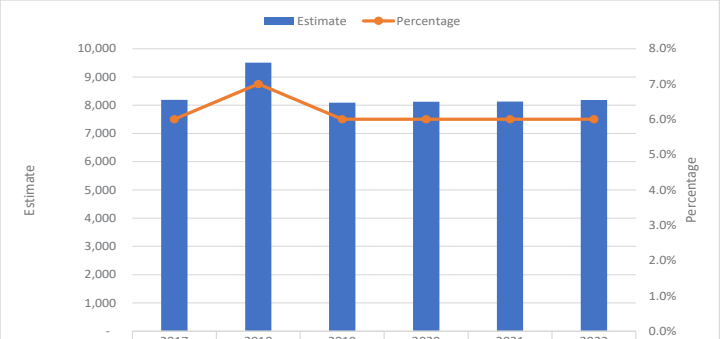
- Substance Abuse and Mental Health Services Administration (SAMHSA)

PREVALENCE

# 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.




| | 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.

## 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 (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:**

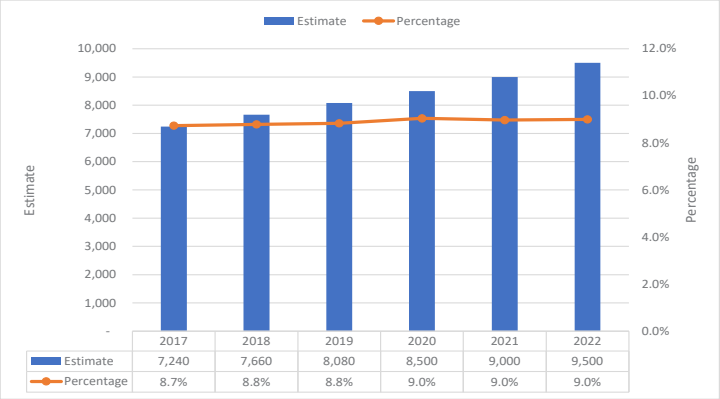

- Agnew:: Beck LLC, Hornby Zeller Associated, Inc. (2016). Alaska Behavioral Health Systems Assessment Final Report.
- Costello , E.J., Messer, S.C., Bird, H.R., Cohen, P., Reinherz, H.Z. (1998). The prevalence of serious emotional disturbance: a re-analysis of community studies. Journal of Child and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

PREVALENCE

# 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.




| | 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.

## 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

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:**

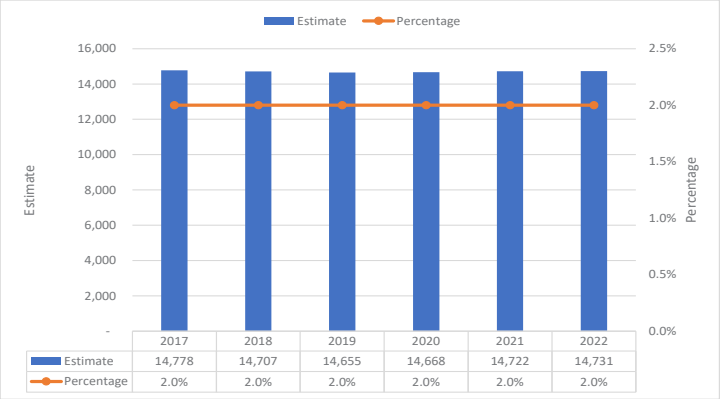
- Alzheimer's Association
- Chicago Health and Aging Project

PREVALENCE

# 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.




| | 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.

## 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).

## 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:**

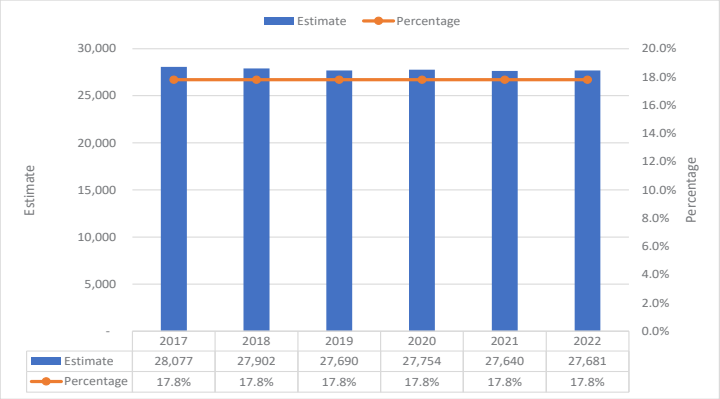

- Alaska Department of Health, Division of Senior and Disabilities Services. Traumatic and Acquired Brain Injury Program.
- Alaska Department of Health, Chronic Disease Prevention and Health Promotion. Injury Prevention Program.
- University of Alaska Anchorage Center for Human Development. The Alaska 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.

PREVALENCE

# P6: Alaskans with developmental disabilities (Ages 3 to 17 years)

## 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:**

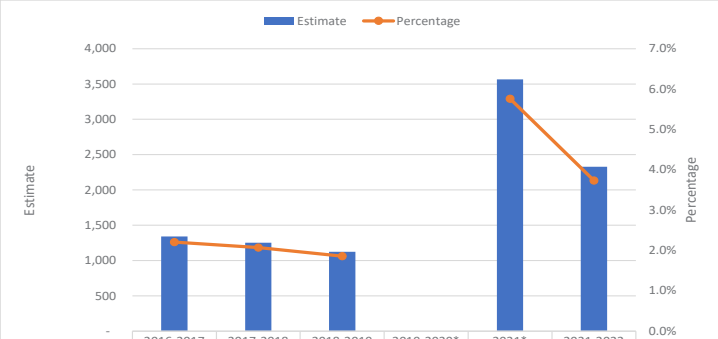

- Larson SA, et al. (2001). Prevalence of Mental Retardation and Developmental Disabilities: Estimates from the 1994/1995 National Health Interview Survey Disability Supplements. American Journal on Mental Retardation. 106(3).

PREVALENCE

# P7: Alaskans with alcohol use disorder in the past year (ages 12 to 17)

## 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:**

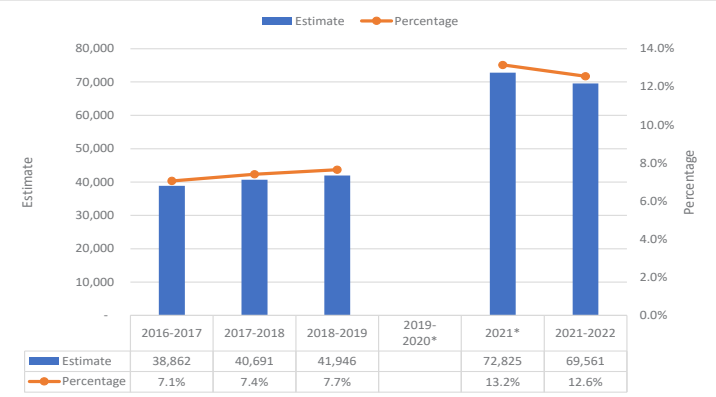
- Substance Abuse and Mental Health Services Administration (SAMHSA)

PREVALENCE

# P8: Alaskans with alcohol use disorder in the past year (ages 18+)

## 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.

## 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:**

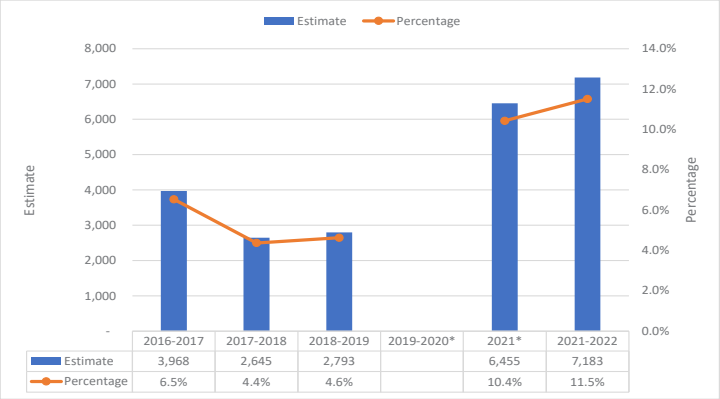
- Substance Abuse and Mental Health Services Administration (SAMHSA)

PREVALENCE

# 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.




| | 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.

## 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:**

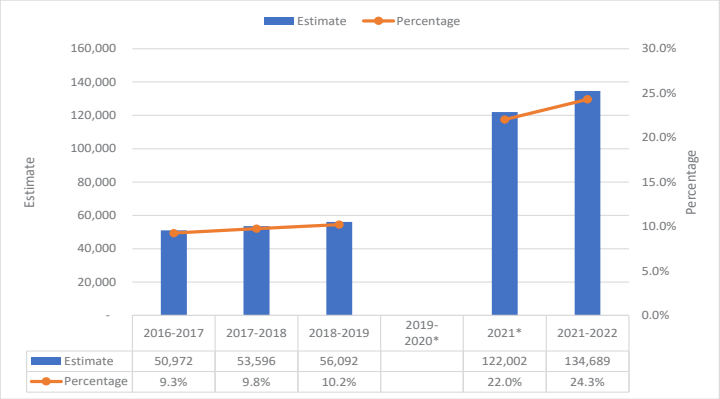
- Substance Abuse and Mental Health Services Administration (SAMHSA)

PREVALENCE

# P10: Alaskans with substance use disorder in the past year (ages 18+)

## 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.




| | 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.

## 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)


Trust

Alaska Mental Health
Trust Authority