SKILLS FOR A HEALTHY LIFE

A

A student should be able to acquire a core knowledge related to well-being.

A student who meets the content standard should:

1) understand that a person's well-being is the integration of health knowledge, attitudes, and behaviors;
2) understand how the human body is affected by behaviors related to eating habits, physical fitness, personal hygiene, harmful substances, safety, and environmental conditions;
3) understand and identify the causes, preventions, and treatments for diseases, disorders, injuries, and addictions;
4) recognize patterns of abuse directed at self or others and understand how to break these patterns;
5) use knowledge and skills to promote the well-being of the family;
6) use knowledge and skills related to physical fitness, consumer health, independent living, and career choices to contribute to well-being;
7) understand the physical and behavioral characteristics of human sexual development and maturity; and
8) understand the ongoing life changes throughout the life span and healthful responses to these changes.

B

A student should be able to demonstrate responsibility for the student's well-being.

A student who meets the content standard should:

1) demonstrate an ability to make responsible decisions by discriminating among risks and by identifying consequences;
2) demonstrate a variety of communication skills that contribute to well-being;
3) assess the effects of culture, heritage, and traditions on personal well-being;
4) develop an awareness of how personal life roles are affected by and contribute to the well-being of families, communities, and cultures;
5) evaluate what is viewed, read, and heard for its effect on personal well-being; and
6) understand how personal relationships, including those with family, friends, and co-workers, impact personal well-being.

C

A student should understand how well-being is affected by relationships with others.

A student who meets the content standard should:

1) resolve conflicts responsibly;
2) communicate effectively within relationships;
3) evaluate how similarities and differences among individuals contribute to relationships;
4) understand how respect for the rights of self and others contributes to relationships;
5) understand how attitude and behavior affect the well-being of self and others; and
6) assess the effects of culture, heritage, and traditions on well-being.

D

A student should be able to contribute to the well-being of families and communities.

A student who meets the content standard should:

1) make responsible decisions as a member of a family or community;
2) take responsible actions to create safe and healthy environments;
3) describe how public policy affects the well-being of families and communities;
4) identify and evaluate the roles and influences of public and private organizations that contribute to the well-being of communities;
5) describe how volunteer service at all ages can enhance community well-being; and
6) use various methods of communication to promote community well-being.

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AKVDRS Suicide Death Update — Alaska, 2012–2017

Background

During 2012–2017, Alaska's suicide rate was either the first or second highest in the nation.[1] Suicide was the leading cause of death among Alaskans aged 10–64 years and is the sixth leading cause of death overall in Alaska.[1] The purpose of the Alaska Violent Death Reporting System (AKVDRS) is to support development, implementation, and evaluation of programs and policies designed to reduce and prevent violent deaths. This *Bulletin* provides a summary overview of recent AKVDRS suicide death data.

Methods

AKVDRS data from 2012–2017 were analyzed using the abstractor-assigned manner of death following National Violent Death Reporting System guidelines. Deaths were counted if the decedent was fatally injured in Alaska. Unadjusted (crude) rates were calculated for 2012–2017 using the most current (v. 2017) Alaska Department of Labor's population estimates data.

Results

During 2012–2017, 1,103 suicides were identified and recorded in AKVDRS and accounted for most (1,103/1,614, 69%) of the violent deaths in Alaska. The average annual unadjusted suicide rate was 25.0 per 100,000 persons overall and 29.2 per 100,000 persons aged ≥10 years.

The highest rates by sex and age were among males aged 20–24 years and 70–74 years (85.7 and 70.3 per 100,000 persons, respectively) and females aged 20–24 years (20.6 per 100,000 persons). The highest rates by race were among American Indian/Alaska Native (AI/AN) people (46.6 per 100,000 persons), followed by Whites, Blacks, Asian/Pacific Islanders, and people of two or more races (22.4, 19.9, 7.7, and 19.0 per 100,000 persons, respectively). Rates by region were highest in the Southwest and Northern regions (50.5 and 50.1 per 100,000 persons, respectively), and lowest in the Southeast region (17.3 per 100,000 persons). The Anchorage/Mat-Su region had the largest rate increase (61%) during 2012–2017.

Of the 1,103 suicides recorded during 2012–2017,

- the most commonly documented incident characteristics included proven/suspected alcohol intoxication, current depressed mood, and intimate partner problems (Figure 1);
- 397 (36%) decedents had a documented alcohol and/or substance abuse problem;
- 668 (61%) decedents were tested for alcohol; of which, 272 (41%) tested positive and 207 (31%) had a blood alcohol concentration (BAC) ≥0.08 g/dL (range: 0.01–0.65 g/dL);
- 668 (61%) decedents were tested for opiates; of which, 103 (15%) tested positive and 29 (4%) died as a result of an opiate overdose;
- 1,065 (97%) decedents had known precipitating circumstances; the most common (besides mental health and substance use problems) were physical health problems (219, 21%), criminal/legal problems (138, 13 %), and job problems (125, 12%; Figure 1);
- 404 (37%) decedents had a documented current mental health problem (Figure 2); of these, 102 (25%) had a documented substance abuse problem and 241 (60%) were receiving treatment for mental illness;
- 403 (37%) decedents had intimate partner problems; of which, 132 (33%) had an identified crisis event within 2 weeks of their death;
- 563 (51%) decedents were never married, 287 (26%) were married, 191 (17%) were divorced, and 62 (6%) were widowed, separated, single, or of unknown marital status;
- 204 (18%) decedents were current or former U.S. military;
- 9 (<1%) decedents were involved in combination homicide-suicide incidents; and
- 691 (63%) deaths involved a firearm, 275 (25%) involved hanging/strangulation/suffocation, 97 (9%) involved poisoning, and 40 (3%) involved other weapons.

Figure 1. Incident Characteristics of Suicides (N=1,103) — Alaska, 2007–2012*

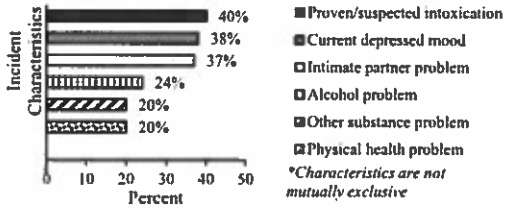
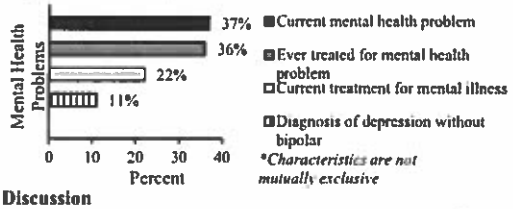


Figure 2. Mental Health Characteristics of Suicides (N=1,103) — Alaska, 2012–2017*



Discussion

Compared to 2007–2011, Alaska's average annual unadjusted suicide rate was 13% higher during 2012–2017 (increasing from 25.8 to 29.2 per 100,000 persons aged ≥10 years).[2] Suicide occurred in higher rates among males, AI/AN people, and persons aged 20–24 years. Although suicide rates remained highest in rural areas, rates increased in urban areas during 2012–2017.

Use of alcohol and other substances was frequently identified among suicide decedents, however, toxicology testing was not performed on all decedents during 2012–2014. Routine postmortem toxicology testing of all suicide decedents was initiated in 2015; the results of which are available in a separate report.[3] Alcohol use associated with suicide declined from 45% during 2007–2011 to 41% during 2012–2017; and conversely, opiate use increased from 12% to 15%.[2,3] Toxicology testing of suicide decedents helps improve our understanding of trends and our ability to characterize the role of substance use in suicides, which can be useful for developing targeted public health prevention strategies and clinical screening guidelines.[4]

The increase in postmortem forensic toxicology testing might have contributed in-part to the observed increase in opiate-positive test results and should be interpreted with caution.

References

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National Health Education Standards

The National Health Education Standards (NHES) were developed to establish, promote, and support health-enhancing behaviors for students in all grade levels—from pre-Kindergarten through grade 12. The NHES provide a framework for teachers, administrators, and policy makers in designing or selecting curricula, allocating instructional resources, and assessing student achievement and progress. Importantly, the standards provide students, families and communities with concrete expectations for health education.

First published in 1995, the NHES were created in response to several model standards being developed for other areas of education by educational leaders across the United States in the early 1990s. With support from the American Cancer Society, the Joint Committee on National Health Education Standards was formed to develop the standards. Committee members included:

- American Public Health Association
- American School Health Association
- SHAPE America (Society of Health and Physical Educators)

Over the last decade, the NHES became an accepted reference on health education, providing a framework for the adoption of standards by most states. A review process begun in 2004 resulted in revisions to the NHES that acknowledged the impact and strength of the original document and took into account more than 10 years of use nationwide. The *2nd edition National Health Education Standards—Achieving Excellence* promises to reinforce the positive growth of health education and to challenge schools and communities to continue efforts toward excellence in health education.

A Look at the Health Standards

The NHES are written expectations for what students should know and be able to do by grades 2, 5, 8, and 12 to promote personal, family, and community health.

Standard 1	Students will comprehend concepts related to health promotion and disease prevention to enhance health.
Standard 2	Students will analyze the influence of family, peers, culture, media, technology, and other factors on health behaviors.
Standard 3	Students will demonstrate the ability to access valid information, products, and services to enhance health.
Standard 4	Students will demonstrate the ability to use interpersonal communication skills to enhance health and avoid or reduce health risks.
Standard 5	Students will demonstrate the ability to use decision-making skills to enhance health.
Standard 6	Students will demonstrate the ability to use goal-setting skills to enhance health.
Standard 7	Students will demonstrate the ability to practice health-enhancing behaviors and avoid or reduce health risks.
Standard 8	Students will demonstrate the ability to advocate for personal, family, and community health.

Creating an Effective Health Education Curriculum

Although the NHES provides a framework for health education, teachers, administrators, and policymakers, it should also take into account the characteristics of an effective health education curriculum.