34TH ALASKA STATE LEGISLATURE

Session

State Capitol, Rm. 118
Juneau, AK 99801
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Interim

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House Military and Veterans' Affairs, Committee Co-chair

Joint Armed Services Committee, Co-chair

House Health and Social Services Committee

REPRESENTATIVE ANDREW GRAY

House Bill 232 (34-LS1002\A)

Sponsor Statement as of January 21, 2026

"An Act relating to examination and treatment of minors; relating to consent for behavioral health and mental health treatment for minors 16 years of age of older; and providing for an effective date."

The average age of onset of any mental health issue, from mood disorders to thought disorders, is age 14 years. The earlier a mental health issue is detected, the easier it is to treat. Recognition of this health need and obtaining treatment for it can be the most important thing parents will ever do for their children.[1]

Suicide is the third leading cause of death among kids 10-14 nationwide, and the second leading cause in the 15-34 demographic. More than 12% of teens aged 12-17 have had at least one major depressive episode. Teen girls attempt suicide more often, but teen boys succeed more frequently with a suicide rate 4 times higher.[2]

Mental health issues like depression and anxiety are rising among Alaska's youth, and our suicide rates continue to remain among the highest in the nation. In 2023, 22% of high school students reported that they had considered suicide; 43% reported feeling sad or hopeless. Research shows that behavioral health services are critical to support these youth. Many teenagers are unable to access the help they desperately need due to parental consent being required for behavioral health services. Lowering the age at which minors can consent to mental and behavioral health services would allow a child in need to receive timely help before his/her situation worsens or symptoms escalate.

The parental consent requirement can be detrimental to effective treatment and often leads to long-term, negative consequences and delayed care. At age 16, teens in Alaska already have the right to drive, work, and make certain decisions about their education. Stigma surrounding mental health can prevent teens from seeking help, especially in rural areas where privacy concerns are heightened. Lowering the age of consent from the current age of 18 to 16 would encourage teens to seek care when they need it, without fear of judgement, increasing the odds of a successful early intervention.

Senate Bill 90 would allow teenagers aged 16 or older to consent to five 90-minute outpatient mental health sessions. After these initial sessions, a parent or guardian would be contacted to determine the next steps for continued treatment.

Allowing teens to make decisions about their mental health fosters a sense of responsibility and self-esteem. Empowering youth to seek help directly results in healthier individuals and communities, preventing issues like substance abuse or suicide. When teens are given control over their treatment, they are more likely to engage in therapy and follow through with necessary care. Lowering the age of behavioral health consent in Alaska from 18 to 16 is essential for addressing the growing mental health challenges among Alaska youth. By empowering teens to make decisions about their own care, we can ensure timely intervention, reduce stigma, and create healthier family connections and communities.

1. Medina, John. Brain Rules for Babies, Pear Press, 2nd edition, 2014, pg. 293.
2. Medina, John. Attack of the Teenage Brain, ASCD, 2018, pgs.147-150.

HOUSE BILL NO. 232

IN THE LEGISLATURE OF THE STATE OF ALASKA

THIRTY-FOURTH LEGISLATURE - FIRST SESSION

BY REPRESENTATIVE GRAY

Introduced: 5/19/25
Referred: Health and Social Services

A BILL

FOR AN ACT ENTITLED

"An Act relating to the examination and treatment of minors; relating to consent for behavioral and mental health treatment for minors 16 years of age or older; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 25.20.025(a) is amended to read:

(a) Except as prohibited under AS 18.16.010(a)(3),

(1) **a minor who provides documentation required under (d) of this section demonstrating that the minor is an unaccompanied homeless minor or** a minor who is living apart from the minor's parents or legal guardian and who is managing the minor's own financial affairs, regardless of the source or extent of income, may give consent for medical**, behavioral, mental health,** and dental services for the minor;

(2) a minor may give consent for medical and dental services if the parent or legal guardian of the minor cannot be contacted or, if contacted, is unwilling

either to grant or withhold consent; however, where the parent or legal guardian cannot be contacted or, if contacted, is unwilling either to grant or to withhold consent, the provider of medical or dental services shall counsel the minor keeping in mind not only the valid interests of the minor but also the valid interests of the parent or guardian and the family unit as best the provider presumes them;

(3) a minor who is the parent of a child may give consent to medical**, behavioral, mental health,** and dental services for the minor or the child;

(4) a minor may give consent for diagnosis, prevention or treatment of pregnancy, and for diagnosis and treatment of venereal disease;

(5) the parent or guardian of the minor is relieved of all financial obligation to the provider of the service under this section.

*** Sec. 2.** AS 25.20.025 is amended by adding a new subsection to read:

(d) To establish that a minor is a homeless unaccompanied minor for purposes of giving consent under (a)(1) of this section, the minor must possess documentation stating that the minor is 16 years of age or older, does not have a fixed, regular, adequate nighttime residence, and is not in the care and physical custody of a parent or guardian. The document must be signed by

(1) a director or the designee of a director of a governmental or nonprofit entity that receives public or private funding to provide services to individuals who are homeless;

(2) a local educational agency liaison for homeless children and youth designated under 42 U.S.C. 11432(g)(1)(J)(ii), a local educational agency foster care point of contact designated under 20 U.S.C. 6312(c)(5)(A), or a licensed clinical social worker employed by a school in the state;

(3) an attorney who represents the minor in any legal matter; or

(4) the minor and two adults with actual knowledge of the minor's circumstances.

*** Sec. 3.** AS 25.20 is amended by adding a new section to read:

Sec. 25.20.028. Behavioral and mental health treatment of minors. (a) A minor who is 16 years of age or older may give consent to receive outpatient behavioral or mental health services from a mental health provider for up to five

outpatient appointments of up to 90 minutes each. A mental health provider may not prescribe medication to a minor receiving behavioral or mental health services without obtaining the consent of the minor's parent or guardian. After the fifth appointment, a mental health provider may continue to provide behavioral or mental health services to the minor only as provided in (b) or (c) of this section.

(b) Not later than the fifth appointment and upon consultation with the minor, the mental health provider, in conjunction with the provider's supervisor if the mental health provider has a supervisor, shall determine whether attempting to obtain the consent of the minor's parent or guardian to provide behavioral or mental health services would be detrimental to the minor's well-being. Attempting to obtain the consent of the minor's parent or guardian would be detrimental to the minor's well-being if

(1) the behavioral or mental health services are related to allegations of neglect, sexual abuse, or mental or physical abuse by the minor's parent or guardian; or

(2) the mental health provider finds that

(A) requiring the consent of the minor's parent or guardian would cause the minor to reject behavioral or mental health services;

(B) failing to provide behavioral or mental health services to the minor would be detrimental to the minor's well-being;

(C) the minor sought behavioral or mental health services knowingly and voluntarily; and

(D) the minor has the maturity to productively participate in behavioral or mental health services.

(c) If the mental health provider determines that attempting to obtain the consent of the minor's parent or guardian would not be detrimental to the minor's well-being, the mental health provider shall inform the minor that the consent of the minor's parent or guardian is required to continue providing behavioral or mental health services to the minor. The mental health provider shall discontinue behavioral or mental health services to a minor who does not permit the mental health provider to obtain the consent of the minor's parent or guardian and notify the minor's parent or

guardian that the services were provided. If the minor permits the mental health provider to obtain the consent of the minor's parent or guardian, the mental health provider shall make reasonable attempts to obtain that consent. The mental health provider shall document each attempt to obtain consent in the minor's clinical record. The mental health provider may continue to provide behavioral or mental health services to the minor without the consent of the minor's parent or guardian if

(1) the mental health provider has made at least two unsuccessful attempts to contact the minor's parent or guardian to obtain consent by mail, electronic mail, or telephone; and

(2) the mental health provider has the written consent of the minor.

(d) If the mental health provider determines that attempting to obtain the consent of the minor's parent or guardian would be detrimental to the minor's well-being, the mental health provider shall document the basis for the determination in the minor's clinical record. The mental health provider may continue to provide behavioral or mental health services to the minor upon the minor's written consent. The mental health provider and the mental health provider's supervisor, if the mental health provider has a supervisor, shall evaluate the determination made under (b) of this section every 60 days until either the mental health provider discontinues providing services to the minor or the minor turns 18 years of age.

(e) A mental health provider may not inform the parent or guardian of a minor receiving behavioral or mental health services under (d) of this section of those services without the written consent of the minor. A mental health provider shall inform a minor before disclosing to the minor's parent or guardian information regarding any behavioral or mental health services provided to the minor. The mental health provider may not disclose the information to the parent or guardian if the minor discontinues the behavioral or mental health services upon being informed of the mental health provider's intent. A mental health provider may deny a minor's parent or guardian access to any part of the minor's clinical record if the mental health provider has compelling reasons for the denial.

(f) The parent or guardian of a minor is relieved of all financial obligation to the provider of a service under this section.

(g) Nothing in this section may be construed to remove liability of the person performing the examination or treatment for failure to meet the standards of care common throughout the health professions in the state or for intentional misconduct.

(f) In this section, "mental health provider" means a behavioral health professional as defined in AS 14.30.174(b) and a mental health professional as defined in AS 47.30.915.

*** Sec. 4.** AS 47.10.084(c) is amended to read:

(c) When there has been transfer of legal custody or appointment of a guardian and parental rights have not been terminated by court decree, the parents shall have residual rights and responsibilities. These residual rights and responsibilities of the parent include, but are not limited to, the right and responsibility of reasonable visitation, consent to adoption, consent to marriage, consent to military enlistment, consent to major medical treatment except in cases of emergency or cases falling under AS 25.20.025 **or 25.20.028**, and the responsibility for support, except if by court order any residual right and responsibility has been delegated to a guardian under (b) of this section. In this subsection, "major medical treatment" includes the administration of medication used to treat a mental health disorder.

*** Sec. 5.** AS 47.12.150(c) is amended to read:

(c) When there has been transfer of legal custody or appointment of a guardian and parental rights have not been terminated by court decree, the parents shall have residual rights and responsibilities. These residual rights and responsibilities of the parent include the right and responsibility of reasonable visitation, consent to adoption, consent to marriage, consent to military enlistment, consent to major medical treatment except in cases of emergency or cases falling under AS 25.20.025 **or 25.20.028**, and the responsibility for support, except if by court order any residual right and responsibility has been delegated to a guardian under (b) of this section.

*** Sec. 6.** This Act takes effect January 1, 2026.

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REPRESENTATIVE ANDREW GRAY

House Bill 232 Sectional Analysis

(Version 34-LS1002\A) January 21, 2026

"An Act relating to examination and treatment of minors; relating to consent for behavioral health and mental health treatment for minors 16 years of age of older; and providing for an effective date."

Section 1. Amends AS 25.20.025: Examination and Treatment of Minors.

This section adds youth who provide documentation demonstrating they are an unaccompanied homeless minor to the list of minors who can consent to medical treatment.

This section would add behavioral and mental health services to the list of services an unaccompanied homeless minor, a minor living apart from their parents or legal guardian, and a minor who is the parent of a child, are able to consent to.

Section 2. Adds new subsections to AS. 25.20.025: Examination and Treatment of Minors.

This section adds new subsections relating to documentation required by homeless unaccompanied minors for the purposes of giving consent.

The documentation must state that the minor is:

1. 16 years of age or older
2. Does not have a fixed, regular, adequate nighttime residence; and
3. Is not in the care and physical custody of a parent or guardian,

And the document must be signed by:

1. A director or designee of a director of a governmental or nonprofit entity that receives funds to provide assistance to those who are homeless;
2. A local educational agency liaison for homeless youth, a local educational agency foster care point of contact, or a licensed clinical social worker employed by a school in the state;
3. An attorney that represents the minor; or
4. The minor and 2 adults with actual knowledge of the minor's situation.

Section 3. Adds a new section to AS. 25.20: Parent and Child.

This section would give a minor aged 16 years or older the ability to consent to receive five 90-minute sessions of outpatient behavioral or mental health appointments, without obtaining the consent of the minor's parent or guardian. A mental health provider may not prescribe medication without consent of the parent or guardian. After the fifth appointment, a provider may continue to provide services to the minor if:

1. Attempting to get consent from the minor's parent of guardian would be detrimental to the minor's well-being by:
    a. The behavioral or mental health services are related to allegations of neglect, sexual abuse, or mental or physical abuse by the minor's parent or guardian; or
    b. The provider finds that requiring the consent of the minor's parent or guardian would cause the minor to reject services, failing to provide services would be detrimental to the minor's well-being, the minor sought services knowingly and willingly, and the minor has the maturity to productively participate in services.
2. The provider determines that contacting the parent or guardian would not be detrimental to the minor's well-being, the provider has informed the minor that parental consent is required to continue services, the provider has made at least two unsuccessful attempts to contact the minor's parent or guardian by mail, e-mail, or phone, and the mental health provider has the written consent of the minor.

If a provider continues treatment due to the belief that obtaining consent from the minor's parent or guardian would be detrimental to the minor's well-being, the mental or behavioral health provider may continue services with documentation of the determination in the patient's clinical record, written consent from the minor, and evaluations every 60 days about if the minor's well-being is continually in question until either the provider discontinues services, or the minor turns 18 years of age.

If a mental health provider has decided to continue services due to the belief that obtaining the parent or guardians consent would be detrimental to the minor's well-being, they may not contact the minor's parents or guardian without written consent from the minor. A provider may not disclose the information to the parent or guardian if the minor chooses to discontinue services after being informed that they must obtain parental consent after 5 sessions. A provider may deny a minor's parent or guardian

access to any part of the minor's clinical record if the provider has compelling reasons to deny the parent or guardian access.

A parent or guardian is relieved of any financial obligation to pay for services consented to by this new section.

Nothing in this new section can be taken as an excuse to remove liability or the person performing examination or treatment for failure to meet typical standards of care in the state.

Section 4. Amends AS. 47.10.084(c): Legal custody, guardianship, and residual parental rights and responsibilities.

This section adds the new section from section 3 to the list of exceptions of a parent's residual rights and responsibilities.

Section 5. Amends AS. 47.12.150(c): Legal custody, guardianship, and residual parental rights and responsibilities.

This section adds the new section from section 3 to the list of exceptions of a parent's residual rights and responsibilities.

Section 6. Effective date.

This section provides for an effective date of January 1, 2026.

Age of Consent in the U.S.

Behavioral and Mental Health

Updated 3.13.25

State	Behavioral Health Consent
Alabama	14
Alaska	18
Arizona	18
Arkansas	16
California	12
Colorado	12
Connecticut	Any age
Delaware	14
Florida	13
Georgia	16
Hawaii	14
Idaho	18
Illinios	12
Indiana	18
Iowa	18
Kansas	14
Kentucky	16
Louisiana	18
Maine	18
Maryland	12
Massachusetts	16
Michigan	14
Minnesota	16
Mississippi	15
Missouri	18
Montana	16
Nebraska	18
Nevada	12
New Hampshire	16
New Jersey	16
New Mexico	16
New York	16
North Carolina	18
North Dakota	18
Ohio	14
Oklahoma	16
Oregon	14
Pennsylvania	14
Rhode Island	18
South Carolina	16
South Dakota	18
Tennessee	16
Texas	18

State	Behavioral Health Consent
Utah	18
Vermont	14
Virginia	14
Washington	13
West Virginia	18
Wisconsin	14
Wyoming	18

From the office of Senator Cathy Giessel

School Mental Health

REPORT CARD

2025

inseparable

Powered by the Hopeful Futures Campaign

Emphasize Early Intervention

Early intervention is key to helping youth before their problems become more serious. Research shows that the earlier a person gets effective support, the better the outcomes. One of the best ways to spot problems early is to provide school mental health screenings. Just as early identification of vision challenges can lead to the simple but life-changing intervention of glasses, the early identification of mental health struggles can lead to life-changing or even life-saving support for a young person with challenges.

Other policies also play critical roles in early intervention, including requiring an MTSS framework for school mental health services; promoting family and caregiver engagement; and providing safe ways for students to report concerns and get support from mental health professionals.

Policy Recommendations

- **Require every school district to adopt an MTSS or Positive Behavioral Interventions & Supports framework for delivering school mental health services to students**
- **Facilitate safe means for reporting mental health concerns, such as through a digital platform**
- **Provide annual mental health screenings**
- **Engage families and caregivers in supporting youth mental health**

State Examples

Emphasize Early Intervention

MTSS Framework

CALIFORNIA AB 2711 (2024) ensures that students who voluntarily disclose substance use to seek help are protected from suspension or expulsion, promoting a supportive approach over punitive measures. This bill aligns with MTSS to create safer school environments and encourage early intervention for students' mental health and substance use concerns.

MICHIGAN SB 0568 (2024) promotes the MTSS framework across schools to provide structured support for students' academic and mental health needs. The legislation also emphasizes professional development for school staff to effectively deliver these tiered services.

VIRGINIA HB 6001 (2023) ensures that all school districts implement the MTSS framework for mental health services. Additionally, the Virginia Tiered System of Supports includes family engagement and universal mental health screenings as part of its approach to school-based mental health.

Safe Reporting

DELAWARE developed an app, Safe DE, for students, families, and school staff that includes a crisis text line and mental health education and resources. The app enables students to confidentially voice a concern or ask for help for themselves or others.

WASHINGTON HB 1580 (2023) establishes a children's crisis response system with a digital component to report concerns, improve access to mental health support, and facilitate rapid response to students in crisis.

State Examples

Emphasize Early Intervention

Mental Health Screenings

COLORADO HB 23-1003 (2023) creates a mental health screening program available to public schools serving grades 6–12. The legislation requires use of an evidence-based screening tool and specifies responses related to screening results.

LOUISIANA HB 353 (2023) requires the Department of Education to develop a pilot program in three school systems to implement trauma-informed mental health screenings and provide related mental health services.

Family and Caregiver Engagement

MINNESOTA Providers may use funding from school-linked mental health grants to support families in meeting their child's needs, including navigating health care, social service, and juvenile justice systems.

Additional Resources

States can also leverage existing resources to support families and caregivers as they look to improve their child's wellbeing. For example, the National Council for Mental Wellbeing provides Youth Mental Health First Aid courses for adults, and NAMI offers a free education program, available in-person and online, for parents and caregivers of youth experiencing mental health conditions.

State Spotlight on Supporting School Safety and Crisis Response in Utah

SafeUT is an app designed to help keep schools and students safe. It allows students, families, caregivers, and educators to submit confidential tips on concerns like bullying, school safety threats, and violence. Tips are triaged by trained professionals who alert school administrators and others, as necessary. It also has chat and phone call features that allow users to speak with a master's level counselor or connect with the Utah Crisis Line (with the same staff as the 988 Suicide & Crisis Lifeline) for a wide range of concerns, such as self-harm, life challenges, and drug and alcohol problems. All services are provided at no cost, 24/7, every week of the year.

Established in 2015 through **UTAH** SB 175, SafeUT is nationally recognized for its effectiveness in saving lives and de-escalating potential school threats by having mental health professionals, rather than law enforcement, respond first.

SafeUT's Impact in 2023

885,519+ students
with access to the app

30,503 total chats
started with SafeUT counselors

9,204 total tips
submitted from K–12 and higher education, including parents/guardians and educators

Improve Connections to Mental Health Services

While school-based professionals are critical to support students with low to moderate mental health concerns, it is also important for districts to coordinate linkages with the community when a student needs more intensive and specialized services. For example, a student might be dealing with an eating disorder, but there might not be a trained specialist in the district. However, through a connection made by a district mental health coordinator, the student can be connected to an expert provider in the community or via telehealth.

Additionally, states may find it helpful to create dedicated positions within the state to facilitate coordination between the state education agency, Medicaid agency, and other child-serving agencies to support the implementation of effective school mental health programs. Dedicated state-level staff can also help provide guidance to districts on ways to enhance school-linked services and improve connections to community-based care.

Policy Recommendations

- **Implement school-linked telemental health programs to supplement school-based services or provide access in under-staffed schools**
- **Facilitate school-linked mental health programs that provide access to community mental health professionals on school grounds**
- **Require school-based health centers to provide onsite mental health expertise or access to mental health services via telemental health**
- **Fund school or school district coordinators to facilitate school, community, and family connections**
- **Fund state-level positions to coordinate across agencies and support local education agencies in implementing school mental health programs**

State Examples

Improve Connections to Mental Health Services

School-Linked Telemental Health Programs

COLORADO SB 24-001 (2024) makes permanent the "I Matter" program, which offers free telemental health services to Colorado youth.

TEXAS SB 11 (2019) establishes telemental health services for at-risk children and youth through the Texas Child Health Access Through Telemedicine (TCHATT) program. The program supports local school districts in identifying and assessing mental health needs and providing access to services.

WASHINGTON SB 5187 (2023) funded a pilot program for rural school districts to provide students with access to mental health professionals using telemedicine. Aimed at addressing geographic barriers and workforce shortages, this program also allowed funding to be used for copays or fees for telemedicine visits if not covered by a student's public or private insurance.

School-Linked Community Mental Health Services

FLORIDA HB 5101 (2024) requires school districts to create mental health programs with direct hires and partnerships with local mental health providers, focusing on early identification and support for students in need.

VIRGINIA SB 1043 (2023) directs the Department of Education to create a model memorandum of understanding between school boards and community mental health services providers that sets parameters for the provision of mental health services for students.

State Examples

Improve Connections to Mental Health Services

School-Based Health Centers

CALIFORNIA offers a grant program to help school-based health centers provide mental health services.

MARYLAND allows for Medicaid reimbursement of mental health services provided through school-based health centers.

School-Based Mental Health Coordinators

ALABAMA HB 123 (2022) mandates each school district and independent school system to employ a mental health service coordinator.

FLORIDA HB 899 (2022) requires each district school board to identify a mental health coordinator responsible for overseeing the coordination, communication, and implementation of student mental health policies and procedures.

MARYLAND SB 1265 (2018) requires each school district to appoint a mental health service coordinator to collaborate with local providers, social services, and other entities that provide mental health services.

NORTH DAKOTA SB 2149 (2019) directs each school district to designate a behavioral health resource coordinator. The state also established the Behavioral Health in Education: Resources and Opportunities (B-HERO) Technical Assistance Center in 2021 to help school resource coordinators better support students, families, school staff, and communities.

State Examples

Improve Connections to Mental Health Services

State Mental Health Coordinators

ILLINOIS SB 724 (2023) establishes a Children's Behavioral Health Transformation Officer to lead interagency efforts to support youth with complex mental health needs.

MISSOURI HB 2002 (2024) provides funding for a state-level school-based mental health coordinator.

Suicide Data: United States

Suicide is a public health problem and leading cause of death in the United States. Suicide can also be prevented – more investment in suicide prevention, education, and research will prevent the untimely deaths of thousands of Americans each year. Unless otherwise noted, this fact sheet reports 2020 data from the CDC, the most current verified data available at time of publication (February 2022).

45,979 Americans died by suicide making it the **12th leading cause of death**.

- **3rd** leading cause of death for ages 10-19
- **2nd** leading cause of death for ages 20-34
- **4th** leading cause of death for ages 35-44
- **Over one third** of people who died by suicide were 55 or older

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10% of adult Americans have thought about suicide.

1.2 million Americans attempted suicide.

54% of Americans have been affected by suicide in some way.

Men died by suicide **3.9x** more often than females.

Females were **1.8x** more likely to attempt suicide.

54% of firearm deaths were suicides.

53% of all suicides were by firearms.

In 2019, the suicide rate was **1.5x higher for Veterans** than for non-Veteran adults over the age of 18.

90% of those who died by suicide had a diagnosable mental health condition at the time of their death.

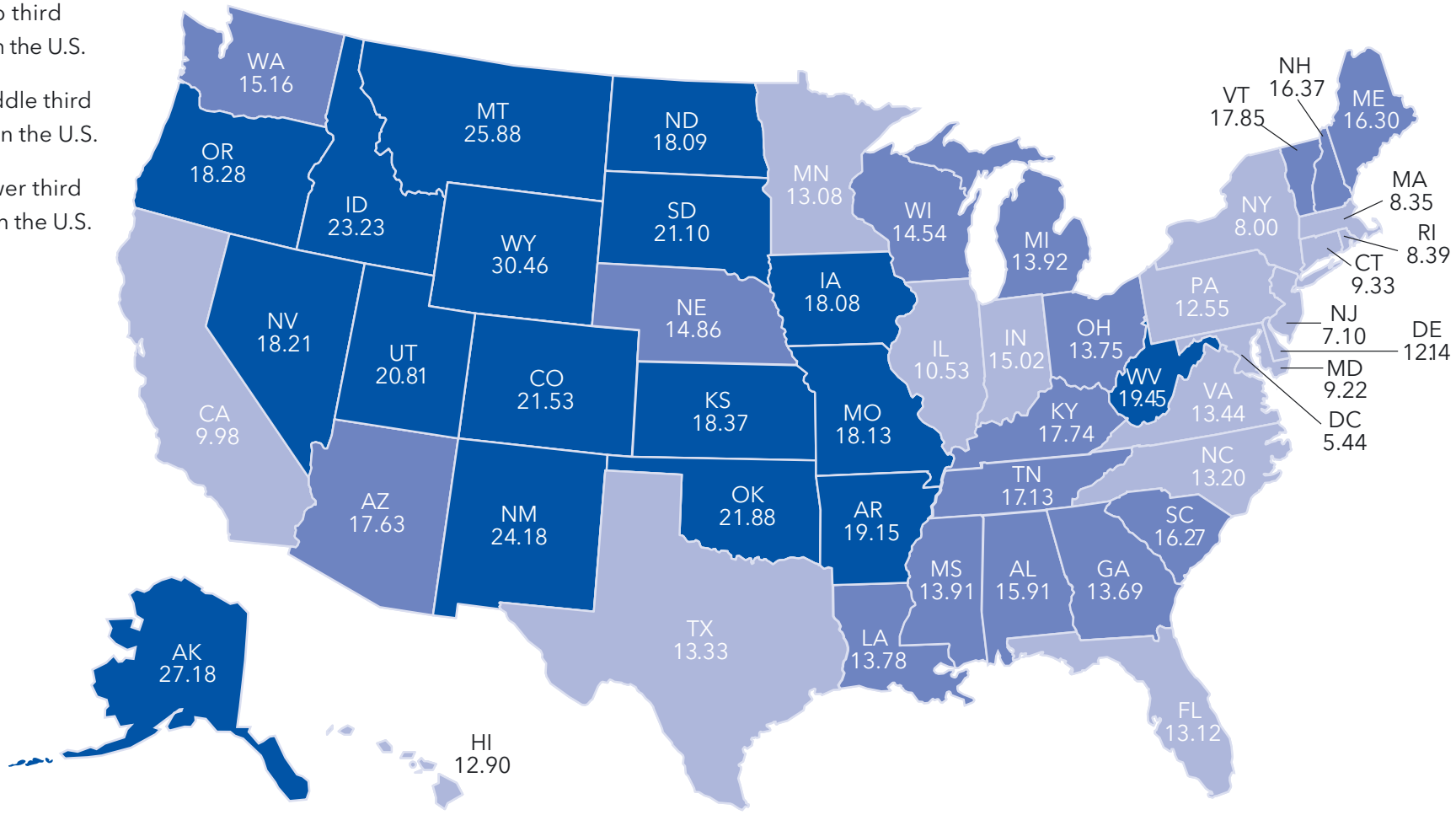
46% of Americans ages 18+ living with a mental health condition received treatment in the past year.

72% of communities in the United States did not have enough mental health providers to serve residents in 2021, according to federal guidelines.

See full list of citations at **afsp.org/statistics**.

Suicide Data: United States

- States in the top third of suicide rates in the U.S.
- States in the middle third of suicide rates in the U.S.
- States in the lower third of suicide rates in the U.S.

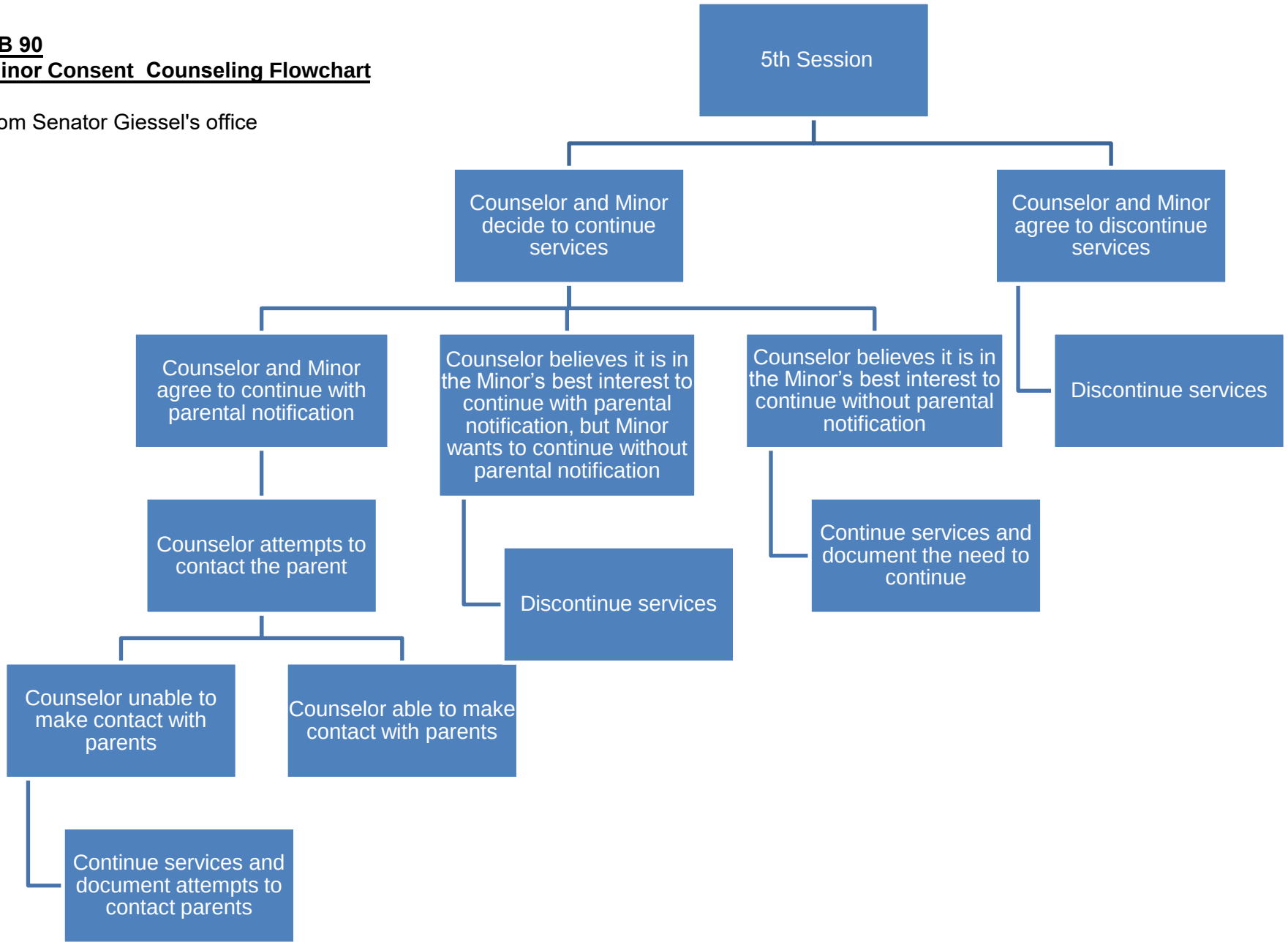


See full list of citations at **afsp.org/statistics**.

American Foundation for Suicide Prevention

SB 90
Minor Consent Counseling Flowchart

from Senator Giessel's office



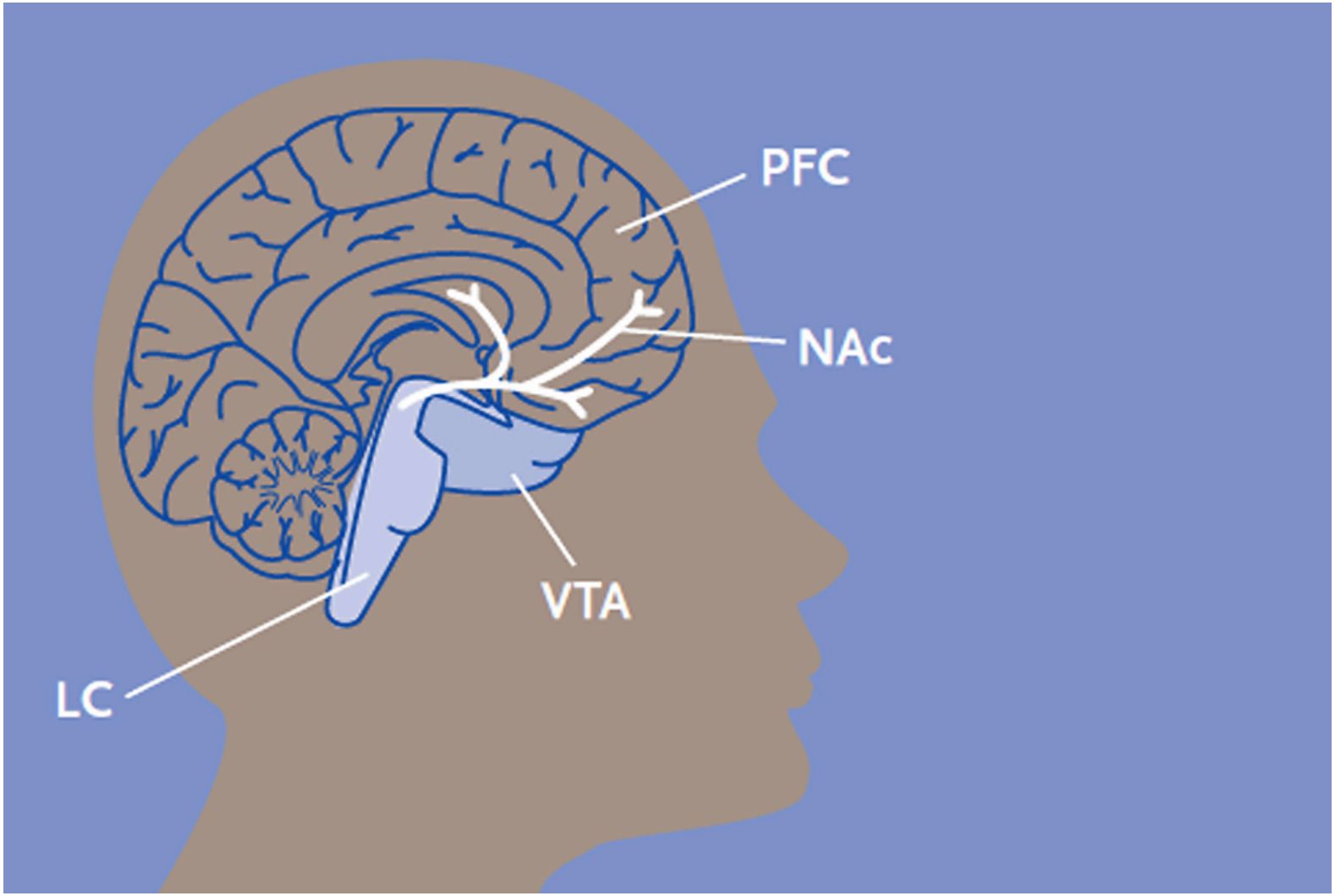
The Science of Opioid Use Disorder

Joshua Sonkiss, MD

Anchorage Community Mental Health Services

February 13, 2017

The reward circuit



Kosten TR. The neurobiology of opioid dependence: implications for treatment. Sci Pract Perspect. 2002 Jul;1(1):13-20

STATE OF ALASKA
DEPARTMENT OF HEALTH

Behavioral Health Roadmap for Alaska Youth

Leah Van Kirk
Health Care Policy Advisor

Tracy Dompeling
Director, Division of Behavioral Health

April 11, 2024

Prevention & Early Intervention

- Increase access to school-based Medicaid services in progress
- Increase youth utilization of call center for prevention in progress
- Systems navigation for parent and families

Outpatient Supports

- Improve claims processing in progress
- Implement behavioral health organization in progress
- Increase federal funding for youth-focused initiatives in progress

Crisis & Subacute Care

- Improve crisis continuum services in progress
  - Expand mobile crisis teams
  - Bolster crisis stabilization and short-term residential services
- Increase youth suicide prevention efforts in progress

Residential & Inpatient Services

- Improve care pending hospital transfers
- Add long-term residential care for specialized populations
- Expand therapeutic treatment homes in progress

Questions?

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www.axios.com /2023/10/24/children-fentanyl-addiction-treatment

Addiction treatment for kids and teenagers lags far behind demand

Caitlin Owens ⁝ 6-7 minutes ⁝ 10/24/2023

An alarming rise in overdose deaths among children and teenagers is colliding with an inadequate pediatric mental health system — including a lack of addiction treatment.

Why it matters: Limited treatment options and coverage gaps mean that many kids aren't getting needed care that could help prevent them from developing a deeper and potentially deadly addiction.

By the numbers: Pediatric opioid deaths began to spike with the rise in fentanyl availability in the mid-2010s.

- Median monthly overdose deaths among adolescents ages 10-19 increased by 109% between the second half of 2019 and the second half of 2021, according to Centers for Disease Control and Prevention data from last year. Deaths involving illicitly manufactured fentanyl increased by 182%.

The big picture: Opioid misuse is only one factor in a growing mental health crisis among children that was exacerbated by the pandemic, prompting children's health advocacy organizations to declare a national state of emergency two years ago.

- The national drug overdose crisis has also worsened since the beginning of the pandemic, with more than 100,000 Americans dying each year.
- Only a small portion of those deaths involve children and teenagers. But experts say it can be especially difficult to find treatment options for this group.
- When it comes to substance addiction, "most of the resources in this country have been geared towards adults," said Matthew Cook, CEO of the Children's Hospital Association.
- "We have a shortage of trained clinicians, whether they're physicians, social workers or other clinicians, who can help identify these issues and then treat these issues in kids."

Between the lines: Treatment options are often restricted by the availability of providers — including the availability of providers who take a child's insurance.

- As of last year, more than half of U.S. children are covered through Medicaid — which generally pays less than commercial insurance — or the Children's Health Insurance Program, per the Department of Health and Human Services.
- "Medicaid can't make providers appear out of thin air," said Lindsey Browning, director of Medicaid programming at the National Association of Medicaid Directors, pointing to workforce shortages.

- State Medicaid programs generally offer more comprehensive behavioral health benefits for kids than private insurance does, Browning said. But health care providers have long complained about Medicaid reimbursement rates being too low, and some don't accept it.
- "You can't make somebody take Medicaid," Browning said.

What's happening: Kids who need substance use care usually go to the ER — but instead of being moved to the appropriate setting or bed, they sometimes stay there, Cook said.

- "What you see is a delay in care, and perhaps an [inability] to arrange that care."

Zoom in: Sivabalaji Kaliamurthy, director of the addiction clinic at Children's National, said he is one of the few pediatric addiction specialists in the greater Washington, D.C., area, which includes parts of Maryland and Virginia.

- Children struggling with fentanyl use tend to enter the health care system following an overdose, to ask for help or seek care for a health condition related to use, he said.
- Kaliamurthy runs an outpatient treatment clinic, but he said that some children need more intensive treatment. In the D.C. area, he said, there are no residential treatment programs for kids that take Medicaid, and just a few accept private insurance.
- "I have a lot of kids who are struggling, and it's hard because I don't have a lot of treatment options for them … it's hard for me to motivate them to go to rehab when that option doesn't exist," Kaliamurthy told Axios.
- "Some of these kids, my goal is to keep them safe until they're 18 so they can access the adult treatment," he added.

But treatment shortages extend beyond residential treatment.

- "We don't have enough people trained to take care of young people with opioid use disorders, and we don't necessarily have the right people trained," said Sharon Levy, chief of the division of addiction medicine at Boston Children's Hospital.
- Levy runs a clinical outpatient program and also advises primary care physicians on how to provide substance abuse care for kids.
- Although residential care is "a very important part of the treatment system," she said, "it's really hard to get kids and families to accept residential treatment, in my experience."
- "I think the only way we'll really solve this problem is if addiction medicine specialists pair with physicians who care for young people," she added.

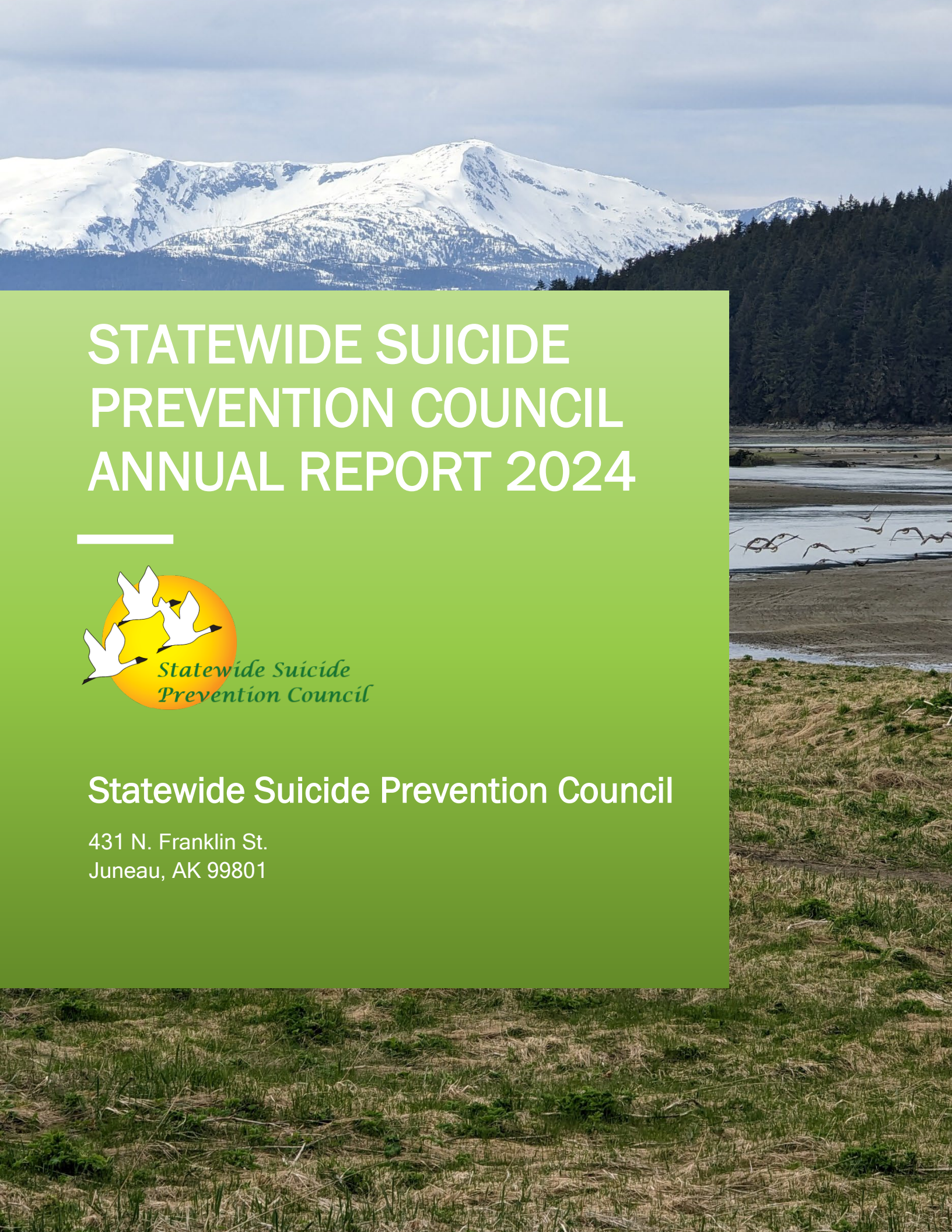
And despite expert recommendations, evidence suggests that children are much less likely than adults to receive effective medications treating opioid use disorder.

- In 2021, only 11% of children and adolescent Medicaid enrollees with opioid use disorder received medication treatment, compared with 70% of enrollees between the ages of 19 and 44, according to an HHS internal watchdog report.

- "I'm not arguing that every young person with an addiction should be on Suboxone, but if you're using intravenous drugs at 16, including heroin or now fentanyl … even 10 years ago it was still recommended as a course of treatment, but it's relatively infrequently accessed," said Jeffrey Wilson, a psychiatrist at Children's Hospital of The King's Daughters in southeastern Virginia.

The bottom line: "In adult addiction medicine, really what you're doing is managing a chronic disorder, for the most part," Levy said.

- "But for younger people for whom there's potentially more opportunity for recovery, if we get in and treat younger people, we really have the potential to change a life course."



STATEWIDE SUICIDE PREVENTION COUNCIL ANNUAL REPORT 2024

Statewide Suicide Prevention Council

Statewide Suicide Prevention Council

431 N. Franklin St.
Juneau, AK 99801

Statewide Suicide Prevention Council Annual Report 2024

Introduction

The State of Alaska's Statewide Suicide Prevention Council (SSPC) was established by the Alaska State Legislature in 2001 (AS 44.29.350) and serves as an advisory council to the Legislature and Governor regarding suicide awareness and prevention.
The duties of the council are to:

- Improve health and wellness throughout the state by reducing suicide and its effect on individuals, families, and communities.
- Broaden the public's awareness of suicide and the risk factors related to suicide.
- Enhance suicide prevention services and programs throughout the state.
- Develop healthy communities through comprehensive, collaborative, community-based, and faith-based approaches.
- Develop and implement a statewide suicide prevention plan.
- Strengthen existing and build new partnerships between public and private entities that will advance suicide prevention efforts in the State.

The council is located within the Department of Health (DOH) Division of Behavioral Health (DBH) and consists of 17 council members 13 of which are voting members and 2 who are non-voting members representing the Alaska State House of Representatives, selected by the Speaker of the House, and 2 who are non-voting members representing the Alaska State Senate, selected by the Senate President. The Governor appoints the 13 voting members from designated stakeholder groups.

2024 Council members included:

Monique Andrews, Military Seat—Eagle River

Sharon Fishel, Department of Education and Early Development —Juneau

Roberta Moto, Rural Seat —Deering

Terese Kashi, Secondary Schools Seat —Soldotna

Tracy Dompeling, Department of Health and Social Services —Juneau

Tonie Protzman, Alaska Mental Health Board —Anchorage

Cynthia Erickson, Public Seat —Tanana

Marcus Sanders, Clergy Seat —Anchorage

Justin Pendergrass, Statewide Youth Organization Seat —Wasilla

Anthony Cravalho, Advisory Board on Alcoholism and Drug Abuse —Kotzebue

Peter Angasan, Alaska Federation of Natives—King Salmon

Dakoma Epperly-May, Youth Member—Anchorage

Senator Elvi Gray-Jackson —Anchorage

Senator Mike Shower —Wasilla

Representative Sara Hannan —Juneau

Representative CJ McCormick —Anchorage

VACANT, Survivor Seat

The council is collocated with the Advisory Board on Alcoholism and Drug Abuse and the Alaska Mental Health Board, which collectively share an Executive Director. The council also has one fulltime staff.

Honoring Barbara Franks and Brenda Moore

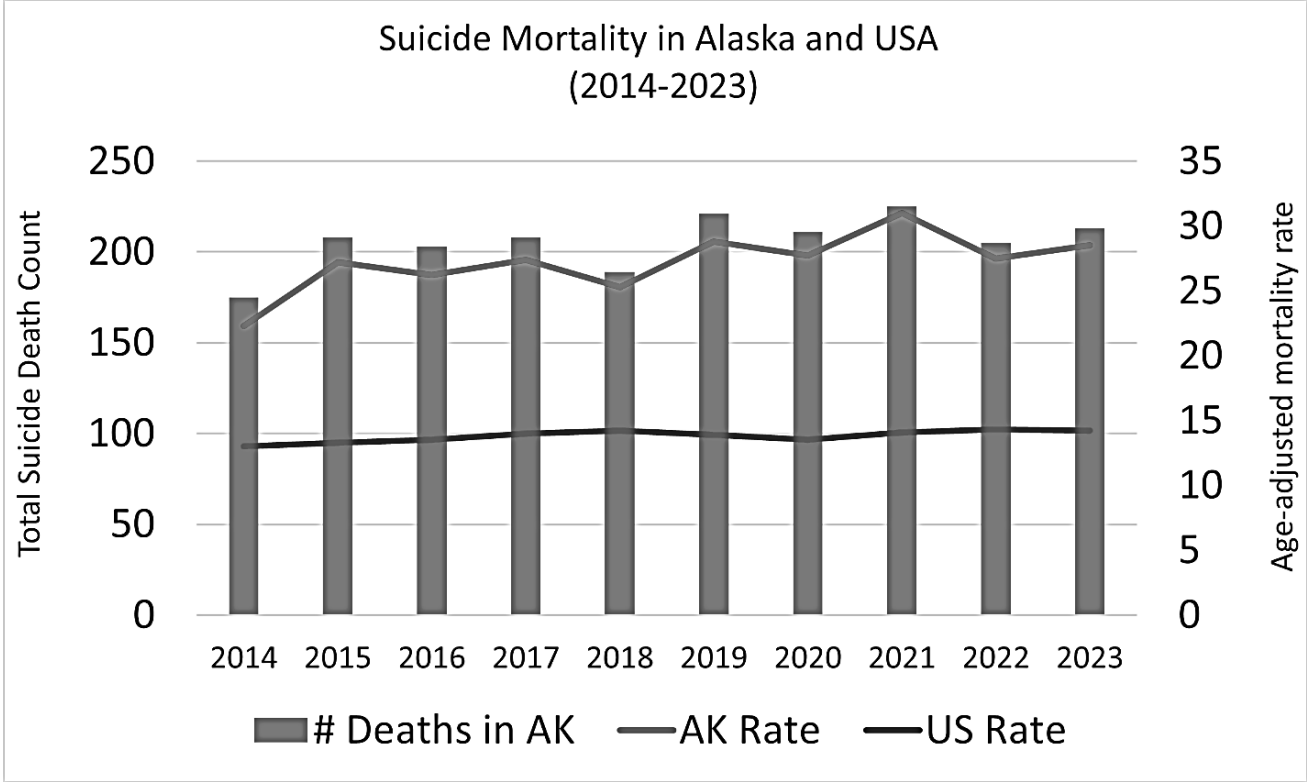
In 2024, the thirty-third Alaska State Legislature honored former SSPC members Barbara Franks and Brenda Moore with Legislative Citations after each served on the council for nearly 20 years.

Barbara Franks's interest in suicide prevention began in 1997 after her son died by suicide, a time when it was difficult to find resources for families and when many communities felt the issue was too taboo to speak about. She has been one of Alaska's greatest and most respected suicide prevention specialists and has worked to save thousands of lives throughout the state. She has spent thousands of hours volunteering on behalf of Alaskans. She has worn many hats, including holding positions at various times with the National Alliance for Mental Illness, the National Suicide Prevention Lifeline Commission/Consumer Support Services, the Alaska Psychiatric Institute, the Arctic Resource Center for Suicide Prevention, Early Childhood Development Commission, and the American Foundation for Suicide Prevention.

Brenda Moore first began volunteering for the Alaska Mental Health Board in 2004, and shortly after began serving on the Statewide Suicide Prevention Council. She spent several terms as the chairperson of each legislative advisory group over that period. She has been a passionate and relentless advocate for Alaskans struggling with mental health issues and substance use disorders. Brenda has volunteered thousands of hours and helped the lives of countless Alaskans through her work on the Alaska Mental Health Board and the Statewide Suicide Prevention Council. She has worked on many projects in many different capacities over the years in the continuum of care for mental health, including volunteering on the Alaska Psychiatric Institute Advisory Board, overseeing the creation and implementation of multiple Alaska Suicide Prevention Plans, working on criminal justice reform, prisoner reentry, peer-to-peer recovery, supportive housing, and much more.

Suicide in Alaska

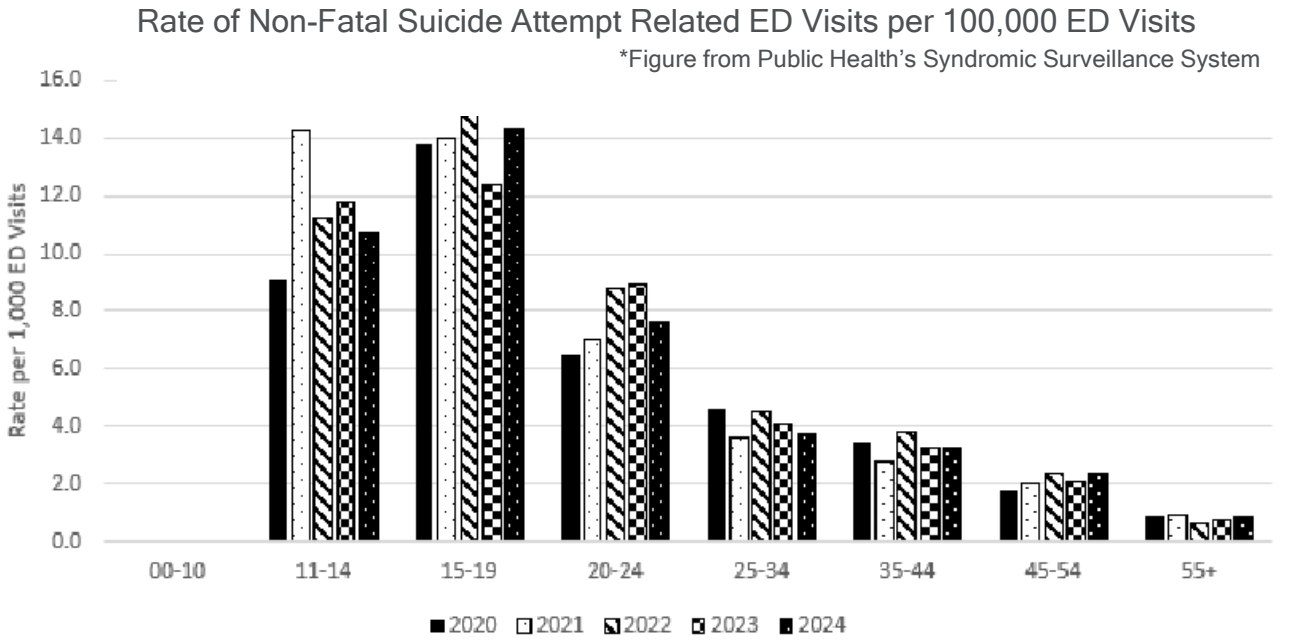
Suicide is a serious public health issue in Alaska that affects all Alaskans- regardless of age, culture, race, region, or socio-economic background. While suicide rates continue to rise across the United States, Alaska has one of the highest suicide rates of any state, at more than double the national average. Alaska Health Analytics and Vital Records releases the official number of suicide deaths in Alaska each fall for the previous year and the 2023 figures were released in September of 2024.



Unfortunately, Alaska continues to have one of the highest rates of deaths by suicide of any state in the nation. There were 213 Alaskans that died by suicide in 2023, a rate of 28.5 per 100,000 people. In 2022 there were 205 Alaskans that died by suicide, a rate of 27.5 per 100,000 people. The highest number on record was 225 deaths by suicide in 2021, with a rate of 27.3 per 100,000. In comparison, the national rate of suicide in 2022 and 2023 was 14.2 deaths per 100,000.

- Young Alaskans continue to be the most at-risk population to die by suicide, with a rate of 43 deaths among 15-24 year olds, 42 deaths among 25-34 year olds, and 43 deaths among 35-44 year olds. Alaska's youth aged 15-24 had the highest rate of suicide for 2023 by any age group, with a crude rate of 42.3 deaths per 100,000.

- Many more Alaskans attempt suicide than die by suicide. In 2023 Public Health's Syndromic Surveillance System identified 1092 suicide attempt emergency department visits. There were 213 Alaskans that died by suicide in that same year.
- Young Alaskans have higher rates of suicide attempts than their adult counterparts.
- Males continue to see the highest total number of deaths by suicides in Alaska, accounting for 167 in 2023, compared to 46 by females. However, more females are hospitalized each year due to suicide attempts.
- While rural Alaska communities have much higher rates of suicide per capita due to population disparities, particularly the Western and Interior regions, the Anchorage and Mat-Su areas had more than 50 percent of all suicide deaths in 2023. There were 113 deaths by suicide in Southcentral in 2023, up from 111 in 2022.
- Firearms continue to be the main method of intentional self-harm in Alaska, with 120 of the 205 suicide deaths in 2023 involving a firearm. Of the remaining, 70 were classified as "other" means, while 14 were determined to be by poisoning.



Alaska Health Analytics and Vital Records will release the official 2024 suicide death figures in the fall of 2025. While it is too soon to discuss those figures, Alaska Health Analytics and Vital Records has indicated that preliminary information shows 2024 will likely be similar to the 2023 figures.

Suicide Prevention Council Activities 2024

Most of the council's activities involve collaboration between stakeholders, supporting various outreach and educational programs, and providing technical assistance as needed. The council and its staff participate in various meetings, conferences, summits and events each year to promote suicide prevention in Alaska. The council also helps support, organize and promote activities for Suicide Prevention Month in September. Governor Dunleavy issued a proclamation for Suicide Prevention Week to be recognized in Alaska as September 8-14, 2024.

Quarterly Council Meetings

The council meets on a quarterly basis and is authorized to conduct one in-person meeting a year, which alternates between urban and rural communities. The other three meetings are conducted via videoconferencing.

The council met in person in Dillingham in October 2024. The meeting was hosted by the Bristol Bay Area Health Corporation at its medical campus. It was given a community welcome by current Speaker of the House Bryce Edgmon and Curyung Tribal Chief Tiffany Webb.

Highlights of the meeting included a presentation and discussion with the Curyung Tribe Wellness Program about its emerging suicide prevention efforts, current work, and future aspirations. There was also a presentation and discussion with the Bristol Bay Area Health Corporation on the behavioral health services it provides to Dillingham and the surrounding communities. There was also a presentation from SAFE, Bristol Bay's shelter, prevention and advocacy agency for domestic violence and sexual assault victims.

Key takeaways from the community organizations include:

- The need for more "upstream" wellness and prevention efforts in the region and investing in the communities, particularly for the youth.
- The need for barriers to be broken down in rural communities and there is a need for more services.
- The need for improved collaboration with the Office of Children's Services.
- The need for more community-level data related to suicide deaths and attempts.

The council also heard reports from other partner organizations and agencies, including the Division of Behavioral Health, the Alaska Mental Health Board, the Advisory Board on Alcoholism and Drug Abuse, the Alaska Mental Health Trust Authority, and the Department of Education and Early Development.

Public comment was held and key themes included:

- Cultural identity and community connection
- Trauma-informed care
- Education and youth support
- Workforce and resource gaps
- Systemic distrust and lack of person-centered care

Alaska Suicide Prevention Conference

The SSPC cohosted the "2024 Alaska Suicide Prevention Conference: Messages of Healing, Support, and Resilience" in partnership with the Division of Behavioral Health May 1-2, 2024, at the Egan Center in Anchorage. The attendance at the two-day conference increased by nearly 30 percent compared to the 2023 conference, with 211 in-person attendees as well as about 20 joining virtually each day. While most of the participants were from the Anchorage area, Alaskans from all corners of the state attended, as well as people from 10 other states as far away as Maine. Attendees came from all walks of life and professions, including suicide survivors, medical providers, tribal health officials, coalition members, treatment and recovery specialists, active military, educators, law enforcement, and more. This was the inaugural year of inviting youth to attend the full conference, and 10 youth attended the event. In addition, continuing education credits were offered and 85 participants took advantage of the opportunity and applied for their professional licensure.

The conference included 10 keynote speakers, 26 breakout session speakers, as well as an in-person welcoming from Lt. Governor Nancy Dahlstrom. The conference focused on a wide variety of topics related to the "web of causality" of suicide, including prevention, intervention, and postvention. Other topics included suicide prevention in Alaska's military, school-based peer-to-peer prevention models, intersectionality between eating disorders and suicidality, innovation of indigenous practice-based suicide prevention, safety planning training, Promoting Community Conversations About Research to End Suicide (PC Cares), intersections of human trafficking and suicidality, suicide prevention in peer support and tribal health programs.

According to participants surveyed, people felt personally impacted by the presenters, felt like they learned Alaska-specific suicide prevention resources, and that they could apply the content back to their work. Over 90% of respondents indicated the conference increased their knowledge of suicide prevention and 92% committed to taking action with their organization as a result of what they learned during the conference.

Prior to the conference, on April 30, SSPC and DBH cohosted a pre-conference Youth Summit for high school age students and their chaperones at the Captain Cook Hotel. Roughly two dozen students from throughout Alaska participated in The Connect Training Program, a comprehensive suicide prevention model on the best practice registry developed and trademarked by NAMI New Hampshire that was made possible through a federal grant received by DBH.

Suicide Awareness, Prevention & Postvention School-Based Program

The council has had a longtime partnership with the Department of Education and Early Development (DEED) to administer the Suicide Awareness, Prevention, & Postvention (SAPP) program. Along with other school-based suicide prevention activities including educator trainings and crisis response, the SAPP program distributes grants to school districts to promote suicide prevention and awareness in their communities. Many of the grantees include peer-to-peer awareness and intervention models that have shown to be highly effective in youth suicide prevention efforts.

SAPP grant funds are distributed equally (50/50) to both rural and urban school districts. The current 8 grantees include the North Slope Borough School District, Fairbanks NorthStar Borough School Districts, Kenai Peninsula Borough School District, Juneau School District, Petersburg School District, Nenana School District, Matanuska Susitna Borough School District and the Anchorage School District.

Along with some funding going toward technical assistance, the SAPP program also funds the development of DEED's eLearning courses related to suicide awareness, prevention, and postvention, and other topics related to the "web of causality" related to suicide. These courses comply with the State of Alaska's statutory requirements to provide free suicide prevention trainings to all certified educators in Alaska. There are currently 5 courses specific to suicide in the eLearning system. The SAPP program also pays for 500 seats open to the public to take these courses each year. The 5 courses continue to train thousands of Alaska in suicide prevention, with 3,086 courses completed in the 2023-24 school year, and 52,415 courses completed since they were created.

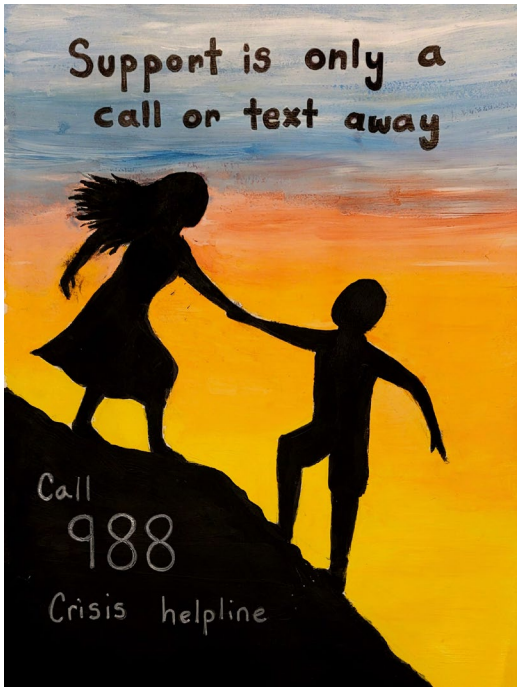
During the 2024 annual SAPP grantee meeting, all grantees participated in The Connect Training Program, the comprehensive suicide prevention model on the best practice registry developed and trademarked by NAMI New Hampshire, so they could bring what they learned back to their districts.

Alaska Careline

The council continues to partner with and support the efforts of the statewide Careline Crisis Intervention line. Careline is a crisis line based in Fairbanks that is staffed 24 hours a day, seven days a week, by trained Alaskans. It is not strictly for people experiencing suicidal ideation but is also a line for people going through any crisis that need someone to talk to. The main reasons people identified for contacting the Careline were loneliness, mental illness, anxiety, relationships, depression, and crisis.

In 2022, the nationwide 988 three-digit crisis line number was implemented after federal legislation was passed in Congress. While the Alaska-specific toll-free number 1-877-266-4357 is still active, the council and numerous state agencies, tribal organizations, community coalitions, and nonprofits worked to integrate the 988 crisis number in Alaska through the help of a federal grant to address coordination, capacity, funding, and communications strategies.

Since the implementation of the 988 number, the number of calls to Careline have steadily increased. In Fiscal Year 2012 there were 6,956 calls received by Careline. By FY 2022, when 988 was implemented, the number had risen to 16,734. In FY 2024, that number had nearly doubled to 32,470.



The council, in partnership with the Division of Behavioral Health and Careline, continues to promote the 988 number by distributing thousands of posters, magnets, stickers, and other materials, as well as through media advertising. This includes DBH's "988 Create" annual youth art contest to help promote the crisis line to some of Alaska's most vulnerable citizens.

The council also continues to partner with the Alaska Mental Health Trust Authority, DBH, and others to support and promote the Crisis Now model in Alaska. As part of the Crisis Now framework a trained mobile crisis teams to respond in person to individual in crisis who contact 911 or 988 (statewide crisis call center) to reduce the burden on law enforcement officials and medical facilities. The Trust approved $850,000 each for mobile crisis teams in Fairbanks and the Mat-Su to implement the model in those communities. This investment is already showing significant returns in terms of community impact. The Trust reports that 89% of crises were resolved by the mobile crisis teams without the involvement of law enforcement in the Mat-Su. The federal Substance Abuse and Mental Health Services Administration sets a

benchmark for 70% of community resolutions, and both these communities have exceeded that. The council continues to work with its partners to see the model introduced in other Alaskan communities. These outcomes highlight the growing importance and effectiveness of 988 and mobile crisis teams in Alaska's behavioral health crisis response system. By providing timely community-based interventions, there is a reduction in emergency room visits and law enforcement involvement in mental health crises. This not only leads to better outcomes for individuals in crisis but also represents more efficient use of healthcare and public safety resources.

Alaska Suicide Cluster Response Team

The SSPC has partnered with the Department of Health to develop a suicide cluster identification and response protocol. A suicide cluster is defined by the Center for Disease Control and Prevention as a group of suicides, suicide attempts, or self-harm events that occur closer together in time and space than would normally be expected in a given community. The Alaska Suicide Cluster Response Team (ASCRT) utilizes the Division of Public Health's Syndromic Surveillance System to identify when there have been abnormal increases in suicide related hospital and emergency department visits within communities and provide notification and support to the impacted communities in an effort to reduce contagion.

To develop an intentional response protocol that is responsive to Alaska's unique geographical and sociocultural climate, the council, in partnership with the Department of Health, has connected with other states, held community conversations, and solicited ideas from tribal partners as well as regional and community suicide prevention coalitions. The work to develop a response protocol is ongoing. Currently, the ASCRT is developing an ESSENCE alert bulletin to be distributed over DBH's suicide prevention listserv. This alert bulletin would include information on impacted communities and known demographic and other variables associated with the increased suicide activity. The alert bulletin would also include resources like postvention supports, information on the 988 Suicide and Crisis Lifeline, safe messaging guidance, and targeted resources for groups identified as at-risk, such as youth.

Additional work is needed to finalize and expand the identification protocol, bolster community capacity to respond, and develop notification infrastructure. The council remains committed to this work and all work to reduce suicide contagion and support Alaskan communities impacted by suicide.

Conclusion

The Statewide Suicide Prevention Council will continue to work with local suicide prevention groups, suicide survivors, partners, and other stakeholders to implement the goals and strategies in the 5-year state suicide prevention plan "Messages of Hope: Promoting Wellness to Prevent Suicide in Alaska 2023-2027". Both upstream and primary prevention efforts are needed to reduce suicide in Alaska, with a strong focus on adolescents and young adults, and American Indian and Alaska Natives. 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.

EVERGREEN ECONOMICS

MESA FY2025 – FY2045

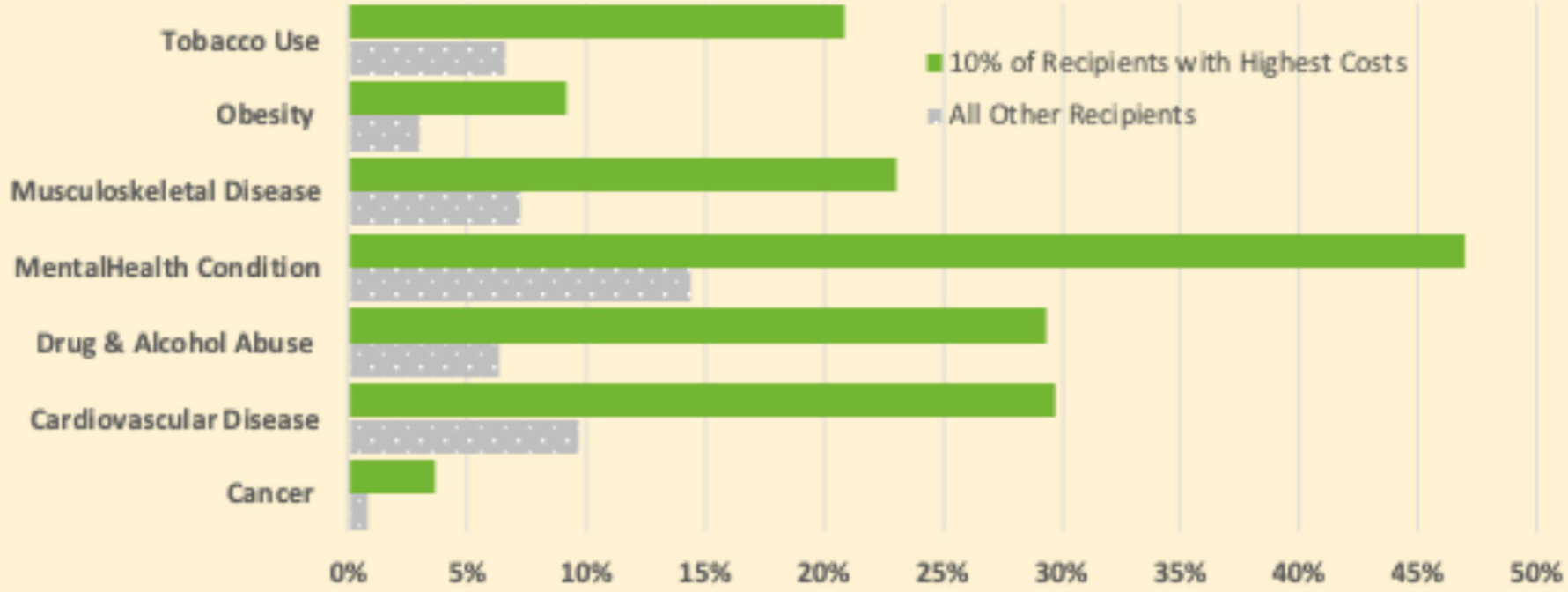
Long-Term Forecast of **M**edicaid **E**nrollment and **S**pending in **A**laska

March 3, 2025

High-Cost Recipients & Chronic Conditions

The 10% of Medicaid recipients with highest costs are much more likely to have one or more diagnosed chronic conditions.

Proportion of Recipients Diagnosed with Certain Chronic Conditions, FY2024



Alaska Long-Term Medicaid Forecast

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