Alaska State Legislature

Representative Matt Claman

Session: State Capitol, Juneau, AK 99801 Phone: 465-4919
Interim: 1500 W. Benson Blvd., Anch, AK 99503 Phone: 269-0130

House Bill 181
Sponsor Statement v. A

"An Act relating to mental health education."

HB 181 amends the existing health education curriculum statute to include mental health curriculum in all K-12 health classrooms in order to adequately educate students on vital information pertaining to mental health symptoms, resources, and treatment.

Currently, the health curriculum guidelines include prevention and treatment of diseases; learning about "good" health practices including diet, exercise, and personal hygiene; and "bad" health habits such as subsistence abuse, alcoholism and patterns of physical abuse. But the guidelines do not address mental health.

Following passage of HB 181, the Alaska State Board of Education and Early Development and the Alaska Department of Education and Early Development (DEED) will develop guidelines for instruction in mental health in consultation with the Alaska Department of Health and Social Services (DHSS) and representatives of national and state mental health organizations. Such organizations could include but are not limited to: the National Council for Behavioral Health, Providence Health and Services Alaska, Southcentral Foundation, Anchorage Community Mental Health Services, Inc., North Star Behavioral Health System, and the National Alliance on Mental Health Illness Alaska. The standards will be developed in consultation with counselors, educators, students, administrators, and other mental health organizations in order to form effective guidelines for school boards, teachers, and students.

After standards have been developed, the Alaska State Board of Education and Early Development and DEED will be responsible for implementation throughout the Alaska school system. As with existing health education curriculum, the DEED, the DHSS, and the Council on Domestic Violence and Sexual Assault will provide technical assistance to school districts in the development of personal safety curricula. An existing school health education specialist position will assist in coordinating the program statewide.

The state has a responsibility to treat the current mental health crisis in Alaska as a serious public health issue. By creating mental health education standards and encouraging schools to teach a mental health curriculum, HB 181 aims to decrease the stigma surrounding mental illnesses and increase students' knowledge of mental health, encouraging conversation around and understanding of the issue.

HOUSE BILL NO. 181

IN THE LEGISLATURE OF THE STATE OF ALASKA

THIRTY-FIRST LEGISLATURE - SECOND SESSION

BY REPRESENTATIVES CLAMAN, Drummond, Hopkins

Introduced: 1/21/20
Referred: Education, Finance

A BILL

FOR AN ACT ENTITLED

"An Act relating to mental health education."

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

*** Section 1.** The uncodified law of the State of Alaska is amended by adding a new section to read:

LEGISLATIVE INTENT. It is the intent of the legislature that the Board of Education and Early Development develop guidelines for instruction in mental health in consultation with representatives of mental health organizations, including the National Council for Behavioral Health, Providence Health and Services Alaska, the Southcentral Foundation, Anchorage Community Mental Health Services, Inc., the North Star Behavioral Health System, and the National Alliance on Mental Illness Alaska.

*** Sec. 2.** AS 14.30.360(a) is amended to read:

(a) Each district in the state public school system shall be encouraged to initiate and conduct a program in health education for kindergarten through grade 12. The program should include instruction in [PHYSICAL] health and personal safety including alcohol and drug abuse education, cardiopulmonary resuscitation (CPR),

early cancer prevention and detection, dental health, family health including infant care, environmental health, **mental health,** the identification and prevention of child abuse, child abduction, neglect, sexual abuse, and domestic violence, and appropriate use of health services.

*** Sec. 3.** AS 14.30.360(b) is amended to read:

(b) The state board shall establish guidelines for a health and personal safety education program. **Health guidelines must provide standards for instruction in mental health and shall be developed in consultation with the Department of Health and Social Services and representatives of national and state mental health organizations.** Personal safety guidelines shall be developed in consultation with the Council on Domestic Violence and Sexual Assault. Upon request, the Department of Education and Early Development, the Department of Health and Social Services, and the Council on Domestic Violence and Sexual Assault shall provide technical assistance to school districts in the development of personal safety curricula. A school health education specialist position shall be established and funded in the department to coordinate the program statewide. Adequate funds to enable curriculum and resource development, adequate consultation to school districts, and a program of teacher training in health and personal safety education shall be provided.

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Session: State Capitol, Rm 118 Juneau, AK 99801 Phone: 465-4919
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House Bill 181
Sectional Analysis — Version A

Section 1
Legislative Intent
Adds intent language stating it is the intent of the legislature that the Board of Education and Early Development develop guidelines for instruction in mental health in consultation with representatives of mental health organizations, including the National Council for Behavioral Health, Providence Health and Services Alaska, Southcentral Foundation, Anchorage Community Mental Health Services, Inc., North Start Behavioral Health System, and the National Alliance on Mental Health Illness Alaska.

Section 2
AS 14.30.360. Health education curriculum; physical activity guidelines.
Amends AS 14.30.360 by removing the word "physical" when referencing instruction for health education and adding "mental health" to the list of curriculum items each district includes in their health education programs.

Section 3
AS 14.30.360. Health education curriculum; physical activity guidelines.
Amends AS 14.30.360 by clarifying that health guidelines developed by the Board of Education and Early Development must provide standards for instruction in mental health and be developed in consultation with the Department of Health and Social Services and representatives of national and state mental health organizations.

State of Alaska Epidemiology **Bulletin**

Department of Health and Social Services
Adam Crum, MSPH, Commissioner
Jay C. Butler, MD, Acting Chief Medical Officer

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Anchorage, AK 99503 http://www.dhss.alaska.gov/dph/Epi

Division of Public Health
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Editors:
Joe McLaughlin, MD, MPH
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Bulletin No. 1 January 2, 2019

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*

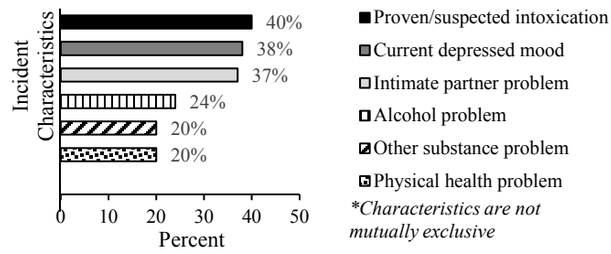
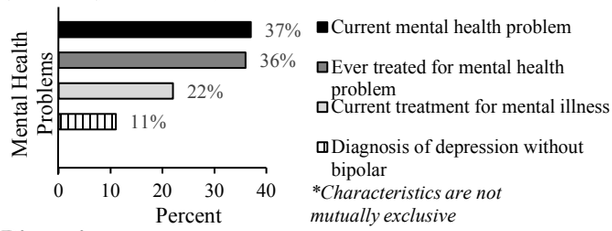


Figure 2. Mental Health Characteristics of Suicides (N=1,103) — Alaska, 2012–2017*



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

1. Centers for Disease Control and Prevention. Web-based Injury Statistics Query and Reporting System. Available at: https://www.cdc.gov/injury/wisqars/nvdrs.html
2. Alaska Epidemiology *Bulletin*. Summary of Violent Deaths ─ Alaska, 2007–2011. No. 2, January 14, 2013. Available at: http://www.epi.alaska.gov/bulletins/docs/b2013_02.pdf
3. Alaska Epidemiology *Bulletin*. Alaska Suicide Toxicology Project 2015-2017. Volume 21; No. 1, January 2, 2019. Available at: http://www.epi.alaska.gov/bulletins/docs/rr2019_01.pdf
4. Alaska Suicide Prevention Council. Casting the Net Upstream: Promoting Wellness to Prevent Suicide, Annual Report 2017. Available at: http://dhss.alaska.gov/SuicidePrevention/Documents/pdfs/CTN_Implementation_Report_2017.pdf

(Contributed by: Deborah Hull-Jilly, MPH and Scott Saxon, Injury Surveillance Program, Section of Epidemiology.)

Centers for Disease Control and Prevention

CDC Healthy Schools

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

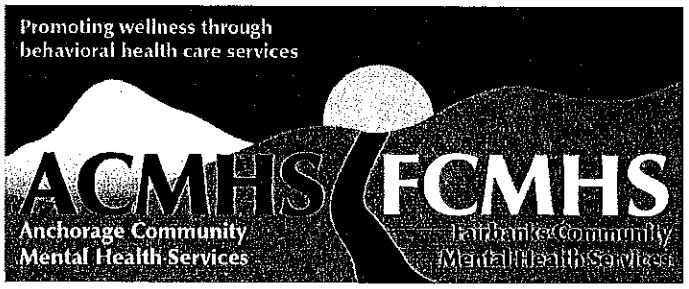
The NHES are written expectations for what students should know and be able to do by grades 2, 5, 8, and 12 to promote personal, family, and community health.

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.

Page last reviewed: March 27, 2019



4020 Folker Street • Anchorage, Alaska 99508 • 907-563-1000 • (Fax) 907-563-2045 • e-mail: info@acmhs.com • website: www.acmhs.com

January 28, 2020

Representative Matt Claman
House of Representatives

Dear Representative Claman,

We were so pleased to learn about House Bill 181, the bill requiring public schools in Alaska to include mental health curriculum in eight grade health classes. Thank you for championing this important piece of legislation. We are honored to be named as one of the organizations to help develop the curriculum and look forward to that work!

As part of our work at the Power Center (formerly Alaska Youth Advocates) and Alaska Seeds of Change, we were selected to be part of a national learning collaborative to improve access to mental health care and reduce anxiety and depression for transition age youth, ages 13-23. One of the biggest goals of the project is to increase young people's awareness of their own mental health, what common mental health conditions are and how they might manifest themselves, and to reduce the stigma and increase knowledge about getting help for those conditions. What isn't known can be scary, and young people need to know that mental health treatment CAN help and that is possible to live full and satisfying lives, even with a chronic serious mental illness. This legislation goes a long way toward expanding that knowledge base in Alaska!

As an agency, we have previously worked with the Department of Education and Early Development on initiatives to promote trauma-informed schools, and we are eager to partner again for this work. Some of our staff are in the process of finalizing a "Mental Wellness 101" workshop that we will use internally, so they are primed and ready!

Thank you again for your leadership in introducing this legislation.

Yours sincerely,

Jim Myers
CEO

alaska children's trust

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alaskachildrenstrust.org

3 February 2020

Representative Matt Claman
Alaska State Legislature
Capital Building, Rm 420
Juneau, AK 99801

Re: HB 181: An Act Relating to Mental Health Education

Dear Representative Matt Claman,

Alaska Children's Trust (ACT) extends its support for HB 181, "An Act relating to mental health education." Alaska Children's Trust works to prevent child abuse and neglect across the state.

House Bill 181 works to expand existing health education requirements by directing the Board of Education and Early Development to develop guidelines ensuring the inclusion of mental health education in grades Kindergarten through 12th grade. ACT supports HB 181 both for its capacity to increase identification of child abuse and neglect through greater discussion of mental health; and to promote resilience within our childhood population.

Alaska has one of the highest per capita rates of child abuse and neglect in the country. HB 181 works to increase awareness of the signs and symptoms of mental illness, which supports early identification and intervention in cases of child abuse and neglect. HB 181 also works to reduce stigma surrounding mental health by empowering youth to seek resources for support and treatment in cases of mental illness.

Alaska Children's Trust also supports HB 181 for working to promote resilience within Alaska's youth population. The Adverse Childhood Experiences (ACEs) study demonstrated the significant influence of childhood experiences in shaping lifetime health. Abuse, neglect, and family dysfunction both directly affect a child's mental health status in the short term and as they grow to become members of society. While recognizing that adversity is a natural part of life, ACT supports this bill's aim of providing youth with the tools necessary to address trauma through healthy coping skills.

House Bill 181 aligns with our core goals of fostering healthy development in children, promoting resilience, and strengthening families across Alaska. ACT applauds Representative Claman's willingness to openly address the importance of mental health in our childhood population. We look forward to continuing to work together to advance these shared goals.

Sincerely,

Trevor J. Storrs
President/CEO

From:	Jordan Posamentier
To:	Rep. Matt Claman
Subject:	Letter of Support for HB181
Date:	Thursday, February 06, 2020 8:47:23 AM
Attachments:	Outlook-5aknjcet.png

Dear Representative Claman,

On behalf of Committee for Children, I am writing to express our support for HB181. As a global nonprofit dedicated to helping children everywhere, including Alaska, thrive socially, emotionally, and academically, we applaud your efforts to include instruction standards on mental health into health guidelines and to encourage this type of instruction in public school systems.

If there is opportunity to work on this bill, **we would suggest including the insertion of *evidence-based* instruction on SEL with mental health instruction**. Skills from all five SEL competencies, self-awareness, self-management, responsible decision making, social awareness, and healthy relationships, demonstrate an impact on promoting student well-being; thus, it would be beneficial to add SEL in instruction for students. As a case in point, Anchorage School District provides a shining example and leadership in SEL.

Perhaps of further interest to this legislation, Committee for Children recently published a resource that examines the connection between SEL and youth suicide prevention, which you can access here.

Your educator workforce probably knows us by our flagship evidence-based SEL program, Second Step. But we do more than develop programs. As you advance this and related policy, we are here to serve as a resource, whether it be to connect you with our researchers, experts in the field, or SEL experts in your state, or to provide advocacy, policy support, or thought partnership.

Thank you for your work to further and improve students' learning experiences in Alaska.

Sincerely,

Jordan Posamentier

Jordan Posamentier | Director of Policy & Advocacy
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jposamentier@cfchildren.org
Committee for Children

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.

Alaska Youth Risk Behavior Survey

Preliminary 2017 Highlights

Alaska Youth Risk Behavior Survey

About the Alaska Youth Risk Behavior Survey

The Alaska Youth Risk Behavior Survey (YRBS) is part of an epidemiological surveillance system established by the Centers for Disease Control and Prevention (CDC) in 1990 and first implemented in Alaska in 1995. The YRBS is a biennial, anonymous, and voluntary survey that is used to monitor the prevalence of health risk behaviors among youth in grades 9-12. Youth are asked to report health behaviors that directly lead to illness, disease, and death among youth and adults. The statewide traditional high school survey includes students in public traditional high schools (excluding boarding, correspondence, home study, alternative, and correctional schools). The Alaska YRBS is administered by the Department of Health and Social Services, with support from the Department of Education and Early Development. Participation requires written parental consent.

Alaska YRBS Preliminary 2017 Highlights

This report provides a brief summary of 2017 YRBS results for Alaska traditional high school students and a selection of short- and long-term trends. Long-term trends inform and help to evaluate programmatic activities, while short-term trends can provide more immediate, actionable information. A final Alaska YRBS 2017 Highlights report that will include U.S. and Alaska alternative high school results will be published in summer 2018.

Accessing Survey Data

More detailed 2017 Alaska YRBS results are available online: **dhss.alaska.gov/dph/Chronic/Pages/yrbs/yrbsresults.aspx**.

Alaska YRBS data also are available online by year, sex, race/ethnicity, and geographic region. For more information, maps, and a database that can be queried, visit: **dhss.alaska.gov/dph/InfoCenter/Pages/ia/default.aspx**.

2017 Alaska YRBS Traditional High School Sample

In 2017, 43 schools from 19 school districts were randomly chosen for the statewide traditional high school YRBS sample to provide results that are representative of Alaska high school students. Forty (93%) of the selected schools participated, and 1,343 (66%) students in selected classes submitted surveys. The overall response rate was 62%.

Healthy Alaskans 2020

Eight YRBS measures are among the 25 Healthy Alaskans 2020 leading health indicators. These measures assess overweight, obesity, physical activity, tobacco use (exclusive of e-cigarettes), alcohol abuse, social support, mental health, and interpersonal violence. More information and current Healthy Alaskans 2020 reports are posted online: **hss.state.ak.us/ha2020/default.htm**.

NEW Signifies that 2017 was the first year this question was a part of the survey.

* Trends noted as increases or declines are statistically significant, $p < 0.05$.

Summary of the 2017 Alaska Traditional High School Results*

Weight Status, Physical Activity, and Nutrition

- Nearly 18% of students are overweight, an increase since 2013, and 13.7% have obesity.
- Short- and long-term trends show decreasing soda consumption. In 2017, 14.7% of students drank a soda 1 or more times per day, compared to 21.8% in 2007.
- The percentage of students who drank a sports drink 1 or more times per day also decreased (13.1% in 2015, 10.2% in 2017).
- These trends do not capture consumption of other sugary drinks.
- A decrease in overweight and obesity prevalence is not expected until overall consumption of sugary drinks declines for an extended period.
- The percentage of students who meet the national recommendations for physical activity of 60 minutes every day (18.4% in 2017) has not changed significantly since 2011.
- Up from 23.4% in 2007, 40.6% of students now spend 3 or more hours each day (on an average school day) playing video or computer games, or using a computer, smartphone, or tablet for something other than school work.

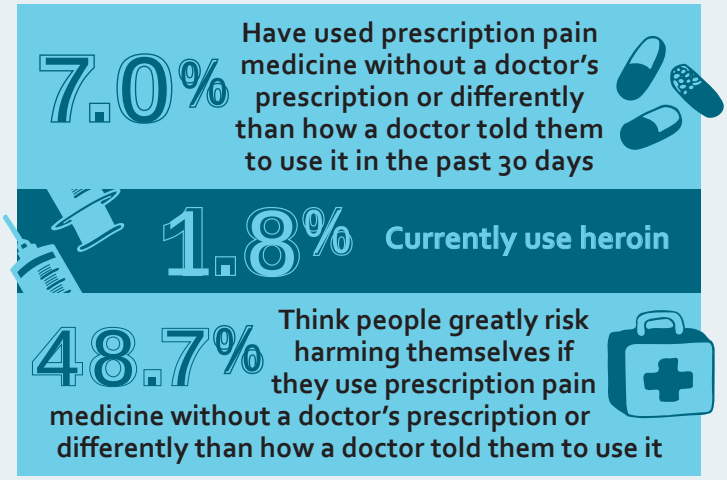
Tobacco

- Since 2007, there have been declines in daily (2.1% in 2017), frequent (2.8% smoked 20 of the past 30 days), current (10.9% smoked during the past 30 days), and initiation of (34.0% ever tried smoking) cigarette smoking. Between 2015 and 2017, there were no significant changes in any of these measures.
- Nearly 54% of students think there is a great risk of harm in smoking 1 or more packs of cigarettes per day; this is a decrease since 2013 and 2015.
- There has not been significant change in initiation (39.9% in 2017) or current use (15.7%) of electronic vapor products since 2015.

Alcohol and Other Drugs

- Nearly 14% of students report current binge drinking (4 or more drinks for females, 5 or more drinks for males in a row during the past 30 days).
- Since 2007, there have been declines in initiation of drinking alcohol (56.5% ever drank in 2017) and current drinking (22.8%).
- The percentage of students who have ever used marijuana (41.5% in 2017) has decreased since 2007, while current use (21.5% in 2017) has not changed significantly.
- More than 38% of students think there is great risk of harm in consuming 5 or more alcoholic drinks 1 to 2 times per week, an increase since 2015.
- Almost 19% of students think that there is great risk of harm in using marijuana 1 to 2 times per week. NEW

Opioids NEW



Student Connectedness

- Nearly 56% of students report that they do not feel alone in their life, a decline from 65.2% in 2007.
- The percentage of students who feel that their teachers care about and support them (59.0% in 2017) has increased since 2007.
- Fifty-two percent of students feel like they matter in their community.

Safety

- Riding in a car or other vehicle with a driver who has been drinking (16.4% in 2017) has decreased since 2007, but increased since 2013.
- Among students who ride a bicycle, the percentage of students who rarely or never use a bicycle helmet (71.2% in 2017) has decreased since 2007, but increased since 2015.
- Among students who drive a car or other vehicle,
  - 37.2% talk on a cell phone while driving. NEW
  - 28.6% text and email while driving.
  - 16.0% drive when they have been using marijuana. NEW
  - 4.3% drive when they have been drinking alcohol, which has not changed significantly since 2013.

Violence

- One in 10 students has experienced sexual violence (being forced by anyone to do sexual acts) during the past year. NEW
- Among dating students, the percentage of students who have experienced physical dating violence during the past year (7.3% in 2017) has not changed significantly; however, sexual dating violence (5.5%) has decreased since 2013.
- Bullying on school property has remained flat (23.3% in 2017), but electronic bullying (19.8%) has increased since 2011.

(violence continued)

- There has been both a short- and long-term increase in the percentage of students who do not go to or from school because they feel unsafe at school or on their way to school (11.5% in 2017).

Suicide and Mental Health

- More than 1 in 3 students (36.1% in 2017) report feeling sad or hopeless (almost every day for at least two weeks) during the past year, an increase since 2007.
- At 22.8%, the percentage of students who have seriously considered suicide has increased since 2007.
- The percentage of students who made a suicide plan (20.7% in 2017) has increased since 2007 and since 2015.
- More than 12% of students made at least one suicide attempt during the past year, an increase since 2013.
- Among students who have considered, planned, or attempted suicide during the past year, 46.8% have talked to someone about suicide. NEW

Sexual Activity

- Since 2007, there have been decreases in the percentages of students who have ever had sexual intercourse (36.9% in 2017), have had sexual intercourse during the past 3 months (25.2%), and have had sexual intercourse with 4 or more partners during their life (10.4%).
- Among sexually active students,
  - 56.7% report using a condom during last sexual intercourse, which is not a significant change in use since 2007.
  - 10.7% report using an IUD or implant before last sexual intercourse, which is an increase in use since 2013.
- Nearly 86% of students have been taught in school about preventing sexually transmitted diseases.

Supporters of the Alaska YRBS

Special thanks goes to the Advisory Board on Alcoholism and Drug Abuse, Alaska Council on Domestic Violence and Sexual Assault, Alaska Division of Behavioral Health, Alaska Division of Juvenile Justice, sections within the Alaska Division of Public Health, Alaska Native Tribal Health Consortium, The Research Institute at Nationwide Children's Hospital, and United Way of Mat-Su. Additional thanks goes to the participating school districts and students, and to our many community partners.

Alaska Youth Risk Behavior Survey Traditional High School Trends, 2007-2017, 2015-2017

Prevalence of Selected Risk Behaviors for Students in Traditional High Schools (grades 9-12)

	2007	2009	2011	2013	2015	2017	2007-2017 Long-term Trend*	2015-2017 Recent Trend
Rode with a driver who had been drinking alcohol one or more times during the past 30 days	23.5%	21.3%	18.6%	13.1%	14.3%	16.4%	●	⟷
Did not go to school because they felt unsafe at school or on their way to or from school on at least one of the past 30 days	5.5%	6.0%	4.7%	6.2%	8.8%	11.5%	●	●
Were electronically bullied during the past year	--	--	15.3%	14.7%	17.7%	19.8%	●	⟷
HA-2020 Experienced physical dating violence during the past year (among students who dated or went out with someone)	--	--	--	9.1%	9.5%	7.3%	⟷	⟷
Experienced sexual dating violence during the past year (among students who dated or went out with someone)	--	--	--	11.4%	10.1%	5.5%	●	●
HA-2020 Felt so sad or hopeless, daily for two weeks in a row, they stopped doing usual activities during the past year	26.9%	25.2%	25.9%	27.2%	33.6%	36.1%	●	⟷
Made a suicide plan during the past year	14.2%	11.7%	12.8%	13.9%	16.7%	20.7%	●	●
Attempted suicide one or more times during the past year	10.7%	8.5%	8.7%	8.4%	10.7%	12.1%	⟷	⟷
Smoked cigarettes on at least one of the past 30 days (current use)	17.8%	15.7%	14.1%	10.6%	11.1%	10.9%	●	⟷
Think people greatly risk harming themselves if they smoke one or more packs of cigarettes per day	--	--	--	65.3%	60.0%	53.6%	●	●
Had at least one drink of alcohol on at least one of the past 30 days (current use)	39.7%	33.2%	28.6%	22.5%	22.0%	22.8%	●	⟷
HA-2020 Used marijuana one or more times during the past 30 days (current use)	20.5%	22.7%	21.2%	19.7%	19.0%	21.5%	⟷	⟷
Used heroin one or more times during their life	1.6%	3.3%	2.4%	2.2%	2.2%	2.2%	⟷	⟷
Ever had sexual intercourse	45.1%	43.5%	38.3%	38.6%	35.9%	36.9%	●	⟷
Used a condom during last sexual intercourse (among students who were sexually active)	60.8%	62.2%	59.6%	60.4%	61.9%	56.7%	⟷	⟷
HA-2020 Were overweight	16.1%	14.4%	14.4%	13.7%	16.7%	17.5%	⟷	⟷
HA-2020 Were obese	11.0%	11.9%	11.5%	12.4%	14.0%	13.7%	⟷	⟷
Drank a soda one or more times per day during the past 7 days	21.8%	20.1%	17.6%	15.8%	18.8%	14.7%	●	●
HA-2020 Were physically active for at least 60 minutes on each of the past 7 days	--	--	21.3%	20.9%	20.9%	18.4%	⟷	⟷
Feel like they matter to people in their community	50.6%	54.0%	54.6%	54.6%	52.7%	52.0%	⟷	⟷
Feel that their teachers really care about them and give them a lot of encouragement	56.1%	59.4%	56.7%	64.1%	62.1%	59.0%	●	⟷

* Trend from 2007 or earliest available data point

HA-2020 Healthy Alaskans 2020 (HA2020) health indicator.

● **Trend shows statistically significant decrease in risk**

● **Trend shows statistically significant increase in risk**

⟷ **Trend shows no statistically significant change in risk**

Significance of long-term trend based on logistic regression model controlling for sex, race/ethnicity, and grade, $p < 0.05$; significance of recent trend based on t-test analysis, $p < 0.05$.

Alaska Department of Education & Early Development

dhss.alaska.gov/dph/Chronic/Pages/yrbs/yrbs.aspx

State of Alaska, Department of Health and Social Services