Anchorage, Alaska

marcia howell
8/14/2017

Name of community:
Anchorage, Alaska

Are you applying for Safe Communities accreditation for the first time?:
No. Our community is a currently accredited Safe Community and is applying for reaccreditation.

If you are applying for reaccreditation, has there been a change in coalition leadership since the previous accreditation?:
No

In your last 5 years of accreditation, what have been your coalition's biggest achievements? :
Checked over 1500 car seats. Developed Youth Matter mini grant program: designed to develop feelings of civic self-efficacy among youth. The Anchorage Youth Development Coalition merged with us expanding the reach and expertise for our protective factor initiatives. Received new funding to decrease bullying and its consequences. Began implementing the CarFit program.

In the last 5 years, what have been your coalition's biggest challenges and how have you worked to overcome them?:
Our staff nearly doubled and our budget grew about 150%. This results in more time spent on administrative and fiscal management. We partnered on a bullying initiative with two other local coalitions, which has been a long slow process. It took two years to work through a community needs assessment and strategic planning. We expect the outcomes to be worth it. We partnered with another coalition on our opioid misuse and heroin use prevention. In this effort the assessment and planning only took one year. However, it has been challenging mixing different styles of work, balancing the need some people have to just do something, anything. And others who approach the work more academically, and want to do a thorough job of assessing the problem and strategies first.

How has accreditation helped your community?:
International accreditation has provided us with a credential that funders seem to appreciate. It also has provided opportunities for us to learn from others engaged in similar work around the country and the world. And in a few instances, we were able to secure funding through NSC, which was especially nice.

Has the community submitted a Letter of Intent and the required application fee for Safe Communities accreditation?:
Yes

SECTION 1: CONTACT INFORMATION:
List the two key contacts Safe Communities America staff and reviewers will work with during the
application process. Contacts should be leaders within the coalition who have been involved with the
coalition development and can include the coalition chair or a representative from the lead agency.

Contact 1: Name :
Marcia Howell

Contact 1: Organization:
Alaska Injury Prevention Center

Contact 1: Title:
Executive Director

Contact 1: Email:
marcia.howell@alaska-ipc.org

Contact 1: Phone:
907-929-3939

Contact 1: Mailing Address:
4241 B Street, Suite 100

Contact 2: Name:
Beth Schuerman

Contact 2: Organization :
Alaska Injury Prevention Center

Contact 2: Title:
Projects Director

Contact 2: Email:
beth.schuerman@alaska-ipc.org

Contact 2: Phone:

907-929-3939

Contact 2: Mailing Address:
4241 B Street, Suite 100

SECTION 2: COMMUNITY DESCRIPTION:
n/a

Describe your community's history and what makes your community unique.:
The Municipality of Anchorage, Alaska includes the communities of Anchorage, Chugiak, Eagle River, Joint Base Elmendorf-Richardson, Girdwood, and communities along Turnagain Arm. It is estimated that in 2015, 298,908 people lived in Anchorage (State of Alaska Department of Labor and Workforce Development, 2016). It is the largest community in the state, with just over 40% of Alaska's population.

Located in Southcentral Alaska, the Anchorage metropolitan area sits in a bowl with Cook Inlet to the west, and Chugach State Park to the east. The Municipality is just over 1,700 square miles, with an average of 171.2 persons per square mile. Warmed by Pacific currents, the city has a mild northern climate (Anchorage Convention & Visitors Bureau, n.d.). The average temperature is 37°F, with an average annual high of 43.7°F, and average low of 30.3°F (US Climate Data, n.d.).

The Dena'ina are indigenous peoples of the Cook Inlet Region where Anchorage is situated. Like other Alaska Native groups, the Dena'ina population has decreased by more than half of the pre-1700s numbers. Colonization of southern Alaska began with Russian explorers in the late 1700s. English explorer Captain James Cook is often cited as one of the early non-Native outsiders to colonize the area in 1778. In 1867, the United States paid Russia $7.2 million for settling rights. Alaska gained statehood in 1959 (Cook Inlet Historical Society). Anchorage began to emerge around 1914 out of a tent city built in Ship Creek Landing, a port for the Alaska Railroad (Cook Inlet Historical Society).

Growth of Anchorage and the larger Alaska economy continued between 1930-1950 as military presence grew, and air transportation became increasingly important. Anchorage International Airport opened in 1951, while Elmendorf Air Force Base and Fort Richardson, now known as Joint Base Elmendorf-Richardson (JBER), were constructed in the 1940s. The 1968 discovery of oil in Prudhoe Bay created an economic boom for Alaska, and the oil industry continues to be a major part of the economy to this day (Municipality of Anchorage).

Other interesting facts:
- Anchorage is slightly farther north than Oslo, Stockholm, Helsinki and Saint Petersburg and is as far west as Honolulu, Hawaii
- Anchorage has more espresso stands, per capita, than anywhere in the U.S
- Approximately 250 black bears and 60 grizzly bears live within urban Anchorage

and the surrounding area.

- Moose are also a common sight in Anchorage with a summer population of 250 that increases to more than 1,500 moose during the winter.
- There are 105 miles of groomed cross¬ country ski trails in Anchorage.

Why is your community seeking Safe Communities accreditation?:
Anchorage has been an accredited International Safe Community since 1998. We believe in the collaborative culture behind the safe community initiative. It really does take a whole community to make good things happen. And it is nice to be "accredited." And it helps the Mayor when re-election time comes around.

Who in your community (person/agency) is taking the lead in organizing this effort? Why?:
The Alaska Injury Prevention Center has been the Anchorage Safe Community lead since 1998. We are a well funded, professional and well trained staff. We work well with multiple organizations around the city and state. We are also well connected with policy makers, funders and government divisions. At the same time, we are more nimble and flexible than government and larger organizations which allows us to get things done efficiently and innovatively.

SECTION 3: CRITERIA TO BE A SAFE COMMUNITY:
Demonstrate how your community meets the following four criteria for Safe Communities America accreditation: Sustained Collaboration; Data Collection and Application; Effective Strategies to Address Injury; and Evaluation Methods.

Criteria 1: Sustained Collaboration:
An infrastructure based on partnerships and collaboration representing a cross-section of community leaders and organizations committed to improving community safety.

Official coalition name: :
Alaska Injury Prevention Center

Date coalition formed::
01/01/1995

Mission statement: Include a mission statement for the coalition. :
Prevent Injuries, Promote Wellbeing and Improve Safety

Communications tactics:
AIPC utilizes multiple methods of communication to reach coalition members, partners, funders, board members, local, statewide, national and international. Details of our communications plan are attached. Our modes of communication include a Facebook page, newsletter, website, email blasts, presentation at conferences, membership on several speakers bureaus, as well as participation as subject matter experts on multiple advisory boards and strategic planning committees. Additionally, we have developed relationships with our local news crews and they request interviews about monthly, when an injury issue is in the news.

Describe ongoing participation in national and international Safe Communities Networks. :
AIPC has had at least one member participate in all of the SCAN annual conferences, has a certified Safe Community accreditation reviewer on staff.

Describe how you share the Safe Communities model and your coalition's work with external audiences.:
AIPC has participated and presented in all of the WHO World Injury Prevention and Safety Promotion conferences since 2006, has participated and presented in multiple International Safe Community Conferences and regional conferences including in Prague, Christchurch, Harstad Norway, and Merida, Mexico. AIPC staff also are the founders and chair the International Safety Media Awards that take place at the WHO Safety Conferences. All Safe Communities, worldwide are invited to participate, and many from the US have received awards since its inception in 2006, in Durban South Africa. Additionally, AIPC hosted the International Safe Communities Conference in Anchorage in 2001.

Criteria 2: Data Collection and Application :
What does the local data indicate about injuries in the community? How is the coalition applying the data to set goals? Include the most recent data available.

Data sources:
Data Sources

Alaska Highway Safety Office Fatality Analysis Reporting System (FARS)
Alaska Trauma Registry (ATR)*

Municipality of Anchorage Traffic Records
National Occupant Protection Use Survey
State of Alaska Crash Reports
Alaska Transportation Marketing Survey
Alaska Department of Health and Social Services Division of Public Health, Section of Chronic Disease Prevention and Health Promotion
Qualitative data from AIPC focus groups
Alaska Bureau of Vital Statistics mortality database
State of Alaska Department of Health and Social Services, Division of Public Health, Epidemiology: http://www.epi.alaska.gov/bulletins/docs/b2016_06.pdf
Adult Perceptions of Anchorage Youth (APAY Survey)
Youth Risk Behavior Survey (YRBS)
National Survey on Drug Use and Health (NSDUH)
Prime for Life Survey
Young Adult Survey
4A's Heroin User Survey
Anchorage Police Department, DEA and Alaska State Troopers
Behavior Risk Factor Surveillance Survey (BRFSS)

*The Alaska Trauma registry stopped recording poisonings of adults in 2011. For unintentional poisoning from opioid overdoses, please see the attached HVHC PFS needs assessment. For intentional poisonings (suicide attempts) please review data from 2009-2010. There are listed separately in the injury trend data sheet on the last page.

How has data been used to prioritize the coalition's strategies? :
AIPC staff and partners have gathered and analyzed data from multiple sources for a variety of purposes over the years. We employ epidemiological data review methods with archived data, engage in gap analysis, and collect quantitative and qualitative primary data when existing data is insufficient. We use a hybrid process, incorporating public health and behavioral health planning modes. With that data we bring together stakeholders from a variety of sectors to review the findings, conduct literature reviews and look at existing "best practice" lists, and assess community readiness for potential initiatives. Then, depending on the process outcomes, we develop evaluation criteria and implement.

Attached, at the end of this submission, are several documents that show how we have assessed multiple community safety issues, by analyzing a wide variety of data. Along with those reports are implementation plans, including evaluation methods to address the findings of the assessments.

How will data be used to monitor injury trends and success of implemented programs? :
The process listed above, and the process listed below are cyclical. They are not done in a vacuum. The answer to this question is that we monitor the ongoing evaluation results, on the process level, and on intermediate and long term outcome levels. Based

on this information we make adjustments as needed, including ditching practices that turn out to be useless, adjusting efforts that show potential but need to be recalibrated, and push for sustainability of great efforts that can become "institutionalized" by organizations such as the school district, criminal justice system, etc.

How will data be used to determine future injury prevention strategies? :
Periodically AIPC, and its partners review data trends to determine where to focus our efforts. As part of that process we consider a variety of factors. We have a prioritization matrix that helps us focus on unmet community needs. Part of the process includes conducting literature reviews to determine the most recent findings regarding best practices. Where best practices are slim or under-researched, we design strategies based on latest research developments. Because many of the health issues include unsafe behaviors, we spend a lot of time determining which behavior change theories and theoretical constructs would best suit our needs, and those of our target audiences.

Based on your data and/or coalition priorities, identify at least three injury areas your coalition is addressing. :
Traffic safety
Substance use/misuse
Violence

Criteria 3: Effective Strategies to Address Injuries:
Coalition-supported initiatives should be promising or evidence-based and address the injury priorities listed above. Strategies should include current projects or projects in the planning stages. At least three coalition-supported projects must be included in the application.

A list of evidence-based strategies (not exhaustive) can be found here.

Criteria 4: Evaluation Methods:
Describe how each project is being measured and evaluated.

SECTION 4: Community Inventory of Safety and Injury Initiatives:
Conduct a community-wide audit and document all the injury-related programs, policies, and practices available in your community.

* Note: Many local health departments may have completed a Community Needs Assessment. Consider working with these organizations in putting a comprehensive inventory for Safe Communities America accreditation.

ADDITIONAL INFORMATION:
n/a

Are there any additional stories you would like share about your work in becoming a safe community? :

Ms. Carrie Nie
Safe Communities America
National Safety Council
1121 Spring Lake Drive
Itasca, Illinois 60143

Dear Ms. Nie

The Municipality of Anchorage is committed to promoting safety in our community. As you know Anchorage has been a designated Safe Community since 1998. We look forward to engaging in the re-designation process with the help of our partners at the Alaska Injury Prevention Center.

Over the years we have found that it takes multiple stakeholders working together to make change. We are committed to using data to inform the prioritization of our efforts. At the same time we believe this cannot be done in a vacuum, but work hard to be inclusive by involving members of the community all along the way.

Thank you for your consideration of our application as well as the time you devote to making America and all of our communities safer.

Best Regards,

Mayor Ethan Berkowitz

The Alaska Injury Prevention Center

5/15/2017

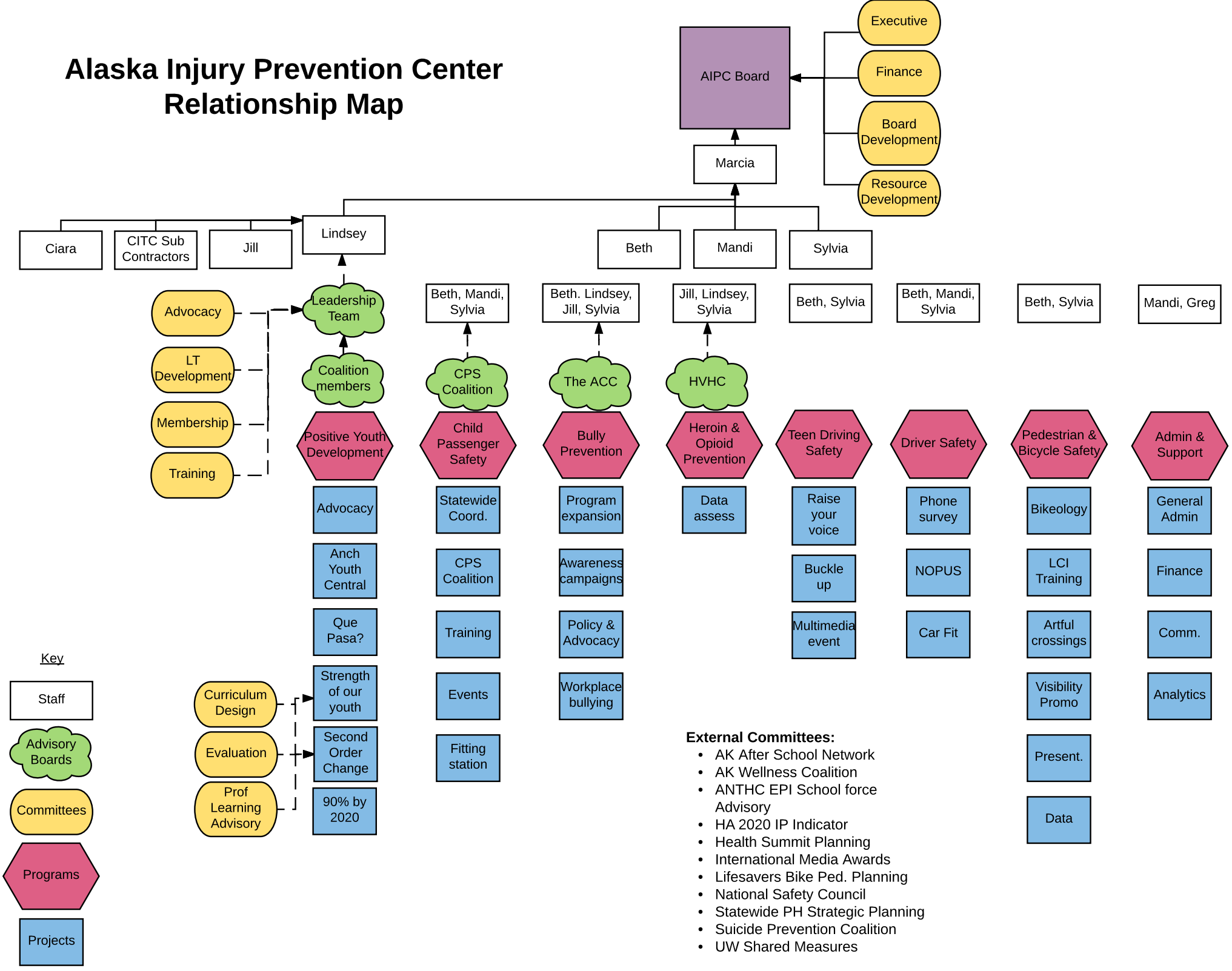
Board of Directors

BOARD MEMBER	ORGANIZATION	E-MAIL	Joined
Glaser, Gordon	Retired - SOA DPH Health Program M	mensch@acsalaska.net	1/1/1998
Johnson, Nathan	Providence Health and Services Alaska	nathan.johnson@providence.org	8/5/2015
Kerosky, Michael (Non-Voti	Senior Strategist	mekerosky@me.com	2/18/2015
Kompkoff, Krystal	Alaska Job Corps Center, OA/CTS Manager	kkompkoff@yahoo.com	11/10/2015
Orley, Soren	Assoc. Professor UAA	seorley@uaa.alaska.edu	4/22/2009
Saylor, Brian (non-voting	Retired Director, Institute for Circumpolar Health	Bsaylor@gci.net	6/27/1905
Strayer, Hillary	ANTHC Injury Prevention Specialist	hdstrayer@anthc.org	1/11/2011
Sullivan, Ronni	Retired Director Southern Region EMS	ronni@gci.net	6/28/1905
Taylor, Corlis	Mngr., Hosp. Educ.& Media Fairbanks Memorial H	corlis.taylor@foundationhealth.org	
Washington, Angie	Trauma Nurse Director	alwashington@anthc.org	3/8/2016

Stakeholders	Organizational Affilitation	Sector
Daniel Losk	State Farm	Funder
June May	South East Alaska Region Health Corp	Program Partner
Judith Owens	University of AK Community Engagement	Program Univeristy
Brice Wilbanks	Starfish Enterprise	youth
Haley Edmonson	Raise Your Voice	Youth
Samuel Chang	Raise Your Voice	Youth
Lori Grassgreen	Alaska Association School Boards	Advisory
Heather Coulehan	Alaska Association School Boards	Advisory and Program Partner
Cristy Willer	Cook Inlet Tribal Council	funder
June Sobicinski	United Way of Anchorage	funder
Thomas Azzarella	Alaska Afterschool Network	partner
Karen Zeman	Spirit of Youth	ACC
Katie Dougherty	Anchorage Muni - Vision Zero	City Partner
Sara Clark	State of AK Department of Behavioral Health	Funder

Tom Begich	State Senator	Politician
Charlie Daniels	Healthy Voices Healthy Choices	Program Partner ACC
Rebecca Koford	Youth Court Exec Director	Program partner and advisory
Ingrid Stevens	Alaksa Native Tribal Health Consortium	Advisory ANTHC partner
Tammy Kramer	Alaska Highway Safety Office Director	Funder
Susan Goldenstein	Manager, Prevention, Education & Outreach	National partner
Jane Fellman	Safe Kids Kenai CPH	Program partner
Amber Kroeker	IP Program Coordinator	Statewide partner
Rhonda Schneider	Nome Community Center Exe Dir	Program Partner Statewide
Ellen Provost	Alaksa Native Tribal Health Consortium EPI Direc	Advisory ANTHC Epi partner
Deb Hull-Jilly	State of AK Epi Director	Advisory State Epi Partner VDRS
Katie Reilly	State Injury Prevention Director	Advisory State partner ASVIPP
Anthony Rola	Marketing and Communications	ISMA
Cathy Kwak	Safe Kids Hong Kong	ISMA
Martha Wilcox	Safe Kids Worldwide	ISMA
Barbara Minuzo	Safe Kids Australia	ISMA and Safe Community
Lorie Wolf	The Foraker Group	Partner
Katie Reiley	State IP Director	partner
Laura Herman	Four A's	Program Partner
Kim Kovol	Bean's Cafe	Program Partner
Ambrosia Romig	State Trauma Registry	research
Rhonda Johnson	UAA Public Healh	Research Univeristy
Bridget Hanson	UAA Behavioral Health Resarch	Research University partner
Karen Heath	UAA Center for Human Development	Research University/CHD
Jayne Andreen	Council on DV & SA	
Claire Schleder	Department of Public Health	Funder
Beth Verge	KTUU (NEWS)	Media
Steve Cleary	Alaska Trails	Program partner
Ethan Berkowitz	Mayor of Anchorage	Politician

Alaska Injury Prevention Center Relationship Map



External Committees:

- AK After School Network
- AK Wellness Coalition
- ANTHC EPI School force Advisory
- HA 2020 IP Indicator
- Health Summit Planning
- International Media Awards
- Lifesavers Bike Ped. Planning
- National Safety Council
- Statewide PH Strategic Planning
- Suicide Prevention Coalition
- UW Shared Measures

ALASKA TRAILS

Enhancing Alaska's trails through advocacy, education and technical assistance.

P.O. Box 100627 Anchorage, AK 99510
Ph: 907.334.8049 Email: office@alaska-trails.org

www.alaska-trails.org

August 3rd, 2017

Safe Communities America
National Safety Council
1121 Spring Lake Drive
Itasca, Illinois 60143

To Whom it may Concern:

Thank you for you for the opportunity to write in support of the Alaska Injury Prevention Center's (AIPC) application to the National Safety Council to renew Anchorage's accreditation as a Safe Community. In my role as Executive Director of Alaska Trails and as a board member for Bike Anchorage, I have had the privilege of working with AIPC on a number of different projects. Their dedication and professionalism has been a great asset to increasing safety and awareness – particularly for walkers and bikers – in Anchorage.

Alaska Trails is proud to work with AIPC and others on increasing safe opportunities for walking and biking in Anchorage. Trails, bikes lanes and pedestrian infrastructure are a sustainable, local, accessible choice for many activities year-round for both children and adults. Trails provide another active choice in the community that can lead individuals down the path away from obesity. Alaska Trails is works with partners like AIPC to highlight the health and economic benefits of trails and the many other benefits they bring to Anchorage and communities across Alaska.

Thank you for your time and consideration.

Sincerely,

Steve Cleary

Steve Cleary
Executive Director, Alaska Trails

Alaska Trails is a 501c3 non-profit, Tax ID #: 73-1677483

ALASKA NATIVE
TRIBAL HEALTH
CONSORTIUM

Roald Helgesen
ANTHC Chief Executive Officer
ANMC Administrator

August 8, 2017

Marcia Howell
Executive Director
Alaska Injury Prevention Center
4241 B Street, Suite 100
Anchorage, AK 99503

Dear Ms. Howell:

The Alaska Native Tribal Health Consortium is pleased to write this letter in support of our partnership with the Alaska Injury Prevention Center. The Alaska Native Tribal Health Consortium's Injury Prevention Program is committed to reducing the burden of injuries among Alaska Native People by working with other Alaskan organizations to develop innovative and culturally-appropriate injury prevention interventions. ANTHC's Injury Prevention Program has collaborated with the Alaska Injury Prevention Center for more than a decade, both as a partner agency and by participating on the Alaska Injury Prevention Center board.

All Alaskans, including the Alaska Native population, have benefitted from the efforts of the Alaska Injury Prevention Center. Together our organizations have provided Child Passenger Safety training and check-up events in Anchorage and rural communities around the state. We have partnered on publications on suicide characteristics and recently provided formative support for the Anchorage Collaborative Coalition focused on improving mental health and reducing suicidal tendencies of Anchorage youth. Staff from our program and the Alaska Injury Prevention Center often join forces to do outreach events and presentations at national and state conferences and are currently working together, along with the State of Alaska, to develop a statewide Injury Prevention Plan as part of the Alaska State Violence and Injury Prevention Program efforts. Our program's participation on the Alaska Injury Prevention Center board allows us to continually explore new avenues for collaboration.

The Alaska Native Tribal Health Consortium values the partnership with the Alaska Injury Prevention Center and looks forward to continued collaboration on reducing injuries and improving wellness for all Alaskans for many years to come.

Sincerely,

Roald Helgesen
Chief Executive Officer

Alaska Native Tribal Health Consortium
4000 Ambassador Drive, Anchorage, Alaska 99508
Main: (907) 729-1900 | Fax: (907) 729-1901 | **anthc.org**

SAFE KIDS KENAI PENINSULA

central peninsula hospital

August 8, 2017

Safe Communities America
National Safety Council
1121 Spring Lake Drive
Itasca, Illinois 60143

Topic: Safe Communities America Accreditation Program

Dear Safe Communities America,

Safe Kids Kenai Peninsula Coalition/Central Peninsula Hospital has worked in partnership with Alaska Injury Prevention Center (AIPC) in Anchorage for 17 years.

AIPC is a vital organization that has been involved in making a difference in saving lives not only in Anchorage but throughout the state of Alaska. They have done this in part through their partnerships, data collection, media campaigns, and programs that provide evidence based education and distribution of safety items.

Their partnership with Safe Kids programs throughout the state has mainly been with child passenger safety. Together we are working toward the same goal of making all Alaskan children safer when being transported in motor vehicles. AIPC data collection on seat belt and bike helmet usage throughout the state has provided our community with creditable data for our programs.

AIPC has reached out to the Kenai Peninsula High Schools by bringing safe driving awareness programs to our high schools. Their pedestrian safety program with "Be Safe Be Seen" reflective tape, reflective hats and gloves has also reached thousands of Alaskans.

As coordinator of Safe Kids Kenai Peninsula Coalition I highly recommend Alaska Injury Prevent Center for your Safe Communities America accreditation program.

Yours Truly,

Jane B. Fellman

Jane B. Fellman RN
Coordinator Safe Kids Kenai Peninsula Coalition

250 Hospital Place, Soldotna AK 99669
907-714-4539 / fax 907-714-4696
www.cpgh.org / email safekids@cpgh.org

AIPC
Alaska Injury Prevention Center.org

AIPC Board of Director's Meeting
12:00 – 1:30 pm
May 15, 2017

Welcome. Hillary called the meeting was called to order at 12:10 pm.

Nathan Johnson	Krystal Kompkoff	Sylvia Craig
Michael Kerosky	Lisa Fousek A::B	Lindsey Hajduk
Angie Washington	Marcia Howell	Ciara Johnson
Hillary Strayer	Beth Schuerman	Mandi Seethaler

Internal Minutes from March 14, 2017

- Quorum not present. Action Item: Mandi will email March minutes for a vote.

Action Items from March 14, 2017 Meeting:

- Mandi will re-email the Matrix with instruction to the Board. Completed 3/15/17. This item will be tabled until after the re-branding project is complete. If there are any Board Members that would like to work on this now, please contact Marcia.
- Mandi will re-email the co-tenant flyer to the Board. Completed 3/15/17
- Marcia will update the Board via email regarding the meeting with the State about the ACC. Completed 3/15/17
- A::B will forward the Power Point and the notes, Mandi will distribute them to the Board. The notes will be very informal. Completed 3/15/17
- Mandi will Doodle new dates for the May meeting. Completed 3/22/17

New Business

- Branding Conversation with Agnew::Beck. Lisa presented a PowerPoint (attached) and the group had a discussion. Lindsey will work with A::B on the next step and will contact the Board. Please watch for those emails. This presentation and discussion lasted about an hour.

Old Business

- Update on ACC and continuation funding. Marcia informed the Board that a new MOA has been signed between the members of the ACC and it has been accepted by the State. This will allow each group more autonomy while still sharing the

evaluation component. Each group will have continued funding to do our own work.

- Board Member Matrix. This item will be tabled until after the re-branding project is complete. If there are any Board Members that would like to work on this now, please contact Marcia.
- Lease Renewed. We successfully negotiated a lease agreement to stay in our current office space. Lindsey and Jill will move down the hall, which will still give us the option to find a suitemate for the front two offices and perhaps the reception area. If you know of someone looking for space, please have him or her contact Mandi. The increase to our current rent is about $500.

Financial Report

- Grant Fiscal Report. See attached. Special note, under each of the major grants are notes about anticipated funding next year. Marcia assured the Board that there is potential DBH funding after year four of the current project, possibly a year 5 or a different four-year project. We anticipate we will be able to complete the contract with HVHC (SPFPS) for less than the contract amount. Unused funds will be allocated to the Unrestricted Class. HVHC will likely contract with us again to evaluate the project in year two. Big thank you to Beth for securing another year of State Farm funding and a new grant for the Buckle Up For Life Program. The application for the AHSO grant was submitted last week. Tammy Kramer indicated that she would like for us to do the NOPUS project this year after it is approved.

Program Reports

- Award. The Dimond High School Student Government group nominated Beth and Sylvia for the 2016-2017 Anchorage Education Association, Friend of Education Award. AIPC was the only community member to receive an award. This highlights the dedication Beth and Sylvia have to safe teen driving!
- Opioid/Heroin Assessment. The assessment is complete and has been accepted by the State. If you would dike a copy, please contact Mandi. The next step is Strategic Planning.
- Youth Matter Mini Grant. See the attached flyer, as part of the implementation for the DBH Grant AIPC will offer Mini Grants for youth-led initiatives. This is a strength-based approach to preventing bullying. Lindsey was key in getting this project put together!
- Safe Communities Recertification Process. Marcia is working on our recertification as a Safe Community. This international designation and certification gives us access to a network of other agencies involved in similar work. It is useful for grant writing to establish credibility that we engage

community members, use data to determine which issues to address via best practices covering a broad range of topics to a variety of people. Lindsey will attend the Safe Communities Conference this fall.

- Second Order Change. Ciara, Lindsey and Jill have are wrapping up the pilot year of this four year project. A very successful first year provided valuable information on how to improve the project for year two. Applications are now available for next year. Two new agencies have applied, HVHC and Nine Star, and two returning agencies have already submitted their application, 21st Century and Campfire. Michael commented that the program received a very high compliment during the evaluation; each Executive Director that participated wants to continue to have their staff participate. Ciara and Lindsey presented the project at the Ready by 21 Conference, many major programs such as Boston Public Schools, are interested in using the agenda for professional development. Marcia shared that Second Order Change ties to bullying and is supported in part by the DBH Grant.
- Beth thanked Angie Washington for connecting her with the ROTC students. They were extremely helpful at Kids Day and it was a great partnership!

Action Items

- Mandi will email the March Board Meeting minutes for an email vote.
- Lindsey will connect with the Board regarding the next steps for re-branding.

Next Board Meeting

- July 11, 2017
- September 12, 2017 (Annual Meeting)
- November 14, 2017

Meeting Notes

Alaska Injury Prevention Center Branding Project: Meeting with the Board

March 14, 2017
12-1p.m. AIPC Offices

Participants

- Brian Saylor
- Soren Orley
- Nathan Johnson
- Michael Kerosky
- Marcia Howell
- Beth Schuerman
- Gordon Glaser
- Ronni Sullivan
- Sylvia Craig
- Lindsey Hajduk
- Mandi Seethaler
- On the phone: Corlis
- Angie Washington

Questions

Core Purpose: Promote wellness, prevent injury, and improve safety in Alaska.

1. **Who are your target markets?**

Intergenerational, youth, AYDC board serves agencies, AIPC serves individuals, AIPC targets at-risk populations – safety, injury, and those aspects of the population. Challenge of having "injury prevention" in title. Incorporate wellness. At-risk is deficit, not strengths-based. Get away from idea of purely injury. Safety and wellness is strength-based. Kids, seniors, any age – not trying to influence only special groups. Trying to influence the community and general public.

2. **Who are your stakeholders? Prioritize your stakeholders in order of importance.**

Policy makers, Foraker, United Way, State, local governments, non-profits with related causes, strategic alliances, police and fire, medical providers and hospitals. Payers, insurers (state farm). People who benefit – moms with young kids, young drivers, the people who benefit from programs. School district, people who work with youth – 20 agencies pay money to coalition (key stakeholders). Kids at risk of bullying.

3. **How do you want to be perceived by each audience?**

Board wanted to be the go-to organization – a resource and leader in the field. AYDC is strength-based – this should continue. Resource for other organizations. Subject matter experts. Not just concepts, actions are happening. New things and ideas. Good collaborative partner. Not just outcome oriented. AIPC is research-based, evidence-based. Want to be perceived that it's worthwhile and wants to make a difference, that it's evaluated. Experienced, evaluated, experimental.

4. **What is your most unique strength?**

No one else is being the umbrella and doing everything. Drama free group. Well managed. Strong staff. Strength-based

5. **What do you see as current weaknesses in your organization?**

Not known. Invisible. May not be a bad thing – funding agencies know where to go. Don't want to be in the headlines all the time, but need a little more awareness. Move beyond professional model so other people can see them as a more recognizable organization.

6. **What are the trends and changes that affect your service sector?**

Contraction of nonprofit sector and state fiscal crisis. Facing cutbacks. Reach through partners will shrink. More funding is going toward coalitions, less agencies. Evaluation is an upward trend. Strength-based is an upward trend. Recognition of prevention upward. Prevention usually first to go with funding cuts. Health systems are heading in direction of keeping people out of hospital – financial motivation. Awareness of ACEs and developmental process increasing.

7. **Where will your organization be in five years? In ten years?**

Skip

8. **Place yourself in the future. If your organization could do anything or be anything, what would it be?**

Skip

9. **How do you measure success?**

Meeting needs of people who come to us as a resource. Repeat funding sources. Increase in unrestricted reserves, allows them to work on projects that maybe don't have funding.

10. **What are the potential barriers to the success of your services?**

If we move into a world with more collaboration and partnerships, there will be more challenges. As you grow, board and staff changes, people looking at personal targets rather than group – will be a challenge. Stay relevant. Funding – relied almost entirely on state and federal funding.

11. **Who are your organization's peers? Is there a peer that you admire most? If so, why?**

Native health corporations. Overlap and working together for common goals. Data resource. University and evaluation. Safe Kids. Mirror link.

12. **What will be the impact if AIPC changes their name?**

For it – not well known, wouldn't have a big cost. Wouldn't be an issue for the orgs on board. Injury prevention is a smaller box – is limiting. Depends on how you market it and go through the transition. Acronyms are not a strong identity. Hard for others to recognize.

13. **What images, colors, ideas come to mind when we think of the AIPC? Wellness, safety and injury prevention?**

Steer clear of red. Think of blue. Something positive. No injured people on crutches. Intergenerational if people are included. Child to senior. Trust. Strengths based and positive. Wellness. Smiling. Happy. Health. Diversity of what they do and who they serve.

14. **What are the three most important outcomes you hope to achieve from this process?**

Identifiability. Symbol that comes to represent org. Lasting power that you may not get from a stack of letters.

15. **Communicate one message**

Wellness and safety.

Come up with messaging, something catchy.

Notes:

Sample ideas for May. Gather feedback on concepts from outside sources: e.g. senior center during social hour, cps coalition.

May 9th meeting being rescheduled.

AIPC
Alaska Injury Prevention Center.org

Minutes for January 10, 2017
AIPC Board of Directors' Meeting
12:00 -1:00 pm

1) Welcome and Introductions.

Marcia Howell	Krystal Kompkoff	Ronni Sullivan
Lindsey Hajduk	Krystal Mason	Corlis Taylor
Sylvia Craig	Soren Orley	Angie Washington
Mandi Seethaler	Brian Saylor	
Michael Kerosky	Hillary Strayer	

2) Internal Business: (5 minutes)
   a) Approve Minutes from November 16, 2016 Meeting
      i) Ronni moved to approve the minutes. Angie seconded the motion. There were no objections.

3) Action Items from November Board Meeting.
   a) Mandi will send out the attendance for 2015 and 2016 before the next Board Meeting. *Sent via email 11/21/16.*
   b) Marcia will work with Hillary on a matrix that Hillary once provided. Krystal Kompkoff is on an AYDC committee and also has a matrix. They will get together to develop recommendations to be circulated. At the next meeting the Board will create a committee for Board Member solicitation. *Matrix provided at meeting 1/10/17 and AI Mandi will email updated Matrix to Board.*
   c) Lindsey will email Gordon evaluation from SOC. *Done.*
   d) Beth will email Gordon and Angie information about CarFit training and volunteer opportunities including the possibility of working with Bartlett and Dimond JROTCs. *AI Beth is working to plan a CarFit training day before the next board meeting. She will invite all board members and plans to have a CarFit event after the Board Meeting in March.*
   e) Mandi and Jill will coordinate creating an email invitation and distributing. *Sent via email.*
   f) Mandi distribute ASSVIP handout to Board. *Sent via email 11/21/16.*
   g) Mandi will provide the Board with a copy of the final Advocacy Policy. *Sent via email 11/21/16.*
   h) The next Board meeting will scheduled for 15-30 minutes longer. *Due to scheduling conflicts with the conference room the January meeting will only be one hour, but please plan 1 hour and 30 minutes for all future meetings.*

4) Old Business (15 minutes)
   a) Board Member Matrix (move to New Business)
   b) Alaska Health Summit Plenary, January 18, 12-1:15

i) Marcia is part of a team presenting at the Alaska Health Summit to tell the story of the DBH grant. They will discuss the real lessons learned about working with multiple partners and different community members. Everyone is welcome to attend.

5) Financial Report (5 minutes)
   a) Grant Fiscal Report
      i) See attached report. Mandi will correct the error for the UAA Learning by Giving.
   b) Thanks for Board Contributions
      i) The staff is very grateful that every board member contributed for 2016. This is a valuable tool in grant applications. Again, we thank all the board members!
   c) Pick Click Give
      i) Applicants for the PFD can choose AIPC for the Pick Click Give Program. Staff is promoting via our website, newsletters and social media. Please spread the word. Staff is also open to suggestions for promotion.

6) Program Report (15 minutes)
   a) Lindsey's 6 month anniversary
      i) Marcia and the Board congratulated Lindsey on 6 positive and productive months at AIPC. Marcia and the AYDC Leadership Team will conduct the necessary evaluations for her employee file. Lindsey plans to attend the Hopkins Summer Institute for Injury Prevention presented by Dr. Fowler using the Public Health Model. Most of the Staff and Board have attended in the past and have found this to be a very valuable experience. Lindsey welcomes the opportunity to attend.

7) New Business (5 minutes)
   a) Development Plan
      i) Marcia attended Development Plan training at Foraker and presented a copy of the Non-Profit continuum. AIPC is already taking the necessary steps in this process. The branding project that we are working on is vital to this process and timely to the development.
   b) Branding
      i) Lindsey has been working to evaluate the branding proposals from multiple agencies and individuals to guide us through the process of re-branding AIPC and AYDC. After careful consideration, Agnew Beck (AB) is the best agency to assist us with strategic identity development. The first step is a conversation with AB regarding our history, our projects and where do we see ourselves in the future. Based on this conversation the next steps will be developed which could include surveys or more conversations, this may include the board and community partners. What should people feel when they think of us? AB will assist in developing a concept and design for branding that resonates with us. We are hopeful to have significant progress before the summer. We are excited to work with AB as they will have a specialized staff that will attend all meetings so all the different components will participate in the conversation and understand the whole vision. If you are interested in reading

the proposal from AB please contact Lindsey. It is our intention that the branding leads to a better understanding of our agency and mission that we can build our business plan on and pursue funding. Sylvia mentioned that AB proposal indicated experience with similar agencies, so they will have a better understanding of our agency. Marcia related Thea's experience of attending the Division of Behavioral Health conference, which will give her good perspective.

c) Office Location
   i) Our sub-lease expires at the end of October. Right now we are exploring our options, which include moving to a new space, finding a new co-tenant or negotiating our current lease. As part of our investigation into a new tenant, we have created a flyer, which Mandi will email to the board. If you know of someone that might be a good partner, please let Mandi know.
d) Board Member Matrix
   i) Prior to this meeting a matrix was emailed to all board members. Marcia made some edits, which Mandi will email to everyone. Board members should come prepared to the next meeting with suggested edits to the form and in the next two weeks should complete the matrix for themselves and send to Mandi. She will compile the results.
e) Mandi asked for approval to pay the insurance premium electronically. It is over the $5000 limit. Krystal Kompkoff moved to allow this, Hillary seconded the motion. There were no objections, but Soren recommend that Mandi send an email to authorized check signers each month about the payment.
f) Hillary Strayer invited everyone to participate in a flash mob on January 26 at the Native Heritage Center, 5:30 to 7 pm. A local dance group has created a Native Language dance about drowning. They will be filming the project and would love to invite volunteers to attend and dance.
g) Brian is teaching a Capstone course in Public Administration. If you have a project that could use the supervised attention of a very highly motivated graduate student, they are in need of projects. Please contact Brian.

8) Future Meetings. (2nd Tuesday, every odd month 12-1:30 except for Annual Meeting 12:00-2:00)
   a) March 14, 2017
   b) May 9, 2017 (need to reschedule)
   c) July 11, 2017
   d) September 12, 2017 (Annual Meeting 12pm-2pm)
   e) November 14, 2017

9) Action Items
   a) Mandi will email updated Matrix to Board. (get matrix from MH)
   b) Al Beth is working to plan a CarFit training day before the next board meeting. She will invite all board members and plans to have a CarFit event after the Board Meeting in March.
   c) Mandi will email co-tenant flyer to Board.

AIPC
Alaska Injury Prevention Center.org

AIPC Board of Directors' Meeting
12:00 -1:00 pm
November 16, 2016

1) Ronni called the meeting to order at 12:05 Welcome and Introductions. In attendance:

Gordon Glaser	Susan Soule	Lindsey Hajduk
Nathan Johnson	Ronni Sullivan	Mandi Seethaler
Krystal Kompkoff	Angie Washington	
Brian Saylor	Marcia Howell	

Action Item: Mandi will send out the attendance for 2015 and 2016 before the next Board Meeting.

2) Internal Business:
   a) Approve Minutes from September 13, 2016 Meeting
      i) Angie moved to approve the minutes. Krystal Kompkoff seconded the motion, there were no objections.
   b) Thank Susan for her many years of service
      i) On behalf of the board, Ronni offered sincere thanks to Susan for her longtime, invaluable service to the Board. Other Board Members also offered their thanks and expressed how much we will all miss Susan as part of the Board. Marcia presented Susan with a token of appreciation and her thanks. Susan is leaving the Board as she is ready for a change. She is proud of the growth of AIPC and the stability of the organization. She looks forward to helping another new organization do the same. She is still willing to volunteer as needed.
   c) New Board Member Search
      i) The Board had a discussion regarding where to start the search for new members. Considerations included:
         (1) Should specific agencies always have representation, what about financial backers? Some of the agencies that might be a source would be the Alaska State Troopers, Anchorage Police Department, Department of Transportation, AYDC Membership, State of Alaska, State Farm, AAA, and the Safety Council, Anchorage School District.
         (2) The need to balance content expertise with governance ability as well a finding a good fit with current board.
         (3) Number of voting members versus ex officio members.
            (a) There was general agreement that there be an odd number of voting members, and
      ii) that ex officio members are valuable.Action Item: Marcia will work with Hillary on a matrix that Hillary once provided. Krystal Kompfoff is on an AYDC committee and also has a matrix. They will get together to develop recommendations to be circulated. At the next meeting the Board will create a committee for Board Member solicitation.

3) Action Items
   a) Reschedule November Board Meeting. This was handled via Doodle and the next Board Meeting will be held 11/16/16 at noon at AIPC. Completed.
   b) Mandi will take appropriate action to add Krystal to the Bank Signature Card.

Completed.

c) Mandi will email the board to see which members would like to volunteer for this workgroup. This group will Discussion unrestricted funds and cash reserves as part of the Business Plan and Strategic Plan. The email was sent, but no Board Members volunteered.
d) Advocacy Policy – Lindsey will edit and Mandi will send out for an email vote. 4(b) The email was sent, but based on comments will be addressed later in this meeting.
e) Proposed Core Value Revision and Core Programmatic Approach - Mandi will send this to the Board for an email vote. Will include a comparison of current core values. Not enough responses were received to approve. This will be addressed during this meeting.

4) Old Business
   a) Core Purpose and Values
      i) After a useful discussion Krystal Kompkoff moved to approve the Core Purpose and Values as written. Nathan seconded the motion and there were no objections. The new core purpose is: Promote wellness, prevent injury and improve safety (in) of (for all) Alaska(ns). (I'm not sure if the for all Alaskans was included.) The new core values are to be: Innovative, collaborative, Inclusive and Respectful, Data Driven, Strength-based.
   b) Advocacy Policy
      i) After discussion Krystal Kompkoff moved to approve the Advocacy Policy with three edits. A Line 3d will be added to include "supported by data", line 5e will be amended and line 6 will be edited for a typo. (I think the third sentence was to read: AIPC also values the need to advance **good data** driven public.....
      ii) Action Item: Mandi will provide the Board with a copy of the final Advocacy Policy.

5) Financial Report
   a) Grant Fiscal Report
      i) Mandi reported that many grants closed at the end of September. We did an excellent job of maximizing our grant funding. We are in good shape, cash flow is excellent and we have many new grant projects beginning. Mandi did mention that she neglected to include the new CITC 2017 grant for $150,000.

6) Program Report
   a) AYCD Update
      i) The Second Order Change launch event (9/30) was a huge success, with over 80 attendees. We have all three cohorts moving through their SEL training series, with 10 agencies and 50 staff people served.
      ii) We're celebrating the 20th anniversary of positive youth development in Anchorage (November 1996) with a small celebratory dinner last week, and working on some education and public awareness through local media.
      iii) Action Item: Lindsey will email Gordon evaluation from SOC.
   b) Pediatrician Outreach
      i) Beth and Sylvia have created a CPS Brochure for Pediatricians. It will be distributed to doctors around Anchorage as part of a package of injury prevention material for parents which will include Start the Conversation and how to help your teen be a safe driver.
   c) CarFit- Volunteer Opportunity
      i) Funding for the CarFit program was approved the FFY2017 Safe Roads grant. Beth is trained in the program and will be looking for others to be trained. The goal is for

older adults to be mobile as long as possible (while being safe). Gordon volunteered his wife's care for practice.

ii) Action Item: Beth will email Gordon and Angie Washington information about training and volunteer opportunities. It was recommended that Dimond and BartlettJROTCs would love this project.

d) UAA Community Engagement

i) AIPC was awarded $2500 for car seats for immigrant families based on student submitted grants. This opens up a valuable relationship between AIPC and the Community Engagement Department at UAA for future partnerships.

7) New Business

a) Alaska Health Summit

i) AIPC and three other partners were chosen to provide a plenary panel presentation at the Alaska Health Summit on the need for multi-disciplinary collaboration on public health initiatives.

b) ASSVIP Plan

i) Marcia and Hillary are members of the statewide injury and violence prevention strategic planning group. This is the first time in many years the State has put energy into prioritizing injury prevention. They are also looking at utilizing the shared risk and protective factor approach, which is well aligned with our newly approved core purpose..

ii) Action Item: Mandi distribute handout to Board.

c) Holiday Gathering

i) AIPC will host the annual Holiday Gathering on December 9th. An invitation will be sent with more information.

ii) Action Item: Mandi and Jill will coordinate creating an email invitation and distributing.

8) Future Meetings. (2nd Tuesday, every odd month)

a) January 10, 2017 12:00 to 1:00 p.m.

b) March 14, 2017 12:00 to 1:00 p.m.

c) May 9, 2017 12:00-1:00 p.m.

There was conversation that it has become increasingly hard to cover the whole board meeting agenda in one hour. Nathan suggested the time be extended by 15-30 minutes. Nathan moved to adjourn the meeting, Gordon seconded the motion and there were no objections.

Action Items: (MANDI – after edits from Marcia and Lindsey update the list below as necessary)

1. Mandi will send out the attendance for 2015 and 2016 before the next Board Meeting.
2. Marcia will work with Hillary on a matrix that Hillary once provided. Krystal Kompfoff is on an AYDC committee and also has a matrix. They will get together to develop recommendations to be circulated. At the next meeting the Board will create a committee for Board Member solicitationLindsey will email Gordon evaluation from SOC.
3. Beth will email Gordon and Angie information about CarFit training and volunteer opportunities including the possibility of working with Bartlett and Dimond JROTCs.
4. Mandi and Jill will coordinate creating an email invitation and distributing.
5. Mandi distribute ASSVIP handout to Board.
6. Mandi will provide the Board with a copy of the final Advocacy Policy.

The next Board meeting will scheduled for 15-30 minutes longer.

AIPC
Alaska Injury Prevention Center.org

September 13, 2016
AIPC Board of Directors
Annual Meeting
12:00 – 3:00 pm

1) Welcome and Introductions
   a) Hillary Strayer called the meeting to order at 12:10 pm. All in attendance introduced themselves.

Sylvia Craig	Krystal Kompkoff	Mandi Seethaler
Jill Dutton	Soren Orley	Susan Soule
Lindsey Hajduk	Kris Pitts	Hillary Strayer
Marcia Howell	Natasha Price	Ronni Sullivan
Ciara Johnson	Brian Saylor	Angie Washington
Becky Judd	Ruth Schoenleben	
Michael Kerosky	Beth Schuerman	

2) Internal Business
   a) Approve Minutes from May 24, 2016 Meeting
      i) Hillary Strayer moved to approve the May 22, 2016 meeting minutes. Krystal Kompkoff seconded the motion. There were no objections. (Attach Minutes May 24, 2016 Board Meeting)
   b) Board Executive Committee
      i) The executive committee terms are two years. We do not need to hold elections at this annual meeting.
3) Action Items from last meeting
   a) Discuss which AIPC Board Member would like to join the AYDC Leadership Team.
      i) They AYDC Leadership Team has extended an open invitation for a member of the AIPC Board to join the Leadership Team (LT). Susan is willing to join the LT as long as the team is OK with her frequent travel. Michael Kerosky, on behalf of the LT welcomed her!
   b) Deborah and Marcia will plan gathering for AIPC Board and AYDC Leadership Team. Done 7/12/16.
   c) Mandi will send a reminder to those that have not taken the Strength Finder. The reminder was sent and the last board members have agreed to take the Strength Finder.
   d) Mandi will request Bio/Resume from Angie as part of the due diligence for the newest board member. Angie Washington sent her resume and it was distributed to the Board via email.
4) Reports
   a) Presentation of FY 2015 Audit
      i) A full copy of the Audit and Financial Statements (FS) were provided via email to the Board and Leadership Team. Soren Orley (as a person of knowledge) reviewed the Audit and FS and the Draft 2015 990 Tax Return in detail. AIPC is in compliance by filing the 990. The auditor management letter had "no comments", which is the best we can achieve. Soren is pleased that we are in a stable financial situation given the uncertainty of the economy at this time. Our financial position is stronger than the previous year, the

adoption of AYDC has strengthened AIPC and Soren has no concerns at this time.

(1) Email from Michael Foster, Auditor, Foster and Company, September 12, 2016... *"We have audited the financial statements and prepared the IRS form 990 tax return for the year ended December 31, 2015. Your audit received an unqualified opinion which is the best opinion you can get. Your accounting systems and internal controls are properly design and well maintained. For 2015, we tested your non-payroll expense internal controls and found no issues."*

ii) Unrestricted Funds and Cash Reserves. Brian reminded the board of previous discussions regarding a policy for cash reserves. Soren clarified that a true restriction can only be set by an external party. A policy can be drafted, but may be altered by the Board at any time. The policy does not necessarily need to be adopted as a Bylaw. The discussion was tabled for a later date. Action Item: Discussion unrestricted funds and cash reserves as part of the Business Plan and Strategic Plan.

iii) An updated Grant Financial Report was provided to the Board via email but was not discussed at this meeting.

iv) Ronni moved to approve the Audit and Financial Statements, Susan seconded the motion and there were no objections.

b) 2015-2016 Program Highlights

i) The 2016 Annual Report was provided at the Board Meeting. Staff members discussed each program. Please be sure to check out our website to see the videos referred to www.alaskainjurypreventioncenter.org

ii) Marcia will be traveling to Finland for the International Safety Media Awards later this week. The entries this year were outstanding, with 96 entries coming from all over the world! Additionally, Soren's daughter, Shannon will also be traveling to the conference to present her thesis project on teen driving best practices.

c) Strengths Finder

i) Michael Kerosky, a certified Gallup Strength Finder Coach, presented a compilation of the results of the Strength Finder Report of the staff, Board and LT team. It highlights our strengths as an organization and areas where we can develop our skills.

5) New Business

a) Strategic Plan/Retreat Update (Handout from Foraker)

i) Review Highlights

ii) Policy Manual Review and updates (Advocacy)

(1) Lindsey compared the AYDC and AIPC policy manuals. With the help of the AYDC leadership team, policy items were removed from the AYDC manual so that it is only procedural. The AIPC manual will cover policy issues. (Mandi – ask Lindsey for revised procedure manual.)

(2) Advocacy

(a) Prior to the merge, AYDC had begun the process of creating and Advocacy Policy. A draft of that policy was emailed to the Board Members that the AYDC LT proposes that AIPC adopts as policy. A discussion resulted in the following (Action Items):

(i) Lindsey will add verbiage to ensure that Advocacy does not violate grant/contract terms.

(ii) Mandi will email the revised Advocacy policy along with a copy of the Prioritization Matrix to the board. There will be a two-week email input/discussion period. Then Mandi will email the Advocacy policy out for a vote from the Board.

iii) Proposed Core Value Revision & Core Programmatic Approach
   (1) Action Item – Mandi will send this to the Board for an email vote. Will include a comparison of current core values.
iv) Business and Funding Plan Workgroups
   (1) Marcia proposed that we engage Foraker to assist a work group in the development of a business plan and a fiscal/funding/development plan. Action Item: Mandi will email the board to see which members would like to volunteer for this workgroup.
v) Board Giving
   (1) The AIPC staff reminded the Board about the importance of Board Giving. It should be a meaningful donation to the Organization. Board members can send a check or donate on line at www.alaskainjurypreventioncenter.org . This donation allows AIPC to apply for grants specifically with the Rasmuson Foundation, but with other donors as well.
vi) Other Business
   (1) Mandi asked the Board to consider adding Krystal Kompkoff to the bank checking account as an authorized signer. Bank Signature Card
      (a) Ronni moved to add Krystal and Hillary seconded the motion. There were no objections. Action Item: Mandi will process the appropriate paperwork with the bank.

6) Action Items
   a) Mandi – pull out items in orange from above.
7) Future Meetings. (2nd Tuesday, every odd month)
   a) November re-schedule Action Item: Mandi will Doodle the Board for a new meeting. When the date is determined the AYDC Leadership Team will be informed and invited.
   b) January 10, 2017 12:00 to 1:00 p.m.
   c) March 14, 2017 12:00 to 1:00 p.m.
   d) May 9, 2017 12:00-1:00 p.m.

Campaign	Tool	Plan / Message	Audience	Goal	Dates / Deadlines	Measurement / Evaluation
Teen Driving Safety	Raise Your Voice Media Advisory	Notify media of RYV unveiling event. Place videos on AIPC website and Facebook page. Have school districts include information in their newsletters.	Teens, parents, general public.	Raise awareness of the program. Increase student participation.	March 22, 2016 (2017 dates?)	KTUU and KTVA both covered the event. Next year: Promote more at the start. Include info about the $500.
Teen Driving Safety	Buckle Up/Phone Down	Contact ASD and other participating school districts to arrange for media coverage of student activities.	Teens, parents, general public.	Raise awareness of the program. Increase student participation.	March 30 – April 24, 2016 (2017 dates?)	ABC/FOX covered the event at ER High School. Next year: Get a list of more events at other schools. Coordinate timing around Every 15 Minutes event.
Bike Safety	Bikeology Press Release	Contact ASD and other participating school districts to arrange for media coverage of bike safety classes.	Parents, schools, general public.	Raise awareness of the program.	Media avail at Wendler April 13 12:30-1:30.	KTUU, KTVA & ABC/FOX covered the event. Only ABC aired the story.
Seat Belt Use	Click It or Ticket (CIOT)	Support law enforcement statewide to provide support/info regarding Child Passenger Safety. Provide power point training.	Primary: Law Enforcement Secondary: General public to heighten seat belt awareness.	Goal: Increase seat belt use, so that in June when we do the observations for NOPUS (National Occupant Protection Use Survey) the rate will be higher.	May 2016 Meet with APD & AST to coordinate media outreach.	Survey results to be issued July 27
Child Passenger Seats (CPS)	CPS Event in Juneau with JPD, State Farm and AHSO	Flier posted on Facebook. Greg to contact local media to arrange interviews	Parents/grandparents	Increase awareness of child passenger seats and correct installation	Send media request: July 7 Event: July 14	How many media interviews? How was the turnout?
Driver Safety	Driver Behavior Phone Survey	Encourage people to take the phone survey	All Alaskans	Encourage people to take the survey	July 18 – Earned media July 20 – Survey begins New Dates???	How many media interviews? How was the response to the survey?
Seat Belt Use	Visual Survey	Announce results of the May survey	All Alaskans	Seat belt use awareness	July 27 – Press Release New Dates???	
Driver Safety	DWI Awareness/APD Campaign	Drive Sober or Get Pulled Over		DWI awareness	August 17 – Sept 5, 2016	AIPC to be available for interviews.
Pedestrian Safety	Artful Crossings				September	
Opioid Use	National Alcohol and Drug Addiction Recovery Month	AIPC staff to be available for interviews.			September	
Child Passenger Seats (CPS)	CPS Week	AIPC staff to be available for interviews. Greg to promote 9/23 car seat check	Parents/grandparents/ all Alaskans	Increase awareness of child passenger seats and correct installation	Sept. 18 - 24 Sept. 15 - Media Advisory Sept 23 car seat check	How many media interviews? How was the turnout?
Fall Prevention	Fall Prevention Awareness Week	AIPC staff to be available for interviews. Team with DPH?			September 22 – 28, 2016	
Teen Driving Safety	Teen Driver Safety Week				October 16 – 22, 2016	
School Bus/Pedestrian Safety	National School Bus Safety Week	AIPC staff to be available for interviews.		Increase awareness of pedestrian safety, support national campaign.	October 16 – 22, 2016	
Poison Prevention	National Poison Prevention Week	AIPC staff to be available for interviews.			March 19 – 25, 2017	
Driver Safety	Distracted Driving Awareness Month	AIPC staff to be available for interviews.			April 1 - 30, 2017	

Public Health	National Public Health Week	Various topics. AIPC staff to be available for interviews.			April 3 - 9, 2017	
Playground Safety	National Playground Safety Week	AIPC staff to be available for interviews.			April 24 – 28, 2017	
Bike Safety	National Bike Month		Parents, schools, general public.		May 1 - 31, 2017	
Mental Health	Mental Health Month	AIPC staff to be available for interviews.			May 1 - 31, 2017	
Teen Driving Safety	Global Youth Traffic Safety Month		Teens, parents, general public.		May 1 - 31, 2017	
Seat Belt Use	CIOT Campaign	AIPC staff to be available for interviews.	General public to heighten seat belt awareness.		Earned media: May 8 – June 15, 2017 Paid media: May 15 – 29 Enforcement: May 22 – June 4	
Generic AIPC Promotional Ideas						
AIPC Promotion	All topics	Host an annual open-house for media.	Media	Increase public awareness of the mission and programs of AIPC.	????	Measure increase in media contacts.
AIPC Promotion	All topics	Write and distribute “evergreen” press releases on AIPC’s five main focus areas Bike Safe, Walk Safe, Drive Safe, Car Seats, and Teens	Media	Increase public awareness of the mission and programs of AIPC.	????	Measure increase in media contacts.

Anchorage Demographic Data

2016 Estimates

Median age: 32
Percent of population -
Male: 51%
Female: 49%

Under 5 years:	21,826
5 to 9 years:	20,524
10 to 14 years:	20,331
15 to 17 years:	12,490
18 and 19 years:	7,685
20 years:	3,993
21 years:	4,028
22 to 24 years:	13,861
25 to 29 years:	23,958
30 to 34 years:	20,130
35 to 39 years:	19,149
40 to 44 years:	19,059
45 to 49 years:	21,749
50 to 54 years:	21,713
55 to 59 years:	18,769
60 and 61 years:	6,253
62 to 64 years:	7,512
65 and 66 years:	3,786
67 to 69 years:	4,432
70 to 74 years:	4,860
75 to 79 years:	3,373
80 to 84 years:	2,221
85 years and over:	1,674

Education: 2011-2015
93% of those over 25 had a high school diploma or equivalent
33% of those over 25 had a bachelor's degree or higher

Unemployment July 21, 2017
5.90%
Unemployment Trends

Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Annual
2017	5.6	5.9	5.8	5.8	5.7	5.9							
2016	5.4	5.7	5.5	5.3	5.3	5.6	5.1	4.9	5.2	5.1	5.1	5.1	5.3
2015	5.3	5.4	5.3	5	4.9	5.2	4.7	4.5	4.8	4.8	5	4.9	5
2014	5.5	5.8	5.6	5.4	5.2	5.6	5.1	5	4.9	4.7	4.9	4.7	5.2
2013	5.6	5.6	5.4	5.3	5.1	5.5	5	4.8	4.8	4.9	5	4.9	5.2

2012	6	6.1	5.9	5.6	5.4	5.7	5.2	4.9	4.8	4.8	4.9	5.1	5.4
2011	6.6	6.7	6.5	6.2	6	6.2	5.7	5.5	5.5	5.4	5.5	5.5	6
2010	7	7.4	7.3	6.9	6.7	6.8	6.2	6.1	6.2	6.1	6.3	6.1	6.6
2009	6.2	6.4	6.5	6.3	6.4	7.1	6.6	6.4	6.7	6.6	6.4	6.5	6.5
2008	5.4	5.4	5.4	5	5.2	5.6	5.1	5.1	5.1	4.9	5.1	5.3	5.2
2007	5.3	5.3	5	4.9	4.6	5.1	4.6	4.7	4.9	4.6	4.7	5	4.9
2006	5.8	6.1	5.7	5.5	5.2	5.4	5	4.9	5.1	4.5	4.7	4.8	5.2
2005	6	6.3	5.8	5.6	5.2	5.6	5.2	5	5.4	5	5.4	5.3	5.5
2004	6.4	6.5	6.5	6.2	5.8	6.3	5.6	5.5	5.6	5.2	5.4	5.5	5.9
2003	6.4	6.8	6.5	6.4	6.2	6.9	6.1	6.1	5.9	5.4	5.8	5.7	6.2

These wage data are grouped into 21 occupational groupings. Click on the following group title to go to those occupations.

Hourly wage rates for some occupations where workers typically work fewer than 2,080 hours per year are not available. In these cases, annual wages are provided.

Management

SOC		Occupation Title	Mean Wage	Wage by Percentile				
			Mean	10th	25th	Median	75th	90th
	Nov-11	Administrative Services Managers	50.73	28.98	36.1	45.09	59.54	77.64
	Nov-41	Architectural and Engineering Mana	77.03	46.37	55.91	68.12	91.59	*
11-1011		Chief Executives	80.83	35.59	49.82	72.92	*	*
	Nov-21	Computer and Information Systems	59.07	37.75	44.63	53.59	62.56	86.26
	Nov-21	Construction Managers	63.99	36.58	46.57	59.07	81.35	96.23

	Nov-39	Education Administrators, All Other	44.43	21.07	31.66	46.33	55.98	67.94
	Nov-32	Education Administrators, Element	118,730	98,300	110,210	120,080	130,110	147,040
	Nov-33	Education Administrators, Postsecc	57.41	33.71	38.47	49.25	73.33	91.51
	Nov-31	Education Administrators, Preschoc	31.77	19.65	25.03	31.83	37.36	45.63
	Nov-61	Emergency Management Directors	37.79	24.15	27.8	32.15	35.7	67.23
	Nov-31	Financial Managers	56.75	29.95	39.03	49.74	66.52	85.97
	Nov-51	Food Service Managers	27.67	19.29	21.63	26.12	32.59	39.21
11-1021		General and Operations Managers	55.25	25.87	34.23	47.43	67.68	92.76
	Nov-21	Human Resources Managers	55.04	32.76	40.43	49.39	68.45	79.72
	Nov-51	Industrial Production Managers	49.33	25.41	29.6	37.41	58.43	87.66
	Nov-81	Lodging Managers	33.93	20.13	22.25	28.97	42.52	48.36
	Nov-99	Managers, All Other	55.22	30.15	39.33	51.76	66.94	88.87
	Nov-21	Marketing Managers	51.92	32.41	36.85	44.87	57.91	84.42
	Nov-11	Medical and Health Services Manag	63.08	28.64	35.83	47.62	77.17 *	
	Nov-21	Natural Sciences Managers	50.73	37.87	42.35	48.88	54.81	64.77
	Nov-41	Property, Real Estate, and Commur	31.36	16.16	19.2	23.18	41.46	56.78
	Nov-31	Public Relations and Fundraising M	54.26	33.89	42.51	54.1	62	76.23
	Nov-61	Purchasing Managers	50.84	31.04	41.32	53.41	60.07	66.2
	Nov-22	Sales Managers	52.59	26.13	33.43	45.05	62.16	82.19
	Nov-51	Social and Community Service Man	38.06	21.8	26.21	35.31	47.75	58.14
	Nov-31	Training and Development Manage	42.12	22.5	28.44	39.7	48.06	69.8
	Nov-71	Transportation, Storage, and Distrib	44.15	29.1	35.47	42	50.94	61.96

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Hourly wage rates for some occupations where workers typically work fewer than 2,080 hours per year are not available. In these cases, annual wages are provided.

Business and Financial Operations

		Mean Wage	Wage by Percentile				
SOC	Occupation Title	Mean	10th	25th	Median	75th	90th
13-2011	Accountants and Auditors	38.87	24.99	29.04	36.03	46.06	58.05
13-2021	Appraisers and Assessors of Real Es	38.12	21.74	29.1	39.64	47.11	54.8
13-2031	Budget Analysts	37.71	26.63	31.17	35.57	43.6	50.36
13-1199	Business Operations Specialists, All	38.01	23.19	28.87	35.95	44.85	57
13-1031	Claims Adjusters, Examiners, and In	35.74	24.37	28.2	35.13	42.7	48.99

13-1141	Compensation, Benefits, and Job A	35.47	21.37	25.6	32.6	44.79	54.04
13-1041	Compliance Officers	36.03	22.63	27.81	35.33	42.53	50.36
13-1051	Cost Estimators	44.98	25.63	31.39	45.38	56.71	63.13
13-2051	Financial Analysts	44.16	23.32	31.93	40.93	54.5	64.04
13-2061	Financial Examiners	29.54	14.88	22.97	28.98	37.23	42.3
13-2099	Financial Specialists, All Other	32.54	14.25	19.43	28.02	41.11	56.32
13-1131	Fundraisers	27.95	21.57	24.57	27.31	30.04	36.13
13-1071	Human Resources Specialists	32.65	19.42	24.93	30.03	39.11	48.57
13-2053	Insurance Underwriters	28.02	13.98	16.26	22.36	40.27	48.69
13-1075	Labor Relations Specialists	44.54	29.96	33.69	42.53	57	62.62
13-2072	Loan Officers	36.88	19	21.67	28.36	41.59	66.89
13-1081	Logisticians	42.28	29.25	33.5	39.49	50.36	59.95
13-1111	Management Analysts	41.74	26.3	31.45	40.25	48.21	58.68
13-1161	Market Research Analysts and Mar	32.23	17.5	23.24	31.49	39.74	50.65
13-1121	Meeting, Convention, and Event Pla	27.28	19.88	21.37	23.82	28.09	52.09
13-2052	Personal Financial Advisors	46.46	19.58	25.82	33.29	69.67	79.37
13-1023	Purchasing Agents, Except Wholesa	36.74	22.61	27.74	35.94	45.3	54.16
13-2081	Tax Examiners and Collectors, and	44.3	28.79	34.36	41.62	53.33	57.77
13-2082	Tax Preparers	25.24	13.63	16.74	22.62	33.55	42.24
13-1022	Wholesale and Retail Buyers, Excep	29.51	14.44	21.4	27.63	36.57	47.65

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Hourly wage rates for some occupations where workers typically work fewer than 2,080 hours per year are not available. In these cases, annual wages are provided.

Computer and Mathematical

		Mean Wage	Wage by Percentile				
SOC	Occupation Title	Mean	10th	25th	Median	75th	90th
15-1143	Computer Network Architects	60.27	41.75	50.78	56.65	62.34	76.3
15-1152	Computer Network Support Specia	33.07	18.85	22.49	32.48	42.86	49.24
15-1199	Computer Occupations, All Other	43.89	30.51	37.77	44.85	51.09	57.76
15-1131	Computer Programmers	45.91	24.61	31.9	40.62	48.82	62.24
15-1121	Computer Systems Analysts	39.26	24.98	31.51	39.57	46.84	55.19
15-1151	Computer User Support Specialists	27.47	16.92	21.79	26.89	31.75	40.33
15-1141	Database Administrators	38.54	17.35	24.76	34.96	48.69	60.95

15-1122	Information Security Analysts	42.36	22.52	34.73	42.9	48.33	60.64
15-1142	Network and Computer Systems Ac	41.54	26.74	31.9	39.28	48	64.58
15-2031	Operations Research Analysts	46.69	21.46	29.43	36.18	52.72	81.77
15-1132	Software Developers, Applications	*	*	*	*	*	*
15-1133	Software Developers, Systems Soft	*	*	*	*	*	*
15-1134	Web Developers	26.71	15.78	17.45	21.34	32.45	43.45

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Hourly wage rates for some occupations where workers typically work fewer than 2,080 hours per year are not available. In these cases, annual wages are provided.

Architecture and Engineering

		Mean Wage	Wage by Percentile				
SOC	Occupation Title	Mean	10th	25th	Median	75th	90th
17-1011	Architects, Except Landscape and N	45.68	28.03	38.66	46.62	54.63	61.13
17-3011	Architectural and Civil Drafters	29.22	20.21	23.37	29.14	35	38.6
17-1021	Cartographers and Photogrammetr	28.71	17.53	20.56	25.79	37.28	45.78
17-3022	Civil Engineering Technicians	34.43	23.53	29.55	34.96	38.85	45.11
17-2051	Civil Engineers	59.91	32.87	40.99	52.75	68.06	96.75
17-2061	Computer Hardware Engineers	61.51	39.94	43.7	50.22	61.57	*
17-3023	Electrical and Electronic Engineerin	38.18	25.29	31.83	39.22	45.15	49.02
17-3012	Electrical and Electronics Drafters	29.79	20.79	23.87	29.31	35.68	40.56
17-2071	Electrical Engineers	58.64	34.88	43.05	56.04	70.4	81.66
17-2072	Electronics Engineers, Except Comp	45.51	28.74	34.88	43.3	51.25	61.34
17-3029	Engineering Technicians, Except Dra	36.36	25.15	28.32	35.14	43.77	49.78
17-2199	Engineers, All Other	49.99	25.18	39.8	52.7	62.54	72.25
17-3025	Environmental Engineering Technic	27.64	19.8	24.09	27.77	30.97	36.24
17-2081	Environmental Engineers	68.03	37.8	48.08	57.16	80.17	*
17-2111	Health and Safety Engineers, Excep	58.2	33.43	42.89	63.09	74.18	80.68
17-2112	Industrial Engineers	56.42	34.14	41.2	53.86	66.99	80.09
17-3027	Mechanical Engineering Technician	37.15	21.44	25.32	32.58	45	67.81
17-2141	Mechanical Engineers	70.15	41.14	49.88	62.92	78	*
17-2151	Mining and Geological Engineers, In	62.67	41.52	46.68	57.32	71.25	80.58
17-2171	Petroleum Engineers	76.77	43.66	55.57	70.76	88.72	*
17-3031	Surveying and Mapping Technicians	28.18	15.21	20.64	27.99	34.24	43.2

17-1022	Surveyors	37.37	21.04	25.76	39.37	46.88	52.05

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Hourly wage rates for some occupations where workers typically work fewer than 2,080 hours per year are not available. In these cases, annual wages are provided.

Life, Physical, and Social Science

		Mean Wage	Wage by Percentile				
SOC	Occupation Title	Mean	10th	25th	Median	75th	90th
19-3091	Anthropologists and Archeologists	39.99	26.85	32.22	38.25	47.23	53.91
19-2021	Atmospheric and Space Scientists	45.99	37.37	41.1	45.92	52.5	57.76
19-1029	Biological Scientists, All Other	39.55	25.77	31.17	38.24	44.84	49.47
19-4021	Biological Technicians	20.35	15.21	17.01	18.96	21.79	27
19-2031	Chemists	41.96	32.37	35.58	40.79	48.82	56.4
19-3031	Clinical, Counseling, and School Psy	39.95	18.6	27.32	39.18	48.45	60.56
19-1031	Conservation Scientists	42.51	24.03	28.35	43.42	54.81	63.02
19-4091	Environmental Science and Protect	26.83	17.95	20.27	25.2	32.05	40.09
19-2041	Environmental Scientists and Speci	44.53	25.73	29.97	37.87	48.26	66.14
19-4093	Forest and Conservation Technician	20.4	15.71	17.01	19.1	22.93	26.57
19-4041	Geological and Petroleum Technici	33.67	20.96	24.5	34.15	41.92	47.59
19-2042	Geoscientists, Except Hydrologists a	52.63	31.22	40.76	51.13	66.53	76.73
19-2043	Hydrologists	46.54	31.89	36.23	42.36	48.87	61.63
19-4099	Life, Physical, and Social Science Te	27.94	18.95	21.77	26.39	33.13	40.52
19-2099	Physical Scientists, All Other	46.22	25.77	36.75	44.43	53.33	57.77
19-3039	Psychologists, All Other	45.35	40.03	42.42	45.99	49.41	57.21
19-3099	Social Scientists and Related Worke	36.58	26.33	30.45	36.04	42.35	48.88
19-3051	Urban and Regional Planners	40.46	29.53	33.37	37.96	45.2	56.41
19-1023	Zoologists and Wildlife Biologists	35.97	25.77	28.34	34.48	41.46	48.58

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Hourly wage rates for some occupations where workers typically work fewer than 2,080 hours per year are not available. In these cases, annual wages are provided.

Community and Social Services

		Mean Wage	Wage by Percentile				
SOC	Occupation Title	Mean	10th	25th	Median	75th	90th

21-1021	Child, Family, and School Social Wo	23.39	13.08	15.79	22.88	28.8	33.43
21-2011	Clergy	26.42	15.08	18.79	27.57	30.77	35.4
21-1099	Community and Social Service Spec	25.92	17.29	20.53	24.05	30.47	36.87
21-1094	Community Health Workers	21.43	13.14	14.72	19.58	27.29	30.38
21-1019	Counselors, All Other	25.88	16.36	20.37	25.54	30.71	36.53
21-1012	Educational, Guidance, School, and	33.81	19.58	24.65	32.46	41.84	50.79
21-1091	Health Educators	31.18	19.28	23.1	29.86	36.87	45.1
21-1022	Healthcare Social Workers	29.73	17.61	21.4	30.01	36.62	42.17
21-1023	Mental Health and Substance Abus	21.45	15.25	17.27	21.03	25.62	29.63
21-1014	Mental Health Counselors	33.35	24.28	27.62	32.18	37.97	43.89
21-1015	Rehabilitation Counselors	32.34	18.43	25.17	32.86	40.8	45.73
21-2099	Religious Workers, All Other	16.9	15.08	15.76	16.89	18.03	18.71
21-1093	Social and Human Service Assistant	16.39	12.69	13.59	15.15	18.69	22.52
21-1029	Social Workers, All Other	33.53	18.1	23.36	34.67	42.25	45.54
21-1011	Substance Abuse and Behavioral Di	24.51	19.74	21.38	24.09	27.55	29.91

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Hourly wage rates for some occupations where workers typically work fewer than 2,080 hours per year are not available. In these cases, annual wages are provided.

Legal

		Mean Wage	Wage by Percentile				
SOC	Occupation Title	Mean	10th	25th	Median	75th	90th
23-1011	Lawyers	60.43	37.04	46.2	55.72	68.48	87.55
23-2099	Legal Support Workers, All Other	35.08	18.96	26.14	35.74	42.27	50.26
23-2011	Paralegals and Legal Assistants	33.09	21.04	25.32	30.18	37.66	55.27
23-2093	Title Examiners, Abstractors, and Se	30.02	19.43	25.19	30.34	36.38	39.49

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Hourly wage rates for some occupations where workers typically work fewer than 2,080 hours per year are not available. In these cases, annual wages are provided.

Education, Training, and Library

		Mean Wage	Wage by Percentile				
SOC	Occupation Title	Mean	10th	25th	Median	75th	90th
25-1042	Biological Science Teachers, Postse	82,600	48,240	65,230	80,450	102,100	122,090

25-1011	Business Teachers, Postsecondary	*	*	*	*	*	*
25-9099	Education, Training, and Library Wc	14.74	9.75	9.75	9.76	17.01	30.06
25-2021	Elementary School Teachers, Excep	76,720	56,360	64,040	74,980	88,450	100,350
25-9031	Instructional Coordinators	37.04	23.28	27.66	37.04	46.09	53.29
25-4021	Librarians	38.26	25.08	31.72	38.16	46.55	54.68
25-4031	Library Technicians	21.38	13.61	16.61	20.98	25.99	28.79
25-1022	Mathematical Science Teachers, Po	*	*	*	*	*	*
25-1199	Postsecondary Teachers, All Other	61,830	44,340	53,980	59,490	64,970	77,960
25-2011	Preschool Teachers, Except Special	17.19	10.48	11.61	14.46	18.88	28.71
25-2031	Secondary School Teachers, Except	89,960	63,540	73,010	89,570	110,660	124,040
25-3021	Self-Enrichment Education Teacher	24.07	14.17	20.09	22.36	24.83	31.39
25-2052	Special Education Teachers, Kinder	81,760	58,580	68,420	80,620	96,130	108,100
25-2053	Special Education Teachers, Middle	82,480	56,290	65,490	78,180	101,360	120,150
25-9041	Teacher Assistants	39,650	27,330	33,390	38,980	46,680	52,980
25-3097	Teachers and Instructors, All Other,	71,380	34,100	50,540	71,150	91,910	106,160
25-1194	Vocational Education Teachers, Pos	34.14	23.81	27.12	32.37	38.9	47.49

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Hourly wage rates for some occupations where workers typically work fewer than 2,080 hours per year are not available. In these cases, annual wages are provided.

Arts, Design, Entertainment, Sports and Media

		Mean Wage	Wage by Percentile				
SOC	Occupation Title	Mean	10th	25th	Median	75th	90th
27-1011	Art Directors	44.93	19.83	34.45	43.03	62.4	73.27
27-4011	Audio and Video Equipment Techni	26.44	12.41	17.24	23.52	34.11	45.42
27-4012	Broadcast Technicians	18.63	10.86	13.42	16.82	23.77	29.32
27-2022	Coaches and Scouts	49,750	23,250	36,810	46,910	58,060	69,310
27-3041	Editors	26.66	14.44	18.72	26.05	32.05	38.81
27-1023	Floral Designers	16.46	10.3	12.04	16.29	20.53	23.34
27-1024	Graphic Designers	26.08	16	18.93	27	31.74	37.06
27-1025	Interior Designers	22.23	9.76	15.87	20.55	27.86	31.15
27-3099	Media and Communication Worker	33.82	19.22	24.14	31.1	38.69	49.15
27-1026	Merchandise Displayers and Windo	17.21	11.22	13.24	16.31	20.44	25.43
27-4021	Photographers	24.22	12.92	16.96	21.09	25.39	29.85

27-2012	Producers and Directors	31.41	11.31	20.01	27.34	39.46	62.98
27-3031	Public Relations Specialists	30.24	17.5	21.84	28.42	36.38	47.34
27-3011	Radio and Television Announcers	34.34	12.4	18.66	27.31	31.76	63.67
27-3022	Reporters and Correspondents	*	*	*	*	*	*
27-3042	Technical Writers	30.64	21.85	25.29	29.43	35.34	42.38
27-2023	Umpires, Referees, and Other Spor	43,670	20,300	26,320	48,970	57,360	61,800
27-3043	Writers and Authors	38.53	18.28	26.2	37.32	53.98	59.51

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Hourly wage rates for some occupations where workers typically work fewer than 2,080 hours per year are not available. In these cases, annual wages are provided.

Healthcare Practitioner and Technical

		Mean Wage	Wage by Percentile				
SOC	Occupation Title	Mean	10th	25th	Median	75th	90th
29-1181	Audiologists	24.36	19.58	20.52	22.08	23.63	37.99
29-1011	Chiropractors	54.23	35.14	40.19	52.55	61.45	85.28
29-2021	Dental Hygienists	49.8	39.75	44.38	51.62	57.23	60.6
29-1021	Dentists, General	117.29	74.87	87.5	*	*	*
29-2032	Diagnostic Medical Sonographers	36.55	21.91	29.17	38.97	44.77	48.24
29-1031	Dietitians and Nutritionists	33.78	25.22	27.97	33.19	40.21	45.82
29-2041	Emergency Medical Technicians an	29.71	18.75	24.43	30.32	35.47	38.38
29-1062	Family and General Practitioners	93.23	28.65	47.62	91.6	*	*
29-1199	Health Diagnosing and Treating Pra	46.28	25.76	34.74	38.99	64.3	74.12
29-2099	Health Technologists and Technicia	29.88	19.91	22.07	30	36.2	42.9
29-9099	Healthcare Practitioners and Techn	31.15	17.73	22.4	29.06	38.66	46.09
29-1063	Internists, General	106.83	59.33	70.44	*	*	*
29-2061	Licensed Practical and Licensed Voc	25.56	19.95	21.63	24.42	29.2	32.86
29-2035	Magnetic Resonance Imaging Techr	35.69	27.1	31.22	35.31	40.04	46.36
29-2012	Medical and Clinical Laboratory Tec	26.65	16.82	19.9	24.3	33.93	37.69
29-2011	Medical and Clinical Laboratory Tec	37.22	27.88	32.52	37.62	42.94	46.86
29-2071	Medical Records and Health Inform	20.59	15.69	17.38	20.09	23.54	27.58
29-2033	Nuclear Medicine Technologists	41.04	31.06	36	42.44	47.02	49.83
29-1151	Nurse Anesthetists	74.11	36.09	55.84	78.68	90.98	97.72
29-1171	Nurse Practitioners	53.64	33.28	41.09	51.23	62.41	75.64

29-9011	Occupational Health and Safety Spe	41.65	28.47	32.93	39.24	50.37	59.99
29-9012	Occupational Health and Safety Tec	34.11	18.56	25.11	32.02	44.6	54.22
29-1122	Occupational Therapists	37.09	20.96	30.64	38.47	45.52	50.88
29-2057	Ophthalmic Medical Technicians	20.88	15.23	16.76	19.44	23.81	30.24
29-2081	Opticians, Dispensing	20.6	13.54	16.31	20.47	24.55	28.85
29-1041	Optometrists	91.29	45.76	62.37	85.69 *	*	
29-1051	Pharmacists	64.36	51.67	59.66	67.15	73.98	78.13
29-2052	Pharmacy Technicians	18.73	12.08	14.67	18.98	22.29	24.48
29-1123	Physical Therapists	44	31.67	36.14	43.21	51.04	60.57
29-1071	Physician Assistants	55.24	40.43	46.46	55.33	64.51	74.11
29-1069	Physicians and Surgeons, All Other	107.23	33.47	73.03 *	*	*	
29-2053	Psychiatric Technicians	14.23	10.02	11.81	13.55	15.65	18.47
29-1066	Psychiatrists	122.87	80.15 *	*	*	*	
29-2034	Radiologic Technologists	32.14	21.73	25.77	31.08	38.99	44.96
29-1141	Registered Nurses	41.75	28.68	33.81	41.05	49.36	57.68
29-1126	Respiratory Therapists	34.46	25.96	30.26	34.26	38.02	44.53
29-1127	Speech-Language Pathologists	44.12	32.86	37.81	43.91	49.44	58.62
29-2055	Surgical Technologists	26.72	18.69	22.23	26.39	29.97	36.52
29-1129	Therapists, All Other	39.96	16.34	19.18	26.49	66.27	76.15
29-1131	Veterinarians	48.2	31.26	39.27	45.84	61.3	71.94
29-2056	Veterinary Technologists and Techr	20.36	16.46	18.56	20.78	22.71	23.91

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Hourly wage rates for some occupations where workers typically work fewer than 2,080 hours per year are not available. In these cases, annual wages are provided.

Healthcare Support

		Mean Wage	Wage by Percentile				
SOC	Occupation Title	Mean	10th	25th	Median	75th	90th
31-9091	Dental Assistants	21.73	15.81	18.33	21.75	24.95	28.77
31-9099	Healthcare Support Workers, All Ot	22.03	15.37	17.45	21.58	25.67	30.24
31-1011	Home Health Aides	15.16	9.76	10.89	16.47	18.1	19.08
31-9011	Massage Therapists	41.67	20.3	33.3	39.56	54.97	60.29
31-9092	Medical Assistants	18.86	11.47	16.16	18.74	22.31	25.17
31-9093	Medical Equipment Preparers	20.79	15.64	17.79	20.73	23.44	27.35

31-9094	Medical Transcriptionists	26.47	20.22	22.86	26.64	29.56	33.51
31-1014	Nursing Assistants	17.38	12.7	14.98	17.25	19.51	22.94
31-9097	Phlebotomists	19.25	13.99	16.1	18.59	22.1	26.01
31-2021	Physical Therapist Assistants	27.62	17.53	22.17	28.21	34.36	37.5
31-9096	Veterinary Assistants and Laborato	13.51	10.15	11.61	13.38	14.85	17.21

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Hourly wage rates for some occupations where workers typically work fewer than 2,080 hours per year are not available. In these cases, annual wages are provided.

Protective Service

		Mean Wage	Wage by Percentile				
SOC	Occupation Title	Mean	10th	25th	Median	75th	90th
33-9091	Crossing Guards	18.51	10.47	11.55	18.96	25.43	28.47
33-2011	Firefighters	30.82	18.95	27.11	32.63	36.76	39.24
33-1021	First-Line Supervisors of Fire Fightir	43.96	33.04	40.02	44.05	49.18	55.88
33-1012	First-Line Supervisors of Police and	52.64	33	47.76	54.35	60.18	64.81
33-1099	First-Line Supervisors of Protective	30.04	24.4	25.69	30.41	34.59	37.38
33-9092	Lifeguards, Ski Patrol, and Other Re	14.56	9.76	10.39	14.79	17.82	20.01
33-3051	Police and Sheriff's Patrol Officers	38.75	26.68	33	40.83	45.52	48.62
33-9099	Protective Service Workers, All Oth	15.45	11	12.44	13.83	15.69	21.43
33-9032	Security Guards	23.25	12.91	15.57	20.51	27.79	42.85
33-9093	Transportation Security Screeners	19.21	16.61	16.62	19.08	20.85	22.21

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Hourly wage rates for some occupations where workers typically work fewer than 2,080 hours per year are not available. In these cases, annual wages are provided.

Food Preparation and Serving Related

		Mean Wage	Wage by Percentile				
SOC	Occupation Title	Mean	10th	25th	Median	75th	90th
35-3011	Bartenders	16.29	9.87	11.34	15.01	18.15	24.96
35-1011	Chefs and Head Cooks	16.68	10.68	12.02	14.62	18.27	25.04
35-3021	Combined Food Preparation and Se	11.18	9.75	9.76	10.06	11.48	14.31
35-2019	Cooks, All Other	17.99	12.75	15	17.3	19.41	26.52
35-2011	Cooks, Fast Food	11.93	9.76	9.79	11.06	12.75	16.7

35-2012	Cooks, Institution and Cafeteria	16.77	11.59	14.05	16.59	18.81	22.81
35-2014	Cooks, Restaurant	14.21	10.55	11.75	13.57	15.14	18.99
35-2015	Cooks, Short Order	14.62	10.33	11.32	15.45	17.65	18.97
35-3022	Counter Attendants, Cafeteria, Foo	11.75	9.75	9.76	10.56	12.3	15
35-9011	Dining Room and Cafeteria Attenda	13.43	9.75	9.76	11.15	16.8	19.61
35-9021	Dishwashers	11.22	9.75	9.76	10.1	11.8	14.69
35-1012	First-Line Supervisors of Food Prepa	17.18	10.86	12.77	15.79	20.13	26.73
35-9099	Food Preparation and Serving Relat	14.02	10.45	11.48	13.73	16.46	18.47
35-2021	Food Preparation Workers	12.35	9.76	9.87	11.2	13.95	17.08
35-3041	Food Servers, Nonrestaurant	12.54	9.75	9.76	11.07	15.22	18.02
35-9031	Hosts and Hostesses, Restaurant, L	11.25	9.75	9.75	9.76	10.98	15.96
35-3031	Waiters and Waitresses	16.18	9.78	10.61	14.14	18.83	28

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Hourly wage rates for some occupations where workers typically work fewer than 2,080 hours per year are not available. In these cases, annual wages are provided.

Building and Grounds Cleaning and Maintenance

		Mean Wage	Wage by Percentile				
SOC	Occupation Title	Mean	10th	25th	Median	75th	90th
37-1011	First-Line Supervisors of Housekeep	21.22	14.47	16.19	18.24	26.64	33.96
37-1012	First-Line Supervisors of Landscapir	33.26	22.19	30.72	33.66	36.6	38.36
37-3019	Grounds Maintenance Workers, All	18.4	13.03	14.55	16.99	19.51	28.37
37-2011	Janitors and Cleaners, Except Maids	15.02	9.87	11.24	14.2	17.85	21.97
37-3011	Landscaping and Groundskeeping V	16.06	9.76	12.59	15.86	18.98	22.96
37-2012	Maids and Housekeeping Cleaners	12.76	10.13	10.8	11.98	14.38	16.98
37-3013	Tree Trimmers and Pruners	30	20.08	23.28	29.8	36.2	42.57

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Hourly wage rates for some occupations where workers typically work fewer than 2,080 hours per year are not available. In these cases, annual wages are provided.

Personal Care and Service

		Mean Wage	Wage by Percentile				
SOC	Occupation Title	Mean	10th	25th	Median	75th	90th
39-3091	Amusement and Recreation Attend	13.25	9.93	10.87	12.73	15.32	17.92

39-6011	Baggage Porters and Bellhops	10.27	9.75	9.75	9.76	9.76	11.64
39-9011	Childcare Workers	12.51	9.94	10.76	12.14	14.09	15.23
39-6012	Concierges	17.22	11.19	13.59	17.01	20.74	23.7
39-3099	Entertainment Attendants and Rela	10.77	9.75	9.75	9.76	11.13	13.84
39-1021	First-Line Supervisors of Personal S	19.27	13.07	14.5	19.09	23.4	27.36
39-9031	Fitness Trainers and Aerobics Instru	18.07	9.91	11.47	17.92	22.64	27.9
39-3012	Gaming and Sports Book Writers ar	12.35	10.08	10.56	11.35	13.05	16.77
39-5012	Hairdressers, Hairstylists, and Cosm	16.26	9.76	12.69	14.75	18.56	24.81
39-5092	Manicurists and Pedicurists	13.12	9.76	11.12	13.17	14.48	16.01
39-2021	Nonfarm Animal Caretakers	13.93	9.76	10.37	12.09	15.83	21.17
39-9021	Personal Care Aides	14.95	10.03	12.57	15.6	17.67	18.91
39-9032	Recreation Workers	22.33	13.79	16.56	19.93	25.76	35.5
39-9041	Residential Advisors	17.51	12.22	13.28	15.22	21.02	27.66
39-5094	Skincare Specialists	15.02	12.69	13.59	14.94	16.71	17.97
39-7011	Tour Guides and Escorts	21.42	13.26	15.93	21.6	27.4	30.03
39-3031	Ushers, Lobby Attendants, and Tick	10.21	9.75	9.75	9.76	9.78	11.66

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Hourly wage rates for some occupations where workers typically work fewer than 2,080 hours per year are not available. In these cases, annual wages are provided.

Sales and Related

		Mean Wage	Wage by Percentile				
SOC	Occupation Title	Mean	10th	25th	Median	75th	90th
41-3011	Advertising Sales Agents	26.73	12.94	19.06	25.82	32.48	41.67
41-2011	Cashiers	12.65	10.01	10.68	11.79	14	16.75
41-2021	Counter and Rental Clerks	14.57	10.26	11.6	13.84	16.75	19.93
41-9011	Demonstrators and Product Promo	13.27	10.14	10.75	11.76	14.26	18.77
41-9091	Door-to-Door Sales Workers, News	14.11	9.75	9.75	9.76	12.03	28.7
41-1012	First-Line Supervisors of Non-Retail	37.55	20.07	23.02	31.23	55.15	61.93
41-1011	First-Line Supervisors of Retail Sale	23.11	13.95	16.83	20.42	27.1	34.53
41-3021	Insurance Sales Agents	28.88	15.36	17.27	21.54	28.55	42.36
41-2022	Parts Salespersons	19.57	11.15	14.22	18.83	24.05	29.53
41-9021	Real Estate Brokers	38.11	23.68	31.32	34.01	37.15	39.27
41-9022	Real Estate Sales Agents	31.58	13.28	25.8	32.21	38.61	47.33

41-2031	Retail Salespersons	13.87	9.91	10.77	12.33	14.94	19.16
41-9099	Sales and Related Workers, All Othe	23.04	10.39	11.98	19.21	28.73	44.27
41-9031	Sales Engineers	50.26	31.14	38.07	50.17	61.25	73.73
41-3099	Sales Representatives, Services, All	29.44	13.96	19.47	26.89	36.63	47.98
41-4012	Sales Representatives, Wholesale a	31.38	17.02	22.85	28.97	36.98	46.98
41-4011	Sales Representatives, Wholesale a	40.31	15.83	26.6	37.87	56.33	64.97
41-3031	Securities, Commodities, and Finan	49.27	17.79	24.53	35.1	59.54 *	
41-3041	Travel Agents	19.05	13.4	15.41	17.83	21.77	26.87

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Hourly wage rates for some occupations where workers typically work fewer than 2,080 hours per year are not available. In these cases, annual wages are provided.

Office and Administrative Support

		Mean Wage	Wage by Percentile				
SOC	Occupation Title	Mean	10th	25th	Median	75th	90th
43-3011	Bill and Account Collectors	20.46	11.56	14.24	19.18	24.96	30.76
43-3021	Billing and Posting Clerks	19.77	15.1	16.85	19.37	22.68	25.42
43-3031	Bookkeeping, Accounting, and Audi	23.19	15.44	18.19	22.57	27.65	32.57
43-4011	Brokerage Clerks	24.25	19.68	21.14	23.58	27.24	31.31
43-5011	Cargo and Freight Agents	17.48	11.08	12.97	15.01	19.51	26.44
43-9011	Computer Operators	26.76	19.87	22.95	26.96	29.63	31.63
43-5021	Couriers and Messengers	13.23	9.77	9.81	12.09	15.35	19.12
43-4031	Court, Municipal, and License Clerk	21.72	17.45	18.14	20.73	23.92	26.92
43-4041	Credit Authorizers, Checkers, and C	19.45	13.46	15.81	19.84	22.86	24.93
43-4051	Customer Service Representatives	17.59	10.77	12.98	16.44	21.38	26.51
43-9021	Data Entry Keyers	17.63	9.76	15.41	17.65	20.55	23.75
43-5032	Dispatchers, Except Police, Fire, and	25.72	15.64	18.18	23.02	29.84	37.99
43-4061	Eligibility Interviewers, Governmen	24.94	21.23	21.95	24.39	27.21	30.38
43-6011	Executive Secretaries and Executive	28.45	19.9	22.71	27.02	32.4	38.35
43-4071	File Clerks	17.17	11.97	14.39	17.07	19.84	23.35
43-3099	Financial Clerks, All Other	20.62	9.76	11.02	16.21	26.05	43.85
43-1011	First-Line Supervisors of Office and	31.46	20.06	24.57	29.71	37.16	46.18
43-4081	Hotel, Motel, and Resort Desk Clerk	13.65	10.33	11.52	13.52	15.65	17.68
43-4161	Human Resources Assistants, Excep	21.57	14.56	17.58	21.23	25.08	29.16

43-4199	Information and Record Clerks, All (	20.43	13.54	16.22	20.23	24.43	27.5
43-9041	Insurance Claims and Policy Proces	20.57	13.09	16.33	20.13	24.79	28.76
43-4111	Interviewers, Except Eligibility and I	18.85	13.83	15.74	18.1	21.13	23.54
43-6012	Legal Secretaries	25.27	18.67	19.25	22.95	31	36.18
43-4121	Library Assistants, Clerical	18.22	13.61	15.97	18.28	21.08	23.35
43-4131	Loan Interviewers and Clerks	21.41	9.76	11.7	18.32	24.03	35.15
43-9051	Mail Clerks and Mail Machine Oper	17.62	11.61	15.47	17.6	20.18	23.23
43-6013	Medical Secretaries	19.67	13.17	15.17	18.55	23.97	28.6
43-9199	Office and Administrative Support \	22.64	12.07	17.63	22.67	27.38	30.84
43-9061	Office Clerks, General	22.84	15.65	18.02	21.8	26.54	31.56
43-9071	Office Machine Operators, Except C	19.3	12.18	15.92	20.45	23.05	24.61
43-4151	Order Clerks	17.31	12.39	13.68	16.23	20.68	24.48
43-3051	Payroll and Timekeeping Clerks	23.26	14.63	18.63	23.37	27.85	31.44
43-5031	Police, Fire, and Ambulance Dispato	27.2	23.53	25.54	27.61	29.6	30.86
43-5051	Postal Service Clerks	24.82	18.38	19.6	27.3	27.31	27.88
43-5052	Postal Service Mail Carriers	24.35	16.07	17.7	28.59	28.78	28.78
43-5053	Postal Service Mail Sorters, Process	22.57	15.53	15.64	27.02	27.31	27.54
43-3061	Procurement Clerks	22.96	17.06	19.53	22.48	26.54	28.86
43-5061	Production, Planning, and Expeditir	27	13.29	20.31	26.24	33.5	41.57
43-4171	Receptionists and Information Clerl	15.87	10.11	12.66	15.53	18.69	22.41
43-4181	Reservation and Transportation Tic	16.39	12.52	13.36	14.76	18.66	23.82
43-6014	Secretaries and Administrative Assi	18.64	11.83	14.83	18.05	22.64	27.01
43-5071	Shipping, Receiving, and Traffic Cle	19.1	12.85	15.16	18.11	23.33	27.29
43-5081	Stock Clerks and Order Fillers	14.63	10.07	11.36	13.47	17.08	21.74
43-2011	Switchboard Operators, Including A	15.27	9.76	12.76	14.75	17.74	19.64
43-3071	Tellers	12.6	9.75	9.76	12.08	14.43	17.01
43-9022	Word Processors and Typists	19.11	13.73	17.01	19.28	21.77	23.81

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Hourly wage rates for some occupations where workers typically work fewer than 2,080 hours per year are not available. In these cases, annual wages are provided.

Construction and Extraction

		Mean Wage	Wage by Percentile				
SOC	Occupation Title	Mean	10th	25th	Median	75th	90th

47-2031	Carpenters	33.18	19.91	26.48	33.38	38.97	47.18
47-2051	Cement Masons and Concrete Finis	30.53	14.69	20.94	31.12	40.33	45.68
47-4011	Construction and Building Inspecto	42.59	31.5	37.42	43.45	48.57	51.74
47-4099	Construction and Related Workers,	32.83	17.74	28.45	34.52	38.78	44.78
47-2061	Construction Laborers	23.95	14.53	19.19	24	28.97	33.26
47-5021	Earth Drillers, Except Oil and Gas	26.9	21.06	23.76	26.78	29.26	30.98
47-2111	Electricians	36.99	25.43	31.64	36.74	43.58	49.23
47-2121	Glaziers	29.78	20.13	24.07	30.12	35.69	39.41
47-4041	Hazardous Materials Removal Worl	24.53	19.94	21.41	23.86	27.81	30.35
47-3019	Helpers, Construction Trades, All O	19.16	15.42	17.14	19.74	22.13	23.56
47-3012	Helpers--Carpenters	18.12	12.5	14.87	18.04	21.46	24.22
47-3013	Helpers--Electricians	20.16	13.3	15.38	19.28	25.12	28.87
47-5081	Helpers--Extraction Workers	15.48	12.67	13.53	14.97	17.37	18.94
47-3015	Helpers--Pipelayers, Plumbers, Pipe	23.46	17.77	20.81	24.4	27.32	29.08
47-2131	Insulation Workers, Floor, Ceiling, a	28.53	15.17	18.75	28.78	37.7	44.67
47-2132	Insulation Workers, Mechanical	37.33	28.99	32.75	37.13	43.17	47.52
47-2073	Operating Engineers and Other Cor	35.41	24.52	29.81	35.57	42.3	46.87
47-2141	Painters, Construction and Mainter	27.11	16.78	19.18	27	32.16	39.61
47-2072	Pile-Driver Operators	33.3	20.65	25.77	33.31	41.5	47.24
47-2152	Plumbers, Pipefitters, and Steamfit	32.54	20	25.1	31.3	40.18	47.96
47-2181	Roofers	23.51	16.23	18.4	22.49	28.56	33.08
47-5012	Rotary Drill Operators, Oil and Gas	38.05	24.33	28.79	40.11	46.7	50.63
47-5071	Roustabouts, Oil and Gas	30.26	22.18	25.91	31.15	35.45	37.99
47-5013	Service Unit Operators, Oil, Gas, an	30.69	17.98	22.18	30.16	38.49	46.04
47-2211	Sheet Metal Workers	39.62	25.1	33.87	42.26	46.85	49.64
47-2221	Structural Iron and Steel Workers	28.81	15.36	19.63	33.06	36.41	38.41
47-1011	Supervisors of Construction and Ext	47.23	25.23	31.82	44.53	60.51	74.12

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Hourly wage rates for some occupations where workers typically work fewer than 2,080 hours per year are not available. In these cases, annual wages are provided.

Installation, Maintenance, and Repair

		Mean Wage	Wage by Percentile				
SOC	Occupation Title	Mean	10th	25th	Median	75th	90th

49-3011	Aircraft Mechanics and Service Tecl	31.95	21.9	26.06	31.62	36.73	42.49
49-3021	Automotive Body and Related Repa	26.41	16.96	24.62	27.29	29.81	34.08
49-3023	Automotive Service Technicians and	25.74	14.42	19.06	25.13	32.08	38.39
49-2091	Avionics Technicians	34.1	26.83	31.61	34.29	37.52	40.07
49-3031	Bus and Truck Mechanics and Diese	29.81	20.27	22.8	29.55	36.37	43.01
49-2011	Computer, Automated Teller, and C	21.67	14.97	17.81	21.29	24.45	28.42
49-9012	Control and Valve Installers and Re	35.44	16.54	20.22	41.52	49.63	56.86
49-2094	Electrical and Electronics Repairers,	*	*	*	*	*	*
49-9051	Electrical Power-Line Installers and	40.47	30.93	36.55	42.27	46.25	48.63
49-1011	First-Line Supervisors of Mechanics	40.05	23.52	32.91	41.06	47.81	55.61
49-9021	Heating, Air Conditioning, and Refri	30.11	21.06	26.59	30.27	34.96	37.94
49-9098	Helpers--Installation, Maintenance,	15.32	10.3	12.15	14.75	17.84	21.92
49-9041	Industrial Machinery Mechanics	31.99	18.58	24.46	32.88	38.3	46.31
49-9099	Installation, Maintenance, and Rep	30.56	14.13	25.7	31.62	36.37	39.66
49-9071	Maintenance and Repair Workers, G	24.16	15.11	18.43	23.46	29.25	35.42
49-9043	Maintenance Workers, Machinery	22.34	15.9	18.01	21.8	25.02	30.65
49-9062	Medical Equipment Repairers	31.27	21.11	26.17	30.68	36.53	40.2
49-9044	Millwrights	23.49	15.15	18.04	22.13	28.65	35.23
49-3042	Mobile Heavy Equipment Mechanic	32.12	17.83	27.13	33.58	37.75	43.89
49-3051	Motorboat Mechanics and Service T	23.95	12.08	18.97	24.34	30.52	35.51
49-3052	Motorcycle Mechanics	24.28	17.06	19.36	23.54	28.85	33.72
49-2021	Radio, Cellular, and Tower Equipme	28.07	19.63	22.83	27.21	33	38.67
49-9096	Riggers	23.5	14.29	18.74	25.43	28.41	30.19
49-2098	Security and Fire Alarm Systems Ins	31.57	13.03	23.12	33.93	40.62	47.03
49-2022	Telecommunications Equipment Ins	34.14	17.01	25.74	35.11	43.73	48.92
49-9052	Telecommunications Line Installers	36.47	24.55	31.74	37.65	43.51	47.39
49-3093	Tire Repairers and Changers	14.4	11.31	12.48	13.92	16.19	18.46

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Hourly wage rates for some occupations where workers typically work fewer than 2,080 hours per year are not available. In these cases, annual wages are provided.

Production

		Mean Wage	Wage by Percentile				
SOC	Occupation Title	Mean	10th	25th	Median	75th	90th

51-2099	Assemblers and Fabricators, All Oth	18.11	12.73	15.61	17.84	21	24.11
51-3011	Bakers	18.06	11.61	15.39	18.33	21.44	23.59
51-3021	Butchers and Meat Cutters	21.4	13.54	16.51	21.81	26.6	29.26
51-7011	Cabinetmakers and Bench Carpente	20.12	12.15	15.76	19.71	23.14	32.44
51-4031	Cutting, Punching, and Press Machi	17.36	11.06	14.97	17.57	20.77	23.17
51-9081	Dental Laboratory Technicians	25.21	15.66	21.04	26.46	30.32	33.86
51-1011	First-Line Supervisors of Productior	31.82	14.29	20.83	28.23	41.44	54.6
51-3091	Food and Tobacco Roasting, Baking	11.85	10.03	10.61	11.58	13.01	14.29
51-3092	Food Batchmakers	13.66	9.76	10.16	13.57	16.79	18.32
51-8092	Gas Plant Operators	35.73	25.5	30.48	36.07	43.29	47.34
51-9198	Helpers--Production Workers	18.26	11.54	13.22	16.68	22.29	25.63
51-9061	Inspectors, Testers, Sorters, Sample	30.35	19.58	23.02	27.86	35.42	43.08
51-6011	Laundry and Dry-Cleaning Workers	13.61	9.76	9.85	11.71	17	19.05
51-4041	Machinists	29.52	23.09	26.38	29.36	33.43	37.44
51-9195	Molders, Shapers, and Casters, Exc	20.45	13.67	15.61	19.46	25.76	29.1
51-9111	Packaging and Filling Machine Oper	16.97	10.72	12.62	14.51	19.91	28.05
51-8093	Petroleum Pump System Operators	37.92	27.96	30.27	39.21	45.11	48.58
51-9151	Photographic Process Workers and	18.46	12.37	16.19	18.12	21.5	24.52
51-8013	Power Plant Operators	39.96	33.03	35.95	40.4	45.51	48.61
51-5113	Print Binding and Finishing Workers	26.16	19.98	25.17	27.36	29.5	30.84
51-5112	Printing Press Operators	23.21	13.55	19.55	23.85	28.31	31.01
51-9199	Production Workers, All Other	24.72	11.39	16.96	23.97	30.94	39.28
51-9012	Separating, Filtering, Clarifying, Pre	17.34	10.44	11.89	16.17	21.55	26.83
51-2041	Structural Metal Fabricators and Fit	23.48	13.93	16.7	21.52	31.12	36.52
51-2092	Team Assemblers	15.55	10.93	12.39	14.64	17.9	22.18
51-8031	Water and Wastewater Treatment	34.01	18.78	28.53	35.51	41.3	46.83
51-4121	Welders, Cutters, Solderers, and Br	34.78	21.75	27.76	35.42	43.2	47.49

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Hourly wage rates for some occupations where workers typically work fewer than 2,080 hours per year are not available. In these cases, annual wages are provided.

Transportation and Material Moving

		Mean Wage	Wage by Percentile				
SOC	Occupation Title	Mean	10th	25th	Median	75th	90th

53-1011	Aircraft Cargo Handling Supervisors	30.05	19.03	20.98	23.87	41.92	47.79
53-2022	Airfield Operations Specialists	32.64	16.26	20.78	29.71	36.74	48.28
53-2011	Airline Pilots, Copilots, and Flight Er	*	*	*	*	*	*
53-6031	Automotive and Watercraft Service	13.59	9.9	11.64	13.32	14.82	17.97
53-3022	Bus Drivers, School or Special Client	18.62	15.12	16.35	18.02	20.26	24.73
53-3021	Bus Drivers, Transit and Intercity	25.77	15.4	20.95	27.01	30.34	35.11
53-5021	Captains, Mates, and Pilots of Wate	43.45	28.39	37.09	44.04	49.38	58.84
53-7061	Cleaners of Vehicles and Equipmen	12.69	9.78	10.27	11.7	14.12	17.32
53-2012	Commercial Pilots	96,830	38,150	47,550	66,070	139,820	185,170
53-7021	Crane and Tower Operators	43.09	37.26	40.77	43.98	47.14	49.04
53-3031	Driver/Sales Workers	15.02	10.29	11.35	14.09	17.62	20.68
53-7032	Excavating and Loading Machine ar	27.79	20.34	22.21	25.39	34.01	37.48
53-1021	First-Line Supervisors of Helpers, La	32.43	17.38	20.5	27.97	41.07	47.74
53-1031	First-Line Supervisors of Transporta	37.38	18.17	23.86	35.6	46.95	65.66
53-3032	Heavy and Tractor-Trailer Truck Dri	25.85	15.98	19.52	25.53	30.71	37.58
53-7051	Industrial Truck and Tractor Operat	22.88	13.29	18.89	22.38	27.2	33.85
53-7062	Laborers and Freight, Stock, and Ma	16.96	10.64	12.49	15.06	19.9	26.85
53-3033	Light Truck or Delivery Services Driv	19.32	11.82	14.58	17.89	23.2	29.47
53-7199	Material Moving Workers, All Other	20.74	10.01	12.17	16.17	31.69	36.54
53-7064	Packers and Packagers, Hand	15.2	9.76	11.4	13.85	18.7	22.95
53-6021	Parking Lot Attendants	11.77	9.75	9.76	11.07	13.08	14.8
53-7081	Refuse and Recyclable Material Col	23.55	15.54	19.42	25.24	28.21	30
53-5011	Sailors and Marine Oilers	25.24	20.57	22.69	25.77	28.64	30.37
53-3041	Taxi Drivers and Chauffeurs	13.03	10.4	11.6	12.98	14.32	15.52
53-6051	Transportation Inspectors	47.14	28.61	37.37	48.87	57.76	63.02
53-6099	Transportation Workers, All Other	18.67	11.96	13.69	17.07	23.72	28.67

Consumer Price Index (CPI)

Consumer Price Index for the Municipality of Anchorage and the U.S.

Not Seasonally Adjusted – All Items – Urban Consumers

1960-Present

Note: the percent change is from the same period of the previous year.

	Anchorage						U.S.					
Year	1st Half	Percent Chang	2nd Half	Percent Chang	Annual	Percent Chang	1st Half	Percent Chang	2nd Half	Percent Chang	Annual	Percent Chang
2017	218.616	0.7					244.076	2.2				
2016	216.999	-0.1	218.66	0.9	217.83	0.4	238.778	1.1	241.237	1.5	240.007	1.3
2015	217.111	1.1	216.706	-0.1	216.909	0.5	236.265	-0.1	237.769	0.3	237.017	0.1
2014	214.777	1.9	216.833	1.4	215.805	1.6	236.384	1.7	237.088	1.5	236.736	1.6
2013	210.853	2.7	213.91	3.5	212.381	3.1	232.366	1.5	233.548	1.4	232.957	1.5
2012	205.215	2.5	206.617	2	205.916	2.2	228.85	2.3	230.338	1.8	229.594	2.1
2011	200.278	2.8	202.576	3.6	201.427	3.2	223.598	2.8	226.28	3.5	224.939	3.2
2010	194.834	2.5	195.455	1	195.144	1.8	217.535	2.1	218.576	1.2	218.056	1.6
2009	190.032	1.3	193.456	1.1	191.744	1.2	213.139	-0.6	215.935	-0.1	214.537	-0.4
2008	187.659	4.6	191.335	4.5	189.497	4.6	214.429	4.2	216.177	3.4	215.303	3.8
2007	179.394	1.5	183.08	2.9	181.237	2.2	205.709	2.5	208.976	3.1	207.342	2.8
2006	176.7	4.2	177.9	2.2	177.3	3.2	200.6	3.8	202.6	2.6	201.6	3.2
2005	169.6	2.4	174.1	3.8	171.8	3.1	193.2	3	197.4	3.8	195.3	3.4
2004	165.6	2.8	167.8	2.4	166.7	2.6	187.6	2.3	190.2	3	188.9	2.7
2003	161.1	2.3	163.9	3.1	162.5	2.7	183.3	2.5	184.6	2	184	2.3
2002	157.5	2	159	1.9	158.2	1.9	178.9	1.3	180.9	1.9	179.9	1.6
2001	154.4	2.9	156	2.7	155.2	2.8	176.6	3.4	177.5	2.2	177.1	2.8
2000	150	0.9	151.9	2.4	150.9	1.7	170.8	3.3	173.6	3.5	172.2	3.4
1999	148.6	1.3	148.3	0.9	148.4	1	165.4	1.9	167.8	2.5	166.6	2.2
1998	146.7	1.8	147	1.1	146.9	1.5	162.3	1.5	163.7	1.6	163	1.6
1997	144.1	1.6	145.4	1.2	144.8	1.5	159.9	2.6	161.2	2.1	160.5	2.3
1996	141.8	2.6	143.7	3	142.7	2.7	155.8	2.8	157.9	3.1	156.9	3
1995	138.2	2.9	139.5	2.7	138.9	2.9	151.5	2.9	153.2	2.6	152.4	2.8

Growing Up Anchorage

2015

Anchorage youth and young adult behavioral health and wellness assessment

Anchorage Collaborative Coalitions

UAA University of Alaska Anchorage

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Growing Up Anchorage

Anchorage youth and young adult behavioral health and wellness assessment

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contributors

Karen Heath, M.S., Center for Human Development
Gabriel M. Garcia, Ph.D., Department of Health Sciences
Bridget Hanson, Ph.D., Center for Behavioral Health Research & Services
Marny Rivera, Ph.D., Justice Center

Travis Hedwig, Ph.D., Department of Health Sciences, Center for Human Development
Rebekah Moras, Ph.D., Center for Human Development
Danielle Reed, M.S., Center for Human Development
Curtis Smith, Ph.D., Center for Human Development
Sylvia Craig, Alaska Injury Prevention Center

Editor: Roxann Lamar, M.S., Center for Human Development

Anchorage Collaborative Coalitions Executive Team

Marcia Howell, Alaska Injury Prevention Center

Deborah Williams, Anchorage Youth Development Coalition

Karen Zeman, Spirit of Youth

Charlie Daniels, Healthy Voices Healthy Choices

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Executive Summary

The Anchorage Collaborative Coalitions (ACC), made up of four organizations (Healthy Voices, Healthy Choices; Anchorage Youth Development Coalition; Spirit of Youth; and Alaska Injury Prevention Center), contracted with the University of Alaska Anchorage Center for Human Development (CHD) to do a community assessment on substance use, mental health and suicide. The population for this assessment was youth and young adults in the Municipality of Anchorage. The assessment was completed in two phases. Phase I was a review of existing data from national, state, and local sources (referred to as "secondary data" in the complete report). Phase II focused on the collection and analysis of new data from surveys and focus groups (referred to as "primary data" in the complete report). One goal of the assessment was to engage coalition and community members in the process. Coalition and community partners assisted throughout the process by helping define the gaps in existing data, helping define the areas of interest, and helping identify the focus of new data collection. They attended trainings on data collection and analysis, participated in community discussions about the findings, and participated in focus group data collection and analysis.

Alaska's youth and young adults are impacted by substance use, mental health, and suicide in significant ways. These behavioral health concerns are often interconnected and can have severe consequences. Substance use can lead to problems with school, the law and to youth taking risks that can lead to serious injury or death. Substance use in adolescence can put youth at higher risk for major life impairments and chronic conditions, including severe mental illness. Poor mental health in youth and young adults can lead to poorer physical health in adulthood, higher rates of chronic illnesses, and earlier death. Mental health and substance use disorders are likely the third leading cause of suicide deaths.

In 2012, the Centers for Disease Control ranked Alaska as the second highest state in the nation for per capita suicide deaths. Family members and friends of people who die by suicide experience feelings of guilt, anger, abandonment, and shock. Also, these friends and family members are often at a higher risk for committing suicide in the future.

Phase I Key Findings:

Existing data on Anchorage youth and young adults

The analysis of existing data was designed to: 1) document the prevalence of substance use/abuse, mental health/illness, and suicide; and 2) document the risk and protective factors influencing behaviors, conditions, and outcomes. The focus population for existing data collection was 9-24 year-olds living in the Municipality of Anchorage. The existing data methodology is described on page 28 and key findings from existing data are described in more detail on page 38. Infographics that summarize existing data key findings begin on page 46.

Substance Use

- Alcohol, prescription drugs, and marijuana are the substances most frequently used.
- Substance use is trending downward across nearly all substances and age groups.
- Anchorage youth report higher than national averages on marijuana use and dependence.
- Relatively high percentage of youth (13.9%) report using or observing use of harmful legal products (e.g., inhalants, prescription drugs, solvents, other household products).
- Use of harmful legal products was highest among Alaska Native students.
- Access to trusted adults, sense of value and belonging in the community, youth engagement in extracurricular activities, volunteerism, and faith-based programs may reduce the risk of engaging in substance use behaviors.

Mental Health

- For the years 2010-2012, Anchorage young adults (ages 18-25) experienced slightly higher rates of mental illness than their peers nationwide.
- Anchorage young adults (ages 18-25; years 2010-2012) were more likely to experience major depressive episodes as compared to their nationwide peers; while younger people (12-17) were less likely.
- More than one quarter of Anchorage School District students reported experiencing symptoms of depression over the past year.
- Depressive symptoms were most frequently experienced by Anchorage high school students who identified as Native Hawaiian/Pacific Islander, Latino or other (predominately mixed race).
- Among Anchorage high school students, 9th and 10th graders reported depressive symptoms more frequently than other grade levels.
- Nearly one quarter of Anchorage School District students reported feeling alone in their lives; with students who identified as Latino, Black, and other reporting this more frequently.
- Ninth grade students reported loneliness more frequently than other high school students, and particularly by 12th grade, loneliness was much less common.
- Nearly one quarter of University of Alaska Anchorage (UAA) students (2009 data) reported feeling things were hopeless during the previous month, many more (64%) felt overwhelmed at some point during the previous month, and more than a third felt very lonely and/or very sad.
- More UAA female students reported feelings of hopelessness, being overwhelmed, and loneliness/sadness than male students.
- UAA Alaska Native students reported hopelessness more frequently than White students, while more White students reported feelings of being overwhelmed, lonely, and/or sad than Alaska Native students.

Suicide

- For the years 2004-2013, Anchorage youth and young adults (9-24) completed suicide less often than their peers across the state at 15 per 100,000 (Alaska's overall rate was 23.6 per 100,000).
- Males and Alaska Natives completed suicide more frequently than females and non-Natives among Anchorage youth and young adults (2004-2013).
- Among Anchorage high school students (2009-2013), Alaska Native students considered suicide and attempted suicide at lower rates than three other racial/ethnic groups: Native Hawaiian/Pacific Islander, Latino, and Other (predominantly mixed race).
- Anchorage young adults (21-24) had higher rates of suicide than other age groups.
- Rates of suicidal ideation among young adults (21-25) have increased, with Anchorage rates increasing at a higher rate than Alaska and the US overall.
- Females report more frequent consideration of suicide and planning how they would attempt than males among Anchorage high school students.
- Ninth grade Anchorage high school students reported more frequent consideration and attempts than other grade levels.
- Firearms were the most often used means for suicide completion.

Intermediate Variables

Intermediate variables precede or lead to a particular outcome or set of outcomes, whether they are behaviors or health conditions. Intermediate variables that lead to risk behavior and/or poor health outcomes are called risk factors. Variables that prevent someone from engaging in risk behaviors or prevent someone from having poor health outcomes are considered protective factors. Intermediate variables can have three levels of influence—environmental, interpersonal, or intrapersonal. The environmental level of

influence includes community, policy, and culture. The interpersonal level includes relationships with family members, peers, and others like mentors and teachers. The intrapersonal level includes an individual's lifestyle, knowledge and perceptions (e.g., attitudes and beliefs), biological conditions (e.g., genetics, disability), and demographics (e.g.,gender, race/ethnicity, age).

Environmental Factors.

- In 2013, nearly half of Anchorage youth felt like they mattered in their community, a slight decrease from previous years.
- The majority (68%) of youth agree their school have clear rules and consequences for students' behavior.
- A low percentage of students, between 5 and 9%, missed school because they felt unsafe.
- School suspension rates tend to be fairly stable, though are higher among boys, eighth graders, and ethnic minorities.
- Though school dropout rates have improved over the years, they are higher among 12th graders, ethnic minorities, and students with limited English proficiency.
- One in five UAA students reported being verbally threatened on campus.
- Reported domestic violence at home among young mothers seems to be decreasing overall.
- The number of children ages 9 and up with at least one substantiated report of harm during screening decreased from 490 in 2008 to 155 in 2014.

Interpersonal Factors.

- Youth perceptions of parents' disapproval of youth drinking alcohol have changed - In 2009 almost 80% of youth perceived parents to consider it very wrong and in 2013 it was down to about 64%.
- Youth reporting at least one parent who talked with them about what they did in school every day remained around 44% over a 10 year period.
- There was a slight increase from 2003 to 2013 in youth reporting that teachers really cared about them and gave them encouragement.
- Rates of youth being physically hurt by their boyfriend or girlfriend increased in 2005 and returned to 13% in 2011.
- A low percentage of UAA students (4%) reported being in physically abusive or sexually abusive relationships. More UAA students (12%) reported being in emotionally abusive relationships.
- Around 19% of youth report having been bullied on school property and 15% report having been bullied electronically.
- There has been an increasing proportion of youth reporting feeling alone in their lives.

Intrapersonal Factors.

- The number of youth who perceive drinking alcohol to be harmful and not cool have increased.
- Youth rates of truancy, that is missed classes or school without permission, have decreased.
- Rates of youth volunteering one or more hours per week decreased through the years.
- Youth participation in organized afterschool/ evening/weekend activities has remained steady at about 50% over the years.
- Youth are more physically active and rates of youth participating in physical activity increased to 84% in 2013.
- Compared to their same age peers, girls and youth with mixed race/ethnicity were more likely to be bullied in school or electronically, to report feeling sad or hopeless almost everyday, to be considering suicide, and to be planning an attempt to commit suicide.

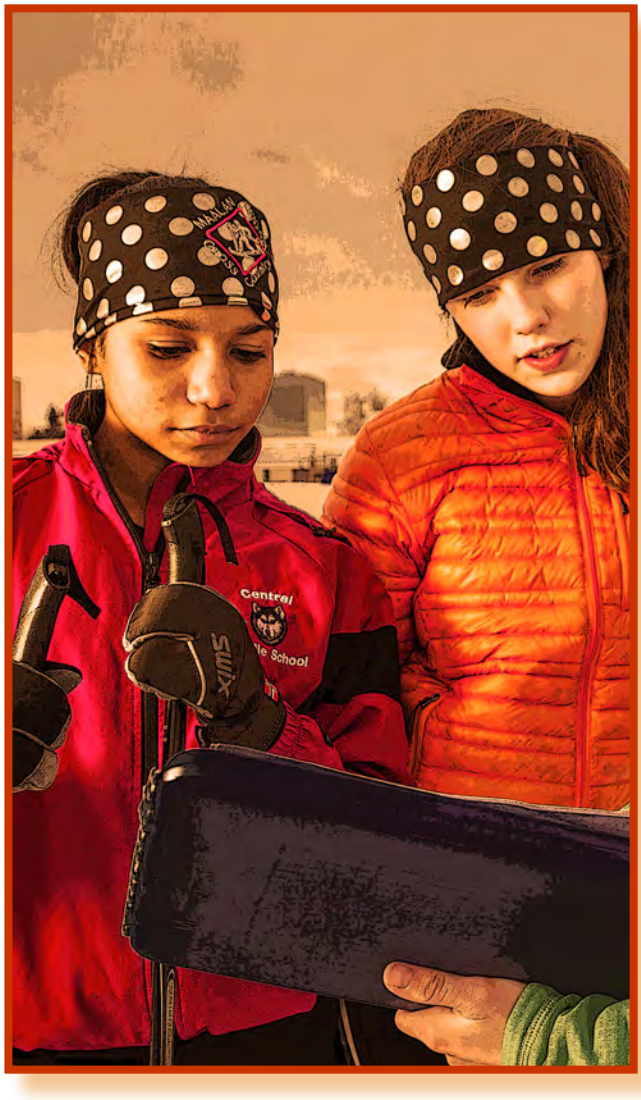
Risk and Protective Factors. Additional analyses were conducted to identify which specific intrapersonal, interpersonal, or environmental factors protected youth from engaging in risk behaviors and conditions. The following table displays some of the strongest protective factors that decreased the likelihood of youth engaging in risk behaviors.

Risk Behaviors	*Strongest Protective Factors*
Current alcohol use, binge drinking, and current marijuana use	Having teachers who really cared and gave encouragement Having regular talks with parents about school
Feelings of sadness, hopelessness, and suicide ideation	Feeling like they mattered in their community Feeling they were not alone
Being bullied in school or electronically	Having teachers who really cared and gave encouragement

Being bullied or having experiences with mental health or suicide ideation are associated with specific risk factors. That is youth are more likely to engage in certain risk behaviors if they experience bullying, have mental health problems, or considered suicide (see table below).

Youth Experiences	*Strongest Risk Factors*
Bullied in school or electronically	Current alcohol use and binge drinking Feeling alone Feeling sad or hopeless Suicide ideation Truancy (i.e., missed school)
Feeling alone and feeling sad or hopeless almost everyday	Seriously considered suicide Planned an attempt to commit suicide

An analysis was done to determine which protective and risk factors made youth more or less likely to experience bullying, sadness/hopelessness, and suicide ideation (see table below).



Risk or Protective Factors	*Likelihood*	*Bullying & Mental Health Outcome*
Feeling like they mattered in their community Having teachers who really cared and gave encouragement	**Less Likely**	To have been bullied in school or electronically To feel sad or hopeless To seriously consider suicide
Feeling unsafe in school	**More Likely**	To have been bullied in school or electronically To feel sad or hopeless To seriously consider suicide
Feeling alone	**More Likely**	To feel sad or hopeless To seriously consider suicide
Volunteering 1+ hours per week in school or community*	**More Likely**	To feel sad or hopeless

**This seems counterintuitive since volunteerism is considered a protective factor. However, it is possible that those volunteering in the community were doing so because they wanted to mitigate feelings of sadness and hopelessness.*

Outcome of Phase I

An outcome of Phase I was a large collection of data that was used to assist the ACC and community in determining priority areas. The primary area of focus chosen by the community was mental health, particularly the variables of bullying and feeling alone. It was also noted that there was a gap in behavioral health data on 18-24 year olds, more specifically 18-24 year olds who do not attend college. New data was collected through a) focus groups of youth and young adults (ages 12-24) on the topics of bullying and feeling alone/sad/hopeless, b) a survey aimed at gathering Anchorage adult perceptions regarding substance use and behavioral health problems of youth, namely bullying, feeling alone, extreme sadness/hopelessness and suicide (Adult Perceptions of Anchorage Youth) and c) a survey aimed at 18-24 year old Anchorage young adults on social support, community perception and involvement, substance use, stress, bullying and/or harassment experiences, psychological well-being, and help-seeking behaviors and perceptions (Young Adult Survey).

Summary of Priority Areas

Bullying

Bullying is defined as intentional and unwanted, aggressive behavior among school-aged children that is repeated and involves a real or perceived power imbalance. Four main types include verbal, physical, social/relational, and cyber. Subpopulations of youth are at increased risk of being bullied including lesbian, gay, bisexual, and/or transgender youth, certain ethnic populations, and students who experience disabilities. Bullying can have several long-term health consequences for everyone involved (victims, perpetrators, and bystanders). Engaging in bullying behavior may lead to substance use, school problems, criminal activity, early sexual activity, and abusive/assaultive behavior. Victims of bullying experience increased likelihood of depression, anxiety, feeling of sadness and loneliness, changes in sleep and eating patterns, loss of interest in activities they used to enjoy, health complaints, decreased academic achievement, and increased likelihood of skipping and/or dropping out of school. Effects on bystanders include increased substance use, mental health problems, including depression and anxiety, and increased school absence.

Feeling Alone

Loneliness is a common problem among youth that can have serious consequences. Feeling alone can have increased risk for school dropout, delinquency and violence, suicide ideation, depression, anxiety and substance use, as well as poor physical health. The causes or contributing factors of loneliness are complex and potentially interwoven. Both individual traits (intrapersonal) and interpersonal factors influence loneliness. Youth who are at higher risk of feeling alone have low social acceptance and low self-esteem. Protective factors that buffer against loneliness include self-esteem, empathy, coping skills, social acceptance, social capital (i.e., friendship quality and quantity), and school engagement.

Some youth are at higher risk of feeling alone. Homeless youth have higher levels of loneliness compared to non-homeless youth. Loneliness in homeless youth can be related to self-esteem, neglect by caregivers, and abuse. Gay, lesbian, and transgender youth are considered higher risk for loneliness as a result of abuse, victimization, and being thrown out of their home as a result of coming out to parents. Also, feelings of loneliness change with age with higher levels of loneliness around age 12 and decreasing by age 18.

Phase II Key Findings:
New data on Anchorage youth and young adults

Adult Perceptions of Anchorage Youth (APAY)

The following are preliminary results from the survey based on 171 respondents. Final survey outcomes will be provided in a supplement to this report. Survey methodology can be found on page 28 of this report and the key findings are discussed in more detail starting on page 58.

- A majority of Anchorage adults reported they were not knowledgeable or only somewhat knowledgeable about behavioral health issues among Anchorage youth such as bullying, extreme sadness/hopelessness, youth feeling alone and suicide.
- A majority of Anchorage adults reported a great deal of concern about behavioral health issues among Anchorage youth, especially suicide.
- Anchorage adults reported most frequently that there was only a little or some community efforts in place to address various behavioral health issues among youth.
- A majority of Anchorage adults are likely or very likely to engage in youth's lives.
- A majority of Anchorage adults agreed or strongly agreed that Anchorage teachers care about and give encouragement to youth.

Young Adult Survey (YAS)

The following are highlights from YAS results. Survey methodology can be found on page 30 of this report and the key findings are discussed in more detail starting on page 61.

- Verbal bullying was the most frequent type of bullying Anchorage young adults (18-24) reported experiencing (29.4%) within the past year.
- Fewer young adults reported experiencing cyber-bullying/harassment within the past year (17.1%) and fewer still reported physical harassment (8.5%).
- Of individuals who reported engaging in bullying, verbal bullying was the most common type reported (6.5%), followed by cyber (4.9%) and physical bullying (2.1%).
- About 20% of Anchorage young adults reported seriously considering suicide within the past year.
- More than half of Anchorage young adults reported they have had a problem for which they thought psychological or mental health services would be helpful and approximately three-quarters of those young adults did receive services.
- Anchorage young adults who did not receive services for mental health issues reported four primary reasons: cost, lack of resources, stigma, and skepticism about mental health services.
- A number of variables were predictors of young adults experiencing mental health issues including experiencing greater stress, having been bullied, being less optimistic, having lived in Anchorage for more years, identifying as a woman (as opposed to a man) and identifying as a sexual minority (as opposed to heterosexual).

Focus Groups

The following focus group findings are divided into findings from bullying focus groups and mental well-being focus groups. Focus group methodology is described starting on page 32 of this report. Focus group findings including direct quotes begin on page 66.

Bullying.

- Bullying was described by participants as verbal bullying; behaviors intended to increase status such as social exclusion, judging, or spreading rumors; physical behaviors and; cyber bullying
- For junior and high school students bullying primarily occurred in school or online and less frequently outside of school settings.
- For 18-24 year olds, bullying typically occurred in work and community environments.
- According to participants the primary reason people are bullied is because they are perceived as different (e.g., race, disability, weight, religious beliefs or customs, skin color, sexual orientation, physical or mental vulnerability, low popularity).
- According to participants, there are a number of reasons people engage in bullying behavior including having low self-esteem, for attention, to fit in, to feel better than others and to stop the bullying they are experiencing.
- The effects of bullying on the victim, according to participants, included feelings of depression,

hurt feelings, signs of apathy, withdrawing or stopping participation in usual activities, lower self-esteem, and suicide.

- Ways to cope with bullying included mental resiliency/strength, empathizing with the bully, relying on friends and standing up to the bully.
- Although participants mentioned going to trusted adults for help, adults were often mentioned second to friends.
- Specific activities to cope with the hurt from bullying included both positives such as religion or spiritual practices and music and negatives such as substance use.
- Participants offered solutions in terms of both intervening with youth engaging in bullying and youth experiencing bullying.
- Solutions focused on youth engaging in bullying behavior included helping them understand how they'll have friends if they don't bully, teaching them the effects that bullying can have on the victims (e.g., suicide), and encouraging them to engage in fun and meaningful activities.
- Solutions focused on youth experiencing bullying included friends offering comfort both in person and on social media, friends/peers standing up to the bully, and talking to friends about it.

Mental Health.

- Participants said they knew when someone was feeling sad, lonely or hopeless when the person:
  - Stopped doing things they used to enjoy
  - Became more negative than they were before and/or talked differently
  - Isolated themselves
  - Changed their body language
  - Expressed feelings of sadness/ hopelessness/loneliness
  - Engaged in self-harming behaviors (e.g., cutting)
- Participants also said some youth may conceal feelings to maintain reputation or avoid stigma.
- Bullying was frequently mentioned as a direct cause or reason for poor mental well being.

	Causes and risks for feeling alone, sad, and/or hopeless
Individual	• Social isolation • Withdrawal • Not knowing where to go for help • Poor sense of self and self-worth • Not seeking help • Experiencing transitions or major life changes • Feeling unsafe in the community
Family	• Trauma • People at home who don't care • Parents not around or available • Family far away and/ or unsupportive
Geographical	• Long, cold, dark winters with possible seasonal affective disorder • Poor transportation in and around Anchorage
Community or Social	• Unsupportive friend/ peer group • Bullying • Feeling like they don't matter to their community • Lack of opportunities to connect with others • Lack of trusted adults • Negative social media • Negative youth culture • Racial, cultural and/ or gendered norms • Perceived societal expectations

- According to participants, stigma and misconceptions about mental health issues both among peers and society, may make it difficult for youth to identify mental health issues and to seek help.
- Protective factors for favorable mental well-being included:
  - Having trusted relationships (peer and trusted adults)
  - Being able to seek support when needed
  - Opportunities for meaningful social

engagement (e.g., sports/exercise, volunteering, clubs, school-based activities

- Opportunities for meaningful introspective or individual activities (e.g., expressing themselves through social media or writing, setting goals, practicing positive thinking and gratitude)
- Opportunities for other meaningful activities (e.g., being outside in nature, participating in religious or spiritual activities, listening to music)

Seeking support was different for the low risk groups as compared to the higher risk groups.

Low Risk	*High Risk*
Sought out support from any trusted person, peer, or adult	Tended to seek support from friends or peers first Tended to have less trust in others and relied more on themselves

- Having safe spaces for youth was emphasized by youth as a way to support mental well-being.
- Feeling connected to the community and to the people who live here was seen as important for mental well being.
- Feeling connected to both their individual ethnic community and to the racial and cultural diversity that makes up Anchorage was seen as important for mental well being.

Solutions were focused at the youth level and community level.

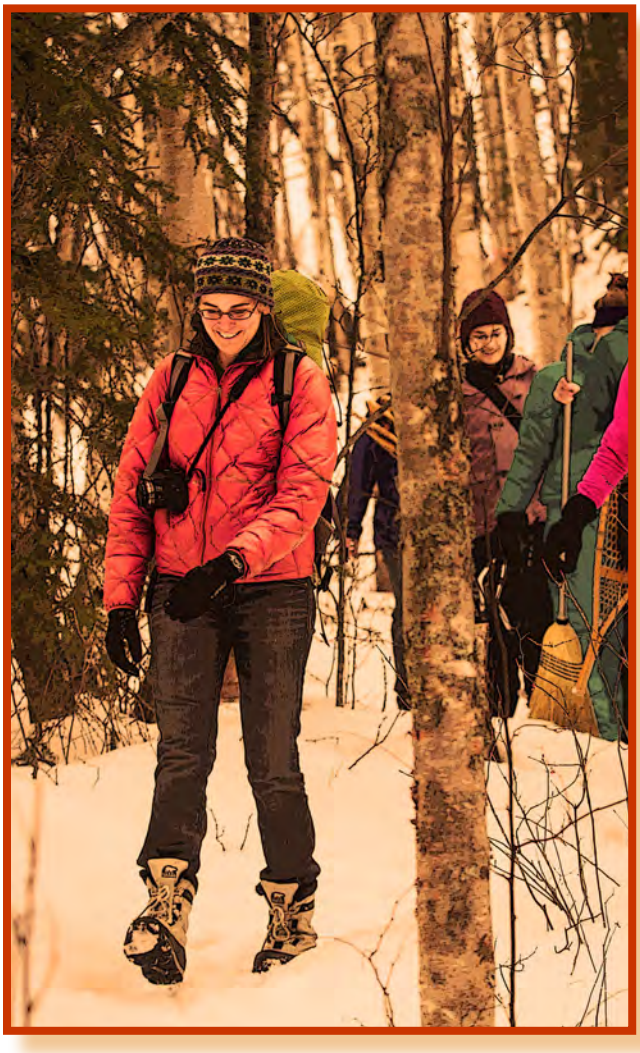
Youth Level Soultions	*Community Level Solutions*
Asking the youth to help with something important so they feel they are making a contribution. Validating the youth's feelings, rather than encouraging their concealment or denying the importance of those feelings. Expressing an interest in the youth's interests. Expressing appreciation by saying thank you when youth help in different capacities.	Providing volunteer opportunities so that youth can feel like they matter to the community Providing youth groups focused on volunteering, gaming, and activities. Providing community centers with affordable entry fees and easy access including transportation. Providing community-wide youth annual convention/celebration.

Synthesis and Recommendations

Considering the results of the existing and new data, it is recommended for the next steps that the ACC focus on the following three intermediate variables for youth aged 12 to 24:

- **Feeling alone**
- **Trusted relationships**
- **Youth feeling they matter to the community**

These three intermediate variables as evidenced throughout this report and data analysis are key variables for having an impact on bullying, sadness/hopelessness, and suicide and thus improving the mental health of Anchorage youth.



Giving Helping Growing

Introduction

Purpose

In January 2015, The University of Alaska Anchorage (UAA) Center for Human Development (CHD) was awarded a contract from the Anchorage Collaborative Coalitions (ACC) to work in conjunction with the ACC on a community assessment to evaluate behavioral health indicators and related demographic, social, economic, and environmental factors pertaining to youth and young adults aged 9-24 in Anchorage, Alaska. In broad terms, the assessment process focused on three major areas: substance use, mental health, and suicide.

Karen Heath at CHD was designated as the UAA Principal Investigator of the project, leading a UAA Assessment Team consisting of research professionals at CHD and faculty with particular expertise from other UAA units: the Justice Center, the Center for Behavioral Health Research and Services, and the Department of Health Sciences.

The UAA Assessment Team was tasked with assisting the ACC to implement SAMHSA's Strategic Prevention Framework (SPF), a 5-step process with cultural competence at its heart. The first step is to systematically gather and examine data to identify problems in the community and in the population of interest. It includes examining conditions that put communities at risk and conditions that could protect against problems. Implementing this first step not only required conducting a community assessment, but also building capacity of the ACC for planning, implementing, and evaluating future prevention efforts.

Background

The community assessment process was conducted in two major phases. The first focused on accessing and analyzing secondary data from national, state, and local sources. Substance use, mental health, and suicide were assumed to have overlapping risks leading to problems that often begin in adolescence or young adulthood and can lead to long-term, serious consequences for youth, families, and communities.

Substance Use

The 2013 Alaska Scorecard prepared by the Alaska Mental Health Trust Authority (AMHTA) noted that 13% of Alaska's high school students engaged in binge drinking in the past 30 days (as per results of the Youth Risk Behavior Survey-YRBS). They noted a rise in illicit drug use (age 12+) running at least 25% above national rates, and that Alaskans age 18-25 have the highest rates (as per results of the National Survey on Drug Use & Health-NSDUH). Of Alaskans age 9-12, 39% reported using marijuana one or more times, and 20% had used it during the past 30 days; 14% had used prescription drugs without a prescription; and 7% had engaged in "sniffing" (e.g., glue, aerosol products, paint) (as per YRBS).

Individual consequences of substance use can include school suspensions and expulsions, as well as legal charges for consumption and driving while intoxicated (Rivera, Parker, & McMullen, 2012). Substance use in adolescence can put people at higher risks for major life impairments and chronic conditions, including severe mental illnesses (AMHTA, 2013). More immediately, it is often associated with other high-risk behaviors that can lead to serious injury or death.

Alaska's financial burden for underage drinking alone related to acts of violence, traffic accidents, high-risk sexual behavior, crimes, poisonings/psychoses, FAS, other injuries, and alcohol treatment runs well over $300 million per year (Parker, 2010). In per capita dollars (per youth in the population), that puts Alaska at the top in the nation, nearly twice the national average (Parker).

Mental Health

The AMHTA notes the rate of Alaskan high school students who experienced symptoms of depression during the previous 12 months was unacceptably high at 27.2% (2013, as per results of the YRBS). There is evidence of a trajectory from depressive

symptoms in youth to poorer physical health in adulthood (Wickrama, Wickrama, & Lott, 2009). Similarly, poor mental health is disproportionately associated with higher rates of co-morbid chronic illnesses and increased mortality (Parks, Svendsen, Singer, & Foti, 2006). Mental and substance use disorders are likely the third leading cause of suicide deaths (Ferrari, Norman, Freedman, et al., 2014). In addition, adults with any history of mental illness are more than twice as likely as the general population to suffer from unintentional injuries (e.g., motor vehicle injuries) (Wan, Morabito, Khaw, Knudson, & Dicker, 2006), while their risk of homicide injuries can be sevenfold (Crump, Sundquist, Winkleby, & Sundquist, 2013).

Individuals with severe mental illnesses such as schizophrenia, bipolar disorder, and major depressive disorder die on average 25 years earlier than the general population, and their rate of death from co-occurring chronic illnesses (e.g., diabetes, cardiovascular disease, respiratory disease, and infectious diseases) is two to three times that of the general population (Parks et al., 2006). Severe mental illness is also associated with higher risk behaviors and conditions that can be prevented or modified. These include much higher rates of smoking, alcohol consumption, obesity, unsafe sexual behavior, IV drug use, homelessness, victimization, poverty, incarceration, social isolation, as well as increased exposure to TB and other infectious diseases (Parks et al.).

The economic burdens of mental health problems on individuals, families, employers, and society at large (OECD, 2012) are overwhelming to consider. A longitudinal study following children with psychological conditions, their siblings and parents (35,000 individuals) over a 40-year period demonstrated a total lifetime economic cost of 2.1 trillion dollars for these families (Smith & Smith, 2010). One factor in the cost is young people who leave the workforce or never enter it, both in terms of losing what they would contribute and the cost of supporting them. Seventy percent of all new disability benefit claims for young adults are for mental illness reasons (OECD).

Suicide

Alaska has one of the highest per capita rates of suicide in the nation (Statewide Suicide Prevention Council-SSPC, 2010, using data from the Alaska Bureau of Vital Statistics). On average, there are 2.6 suicides in Alaska per week, or over 10 per month. About 78% of suicide deaths are males. The highest rate in the nation by race/ethnicity and age tends to be for Alaska Native males between age 15 and 24.

The individual consequences of suicide attempts include serious injuries and deaths. In 2012 the overall age-adjusted suicide rate in the nation was 12.6 per 100,000 persons in the population (Centers for Disease Control & Prevention-CDC, 2014, using data from the National Center for Health Statistics). This represented more than 40,000 deaths, making suicide the 10th leading cause of death in the U.S. (CDC, 2015). Alaska had the second highest state per capita rate of suicide in 2012 at 23.0 (CDC, 2014).

The family members and friends of people who die by suicide experience a range of grief reactions, often more complex due to the nature of a loved one's death. For example, feelings of guilt, anger, abandonment, and shock may be worse (Jordan, 2001). Survivors are often at a higher risk for committing suicide in the future (Brent, 2010). Estimates of the number of people impacted by a single suicide death range from 6 to 32 people (Berman, 2011).

In terms of consequences to society, the CDC (2015) estimated suicide costs over $44.6 billion per year in the U.S. (medical plus work loss), or an average of $1,164,499 per person. Using this per person cost along with an estimated 2.6 suicides per week in Alaska (SSPC, 2010) renders an estimated total cost of $157,440,265 per year for the state. However, a recent study put the national cost of reported suicide deaths much higher at $58.4 billion per year, with an adjustment for under-reporting jumping it up to $93.5 billion (Shepard, Gurewich, Lwin, Reed, & Silverman, 2015).

Priority Areas of Focus

An outcome of Phase I was a large collection of data that informed gap analysis and assisted the

ACC to identify priority areas for additional data collection to inform prevention efforts. The design of Phase II data collection activities was driven by results from Phase I. Ultimately, the primary area of focus chosen by the community was mental health, particularly the variables of bullying and feeling alone.

Bullying

Bullying is defined as unwanted, aggressive behavior among school-aged children that is intentional, repeated, and involves a real or perceived power imbalance between the victim and perpetrators (Wang, Iannotti, & Nansel, 2009). There are four main types, including verbal, physical, social/relational and cyber (Powell & Jenson, 2010). Verbal and social/relational bullying are the most commonly reported forms.

Students who bully use their power such as physical strength, access to embarrassing information, or popularity to control or harm others. Power imbalances can change over time and in different social situations even if they involve the same people. Bullying tends to occur within school buildings (e.g., classroom, hallway, gymnasium), outside of school (e.g., playground, bus, neighborhood) and on the Internet (Wang, Iannotti, & Nansel, 2009).

Subpopulations of youth can have an increased risk of being bullied. For example, individuals identifying as Lesbian, Gay, Bisexual and/or Transgender are more likely to report experiences with bullying, school violence, and sexual orientation victimization (D'Augelli, Grossman, & Starks, 2006; Grossman et al., 2009). LGBT youth who report high levels of at-school victimization also report higher levels of substance use, suicidality and sexual risk behaviors than their heterosexual peers who report similarly high levels of at-school victimization (Bontempo & D'Augelli, 2002). With more students becoming aware of, identifying, and disclosing sexual attraction and gender identity at younger ages (Grossman et al., 2009) research is needed to better understand how to prevent bullying within this group and target future interventions.

The role of ethnicity in shaping the risk of being bullied has also been studied (Bellmore, Witkow, Graham, & Juvonen, 2004). Students with backgrounds that deviate from what is perceived as normative in a particular context experience increased risk of bullying, racial teasing, and peer victimization (Graham & Juvonen, 2002). Some research has shown that ethnic minority children are more likely to identify their race or culture as the reason for being bullied (Boulton, 1995), but the influence of contextual factors, such as youth ethnicity and identity, urbanicity, and school characteristics have largely been overlooked in previous research (Bradshaw, Waasdorp, Goldweber, & Johnson, 2013). How perceptions of ethnic difference shape the experience of bullying from the perspective of victims, perpetrators, bully/victims and bystanders is of critical importance in identifying those contexts in which bullying occurs and tailoring interventions to make a positive difference in the lives of students.

Students who experience disabilities are also more likely to be bullied and are at particular risk for repeated victimization (Rose, Espelage, & Monda-Amaya, 2009). Data from the Special Education Elementary Longitudinal Study (SEELS) and the National Longitudinal Transition Study-2 (NLTS2) reveal that students with disabilities are over 1.5 times more likely to experience bullying than non-disabled students, and the rate of victimization is highest for students with emotional disturbance across all school levels (Blake, Lund, Zhou, Kwok, & Benz, 2012). Other researchers have reported that having a special healthcare need is generally associated with being bullied, while having a behavioral, emotional, or developmental challenge is associated with bullying others and being a bully/victim (i.e., a bully who also gets bullied) (Van Cleave & Davis, 2006). Students with disabilities who experience bullying once are at high risk for being bullied repeatedly. Specifically, elementary and middle school students with autism and high school students with orthopedic impairments are at the greatest risk for experiencing repeated victimization. These findings have several important implications for future research and school-based interventions (Van Cleave & Davis).

Common risk factors for being bullied include perceived difference, weakness or vulnerability,

depression, anxiety and low self-esteem, few friends and the perception of lacking in popularity (Bollmer, Milich, Harris, & Maras, 2005). Risk factors for bullying behaviors include being well connected, having social power, concern over popularity, desire to dominate or to be in charge, aggressiveness, easily frustrated, less parental involvement, having issues at home, difficulty following the rules, positive view of violence and having other friends who bully (Cook, Williams, Guerra, Kim, & Sadek, 2010).

Bullying can have several long-term health consequences for victims, perpetrators and bystanders (Brank, Hoetger, & Hazen, 2012; Haynie et al., 2001; Hindujah & Patchin, 2010). Documented effects on perpetrators of bullying include alcohol and drug abuse as adults, getting into fights, vandalism, dropping out of school, early sexual activity, criminal convictions, traffic citations and abusive behavior towards partners as adults (Vanderbuilt & Augustyn, 2010). In one large-scale study, data from the 2007 National Survey of Children's Health were reviewed and children aged 6-17 with a diagnosis of depression, anxiety or ADHD were found to be more than 3 times as likely to be a bully (Benedict, Vivier, & Gjelsvik, 2015). The study examined a total of 63,997 children who had data for both parental reported mental health and bullying status nationwide and found that the diagnosis of a mental health disorder is strongly associated with being identified as a bully.

Victims of bullying experience increased likelihood of depression, anxiety, feelings of sadness and loneliness, changes in sleep and eating patterns, loss of interest in activities they used to enjoy, health complaints (often expressed as strategies to avoid school), decreased academic achievement, and increased likelihood of skipping and/or dropping out of school (Klomek, Marrocco, Klienment, Schonfeld, & Gould, 2007; Vanderbilt & Augustyn, 2010). Effects on bystanders include increased use of alcohol, tobacco and other drugs, increased mental health problems, including depression and anxiety, and increased school absence.

These research findings provide critical insight into the contextual factors that shape the experience of bullying and highlight gaps that could be targeted in future school-based interventions. While some groups may be at particular risk for bullying and/or being bullied, it is important to focus interventions on victims, perpetrators, bully/victims and bystanders alike. Since long-term health consequences are associated with the experience of bullying at all levels, attention must be given to those school contexts that may normalize and naturalize bullying behavior. As more is learned about what it looks like, it may be possible to target those contexts in which such behavior is deemed socially permissible, and reshape the social norms around this issue.

Feeling Alone

Loneliness is a common problem among youth that can have serious consequences. Youth who feel alone are at higher risk for school dropout (Levitt, Guacci-Franco, & Levitt, 1994; Page, 1990; Pretty, Andrewes, & Collett, 1994), delinquency and violence (Patterson, DeBaryshe, & Ramsey, 1998; Walker & Gersham, 1997), suicide ideation (Schinka, Van Dulmen, Bossarte, & Swahn, 2012), depression (Ladd & Ettekal, 2013; Qualter, Brown, Munn, & Rotenberg, 2010), anxiety and substance use (Heinrich & Gullone, 2006). Loneliness has also been found to contribute to poor physical health, including nausea, headaches, and eating disturbances (Adam et al., 2011; Caciopp et al., 2002; Pritchard & Yalch, 2009; Segrin & Passalacqua, 2010). While loneliness is recognized as a correlate of depression, there is debate over whether loneliness leads to depression or depression leads to loneliness (Lalayants & Prince, 2015). For example, Lasgaard, Goossens, and Elkit (2011) report depression as a predictor of loneliness, but not vice versa, while Vanhalst et al. (2012) indicate loneliness as a unidirectional predictor of depression. More recent longitudinal research by Lalayants and Prince (2015) suggests a bidirectional relationship between loneliness and depression and related outcomes (i.e., school disengagement and low future expectations) among adolescent females in the child welfare system. Lonely females were 5.09 times more likely than other females to be depressed, 2.68 times more likely to disengage from school, and 3.54 times more likely to have low expectations for the future. Female youth experiencing depression were 5.02 times more likely to be lonely than those females who did not report depression and females

who were disengaged from school were 2.93 times more likely to be lonely than females who remained in school.

The causes or contributing factors of loneliness are complex and potentially interwoven. Loneliness in adolescence is influenced by individual traits (intra-individual characteristics) and situational factors (inter-personal experiences) (Heinrich & Gullone, 2006; Vanhalst, Luyckx, & Goossens, 2014). Examples of intra-individual characteristics would be shyness and self-esteem, while inter-personal experiences refer to social acceptance among peers, peer victimization (e.g., bullying), friendship quality, and friendship quantity. Each characteristic is individually known to contribute to loneliness and some of these characteristics interact with each other to predict loneliness (Vanhalst, Luyckx, & Goossens). As an example, youth with low social acceptance and low self-esteem are at higher risk for becoming lonely than youth who have high self-esteem. In addition to peer related inter-personal experiences, parental loneliness predicts loneliness in young adults (Segrin, Nevarez, Arroyo, & Harwood, 2012).

Factors that mediate or buffer against loneliness include self-esteem, empathy, coping skills (social, emotional, and cognitive), social acceptance, friendship quality and quantity, and school engagement (Lalayants & Prince, 2015; McWhirter, Besett-Alesch, Horibata, & Gat, 2002; Vanhalst, Luyckx, & Goossens, 2014). McWhirter et al. found self-esteem to be negatively correlated with loneliness and found higher self-esteem to be related with better coping skills, this included cognitive coping, emotional coping, social coping, spiritual/philosophical coping, and physical coping. Higher levels of social, emotional, and cognitive coping were associated with lower levels of loneliness.

Some populations are thought to be more at risk for loneliness. Rew, Taylor-Seehafer, Thomas, and Yockey (2001) documented homeless youth have higher levels of loneliness. Homeless youth who have also experienced abuse have poor social connectedness and high levels of loneliness (Goodman & Berecochea, 1994; Rew, 2002). Among homeless youth, "sexual abuse was significantly related to loneliness, and inversely related to connectedness, total well-being, current health, prior health, and ability to resist illness" (Rew et al., p.57).

Two studies have used quantitative methods to understand resilience among homeless youth and had opposite results (Perron, Cleverley, & Kidd, 2014; Rew et al., 2001). The study by Rew et al. supports a significant inverse relationship between loneliness and resiliency in homeless youth, such that highly resilient youth are less lonely. However, Perron, Cleverley, and Kidd, did not find a significant relationship between loneliness and resiliency in homeless youth. Homeless youth with more psychological distress (i.e., feeling trapped, hopelessness, giving up, and helplessness) had lower resiliency scores. Kidd and Shahar (2008) used interviews and some quantitative measures to better understand resilience and risk behaviors in homeless youth and found "loneliness was significantly accounted for by self-esteem, neglect by caregivers, and dismissing attachment" (p.169).

Among offender populations, individuals who were both perpetrators of bullying and targets of bullying reported higher levels of loneliness than "pure victims," "pure bullies," or those "not involved" (Ireland & Power, 2004). The study was not able to determine whether loneliness contributed to victimization or if it occurred as a consequence. The study suggested that the "bully/victim group may be the one most stigmatized by peers, as indicated by their avoidant attachment style and increased emotional loneliness in comparison to pure victims" (p.310).

Kidd and Kral (2002) reported gay, lesbian, and transgender youth were at risk for abuse and being thrown out of their homes related to coming out to their parents. Further, LGBTQ youth are more often victimized and report poorer mental health status when compared to heterosexual peers (Whitbeck, Chen, Hoyt, Tyler, Johnson, 2004). Considering these findings with previous literature that links peer victimization and social acceptance to loneliness, it is not surprising that LGBTQ youth have been found to be at higher risk for loneliness (Martin & D'Augelli, 2003; Yadegarfard, Meinhold-Bergmann, & Ho, 2014).

There is some debate regarding gender disparities

in loneliness and depression. Some studies have found no gender difference (Lasgaard, Goossens, & Elkit 2011; Nagle, Erdley, Newman, Mason, & Carpenter, 2003) while others have reported female youth more likely to be depressed and/or lonely than their male counterparts (Koenig & Abrams 1999; Vanhalst et al. 2012). A more recent longitudinal study of 478 youth found no significant difference for levels of loneliness based on gender, race, or family income (Ladd & Ettekal, 2013). However, loneliness did vary based on age, in that levels were higher at age 12 and decreased through age 18 with the largest decrease between grades 6 and 7. Further, it was indicated that not all youth experienced the same loneliness trajectories, meaning some youth remained in a stable non-level or low level, some in a stable high (chronic) level, and some in declining levels.

Community Profile

The Municipality of Anchorage, Alaska includes the communities of Anchorage, Girdwood, Eagle River, and Chugiak. It is the largest community in the state, located in Southcentral Alaska. The Anchorage metropolitan area sits in a bowl with Cook Inlet to the west, and Chugach State Park to the east. The municipality is just over 1,700 square miles, with an average of 171.2 persons per square mile.[1] Warmed by Pacific currents, the city has a mild northern climate, comparable in the warmer months to spring in San Francisco.[2] The average temperature is 37°F, with an average annual high of 43.7°F, and average low of 30.3°F.[3]

History of Anchorage

The Dena'ina are indigenous peoples of the Cook Inlet Region where Anchorage is situated. As other Alaska Native groups, the Dena'ina population has decreased by more than half of the pre-1700s numbers. Colonization of southern Alaska began with Russian explorers in the late 1700s, and English colonizer Captain James Cook is often cited as one of the early non-Native outsiders to invade the area in 1778. In 1867, the United States paid Russia $7.2 million for colonizing rights. Alaska gained statehood in 1959.[4]

Anchorage began to emerge around 1914 out of a tent city built in Ship Creek Landing, a port for the Alaska Railroad. The Cook Inlet Historical Society documents the naming of Anchorage:

"A popular hardware and clothing store, 'The Anchorage,' was actually an old dry-docked steamship named 'Berth.' Although the area had been known by various names, the U.S. Post Office Department formalized the use of the name 'Anchorage,' and despite some protests, the name stuck."[5]

Growth of Anchorage and the larger Alaska economy continued between 1930-1950 as military presence grew, and air transportation became increasingly important. Anchorage International Airport opened in 1951, while Elmendorf Air Force Base and Fort Richardson (now Joint Base Elmendorf-Richardson [JBER]) were constructed in the 1940s. The 1968 discovery of oil in Prudhoe Bay created an economic boom for Alaska, and the oil industry continues to be a major part of the economy to this day.[6]

Demographics

Home to nearly half the state's residents, the Municipality of Anchorage total population estimate is 300,950.[7] According to 2013 data from the United States Census Bureau, the racial/ethnic makeup of Anchorage is approximately:

- 66.6% White
- 8.9% Asian
- 8.6% Hispanic or Latino
- 8.1% American Indian and Alaska Native
- 7.8% Two or more races
- 6.3% Black or African American
- 2.3% Native Hawaiian and Other Pacific Islander

1 United States Census Bureau, accessed 4/6/15; http://quickfacts.census.gov/qfd/states/02/02020.html
2 The Official Source for Anchorage, Alaska Travel Information, accessed 4/7/15; http://www.anchorage.net/anchorage-weather
3 U.S. Climate Data, accessed 4/7/15; http://www.usclimatedata.com/climate/anchorage/alaska/united-states/usak0012
4 Cook Inlet Historical Society, "Anchorage History"; accessed 4/6/15; http://www.cookinlethistory.org/anchorage-history.html
5 Cook Inlet Historical Society, "Anchorage History"; accessed 4/6/15; http://www.cookinlethistory.org/anchorage-history.html
6 Municipality of Anchorage, "History", accessed 4/6/15; http://www.muni.org/FastFacts/Pages/History.aspx
7 United States Census Bureau, accessed 4/6/15; http://quickfacts.census.gov/qfd/states/02/02020.html

Anchorage is home to more Alaska Natives than any other city in the United States.[1] In 2010, 26% of Alaska's Alaska Native population lived in Anchorage.[2] Today, parts of Anchorage are more than 50% people of color. According to the Alaska Department of Labor, Anchorage's Mountain View census area was recently identified as "... the most racially diverse census tract in the entire United States..."[3] The Anchorage population also includes 5,500 military and civilian personnel from the military JBER.[4]

The median Anchorage household income between 2009-2013 was $77,454.[5] An estimated 7.9% of people were recorded as living below poverty level, with 32,947 people 125% below poverty level.[6] Approximately 9.4% of Anchorage residents were "foreign born", meaning not U.S. citizens at birth.

In 2010, there were an estimated 143,617 women and girls, and 148,209 men and boys in Anchorage.[7] In 2013, the Municipality of Anchorage had a recorded 105,208 households.[8] The average household size was 3 people, with a median age of 33 years old. Following is a brief profile of the Anchorage youth populations by age.[9]

Anchorage Youth Population by Age

Ages	*Number of Youth*
20-24	24,379
15-19	21,187
10-14	20,443
5-9	20,618
4 and under	21,961
TOTAL	**108,588**

Between October 1, 2013 and September 30, 2014 there were 7,506 people recorded as homeless in Anchorage.[10] This includes families and individuals in emergency shelters, transitional housing, and permanent supportive housing. In the same time frame, 987 children were represented under the same categories. This does not include people using, "other programs whose primary mission is to provide services to victims of domestic violence, dating violence, sexual assault or stalking", such as rape crisis centers or battered women's shelters.[11]

As of 2012, 15,843 Alaska youth between 6 and 21 years old were being provided services as mandated by the Individuals with Disabilities Education Act.[12] In 2011, 7.9% of Alaskans between the ages of 18 and 64 years old reported a "work limitation" (disability). This percentage translates to about 35,000 adult Alaskans with disabilities (civilian, non-institutionalized adults).[13] According

1 State of Alaska Department of Labor, Anchorage Neighborhoods: Great Diversity Within Alaska's Largest City, by Eddie Hunsinger and Eric Sandberg (September, 2013); accessed 4/7/15; http://labor.alaska.gov/research/trends/sep13art1.pdf
2 State of Alaska Department of Labor, Anchorage Neighborhoods: Great Diversity Within Alaska's Largest City, Eddie Hunsinger and Eric Sandberg, 2013; http://labor.alaska.gov/research/trends/sep13art1.pdf
3 State of Alaska Department of Labor, Anchorage Migration: The Movement Between Alaska's Major Native Areas and Anchorage, by J. Gregory Williams, State Demographer, 2010, http://labor.alaska.gov/research/trends/feb10art1.pdf
4 Joint Base Elmendorf-Richardson; accessed 4/7/15; http://www.jber.af.mil/main/welcome.asp
5 Department if Commerce, Community, and Economic Development: Community and Regional Affairs, "Community: Anchorage"; "Income 2009-2013 ACS 5-Year Estimates"; accessed 4/9/15; http://commerce.state.ak.us/cra/DCRAExternal/community/Details/2d5ef9f0-9855-4b68-9350-bc9d20e81807
6 Department if Commerce, Community, and Economic Development: Community and Regional Affairs, "Community: Anchorage"; "Poverty 2009-2013 ACS 5 Year Estimates"; accessed 4/9/15; http://commerce.state.ak.us/cra/DCRAExternal/community/Details/2d5ef9f0-9855-4b68-9350-bc9d20e81807
7 Department if Commerce, Community, and Economic Development: Community and Regional Affairs, "Community: Anchorage"; "Population by Gender"; accessed 4/9/15; http://commerce.state.ak.us/cra/DCRAExternal/community/Details/2d5ef9f0-9855-4b68-9350-bc9d20e81807
8 US Census Bureau, "Anchorage Municipality, Alaska"; last revised March 31, 2015; accessed 4/9/15; http://quickfacts.census.gov/qfd/states/02/02020.html
9 Department if Commerce, Community, and Economic Development: Community and Regional Affairs, "Community: Anchorage", Population by Age; accessed 4/9/15; http://commerce.state.ak.us/cra/DCRAExternal/community/Details/2d5ef9f0-9855-4b68-9350-bc9d20e81807
10 Sheltered Homeless Persons in Anchorage 10/1/2013-9/30/2014, from the Homeless Management Information System; "Exhibit 1.1 Estimated Homeless Counts during a One-Year Period", p. 11; accessed 4/9/15; http://www.alaskahousing-homeless.org/sites/default/files/AHAR 2014 Anchorage.pdf
11 Sheltered Homeless Persons in Anchorage 10/1/2013-9/30/2014, from the Homeless Management Information System; "Exhibit 3.1 Demographic Characteristics of Sheltered Homeless Persons", p. 3; accessed 4/9/15; http://www.alaskahousing-homeless.org/sites/default/files/AHAR 2014 Anchorage.pdf
12 PowerPoint, "RespectAbility: Alaska and Jobs for PWDs" by Jennifer Laszlo Mizrahi, Slide 4; accessed 4/10/15; http://respectabilityusa.com/Resources/By State/Alaska and Jobs for PwDs.pdf
13 Disability Statistics: "Find U.S. disability statistics in 3 easy steps"; Current Population Survey; accessed 4/10/15; http://www.disabilitystatistics.org/reports/cps.cfm?statistic=prevalence

to 2014 counts compiled in the Annual Disability Statistics Compendium, 21% of Alaska adults living in the community have disabilities (115,613 people).[1] Data for prevalence of various disabilities among Municipality of Anchorage youth or Alaska in general were not found.

Although data on prevalence of queer/questioning, undecided, intersex, lesbian, transgender/ transsexual, bisexual, allied/asexual, gay/ genderqueer, and Two Spirit identified youth (QUILTBAG2; more commonly LGBTQ), were not found, Anchorage has some community services specifically for these populations. The non-profit *Identity's* mission is to, "advance Alaska's LGBT (lesbian, gay, bisexual, and transgender) community through advocacy, education and connectivity."[2] *Identity* organizes a variety of community events with a focus on youth, including a community center, the support groups Q-Club and Translution (supporting trans teenagers), the Youth Leadership Summit, and Pride Prom.[3] The YWCA of Alaska also offers supportive programming for queer youth, with an emphasis on girls/young women and anti-racist work.[4] Support for queer youth is particularly important, as these groups experience higher rates of violence, including bullying.[5]

Anchorage Schools

The Anchorage School District (ASD) has almost 48,000 students, and more than 130 schools and programs.[6] As of 2013, students of color made up more than 50% of total enrollment; the break down is as follows:

- 45% White
- 14% Two or more races
- 11% Hispanic
- 11% Asian
- 9% Alaska Native or American Indian
- 6% Black
- 5% Native Hawaiian or other Pacific Islander

High schools in Anchorage are some of the most diverse in the nation.[7] As of fall 2014, there were 99 different languages spoken by youth in ASD (including English). Students speaking languages other than English made up 20% of the total student population. The following are the most common languages spoken by these groups, and the total number of student speakers:

- Spanish: 1,340
- Hmong: 1,060
- Samoan: 980
- Tagalog: 763
- Yup'ik: 254

Economy & Cost of Living

The latest data from the Anchorage Economic Development Corporation (2012) indicates the five largest industries in Anchorage are:[8]

- Trade, transportation, and utilities
- Education and Health Services
- Professional and Business Services
- Leisure and Hospitality
- Local and state government

As of 2011, the Anchorage labor force was estimated at 157,210 persons, with 147,604 people employed.[9] Following are tables of the various employment sectors, and the top ten occupations in Anchorage as of 2012.

1 Disability Statistics & Demographics, Rehabilitation Research & Training Center: "2014 Annual Disability Statistics Compendium", p. 70; accessed 4/13/15; http://www.disabilitycompendium.org/docs/default-source/2014-compendium/2014_compendium.pdf
2 Identity, accessed 4/13/15; http://identityinc.org/about/
3 Identity, "Upcoming Youth Activities", accessed 4/13/15; http://identityinc.org/services-2/for-youth/
4 YWCA Alaska, "Youth Empowerment"; accessed 4/13/15; http://ywcaak.org/youth-empowerment/
5 Center for Disease Control and Prevention, "Lesbian, Gay, Bisexual, and Transgender Health"; accessed 4/13/15; http://www.cdc.gov/lgbthealth/youth.htm
6 Anchorage School District: "Educating Students for Success for Life", accessed 4/7/15; http://www.asdk12.org/aboutasd/
7 Study Calls Anchorage Schools America's Most Diverse High Schools, by Corey Allen-Young; Channel 2 KTUU February 27, 2014; accessed 4/6/15; http://www.ktuu.com/news/news/study-calls-east-bartlett-west-americas-most-diverse-high-schools/24725354
8 2012 Anchorage Indicators, Municipality of Anchorage & Anchorage Economic Development Corporation, pg. 101; accessed 4/7/15; http://www.muni.org/Departments/OCPD/Planning/Publications/Documents/Full Indicators Report.pdf
9 2012 Anchorage Indicators, Municipality of Anchorage & Anchorage Economic Development Corporation, pg. 96; accessed 4/7/15; http://www.muni.org/Departments/OCPD/Planning/Publications/Documents/Full Indicators Report.pdf

2012 Top Anchorage Employment Sectors[1]

Sector	Number of Workers	% of Total Employed	Female	Male
Trade, Transportation and Utilities	28,938	22.2	11,372	17,561
Educational and Health Services	20,575	15.8	15,658	4,913
Professional and Business Services	15,224	11.7	6,766	8,454
Leisure and Hospitality	15,182	11.6	7,678	7,493
Local Government	11,290	8.7	7,095	4,194
State Government	9,276	7.1	5,100	4,174
Financial Activities	7,417	5.7	4,662	2,754
Construction	6,966	5.3	985	5,981
Natural Resources and Mining	5,159	4.0	1,169	3,990
Other	4,597	3.5	2,631	1,964
Information	3,550	2.7	1,573	1,977
Manufacturing	2,212	1.7	623	1,589
Unknown	115	0.1	56	59

2012 Top Anchorage Occupations[2]

Occupations	Number of Workers	Female	Male
Retail Salespersons	5,087	2,831	2,256
Cashiers	3,290	2,066	1,223
Office and Administrative Support Workers, All Other	2,864	2,238	626
Combined Food Preparation and Serving Workers, Including Fast Food	2,627	1,516	1,111
Office Clerks, General	2,544	1,930	614
Personal Care Aides	2,256	1,711	542
Registered Nurses	2,233	2,011	221
Janitors and Cleaners, Except Maids and Housekeeping Cleaners	2,014	688	1,323
Bookkeeping, Accounting, and Auditing Clerks	1,869	1,622	247
General and Operations Managers	1,814	677	1,137
Waiters and Waitresses	1,752	1,196	556
Executive Secretaries and Executive Administrative Assistants	1,664	1,454	210
Food Preparation Workers	1,663	798	864
Laborers and Freight, Stock, and Material Movers, Hand	1,625	211	1,413
Elementary School Teachers, Except Special Education	1,407	1,164	243
Customer Service Representatives	1,357	979	378
Teacher Assistants	1,302	1,136	166
Maids and Housekeeping Cleaners	1,272	946	325
Receptionists and Information Clerks	1,251	1,146	105
Managers, All Other	1,211	531	680
Transportation Workers, All Other	1,184	262	922
Childcare Workers	1,133	997	136
Construction Laborers	1,118	82	1,036
Stock Clerks and Order Fillers	1,093	305	787
Food Preparation and Serving Related Workers, All Other	1,006	467	539

1 State of Alaska Department of Labor and Work Force Development, Research and Analysis: Alaska Local and Regional Information, Anchorage Municipality; accessed 4/6/15; http://live.laborstats.alaska.gov/alari/details.cfm?yr=2012&dst=01&dst=03&dst=04&r=1&b=3&p=15#ds03

2 State of Alaska Department of Labor and Work Force Development, Research and Analysis: Alaska Local and Regional Information, Anchorage Municipality; accessed 4/6/15; http://live.laborstats.alaska.gov/alari/details.cfm?yr=2012&dst=01&dst=03&dst=04&r=1&b=3&p=15 - ds03

In 2013, housing was the top item of expenditure for Anchorage residents. Average distribution of expenditures included: 40.6% housing; 16.9% transportation; 15.5% food and beverages; 6.6% medical care; 6.7% recreation; 5.7% education and communication; 5% clothing; 3.1% other goods and services.[1] The 2014 Permanent Dividend Fund to Alaska residents helped to offset costs with a $1,884.00 payout.[2]

Transportation

Public highways connect Anchorage to a statewide system, as well as to the Lower 48.[3] The city has a public transportation system with 14 routes, including commuter routes, with almost 1,100 stops, and wheelchair accessible buses.[4] Youth can ride for free on Thursdays during the summer Anchorage also has a paratransit system called AnchorRIDES, which provides transportation to people with disabilities, senior citizens, recipients of Medicaid Home and Community Based Waivers, youth with disabilities transitioning out of public school services, and homeless students, among others.[5] The municipality also supports car pool and vanpool Share-A-Ride programs.[6]

The state owned Ted Stevens International Airport is one of the top cargo airports in the world, annually moving millions of passengers through the area as well.[7] Other public airports include Lake Hood Float Plane Base, the municipal Merrill Field, and the military facilities for the Joint Base Elmendorf-Richardson (JBER), as well as a number of small, private airports.

Anchorage is a port in the Alaska Marine Highway System providing, "safe, reliable, and efficient transportation of people, goods, and vehicles among Alaska communities, Canada, and the 'Lower 48'" including 33 communities in Alaska, as well as Bellingham, Washington, and Prince Rupert, British Columbia.[8] The city also has the Port of Anchorage, with the capacity to serve large vessels, such as cruise ships, and fuel tankers.[9] The Alaska Railroad runs through Anchorage, connecting it to cities and towns along 500 miles of rail, including Girdwood, Seward, Talkeetna, and Fairbanks, among others.[10]

Health Services

Anchorage is ranked the fourth highest in the nation for health care costs, preceded by three other Alaska cities (the most expensive being Fairbanks, Juneau, then Kodiak).[11] Anchorage has four major hospitals,[12] and a plethora of behavioral and mental health services available. The National Alliance on Mental Illness (NAMI) lists 15 community mental health service providers in the Anchorage metro area.[13] The Anchorage Neighborhood Health Clinic serves uninsured and low income individuals and families "regardless of ability to pay", providing $7.8 million in services to almost 14,500 people in 2013.[14] The Alaska

1 The Cost of Living in Alaska: A look at prices around the state over the past year, by Neal Fried, Alaska Economic Trends, July 2014, p. 6; accessed 4/7/15; http://laborstats.alaska.gov/col/col.pdf
2 Alaska Permanent Fund Corporation, "Annual Dividend Payouts"; accessed 4/7/15; http://www.apfc.org/home/Content/dividend/dividendamounts.cfm
3 State of Alaska, Department of Commerce, Community, and Economic Development: Community and Regional Affairs; "Community: Anchorage"; "General Overview": "Transportation"; accessed 4/9/15; http://commerce.state.ak.us/cra/DCRAExternal/community/Details/2d5ef9f0-9855-4b68-9350-bc9d20e81807
4 People Mover, "Reasons to Ride"; accessed 4/9/15; http://www.muni.org/Departments/transit/PeopleMover/Pages/ReasonstoRide.aspx
5 AnchorRIDES Quick Reference Guide: Criteria for Coordinated Transportation Programs, accessed 4/9/15; http://www.muni.org/Departments/transit/AnchorRides/Documents/AnchorRIDES Quick Reference Guide v10-2013.pdf
6 Municipality of Anchorage, "Share-A-Ride", accessed 4/9/15; http://www.muni.org/Departments/transit/ShareARide/Pages/default.aspx
7 Alaska Department of Transporation & Public Facilities: Ted Stevens Anchorage International Airport; accessed4/9/15; http://www.dot.state.ak.us/anc/index.shtml
8 Alaska Department of Transportation & Public Facilities: Alaska Marine Highway System, "Our Mission", accessed 4/9/15; http://www.dot.state.ak.us/amhs/our_mission.shtml
9 Port of Anchorage, accessed 4/9/15; http://www.portofalaska.com/
10 Alaska Railroad Corporation, "Destinations"; accessed 4/9/15; http://www.alaskarailroad.com/travel/Destinations/tabid/129/Default.aspx
11 Alaska Dispatch News, Study: Health care prices in Alaska top nation's cities, by Tegan Hanlon, March 27, 2014; accessed 4/10/15; http://www.adn.com/article/20140327/study-health-care-prices-alaska-top-nations-cities
12 Alaska Regional Hospital; Providence Alaska Medical Center (including St. Elias Specialty, and Providence Extended Care Center); Alaska Native Medial Center; North Star Behavioral Health
13 National Alliance on Mental Illness, accessed 4/10/15; http://www2.nami.org/MSTemplate.cfm?Section=Crisis_Services_and_Mental_Health&Site=NAMI_Anchorage&Template=/ContentManagement/HTMLDisplay.cfm&ContentID=96842
14 Anchorage Neighborhood Health Center 2013 Report to the Community, pgs. 4, 6; accessed 4/10/15; http://anhc.org/wp-content/uploads/2014/05/2013_Annual_Report_WEB-v.21.pdf

Children's Health Insurance program Denali KidCare pays for health care to children and teens through age 18.[1]

Parks & Green Spaces

Within Anchorage, there are nearly 11,000 acres of municipal parkland and 223 parks with 82 playgrounds.[2] There are over 250 miles of trails and greenbelts spanning Anchorage, of which 132 miles are paved.[3] The parks, trails, and greenbelts in Anchorage are operated and maintained by the Anchorage Parks and Recreation Department. The department is also responsible for 110 athletic fields, five pools, and 11 recreation facilities.[4] In partnership with the Anchorage Park Foundation, the Anchorage Parks and Recreation Department offers a Youth Employment in Parks program that hires Anchorage teens to complete park improvement projects each summer.[5]

In addition to the Municipal parks and trails, the Chugach State Park begins just seven miles east from downtown Anchorage.[6] According to the State of Alaska Division of Parks and Outdoor Recreation, "the park contains approximately 495,000 acres of land and is one of the four largest state parks in the United States."[7] The Chugach State Park boasts 280 miles of trail and provides opportunities for off road vehicle use, biking, boating, camping, hiking, snow machine use, and cross-country and backcountry skiing.[8]

1 Denali KidCare - Alaska's Children's Health Insurance Program - (CHIP), accessed 4/13/15; http://dhss.alaska.gov/dhcs/Pages/denalikidcare/default.aspx
2 Municipality of Anchorage, "Parks and Recreation"; accessed 4/7/15; http://www.muni.org/departments/parks/pages/default.aspx
3 Municipality of Anchorage, "Parks and Recreation"; accessed 4/7/15; http://www.muni.org/departments/parks/pages/default.aspx
4 Municipality of Anchorage, "Parks and Recreation"; accessed 4/7/15; http://www.muni.org/departments/parks/pages/default.aspx
5 Anchorage Park Foundation, "Youth Employment in Parks"; accessed 4/9/15; http://anchorageparkfoundation.org/programs/youth-employment-parks/
6 Alaska Department of Natural Resources Division of Parks and Outdoor Recreation, "Chugach State Park"; accessed 4/10/15; http://dnr.alaska.gov/parks/units/chugach/
7 Alaska Department of Natural Resources Division of Parks and Outdoor Recreation, "Chugach State Park"; accessed 4/10/15; http://dnr.alaska.gov/parks/units/chugach/
8 Alaska Department of Natural Resources Division of Parks and Outdoor Recreation, "Recreational Opportunities in Chugach State Park"; accessed 4/10/15; http://dnr.alaska.gov/parks/units/chugach/chooseactivites.htm

Recreational Opportunities

Anchorage offers year round access to innumerable outdoor and urban activities. The Anchorage Convention and Visitors Bureau offers up an extensive list of summer and winter outdoor sporting opportunities, arts, culture, and entertainment sites and events, dining sites, and shopping.[9]

Within Anchorage there are numerous sites that provide opportunities for recreation. Notable sites include:

- Alaska Airlines Center
- Alaska Center for the Performing Arts
- Denai'ina Center
- Egan Center
- Mulcahy Stadium
- Sullivan Arena
- Wendy Williamson Auditorium
- Arts, Sciences and Culture Centers
- Alaska Aviation Museum
- Alaska Botanical Gardens
- Alaska Museum of Science and Nature
- Alaska Native Heritage Center
- Alaska Wildlife Conservation Center
- Alaska Zoo
- Anchorage Museum at Rasmuson Center
- Outdoor Spaces
- Alyeska Ski Resort
- Anchorage Town Square
- Cuddy Family Midtown Park
- Delaney Park Strip
- Hilltop Ski Area
- Kincaid Park

There are two prominent resources connecting youth with recreational opportunities. *Que Pasa Anchorage* maintains a calendar of events for teens to find events and opportunities in Anchorage.[10] *Que Pasa* also maintains a Facebook page that provides updates on recreational opportunities for Anchorage youth. *Anchorage Youth Central* provides youth with a list of categorized resources to connect with local organizations for volunteer and recreational opportunities.[11]

9 Anchorage Convention & Visitors Bureau, "Things to Do"; accessed 4/10/15; http://www.anchorage.net/things-to-do
10 Que Pasa Anchroage, "About"; accessed 4/10/15; http://quepasaanchorage.org/about/
11 Anchorage Youth Central, "Categories"; accessed 4/10/15; http://www.anchorageyouthcentral.org/index.php/categories/

Religious Organizations

A query of the North American Industry Classification System (NAICS) shows there were 199 religious organizations employing 1,373 people in 2012 in the Anchorage metropolitan area.[1] As of April 2015, The State of Alaska's Department of Commerce, Community, and Economic Development contained records for a total of 85 Religious Organizations operating with an active business license in Anchorage, Eagle River, Chugiak, and JBER.[2]

The *Interfaith Council of Anchorage's* members meet monthly to network, engage in dialogue, and address areas of need in the Anchorage community.[3] *Interfaith Council of Anchorage* members include representatives from the Jewish, Buddhist, Catholic, Protestant, Religious Science, and Islamic faiths.[4]

Government

An elected mayor and 11-member assembly serve as the executive and legislative branch of Anchorage's local government.[5] The mayor and assembly members are elected through a non-partisan election; municipal elections are held in April.[6] Elected Mayors serve a three-year term and are limited to serving two consecutive terms, but may be re-elected to office once one full term has intervened.[7]

The Anchorage Assembly acts as the Municipality's legislative body. The 11 elected members of the Assembly serve Anchorage's six districts which are divided as follows: Downtown Anchorage, Eagle River, West Anchorage, Midtown, East Anchorage, and South Anchorage.[8] Two assembly members, with the exception of Downtown Anchorage, represent each of Anchorage's six districts.

There are 38 community councils representing Anchorage's neighborhoods that serve as advisories to the Anchorage Assembly.[9] The community councils are private, non-profit associations comprised of volunteer citizens (i.e. property owners, business managers, and residents) within set geographical neighborhoods designated by the Assembly.[10]

The Municipality of Anchorage lists 34 Departments, Divisions, and Offices, some of which include the Department of Health and Human Services, Office of Emergency Management, Fire Department, Police Department, Parks and Recreation Departments, Municipal Light and Power, Library, Museum, Solid Waste Services, Port of Anchorage, and Public Transportation.[11]

Public Safety, Crime & Legal System

Public Safety services are provided to Anchorage through the Police Department, Fire Department, Office of Emergency Management, and Department of Health and Human Services.[12] The Chugiak Volunteer Fire and Rescue Co., Inc. and Girdwood Volunteer Fire and Rescue provide EMS and Fire Services to the communities of Chugiak and Girdwood, respectively.[13, 14]

1 United States Census Bureau, "Introduction to NAICS"; accessed 4/7/2015; http://www.census.gov/eos/www/naics
2 State of Alaska Department of Commerce, Community, and Economic Development, "Corporations, Business & Professional Licensing; accessed 4/7/15; http://commerce.state.ak.us/CBP/Main/CBPLSearch.aspx?mode=BL
3 Interfaith Council of Anchorage, "Welcome"; accessed 4/10/15; http://www.interfaithanchorage.org/Interfaith_Council/Welcome.html
4 Interfaith Council of Anchorage, "Sixty Second Announcements"; accessed 4/10/15; http://www.interfaithanchorage.org/Interfaith_Council/Sixty_Second_Announcements.html
5 Municipality of Anchorage Mayor's Office, "Local Government"; accessed 4/10/15; http://www.muni.org/Departments/Mayor/Pages/LocalGovernment.aspx
6 Municipality of Anchorage Elections, "Frequently Asked Questions"; accessed 4/9/15; http://www.muni.org/Departments/Assembly/Clerk/Elections/Pages/Frequentlyaskedquestions.aspx
7 Municipality of Anchorage Code of Ordinances, Article V: The Executive Branch. Section 5.01: The office of the mayor; accessed 4/10/15; https://www.municode.com/library/ak/anchorage/codes/code_of_ordinances
8 Municipality of Anchorage Assembly, "About Us"; accessed 4/10/15; http://www.muni.org/Departments/Assembly/Pages/MemberProfiles.aspx
9 Municipality of Anchorage Assembly, "Community Councils"; accessed 4/9/15; http://www.muni.org/Departments/Assembly/Pages/CommunityCouncils.aspx
10 Federation of Community Councils, "About Us"; accessed 4/9/15; http://communitycouncils.org/servlet/content/1548.html
11 Municipality of Anchorage, "Municipal Departments, Divisions, and Offices"; accessed 4/9/15; http://www.muni.org/departments/Pages/default.aspx
12 Municipality of Anchorage, "Public Safety"; accessed 4/9/15; http://www.muni.org/public_safety/Pages/default.aspx
13 Chugiak Volunteer Fire and Rescue Co., Inc.; accessed 4/10/15; http://www.cvfrd.com/
14 Girdwood Fire Department; accessed 4/10/15; http://www.girdwoodfire.com/

As of 2013, a total of 344 police officers were full-time law enforcement employees in Anchorage.[1] The Anchorage Police Department is the largest police department in the state of Alaska. The Anchorage Police Department maintains a Crisis Intervention Team (CIT) of police officers that are educated on mental illness, suicide and crisis intervention, active listening, and de-escalation techniques so that they may respond to calls to persons with mental illness with empathy and respect.[2] More than 90 officers have become APD CIT members since the programs inception in 2011.[3]

Data from the 2013 Anchorage Police Department Annual Statistical Report show a total of 14,476 Uniform Crime Report (UCR) Index Crimes (murder, rape, robbery, aggravated assault, burglary, larceny-theft, and motor vehicle theft) recorded in 2013.[4] A total of 17,612 adult arrests and an additional 1,359 juvenile arrests were made in 2013.[5]

Anchorage's court system is comprised of the Anchorage District Court, Anchorage Trial Courts, and the Anchorage Superior Court.[6] In addition to the traditional court system, the Anchorage Youth Court "provides the opportunity for youth in grades 7 through 12 who are accused of breaking the law to be judged by their peers. It is a court in which the roles of attorneys, judges, bailiffs, clerks, and jurors are filled by youth".[7] Anchorage Youth Court allows youth the opportunity to resolve their legal issues without creating a formal criminal record. Defendants are typically first time offenders and are referred to the Anchorage Youth Court through McLaughlin Youth Center's juvenile probation department.

There are eight youth facilities operated by the State of Alaska's Division of Juvenile Justice. Anchorage's youth facility, McLaughlin Youth Center, has the capacity to detain or provide treatment for 135 youth.[8]

As of 2010, 50% of Anchorage males and 48% of Anchorage females 15 and older were currently married.[9] In 2013, 2,219 marriage licenses were issued for Anchorage residents, or 7.4 per 1,000 residents.[10] Divorce occurrences by census area are not available, but statewide data shows that in 2013 the divorce rate in Alaska was 4.5 per 1,000 residents.[11]

Family Dynamics

The average Anchorage household size in 2010 was 2.64 persons per household.[12] Of the 107,332 Anchorage households in 2010, 36,788 were non-family households; 51,992 married couple households; and 18,552 remaining.[13] In 2011, there were 40,575 family households and 9,910 single mother households containing people less than 18 years of age in Anchorage.[14]

1 The Federal Bureau of Investigation Uniform Crime Reports, "Crime in the United States 2013 Full-time Law Eforcement Employees by City, 2013"; accessed 4/10/15; http://www.fbi.gov/about-us/cjis/ucr/crime-in-the-u.s/2013/crime-in-the-u.s.-2013/tables/table-78/table-78-cuts/table_78_full_time_law_enforcement_employees_alaska_by_city_2013.xls

2 Municipality of Anchorage Police Department "APD Crisis Intervention Team"; accessed 4/10/2015; http://www.muni.org/Departments/police/Pages/Mental_Health.aspx

3 Municipality of Anchorage Police Department "APD Crisis Intervention Team"; accessed 4/10/2015; http://www.muni.org/Departments/police/Pages/Mental_Health.aspx

4 Municipality of Anchorage Police Department, "Crime Analysis/Statistics Home"; accessed 4/10/15; http://www.muni.org/apd

5 Municipality of Anchorage Police Department, "Crime Analysis/Statistics Home"; accessed 4/10/15; http://www.muni.org/apd

6 Alaska Court System, "Alaska Courts Directory"; accessed 4/10/15; http://courts.alaska.gov/courtdir.htm

7 Anchorage Youth Court, "What is Anchorage Youth Court"; accessed 4/10/15; http://www.anchorageyouthcourt.org/intro_to_ayc.html

8 State of Alaska Department of Health and Social Services, Division of Juvenile Justice, "DJJ Facilities"; accessed 4/10/15; http://dhss.alaska.gov/djj/Pages/Facilities/facilities.aspx

9 2012 Anchorage Indicators, Municipality of Anchorage & Anchorage Economic Development Corporation, pg. 71; accessed 4/10/15; http://www.muni.org/Departments/OCPD/Planning/Publications/Documents/Full Indicators Report.pdf

10 The Alaska Bureau of Vital Statistics, "Marriage and Divorce Rates for Anchorage"; accessed 4/9/2015; http://dhss.alaska.gov/dph/VitalStats/Documents/stats/marriage_divorce_statistics/Marriages_Divorces/frame.html

11 The Alaska Bureau of Vital Statistics, "Marriage and Divorce Rates for Anchorage"; accessed 4/9/2015; http://dhss.alaska.gov/dph/VitalStats/Documents/stats/marriage_divorce_statistics/Marriages_Divorces/frame.html

12 2012 Anchorage Indicators, Municipality of Anchorage & Anchorage Economic Development Corporation, pg. 47; accessed 4/7/15; http://www.muni.org/Departments/OCPD/Planning/Publications/Documents/Full Indicators Report.pdf

13 2012 Anchorage Indicators, Municipality of Anchorage & Anchorage Economic Development Corporation, pg. 48; accessed 4/7/15; http://www.muni.org/Departments/OCPD/Planning/Publications/Documents/Full Indicators Report.pdf

14 2012 Anchorage Indicators, Municipality of Anchorage & Anchorage Economic Development Corporation, pg. 49; accessed 4/7/15; http://www.muni.org/Departments/OCPD/Planning/Publications/Documents/Full Indicators Report.pdf

Community Engagement

The task of the Anchorage Collaborative Coalitions (ACC) is to make data driven decisions while designing a future intervention for youth ages 12-24 in the Anchorage Municipality, including the Anchorage bowl, Girdwood, Eagle River, and Chugiak. To do this, various data sets had to be identified, gathered, organized, shared, explored, and finally narrowed down through a prioritization process. To structure these tasks, the ACC organized into teams, including an: ACC Executive Committee Team; Assessment Workgroup Team; and a UAA Assessment Team combining the Center for Human Development research team with other university researchers from the Center for Behavioral Health Research & Services, the Department of Health Sciences, and the Justice Center. The *Data Decisions* section below documents how teams worked together to identify a broad priority area of mental health. The remaining sections document how ACC members were engaged in the primary data collection and analysis processes.

Data Decisions

In early 2015, members of the UAA Assessment team began examining secondary data about Anchorage youth and the three behavioral health indicators of substance use, mental health, and suicide. Secondary data is the information already collected as a result of other research and community projects. For example, the UAA Assessment team gathered data collected by the Anchorage School District, the Behavioral Risk Factor Surveillance System (BRFSS), the Pregnancy Risk Assessment Monitoring System (PRAMS), and the Youth Risk Behavior Survey (YRBS). Some basic demographic data were collected such as youth ages, races, ethnicities, special education service use, genders, languages spoken, etc. There were significant gaps in secondary data available around Alaskan LGBTQ[1] youth, as well as around specific disabilities.

Secondary data were also gathered around "intermediate variables". Intermediate variables include "risk factors" and "protective factors". Risk factors are things that put youth at risk of substance use, mental illness, and suicide. Examples of risk factors are poverty, family problems, abuse, and trauma. Protective factors are things that seem to protect youth from substance use, mental illness, and suicide. Examples of protective factors include having multiple trusted adults around, participating in extracurricular activities, and living in neighborhoods that feel safe.

All secondary data collection by the UAA Assessment Team was guided by feedback from the ACC team, coalition, and community members. In a series of workgroup and open community meetings between January and June 2015, members from across teams met to explore secondary data sets. First, the ACC Assessment Workgroup guided the development of the intermediate variables list upon which the UAA Assessment team focused their secondary data efforts. The original list of intermediate variables came from a report created by the Alaska Division of Behavioral Health (2012).[2]

This workgroup requested the UAA Assessment Team pull from familiar data sets, find new sets, and present the information in Excel tabs, as well as through infographics. Next, the UAA Assessment team presented the gathered data in a series of meetings. They first presented to the ACC Assessment Workgroup and asked members to review the data and 1) to identify the top three things that stood out most and why, and 2) to make recommendations about how to narrow down the intermediate variables, and decide which ones to focus on. This information, provided to the UAA Assessment team, was used to guide the development of presentations for the May 2015 community meetings, including infographics highlighting data around the three behavioral health indicators (mental health, substance, use and suicide) and intermediate variables.

In the fifth month of this community data exploration process, May 2015, presentations of secondary data were provided at three community meetings by members of the UAA Assessment Team. The first, held at the UAF Cooperative Extension on May 4, 2015, engaged five selected

1 Lesbian, Gay, Bisexual, Transgender, Queer; also QUILTBAG2: queer/questioning, undecided, intersex, lesbian, transgender/transsexual, bisexual, allied/asexual gay/genderqueer, and Two Spirit identified.

2 See References Cited secion of report.

representatives from each coalition: 1) Anchorage Youth Development Coalition (AYDC); 2) Healthy Voices, Health Choices (HVHC); and 3) Spirit of Youth (SOY). The data review and prioritization tool (see Appendix A), developed by the ACC Executive Team, was used by participants to identify the top behavioral health priorities (of most concern) for Anchorage youth ages 12-24. Two additional community meetings were held on May 11, 2015, one at the BP Energy Center for the full AYDC coalition, and the second, open to all of the Anchorage Municipality community held at the Spenard Recreation Center.

The ACC Executive Committee Team took feedback from the community meetings, completed prioritization tools, and identified the following:

Priority Issue: Mental Health

Intermediate variables to address: bullying, feeling alone, and sadness/depression

Consequences to achieve: improve mental health, reduce suicide and suicide ideation, reduce substance use

Goal: to decrease conditions that lead to suicide and suicide attempts and increase those that lead to mentally healthy 12-24 year olds in Anchorage.

This information was then presented to the ACC Assessment Workgroup in June of 2015, and their feedback was sought on the proposed priority area(s), the proposed methods for collecting primary data, and suggestions for sampling and segmenting potential participants.

In summary of the data gathering and prioritization processes, below are bullets highlighting the scope of ACC community engagement thus far:

- 4 Assessment Workgroup Team meetings, with at least 22 organizations represented
- 3 invited and/or open community meetings, with at least 33 organizations represented
- 22 UAA Assessment team meetings, with 7 researchers from four centers/departments (bimonthly since January 2015)
- Minimum of bimonthly meetings between the ACC Executive Team lead (Marcia Howell/Deborah Williams) and the UAA Assessment Team lead (Karen Heath)
- 3 full ACC Executive Team and full UAA Assessment Team meetings

At least 45 entities were represented between the Assessment Workgroup and community meetings:

1. Abuse Women's Aid in Crisis (AWAIC)
2. ACT – Reliance Team
3. Alaska Afterschool Network
4. Alaska Cares
5. Alaska Children's Trust
6. Alaska Commission on Postsecondary Education
7. Alaska Division of Juvenile Justice
8. Alaska Injury Prevention Center
9. Alaska Mental Health Trust Authority
10. Alaska Native Tribal Health Consortium
11. Alaska Youth Advocates
12. Anchorage Community Mental Health Services
13. Anchorage Public Library
14. Anchorage Realizing Indigenous Student Excellence (ARISE), Cook Inlet Tribal Council
15. Anchorage School District
16. Anchorage Youth Development Coalition
17. Assembly of God
18. Big Brothers Big Sisters of Alaska
19. Black Arts North Academy
20. Boy Scouts
21. Boys and Girls Clubs
22. Center for Behavioral Health Research & Services, University of Alaska Anchorage
23. Center for Human Development, University of Alaska Anchorage
24. Community Pregnancy Center
25. Cooperative Extension Service, University of Alaska Fairbanks
26. Covenant House
27. Department of Health Sciences, University of Alaska Anchorage
28. Healthy Voices, Health Choices
29. Hope Community Resources
30. Job Corps
31. Justice Center, University of Alaska Anchorage
32. KSKA (radio)
33. Language Interpreter Center
34. Northbridge LLC
35. Parachutes
36. Providence
37. Southcentral Foundation
38. Spirit of Youth
39. Standing Together Against Rape (STAR)
40. Strength Based Strategies
41. Trust Training Cooperative, Center for Human Development, UAA
42. United Way of Anchorage
43. Volunteers of America
44. YEA! Inc. (Youth/Young Adults Empowered

Achievers)
45. YWCA

ACC Member Trainings

A key component of ACC community engagement was the training of coalition members in various research related topics, followed by their participation in the primary data collection process. Between July and October 2015, members of the UAA Assessment Team conducted and/or coordinated 11 trainings on the following 7 topics:

1. Infographics (26 attendees)
2. Institutional Review Board CITI Certification (18 attendees, 2 events)
3. How to Conduct Focus Groups for Research, (19 attendees, 2 events)
4. Qualitative Data Analysis: Focus Groups (9 attendees, 2 events)
5. Quantitative Data Analysis: Indicator-Based Information System for Public Health (AK-IBIS); Web-based Injury Statistics Query and Reporting System (WISQARS); InstantAtlas (12 attendees)
6. Cultural Competency (13 attendees)
7. Key Informant Interviews (18 attendees, 2 events)

The aim of these trainings was to provide a general understanding of these topics, and to become familiar with various kinds of research data. Perhaps most importantly, the Institutional Review Board CITI Certification training was the foundation for certifying interested ACC members, so that they could later be part of the primary data collection process (i.e., conducting focus groups). Twenty-four ACC members, from 14 different organizations became CITI certified following the Institutional Review Board CITI Certification training. Of these, fifteen participated in the primary data collection and analysis process with youth focus groups. Training number highlights:

- 11 research related trainings offered, totaling more than 16 hours of training
- 110+ attendees (duplicate counts)
- 24 CITI-certified members, from more than 14 community organizations
- 15 certified members participated in primary data collection and analysis
- 5 trainings were video taped by the Alaska Teen Media Institute

Recruitment & Co-Facilitation

After ACC community members had successfully completed their CITI certification, their certificates were added to the UAA Institutional Review Board application for focus group research. Once approved, the CITI-certified members began working with the UAA Assessment team members to recruit youth for focus groups. This was an intensive process, with a steep learning curve as all teams, CITI-certified members, and coalition leadership worked together across membership to recruit youth with diverse racial, ethnic, sexual orientation, disability, and socioeconomic identities and backgrounds, as well as from different areas of the municipality. ACC members recruited by posting focus group fliers on organization websites, and in social media pages; strategically hanging fliers at businesses, non-profit agencies, libraries, etc.; and announcing focus groups through organization listservs, newsletters, and email alerts. Here are some of the venues ACC members used to distribute both physical and digital fliers about focus groups:

1. Academy of Hair Design
2. Alaska Athletic Club (Anchorage and Eagle River)
3. Alaska Brain Injury Network
4. Alaska Mental Health Trust Authority
5. Alaska Native Heritage Center
6. Alaska Native Tribal Health Consortium
7. Alaska Public Libraries
8. AWAIC
9. Beans Café
10. Bridge Builders
11. Bridges Counseling Center
12. Catholic Social Services
13. Cook Inlet Tribal Council
14. Covenant House
15. Facing Foster Care (recent graduates)
16. Fire Island Bakery
17. Identity, Inc
18. Joint Base Elmendorf-Richardson (JBER)
19. Kaladi Brothers
20. Language Interpreter Center
21. Laundromats
22. Lucky Wishbone
23. NAMI
24. Nine Star
25. North Star Behavioral Health
26. Parachutes
27. Planned Parenthood
28. Polynesian Cultural Center

29. Que Pasa website
30. RuRAL-CAP
31. Snow City Cafe
32. Spenard Roadhouse
33. STAR
34. Starbucks
35. Steamdot
36. Stone Soup Group
37. Table 6 restaurant
38. Teen Power Center
39. Tommy's Burger Stop
40. TRIO
41. University of Alaska Anchorage
42. YWCA

As CITI-certified ACC members participated in recruiting efforts, they met once again with the UAA Assessment Team to prepare for co-facilitating focus groups, under the supervision of experienced qualitative researchers. Of the 24 CITI-certified ACC members, 15 attended youth focus groups for primary data collection about bullying, and loneliness/sadness/hopelessness. These 15 people received additional training to prepare for the focus group events. Preparation included practicing mock focus groups, and discussing procedures such as handling challenging behaviors and disclosures requiring mandatory reporting. At the events, the CITI-certified members helped with logistics such as food, check in, making pseudonym nametags, and most importantly co-facilitating audio recorded focus group discussions with youth ages 12-24.

Data Analysis

The ACC members who completed the Institutional Review Board CITI Certification training, scored 80% and higher on the CITI certificate itself, engaged in focus group recruitment, completed additional focus group training, and finally worked as co-facilitators and/or event support staff at youth focus groups, were then invited to code focus group transcripts. Coding transcripts required CITI-certified members to meet once again with members of the UAA Assessment Team, and learn about the Consensual Qualitative Research (CQR) process (e.g. domain generation). CITI-certified members were asked to code transcripts of the focus group/s they co-facilitated. They then brought their codes to a meeting with the other CITI-certified members and UAA Assessment Team members who were at the same focus groups, to flush out and organize the most common domains.

Caring
Mentoring
Sharing

Assessment Methodology

The community assessment process was conducted in two major phases. Phase I was focused on accessing and analyzing secondary data from national, state, and local sources. Phase II gathered additional secondary data, but had a main focus on gathering primary data from youth and young adults living in Anchorage. In addition, the UAA Assessment Team was tasked with engaging the community through training and involving ACC members in assessment activities.

Secondary Data

The secondary data the UAA Assessment Team obtained and analyzed was designed to: 1) document the prevalence of substance use/abuse, mental health/illness, and suicide; and 2) document the risk and protective factors influencing behaviors, conditions, and outcomes. The focus population for secondary data collection was 9-24 year-olds living in the Municipality of Anchorage. The purpose to be served by this compilation and analysis was to inform ACC prioritization decisions for the focus of Phase II.

Institutional Review Board approval was sought for two secondary data sources, Youth Risk Behavior Survey (YRBS) and Behavioral Risk Factor Surveillance System (BRFSS). In addition, specific data requests were made to several data banks. Finally, other data was compiled and analyzed using existing data summaries.

For each secondary data source, the UAA Assessment Team scored data quality using a scale designed for this purpose (Hull-Jilly & Casto, 2011). Scoring is 0-2, where 0=absence of desired quality; 1=lack of quality; 2=high level of quality.

In addition to availability and timeliness (ability to get the data within the timeframe of the project), the following indicators were scored as per Hull-Jilly and Casto (p. xvii):

- *Validity* - The indicator accurately measures the specific construct and yields a true snapshot of the phenomenon at the time of the assessment.
- *Consistency* - The method or means of collecting and organizing data should be relatively unchanged over time.
- *Sensitivity* - The measure must be sufficiently sensitive to detect change over time.

Initial scoring of proposed data was provided with the dataset descriptions to help the ACC decide which data to include based on significance of the identified variables within the identified datasets.

The UAA Assessment Team identified data and information gaps to inform design and implementation of a data collection methodology to fill those gaps as much as possible in Phase II, including collection and analysis of additional secondary data.

Database descriptions are included in this report in the section titled *Secondary Data Sources Cited*. The spreadsheets of secondary data and the analyses of that data are included in a supplement to this report.

Primary Data

The UAA Assessment Team designed three data collection methodologies to fill gaps in knowledge with primary data for Phase II. These included two surveys and focus groups. The focus population for primary data collection was 12-24 year olds living in the Municipality of Anchorage.

Adult Perceptions of Anchorage Youth: 2015 Survey

This survey was conducted with several goals in mind. First, the Adult Perceptions of Anchorage Youth (APAY) survey was designed to replicate the Adult Underage Drinking Survey (AUDS) conducted in 2010 to assess how adult perceptions of underage drinking changed over the previous five years. AUDS was conducted to gather community perceptions regarding the extent of the underage drinking problem, underage access to alcohol through social and retail outlets, and consequences of underage drinking. The APAY survey has an expanded focus beyond alcohol

that also gathers adult perceptions of youth marijuana use and prescription drug use for the express purpose of getting high. Last, this survey of adults was conducted to collect community readiness data in the form of adult perceptions regarding other behavioral health problems frequently experienced by Anchorage youth, namely bullying, feeling alone, extreme sadness/ hopelessness, and suicide.

Instrument. The mail survey instrument consisted of 127 questions presented on 12 pages (see Appendix B). The survey contained six major sections: 1) underage substance use problem including acceptance and risks of youth substance use, 2) adult influences on youth substance use, 3) respondents' self-reported substance use, 4) extent of knowledge and concern regarding and community efforts to impact the problems of youth bullying, feeling alone, extreme sadness/ hopelessness, and suicide, 5) engagement in youth's lives, and 6) respondent background information.

The survey incorporated a mixed mode design that allowed participants to complete a paper version of the survey or to complete the survey online if they preferred. The web version of the survey employed a unique PIN log-in that restricted access to the survey to only those people who were included in the random sample.

Recruitment. Randomly selected participants were recruited to participate in the survey following the steps for a five-phase mail out survey as outlined in the *Tailored Design Method* (Dillman, Smyth, & Christian, 2009). In the first mail phase, all sampled individuals were sent a pre-notification letter informing them of the study. In phase two, roughly one week later, the sampled individuals were mailed a paper version of the survey, accompanied by a cover letter outlining our request for participation, survey usefulness, a confidentiality notice, a means to opt-out of the survey and future mailings, our appreciation, and a reiteration of the option to complete the survey online. Two-dollar bills were sent with the survey as an incentive to complete it. In phases three and four postcard reminders of the importance of completing the survey are sent to sampled individuals approximately two and four weeks after the survey was mailed out. In phase five, two weeks after the second postcard was sent out, a new cover letter and replacement mail survey were sent to the remaining individuals who either did not respond to the first four mail notifications or who did not request removal from the mail list. A decision was made to postpone delivery of the second postcard and the final replacement survey until after the new-year. This decision was made to reduce the likelihood of experiencing low survey returns due to administering a survey when people are traveling and preoccupied with holiday activities.

Participants. The target population of the survey was domiciled, non-institutionalized adults residing in the Municipality of Anchorage. The Municipality of Anchorage includes areas surrounding Anchorage north to Eklutna and south to Girdwood. The self-administered survey was mailed to a random sample of 2,237 Anchorage residents. This large random sample was chosen for the purpose of generalizing results to the overall population of Anchorage residents. This initial sample size was chosen based on a power analysis involving the size of the Anchorage population and an expected response rate of 45%.

The random sample took the form of a mailing list purchased from InfoUSA. InfoUSA employs researchers who compile and update a database of millions of consumers and businesses across the United States from public records. Such data can be purchased for research and marketing purposes. The random sample requested from InfoUSA was limited to adults eighteen years and older. The random sample oversampled males and households with teenagers. Male heads of household comprised 60% of the sample and female heads of household comprised 40% of the sample. These percentages were determined based on the representation of males and females in surveys that have been conducted previously. Households with teens were oversampled so that 50% of the sample involved a household with a teenager to ensure sufficient representation of this important group.

The random sample included names and mailing addresses for 2,237 residents of the Municipality of Anchorage. The original drawn sample of

2,237 potential participants was reduced as 269 addresses were found to be undeliverable. Therefore, the final sample included 1,968 Anchorage residents. A response rate will not be computed until the survey closes in January 2016. Preliminary results presented in this report are based on 180 completed surveys received by December 11, 2015. In addition to these preliminary results, an addendum will be submitted in February 2016 that will provide results for the age 18 to 24 sub-population of survey respondents and will include self-reported substance use and abuse data. A final report presenting complete findings will be published in Spring 2016 to the UAA Justice Center website (http://justice.uaa.alaska.edu/).

Limitations of data. A major limitation of the results presented in this report is that they are based on a small, preliminary sample of the earliest survey returns. This limitation will be minimized with the addendum and complete final report that will be completed in February 2016. A general limitation of self-administered surveys is that there may be missing data because respondents intentionally or unintentionally do not provide answers to all questions. A related limitation is that respondents may misunderstand survey items and as a result may convey inaccurate information regarding their perceptions or behaviors.

Young Adult Survey

One identified gap in the available secondary data was relevant data about young adults (18-24 years old). While some data on UAA students in this age range was available, very little data was available for Anchorage overall. To address this gap, a survey specifically for young adults in Anchorage was conducted. Like all assessment activities, the Young Adult Survey (YAS) was pre-approved by the Institutional Review Board at UAA.

Instrument. The survey instrument was created in collaboration with the ACC executive team and included the following domains of interest: social support, community perception and involvement, substance use behaviors, stress, bullying and/or harassment experiences, psychological well-being, help-seeking behaviors and perceptions, and demographic information.

Whenever possible, established scales with psychometrically sound properties were used in this survey. For example, optimism was assessed using the *Positivity Scale – Short Form* from the Center for Ethical Education at the University of Notre Dame (Conchas & Clark, 2002; Narvaez, 2006). Additionally, when appropriate key questions used in other surveys were integrated into this survey. For example, the YRBS item that asks respondents to indicate to what extent they feel like they matter in their community was repeated in the Young Adult Survey.

The survey was prepared in Qualtrics, an online survey software, for electronic distribution. The first page of the online survey contained the consent form and was followed by the survey itself. The last page of the survey contained a thank you message and a link to a separate survey soliciting participants' contact information for those who wished to enter a drawing for compensation. Compensation was a $20 electronic gift card, awarded randomly to 1 in 5 participants.

Recruitment. Participants were invited to take the survey through a variety of recruitment mechanisms. The primary recruitment strategy was Facebook advertising. Other online recruitment was also conducted, including sharing of the opportunity by each coalition and other community partners (including the Anchorage Mayor's Office). Non-electronic strategies included posters and tabling at local events. Media advertising was done in both hardcopy and electronic versions through the Anchorage Press and the Arctic Warrior. Recruitment began at the end of October 2015 and lasted through early December 2015.

Participants. The survey was started 470 times. Nine responses were ineligible due to ages outside of the eligible range and/or not currently living in Anchorage. Those respondents were thanked for their interest, informed that they were ineligible, and not provided with the remainder of the survey. Thorough data cleaning procedures revealed that 56 of the responses were invalid (i.e., spam) responses and they were therefore removed from the dataset and not included in any analyses. Of the remaining responses, 76 did not persist at least halfway through the survey and were also removed. The final sample consisted of

329 responses, including 14 responses that were partially complete (i.e. persisted more than halfway but not to the end of the survey) but retained for analyses whenever possible. Because the number of individuals who saw an invitation to participate is unknown, a response rate cannot be calculated.

All participants reported that they currently lived in Anchorage; length of time that they had lived in Anchorage (during their current period of living in Anchorage, not including any previous time living in Anchorage) ranged from less than one year to their entire lives (i.e., up to 24 years). On average, participants had lived in Anchorage for 11.9 years (*SD* = 8.1). Participants identified as men (41.0%), women (57.1%), transgender (0.3%), and gender non-conforming (1.6%). Most frequently, participants indicated their sexual orientation as heterosexual (77.6%), bisexual (9.8%), and homosexual (5.0%). The sample was predominantly Caucasian (81.4%), with Alaska Native (11.4%), and Asian (11.0%) represented as well. Most frequently, participants reported having a high school diploma (34.1%) or some college (34.4%); approximately half of the sample (52.4%) indicated they were currently either a full- or part-time student.

YAS Participant Demographics

	M	*SD*
Age	21.0	2.1
Years lived in Anchorage	11.9	8.1
Gender	*n*	*%*
Man	130	41.0
Woman	181	57.1
Transgender	1	0.3
Gender non-conforming	5	1.6
Sexual Orientation	*n*	*%*
Asexual	13	4.1
Bisexual	31	9.8
Gay/lesbian/homosexual	16	5.0
Panseuxal	6	1.9
Straight/heterosexual	246	77.6
Other/unknown	5	1.6
Race	*n*	*%*
Alaska Native	36	11.4
American Indian	12	3.8
Asian/Asian American	35	11.0
Black/African American	10	3.2
Native Hawaiian/Other Pacific Islander	10	3.2
White/Caucasian	258	81.4
Note: Respondents chose all that applied.		
Ethnicity	*n*	*%*
Hispanic	32	10.1
Education	*n*	*%*
Less than high school diploma	28	8.8
HS diploma or GED	108	34.1
Trade/technical/vocational training	13	4.1
Some college, no degree	109	34.4
Associate's degree or higher	59	18.6
Student Status	*n*	*%*
Full-time student	46	14.5
Part-time student	120	37.9
Not a student	151	47.6
Health Insurance	*n*	*%*
Insured	236	74.4
Not insured	55	17.4
Unsure	26	8.2
Marital Status	*n*	*%*
Single	218	69.2
Married	49	15.6
Unmarried, living with partner	46	14.6
Divorced/separated	2	0.6
Children	*n*	*%*
Yes, has and lives with child(ren)	35	11.1
Yes, has but does not live with child(ren)	3	1.0
No	277	87.9
Housing Status	*n*	*%*
Own apartment, house, or room	142	44.7
Parent/relative's apt, house, or room	147	46.2
Apartment, house, or room of non-relative	13	4.1
Dorm/college residence	13	4.1
Street/outdoors	3	0.9
Public Assistance	*n*	*%*
Yes, qualify for public assistance	59	18.7
No, do not qualify for public assistance	176	55.9
Unsure	80	25.4
Refugee Status	*n*	*%*
Refugee	3	1.0
Military Affiliation	*n*	*%*
Currently serving	17	5.4
Previously served	3	1.0
No military affiliation	295	93.7

Limitations of data collection. The Young Adult Survey relied on a convenience sampling. While the resultant sample is diverse in the measured demographic characteristics, it may not fully approximate the 18-24 year old population of Anchorage. Additionally, the survey was conducted solely online. Despite recruitment efforts that included both electronic and non-electronic methods, individuals who are active on social media are likely overrepresented while individuals with limited access to technology are less represented. Further, amongst individuals who saw an invitation, the individuals who chose to participate likely were differentially motivated than individuals who declined to participate. Motivations may have been altruistic or financially-driven; and other factors may have also impacted individuals' decisions to participate. Overall, individuals in the sample may not be representative of the entire population of interest.

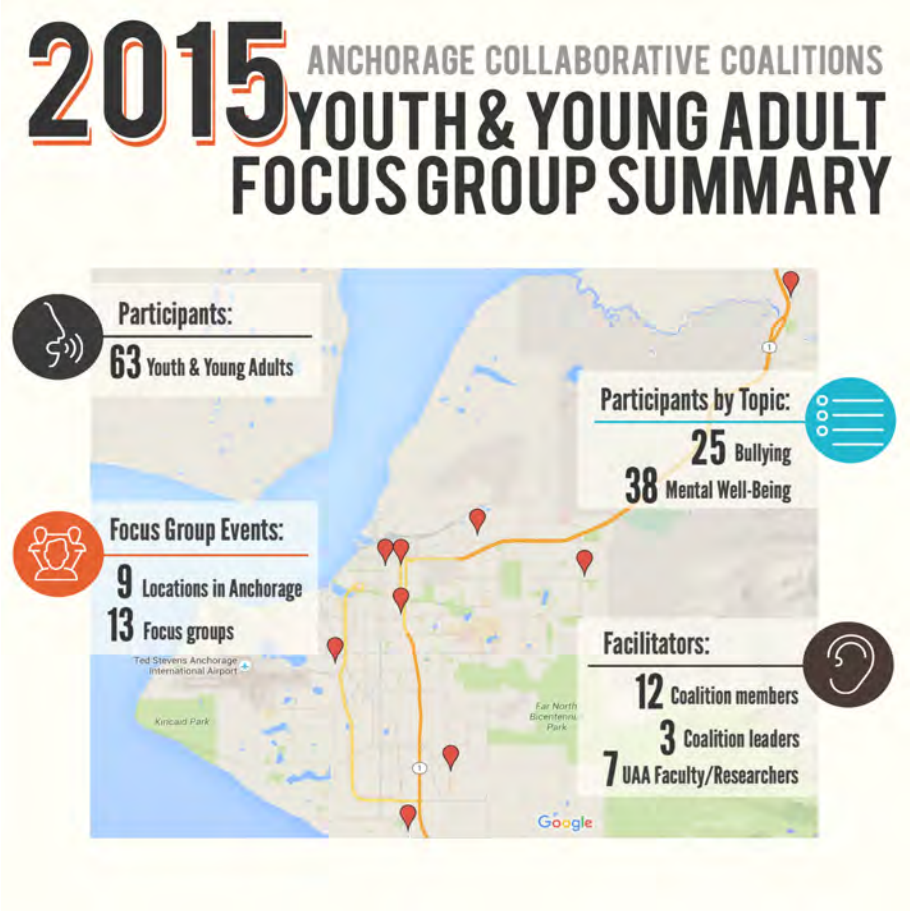
Focus Groups

At the conclusion of the secondary data analysis and prioritization process, it was deemed essential to supplement the quantitative findings with qualitative data regarding youth experiences with mental health and bullying. Focus groups are a method to generate very rich qualitative data. As compared to interviews, focus groups are more efficient given the large amount of data that can be collected in a short amount of time. And unlike interviews, focus groups generate conversation among participants; which provides insight into similarities and differences of participant experiences and allows participants to build on one another's comments. Most importantly for this assessment, focus groups gave a voice to Anchorage youth and young adults by providing an opportunity to express feelings, concerns, experiences, and solutions.

Instruments and protocol. The Anchorage Collaborative Coalitions (ACC) and UAA Assessment Team were interested in answering the following questions for Anchorage youth in middle school (age 12 to 14) and high school (age 14 to 18), and for young adults (age 18 to 24):

- What does bullying look like among Anchorage youth and young adults?
- Why do Anchorage youth feel lonely, sad, and hopeless?
- What protective factors are endorsed by Anchorage youth and young adults?
- What helps Anchorage youth and young adults thrive?
- What helps Anchorage youth and young adults who have experienced bullying, loneliness, sadness, and/or hopelessness to thrive?

These questions were the basis for focus group questions, developed through an iterative process that engaged the UAA Assessment Team, ACC Executive Team, as well as a small sample of Anchorage young adults. Four sets of questions emerged: a) bullying questions for school-age youth 12-18 years old, b) bullying questions for young adults 18-24 years of age, c) mental well-being questions for school-age youth 12-18 years old, and d) mental well being questions for young



adults 18-24 years of age. Focus group questions are in Appendix B.

The UAA Assessment Team proposed to host a total of six focus group events as follows:

1. Bullying	Middle School (12-14)
2. Mental Well-Being	Middle School (12-14)
3. Bullying	High School (14-18)
4. Mental Well-Being	High School (14-18)
5. Bullying	Young Adults (18-24)
6. Mental Well-Being	Young Adults (18-24)

Using a deviant case analysis approach, participants at each focus group event were to be divided into high and low-risk groups. Therefore, a total of six proposed focus group events each divided into two groups would ideally yield a total of 12 focus groups, (i.e., four for each age group). Focus groups were designed to have no more than 10 participants per group.

A focus group screening questionnaire was developed to facilitate the deviant case analysis approach of dividing participants into high and low-risk groups. The screening focused on participant experience being bullied, engaging in bullying behavior, and experience with loneliness, sadness, and hopelessness. Bullying questions were used to split bullying focus groups and mental health questions were used to split mental well-being focus groups. The relevant questions were scored such that a low score indicated low-risk and a high score indicated high-risk. Groups were split only when there were enough participants to place at least four participants in each high and low-risk group. When groups had enough participants to split, high and low-risk groups were determined based on a median split (i.e., questionnaires were ordered lowest to highest and divided evenly down the middle). In the case of a group with an odd number of participants the facilitators reviewed the scores and determined if the middle participant's scores better fit with the low or high-risk group. The screening questionnaires also collected demographic information on participants and these questions varied based on age (school age youth 12 to 18 versus young adults age 18 to 24). Both screening questionnaires are in Appendix B.

In order to be eligible to participate in the focus groups individuals had to meet designated age requirements and have lived in Anchorage for at least six months. Upon arrival at the focus group event, participants were assigned a pseudonym to be used throughout the focus group as well as on the screening questionnaire. After completing the screening, consent and focus group ground rules were read aloud to the group. Focus groups were conducted in a round-robin format allowing each participant an opportunity to answer each question. In addition, the facilitator would alternate who would answer first giving every participant the opportunity to be the first person to answer. Participants could also remark on others' comments and there was time provided for participants to carry on a discussion. Participants did not have to answer every question, could choose to pass, and could leave the focus group at any time. Focus group events generally lasted between two and three hours. Individuals were offered a $20 gift card to a local store for their participation; gift cards were distributed before beginning focus groups as to not coerce individuals into staying.

The UAA Institutional Review Board reviewed and approved questions and protocol. All participants provided informed consent to participate in this research. Youth under the age of 18 followed an informed assent process and a parent or guardian provided informed consent.

Recruitment. Focus group events were hosted in various locations throughout Anchorage that were comfortable and accessible to diverse youth and young adult populations. Youth and young adults were made aware of the focus groups through flyers posted around town and distributed via listservs, word of mouth, and social media posts. ACC executive team members, the assessment team, and community partners helped to distribute flyers and recruit participants. Focus group participants aged 18 to 24 were to remain anonymous and therefore were not asked to RSVP to the event. They were provided contact information for asking questions or requesting specific accommodations.

Recruitment was slightly different for individuals under 18 years of age. These participants could not remain anonymous because they needed parental consent to participate. Therefore, interested individuals and their parents were asked to contact an ACC member in order to complete the consent

form and signup for the focus group event.

Events. Nine focus group events were offered between October 20 and November 12, 2015. Five were on the topic of bullying and four on the topic of mental health. Four events had enough participants to divide into high and low-risk groups, bringing the total number of focus groups to thirteen. The number of participants present at each event ranged from 1 to 15 with an average of 7 participants and a median of 6 participants per event. An individual could participate in only one focus group. A total of 7 UAA assessment team members (i.e., UAA Faculty and researchers), 3 coalition leaders, and 12 coalition members/ community partners helped to host and facilitate the 13 focus groups.

Focus Group Events

Event	*Group*	*Age*	*Topic*	*n*
1	1	12-14	Bullying	4
2	2, 3*	12-14	Mental WB	8
3	4	14-18	Bullying	3
4	5	18-24	Buylling	1
5	6, 7*	14-18	Mental WB	15
6	8, 9*	12-18	Mental WB	9
7	10	18-24	Mental WB	6
8	11	12-18	Bullying	5
9	12, 13*	18-24	Bullying	12
*High/low risk split groups				

Participants. A total of 68 individuals attended a focus group event and 63 stayed to participate in focus groups. There were 25 in focus groups on bullying and 38 in focus groups on mental well-being.

While gender was fairly balanced between women and men in the overall group, more females participated in the school age group and more males participated in the young adult group. Seven percent overall identified as something other than a man or woman. Sexual orientation was asked only of the young adult group and the majority reported as heterosexual (83.3%). The largest race/ethnicity group represented overall was white/Caucasian, however this group only made up 35.3% of participants overall. The next largest race/ethnic group represented was other/ multi-racial (26.5%). Overall, not including other/ multi-racial, a total of five racial/ethnic minorities were represented.

A number of individuals identified as being homeless in the past 12 months (27.3% overall) with the majority of young adult participants reporting homelessness (70.8% of young adults). About 37.5% of young adulst reported they were involved in the criminal justice system in the past 12 months.

Overall Participant Demographics (*N* = 68)

Gender	*n*	*%*
Young woman/woman	26	40.0
Young man/man	34	52.3
Something else	5	7.7
Age		
Range: 12-24 years		
Median: 16 years		
Mean: 16.3 years, *SD*: 3.3		
Race/Ethnicity	*n*	*%*
Alaska Native	5	7.4
Asian/Asian American	7	10.3
Black/African American	8	11.8
White/Caucasian	24	35.3
Native Hawaiian/Pacific Islander	3	4.4
Hispanic/Latino	3	4.4
Other or Multi-Race	18	26.5
Refugee Status	*n*	*%*
Yes	1	1.5
No	67	98.5
Homeless Status last 12 months	*n*	*%*
Yes	18	27.3
No	48	72.7

School Age Youth Demographics (*n* - 44)

Gender	*n*	*%*
Young woman	26	60.5
Young man	14	32.6
Something else	3	7.0
Age		
Range: 12-18 years		
Median: 14 years		
Mean: 14.2 years, *SD*: 1.7		
Grade Status	*n*	*%*
6th grade	3	7.0
7th grade	8	18.6
8th grade	5	11.6
9th grade	11	25.6
10th grade	6	14.0
11th grade	5	11.6
12th grade	5	11.6
Race/Ethnicity	*n*	*%*
Alaska Native	2	2.9
Asian/Asian American	6	8.8
Black/African American	6	8.8
White/Caucasian	15	22.1
Native Hawaiian/Pacific Islander	3	4.4
Hispanic/Latino	3	4.4
Other or Multi-Race	9	13.2
Homeless Status last 12 months	*n*	*%*
Yes	1	2.4
No	41	97.6
Parents in Armed Forces	*n*	*%*
Currently serving	2	4.7
Previously served	5	11.6
Never served	36	83.7

Young Adult Demographics (*n* - 24)

Gender	*n*	*%*
Woman	8	36.4
Man	12	54.5
Something else	2	9.1
Age		
Range: 18-24 years		
Median: 20 years		
Mean: 20.0 years, *SD*: 1.9		
Sexual Orientation	*n*	*%*
Bisexual	1	4.2
Gay/Lesbian/Homosexual	1	4.2
Pansexual	2	8.3
Straight/Heterosexual	20	83.3
Race/Ethnicity	*n*	*%*
Alaska Native	3	12.5
Asian/Asian American	1	4.2
Black/African American	2	8.3
White/Caucasian	9	37.5
Other or Multi-Race	9	37.5
Highest Level of Education	*n*	*%*
< H.S. or currently in H.S.	10	41.7
H.S. graduate or GED	7	29.2
Some college	2	8.3
College graduate	5	20.8
Enrolled as Student	*n*	*%*
Yes	8	33.3
No	16	66.7
Homeless Status last 12 months	*n*	*%*
Yes	17	70.8
No	7	29.2
Involved Criminal Justice last 12 mos.	*n*	*%*
Yes	9	37.5
No	15	62.5
Served in Armed Forces	*n*	*%*
Currently serving	0	---
Previously served	1	4.2
Never served	23	95.8

Limitations of data collection. In considering the limitations of the focus group data collection it is also important to recognize that the purpose of this project was to conduct a community assessment while also engaging and involving coalition members and community partners. There are many benefits to the focus group methods used in this assessment, yet these methods are not without some limitations. First, an important goal of this project was to build capacity among coalition members and as a result a number of coalition members and community partners attended training on human subjects research, focus group methods, and qualitative data analysis. In an effort to provide individuals with real focus group experience, a total of 15 coalition members and community partners assisted in focus group facilitation along with 7 UAA faculty and researchers. That means there were a total of 22 facilitators involved in data collection and though efforts were made to standardize the process there are inherently fluctuations among so many facilitators. On the other hand, a majority of these facilitators also participated in the focus group consensual analysis, which could prove beneficial for the consensual process as a means of checks and balances that may minimize biases in interpreting data.

Second, the recruitment process was more challenging than anticipated. While efforts were made to reach broad audiences through social media and posting of physical flyers in many locations, it was difficult to entice participants to attend. Some participants clearly had a passion for the topic or were motivated by personal experience. However, a number of individuals were personally invited by researchers and coalition members to participate. Additionally, some of the focus groups gathered around a common identity (e.g., a girls sports team or youth organization). In the example of the sports team, the young women originated from different parts of Anchorage and they did not all attend the same school, however they were all familiar with each other due to their common connection. However, in most instances where groups gathered around a common identity, members from the broader community participated, which added a richness to the discussion (i.e., not everyone knew each other).

Learning
Belonging
Engaging

Key Findings

Secondary Data

Note: References to literature cited in the following text are included in the section of this report titled *Literature Cited*. Footnotes in this section are notations of where the data and analyses can be found in a supplement to this report, *ACC Spreadsheet of Secondary Analysis*. Descriptions of datasets cited are in a separate section of this report, *Secondary Data Sources Cited*. The following data sources were included in the analysis:

- Alaska Department of Education and Early Development (ADEED)
- Behavioral Risk Factor Surveillance System (BRFSS)
- Bureau of Vital Statistics (BVS)
- National College Health Assessment (NCHA)
- National Survey of Drug Use and Health (NSDUH)
- Office of Children's Services (OCS)
- Pregnancy Risk Assessment Monitoring System (PRAMS)
- School Climate and Connectedness Survey (SCCS)
- Trauma Registry (TR)
- Youth Risk Behavior Survey (YRBS)

Substance Use

Secondary analyses of data (YRBS, BRFSS, SCCS & NSDUH) collected from youth and young adults in Anchorage document that alcohol, prescription drugs, and marijuana are the substances most frequently used. Substance use overall is trending downward across nearly all substances and age groups.[1]

While the number of youth age 12-17 who are dependent on alcohol and marijuana has declined, youth in Anchorage continue to report higher than national averages on both use and dependence on marijuana.[2] The presence of students under the influence of alcohol and drugs (marijuana, coke, or crack) at local high schools remained steady or declined slightly.[3] However, a significant number of youth still report using and/or observing others using a variety of substances including cocaine, solvents, heroin, methamphetamines, and ecstasy.

Some interesting patterns emerged from secondary data analysis. In particular, during the period from 2005-2013, both alcohol and marijuana use trended downward. In 2005, 41.3% of students reported consuming at least one drink of alcohol or at least one of the past 30 days, while 22.7% of students reported using marijuana one or more times during the past 30 days.[4] In 2013, these percentages were substantially less (24.2% and 16.9% for alcohol and marijuana respectively). There is a less marked downward trend with respect to marijuana use. Also noteworthy is the relatively high percentage of youth (13.9% for the district overall) who report use or observing use of harmful legal products including inhalants, prescription drugs that have not been prescribed for them, as well as solvents and other household products.[5] Rates of harmful legal product use were highest among Alaska Native students.

The literature and secondary data analysis on protective factors related to substance use and positive youth development suggests that access to trusted adults, sense of value and belonging in the community, as well as youth engagement in extra curricular activities, volunteerism, and faith-based programs may reduce the risk of engaging in substance use behaviors (Bobakova, Geckova, Klein, Reijneveld, & van Dijk, 2012; Cooley-Strickland et al., 2009; Johnson et al., 2006; King & Furrow, 2004; McDonald, Deatrick, Kassam-Adams, & Richmond, 2011; Proctor, Linley, & Maltby, 2009; Smith, 2007; Tebes et al., 2007; Youngblade et al., 2007). However, there is less agreement on the role of youth employment. For example, Robert Kaestner et al. (2013) found that

1 YRBS, 2013 - Marijuana; Rx Drugs; Meth, Cocaine, Inhalants; Tobacco; Alcohol
2 NSDUH - Marijuana; Alcohol
3 SCCS - Marijuana, Coke, Crack; Alcohol
4 YRBS - Marijuana; Alcohol
5 NSDUH - Rx Drugs; SCCS - Inhalants

youth who work 26 hours per week or more during school have a significant increased risk of alcohol and tobacco use.

While downward trends over the last decade are a promising development, reported substance use remains high and this could be an area to target for future intervention. However, to be effective, any intervention must be informed by student perspectives, as they are the "experts" in their own social worlds and can help researchers and program/policy makers understand the issues that are most important from a student perspective and the reasons why.

Mental Health

From 2010-2012, young adults (ages 18-25) in Anchorage and Alaska overall experienced slightly higher rates of mental illness than their peers nationwide.[1] Younger people (12-17) in both Anchorage and Alaska overall were less likely to experience major depressive episodes than their peers nationwide, but this pattern reversed for young adults (ages 18-25) in Anchorage. They were more likely than those in Alaska overall, and more likely than their nationwide peers to experience major depressive episodes.

More than a quarter of Anchorage School District (ASD) students reported experiencing symptoms of depression over the past year.[2] Depressive symptoms were most frequently experienced by students who identified as Native Hawaiian/Pacific Islander, Latino, or other. Across grades 3-12, girls reported depressive symptoms more frequently than boys. Among high school students, 9th and 10th graders reported depressive symptoms more frequently than other grade levels. Nearly a quarter of ASD students reported feeling alone in their lives. Students who identified as Latino, Black, and other reported feeling alone more frequently than students of other identified races. Boys and girls reported loneliness at similar rates, while 9th graders reported it more frequently than other high school students. Particularly by 12th grade, loneliness was much less common.

While little data are available on mental health among young adults in Anchorage, some information regarding the experiences of University of Alaska Anchorage students is known. Nearly a quarter of UAA students felt things were hopeless during the past month.[3] Many more (64.0%) had felt overwhelmed at some point over the past month and more than a third felt very lonely and/or very sad. Female students reported these mental health symptoms more often than male students. More Native students reported hopelessness than White students, while more White students reported feelings of being overwhelmed, lonely, and/or sad than Native students.

The most frequently reported mental health diagnoses among UAA students were depression and anxiety.[4] Most UAA students reported that they would consider seeking help from a mental health professional in the future, if warranted.

Suicide

Alaska consistently reports rates of suicide that are among the nation's highest and Alaskan young people are at particular risk, attempting and completing suicide more frequently per capita than Alaskans of other ages and more frequently than their peers in other states (CDC NCIPC, 2015).

From 2004-2013, 408 Alaskans age 9-24 committed suicide, resulting in a rate of 23.6 per 100,000.[5] Rates were relatively consistent across the ten years of reporting. Males completed suicide three to four times more frequently than females. Alaskan Native young people experience rates of suicide more than four times greater than non-Natives. Across the ages of interest, young adults (ages 21-24) completed suicide more frequently than the other age groups.[6]

Across the same time period (2004-2013), young people in Anchorage completed suicide less often than their peers across the state.[7] Resulting from 107 deaths, the rate for Anchorage is 15.0 per 100,000. Patterns of demographic risk are similar for Anchorage as the state overall, with males and Alaskan Natives completing suicide more frequently than females and non-Natives, and young adults ages 21-24 experiencing higher

1 NSDUH - Mental Health
2 YRBS - Mental Health
3 NCHA - Mental Health
4 NCHA - Mental Health
5 BVS - Suicide AK
6 BVS - Suicide AK
7 BVS - Suicide Anch

rates than other age groups. Both across the state and in Anchorage, firearms were the most often-used means for suicide completion.

While rates of suicide have remained relatively constant over the past decade, estimates of suicidal ideation among young adults increased from 2008-10 to 2010-12, with rates among Anchorage young adults increasing at a higher rate than Alaska (and the United States) overall.[1] ASD students, however, reported relatively stable rates of suicidal ideation. While males complete suicide more often than females, ASD girls reported more frequent consideration of suicide as well as more frequent planning about how they would attempt suicide. Among ASD high school students, 9th graders reported more frequent consideration and attempts than other grade levels.[2] The racial disparity seen between Alaska Natives and non-Natives in suicide completions does not exist for suicidal ideation and suicide attempts among ASD students. From 2009-13, Alaska Native ASD students considered suicide and attempted suicide at lower rates than three other racial/ethnic groups: Native Hawaiian/Pacific Islander, Latino, and Other (predominantly mixed race).

Intermediate Variables

Intermediate variables are variables that theoretically precede or lead to a particular outcome or set of outcomes, whether they are behaviors or health conditions. Intermediate variables that lead to risk behavior and/or poor health outcomes are called risk factors, while variables that inhibit one from engaging in risk behavior or prevent one from having poor health outcomes are considered protective factors. Using the socio-ecological framework, intermediate variables can fall in any one of three levels of influence—environmental, interpersonal, or intrapersonal. The environmental level of influence includes community, policy, and culture. The interpersonal level includes relationships with family members, peers, and others like mentors and teachers. The intrapersonal level includes an individual's lifestyle, knowledge and perceptions (e.g., attitudes and beliefs), biological conditions (e.g., genetics, disability), and demographics (e.g., gender, race/ethnicity, age).

1 NSDUH - Suicide
2 YRBS - Suicide

As a frame of reference, this community assessment has three major youth outcomes of interest: substance use, mental health, and suicide. Each of these outcomes has significant associations with intermediate variables from three levels of influence. In the secondary data analysis, the intermediate variables assessed included environmental-level factors related to community, home, and school environments, as well as interpersonal-level factors related to relationships with parents, other adults, peers and teachers. Intrapersonal-level factors included demographic factors and perceptions about substance use and lifestyle. All results reported here are specific for Anchorage, unless otherwise stated.

Environmental Level Factors

Community environment. Among the six different datasets included in the analyses of intermediate variables, only one variable captures the concept of community environment. The YRBS asks high school students, whether they feel like they matter in their community. In 2013, around 48% of youth agreed or strongly agreed that they felt like they mattered in their community. This is about a 5% decline when compared to the same data from the previous two years.[3]

School environment. Three variables from YRBS capture the essence of the school environment among high school students. In YRBS, youth were asked if their schools had clear rules and consequences for students' behaviors. In 2013, about 68% of youth agreed or strongly agreed this was the case, which is a 4% increase from 2003.[4]

Another YRBS variable related to the school environment is whether students did not go to school in the past 30 days because they felt they would be unsafe at school or on their way to school. In 2003, around 5% of students reported not going to school because they felt unsafe. This increased to about 9% in 2005, and since then, rates have gone down. In 2013, about 7% of students reported not going to school because they felt unsafe.[5]

Also asked on YRBS is whether youth have been

3 YRBS - Feel They Matter
4 YRBS - School Clear Rules & Cons
5 YRBS - Felt Unsafe

in a physical fight on school property in the past 12 months. In 2003, almost 8% of youth reported being in a physical fight in school, which increased to about 14% in 2005. Most recent YRBS data shows physical fighting in school at 9% in 2011.[1]

In the 2009 NCHA data, five variables captured factors relevant to the environment of the UAA campus. These variables included experience of physical assault, verbal threat, sexual touching without consent, sexual penetration without consent, and stalking on campus. Among these variables, one emerged as a concern—one in five UAA students reported being verbally threatened on campus.[2] The rest of the variables were not quite significant with rates of less than 10%. However, it is worth noting that variables like these are typically underreported due to a number of factors including the stigma attached to them.

Another aspect of the school environment is the overall student suspension, expulsion, dropout, and graduation rates. Data related to these variables are available from ADEED. Combined suspension rates for grades 3 to 12 tended to be fairly stable from 2010 to 2014. Specifically, in the 2010-11 school year the suspension rate was 17.5 per 100 students, and in 2013-14 it was 19.8. Suspension rates tended to be higher among boys, eighth graders, and ethnic minorities.[3]

Rates of school expulsions have tended to be fairly low for grades 3 to 12. The combined expulsion rate was highest in the 2011-12 school year at 16.6 per 10,000 students, down to 5.6 in 2013-14. Expulsion rates were higher among boys, 9th and 10th graders, and ethnic minorities. The school year 2011-12 recorded the highest expulsion rates among 9th graders at 55 per 10,000 students.[4]

School dropout rates among 7th to 12th graders improved through the years. Anchorage schools experienced the lowest dropout rates in school year 2013-14 at around 3.4%. In 2010-11 and 2011-12, the dropout rates in Anchorage schools were more than 4.0%. Dropout rates tended to be higher among 12th graders, ethnic minorities, and students with limited English proficiency.[5]

Two types of graduation rates are recorded on ADEED: 4-year cohort graduation rate and 5-year cohort graduation rate. The 4-year rates improved by a few percentage points, from around 71% in school year 2009-10 to about 74% in 2013-14.[6] The 5-year rates also improved. In school year 2010-11 it was around 75%, while for 2013-14 it rose to 81%.[7] For both 4-year and 5-year cohort graduation rates, boys, ethnic minorities, and students with limited English proficiency tended to be consistently lower than their same age peers.

Home environment. Four variables were relevant to the type of environment where children and youth lived, namely, housing stability, domestic violence at home, victimization of children, and out-of-home care.

In terms of housing stability, based on the most current (2012) PRAMS data, about 52% of young mothers (less than 25 years old) moved to a new address prior to the birth of their baby and 5% were homeless or had to sleep outside, in a car, or at a shelter. These current rates are fairly close to the rates eight years earlier.[8]

Reported domestic violence at home among young mothers seems to be decreasing overall. Even though around 5.3% of young mothers reported abuse from their husband/partner 12 months pre-pregnancy in 2004 and as much as 10.2% in 2010, this rate decreased to 4.8% in 2012. Similar trends were observed in terms of reported prenatal abuse by husband/partner, 12-month pre-pregnancy controlling partner, prenatal controlling partner, and postpartum controlling partner. The 2004 rates for these aforementioned cases were 3.5%, 7.8%, 7.7%, and 6% respectively, while the 2012 rates were 0.6%, 1.6%, 1.9%, and 3.0%.[9]

OCS provided data on victimization among children. The number of children ages 9 and up with at least one substantiated report of harm during screening decreased from 490 in 2008 to 155 in 2014. A greater proportion of girls than

1 YRBS - Physical Fight in School
2 NCHA - Abuse
3 ADEED - Suspensions
4 ADEED - Expulsions
5 ADEED - Dropout
6 ADEED - 4-year Cohort Graduation
7 ADEED - 5-year Cohort Graduation
8 PRAMS - Housing Stability
9 PRAMS - Domestic Violence

boys were harmed through the years.[1] OCS also provided data on children or youth in out-of-home care. As of January 1, 2015, a total of 949 children or youth from Anchorage were in out-of-home care status. They made up 41% of state placements.[2]

Interpersonal Level Factors

Family relationships. There were several variables related to family relationships. In the YRBS, youth were asked about parental perception of substance use and alcohol use, and how often their parents communicated with them about school. There was a decreasing trend in youth perceptions of parents considering it very wrong for them to have one or two alcoholic drinks per day. In 2009 almost 80% of youth perceived parents to consider it very wrong, while in 2013 it was down to about 64%.[3] On the other hand, the proportion of youth who perceived their parents considered it very wrong for them to smoke marijuana did not significantly change through the years. From 2009 to 2013, it remained around 64%.[4] How often parents communicated with youth also did not significantly change. For the past decade, youth reporting at least one parent who talked with them about what they did in school every day remained at around 44%.[5]

Relationship with other adults. One of the YRBS variables assessed whether youth felt comfortable seeking help from at least one adult besides their parents if they had an important question affecting their lives. Rates of this specific variable decreased in the past decade. In 2003 around 86% of youth had at least one other adult to go to for help, while in 2013 it was down to 82%.[6]

Relationship with teachers. In YRBS, youth relationships with teachers was measured by asking whether teachers really cared about them and gave a lot of encouragement. The rates for this specific variable increased through the years, but not by significant amounts. In 2003, 57% of students agreed or strongly agreed that teachers really cared about them and gave them a lot of encouragement, and in 2013 it increased to 61%.[7]

Peer relationships. YRBS asked several questions related to peer relationships. A couple of these variables are related to youth access to alcohol. YRBS asked if youth obtained alcohol they drank from someone giving it to them or from someone buying it for them. In 2013 almost one-third of youth obtained alcohol from someone giving it to them and about one-quarter obtained it from someone buying it for them.[8]

YRBS also asked whether youth have been physically hurt by their boyfriend or girlfriend in the past 12 months. Rates of youth being physically hurt by their boyfriend or girlfriend increased from about 12% in 2003 to about 18% in 2005. Since then, rates decreased to around 13% in 2011.[9]

In the 2009 NCHA survey, less than 4% of UAA students reported being in physically abusive or sexually abusive relationships, while about 12% reported being in emotionally abusive relationships.[10]

Bullying. Bullying can be considered an interpersonal level factor since it involves peer-to-peer interactions. YRBS asked whether youth have ever been bullied on school property and whether they have been bullied electronically. Rates of ever bullying have remained at around 19% from 2009 to 2013, while rates of ever been bullied electronically remained at around 15% from 2011 to 2013.[11]

SCSS also asks about bullying among elementary, middle school, and high school students. However, unlike YRBS that asks about personal experience of bullying, SCSS asks about observed bullying in school. Observed bullying among students in schools has declined for elementary, middle, and high school students. In 2007, approximately 68% of elementary students, 76% of middle school students, and 70% of high school students reported seeing at least one incidence of bullying in their schools. In school year 2013-2014, the rates declined substantially to 48%, 52%, and 54% among elementary, middle, and high school students, respectively.[12]

1 OCS - Substantiated Victims Data
2 OCS - Out-of-Home Care
3 YRBS - Parent Perception Alcohol
4 YRBS - Parent Perception Marijuana
5 YRBS - Parent Involvement
6 YRBS - Students Seek Help
7 YRBS - Teachers Really Care
8 YRBS - Alcohol Access
9 YRBS - Physically hurt by SO
10 NCHA - Abuse
11 YRBS - Bullying
12 SCCS - Bullying

When YRBS and SCSS bullying data are compared, the trend does not seem to match. Whereas bullying rates on YRBS remain almost the same across the years, SCCS bullying trend is on a decline. However, it is important to note that the two rates are not necessarily comparable. While YRBS looks at bullying experience, SCCS looks specifically at observed or perceived bullying. Due to social desirability issues, self-report of bullying tends to be underreported, whereas observed bullying tends to be overestimated.

Feeling alone. Feeling alone can be considered an interpersonal level factor as well because it is a function of whether or not youth feel they have friends, family, and/or community support. In the YRBS from 2003 to 2013, there has been an increasing proportion of youth reporting feeling alone in their lives. In 2003, about 19% compared to 23% in 2013.[1]

Intrapersonal or Individual Level Factors

Youth perception of alcohol. In YRBS, youth were asked if drinking one or two alcoholic beverages nearly every day has a moderate or great risk of harm. From 2007 to 2013, youth perception of harm increased from 57% to 65%.[2] Additionally, YRBS asked youth if drinking alcohol was cool. Rates of youth perceptions that drinking alcohol is not cool (or little chance of being cool) increased from 59% in 2007 to 74% in 2013.[3]

Youth perception of marijuana. Youth perception regarding the harm of marijuana use is assessed in YRBS. However, this specific topic was asked two different ways through the years, so the rates of youth perceptions of harm are not directly comparable. In 2009 and 2011 youth were asked if they perceived people to have moderate or great risk of harming themselves if they smoked marijuana regularly, while in 2013 youth were asked if they perceived people to have moderate or great risk of harming themselves if they smoked marijuana once or twice a week (operationalizing the term "regularly"). In 2009 and 2011 over 50% of youth perceived people had moderate or great risk of harming themselves if they smoked marijuana regularly. In 2013 around 37% of youth perceived smoking marijuana once or twice a week posed moderate or great risk.[4]

Whether youth think smoking marijuana is cool is also assessed in YRBS. Rates of this variable did not change significantly through the years. In 2007, 66% of youth thought there was little or no chance of being seen as cool if they smoked marijuana, while in 2013 the rate slightly increased to 69%.[5]

Truancy. Youth were asked in YRBS whether they missed classes or school without permission during the past 30 days. Rates of truancy decreased from 32% in 2011 to 24% in 2013.[6]

Volunteer participation. The concept of volunteerism among youth was assessed in YRBS. In particular, the survey asked about spending one or more hours per week helping people without getting paid or volunteering at school or in the community. Rates of youth volunteering one or more hours per week decreased through the years, from 66% in 2003 to 49% in 2013.[7]

Participation in organized afterschool activity. The YRBS asked youth if they took part in any organized after school, evening, or weekend activities per week. Rates did not significantly change through the years. In 2007 approximately 54% of youth took part in organized afterschool/evening/weekend activities per week, while in 2013 this rate slightly decreased to 52%.[8]

Physical activity. Engaging in regular physical activity is an important intrapersonal level factor because literature has shown that such a lifestyle protects youth from poor mental health conditions, such as sadness and suicidal ideation among bullied adolescents (Sibold, Edwards, Murray-Close, & Hudziak, 2015). In YRBS, youth were asked whether they engaged in 60 minutes per day of physical activity on one or more days in the past week. Rates of physical activity have been increasing in the past decade. In 2005, about 78% of youth reported engaging in physical activity, while in 2013, this rate increased to 84%.[9]

1 YRBS - Feel Alone
2 YRBS - Alcohol Perceived Risk
3 YRBS - Alcohol Cool
4 YRBS - Marijuana Perceived Risk
5 YRBS - Marijuana Cool
6 YRBS - Truancy
7 YRBS - Volunteer
8 YRBS - Organized Activity
9 YRBS - Physical Activity

Demographic factors. The YRBS dataset was analyzed to identify which specific demographic variables were associated with bullying, feeling sad or hopeless, and suicidal ideation. The findings showed that compared to their same age peers, girls and youth with mixed race/ethnicity were more likely to be bullied in school or electronically, to report feeling sad or hopeless almost everyday, to considering suicide, and to planning an attempt to commit suicide.[1]

Factors that Protect Youth from Risk Behaviors and Conditions

Additional analyses were conducted using YRBS dataset to identify which specific intrapersonal, interpersonal, or environmental factors protected youth from engaging in risk behaviors and conditions.[2] Two of the strongest protective factors (in descending order) that decreased the odds of current alcohol use, binge drinking, and current marijuana use among youth were having teachers that cared about them and having regular talks with parents about school. On the other hand, the two strongest protective factors that decreased the odds of feeling sad or hopeless almost everyday and having suicidal ideation were feeling like they mattered in their community and feeling they were not alone. As for the strongest protective factors that decreased the odds of youth being bullied in school and being bullied electronically, it was having teachers that really cared about them and gave them a lot of encouragement that made the most difference.

Associated Factors with Bullying, Mental Health, and Suicidal Ideation

Being ever bullied in school or electronically was associated with several risk behaviors and conditions. YRBS analysis revealed that regardless of sex and grade level, being ever bullied in school or electronically was significantly associated with reports of current alcohol use, binge drinking, feeling alone, feeling sad or hopeless almost everyday, suicidal ideation, and truancy.[3] Finally, both feeling alone and feeling sad or hopeless almost everyday were significantly associated with suicidal ideation (both seriously considered suicide and planned an attempt to commit suicide).

1 YRBS - Demographic, Bullying, Mental Health, Suicide
2 YRBS - Table of Intermediate Variables
3 YRBS - Table of Intermediate Variables

Protective and Risk Factors and Their Association with Bullying, Sadness and Hopelessness, and Suicide Ideation

Using YRBS data, a logistic regression analysis[4] was conducted to assess which environmental, interpersonal, and intrapersonal protective and risk factors have a significant effect on bullying, sadness/hopelessness, and suicidal ideation.

Eight protective factors were considered in the regression model, including the following:

- Talking to parents about school everyday
- Having 1 or more adults comfortable seeking help
- Spending 1 or more hours per week volunteering at school or community
- Participating in organized afterschool activities at least 1 day per week
- Feeling that they matter to people in their community
- Having teachers that really care about them
- Having school that has clear rules and consequences for their behavior
- Engaging in physical activity at least 60 minutes per day in the past 7 days

There were two risk factors considered in the regression model:

- Feeling alone
- Missed school in the past 30 days because they felt unsafe at school or on the way to school

Results of the regression analysis show that controlling for age and grade level, youth who feel that they matter to people in their community and have teachers that really care about them are less likely to report ever being bullied in school or electronically, less likely to feel sad or hopeless, and less likely to seriously consider suicide. In contrast, youth who feel unsafe in school or on the way to school are more likely to report ever being bullied in school or electronically, more likely to feel sad or hopeless, and more likely to seriously consider suicide. Similar associations, except for the likelihood of being bullied, were observed among youth who reported feeling alone. Interestingly, findings also show that youth spending one or more hours per week volunteering at school or in the community are more likely to feel sad or hopeless. This seems counterintuitive since

4 YRBS - Regression Protect & Risk Factors

volunteerism is considered a protective factor. However, it is possible that those volunteering in the community were doing so because they wanted to mitigate feelings of sadness and hopelessness.

In summary, bullying, mental health, and suicidal ideation are impacted by intermediate variables at the environmental, interpersonal, and intrapersonal levels. At the environmental level, it is important to make youth feel that they matter in the community and that they feel safe in their schools. With the decreasing rates of youth feeling like they matter in their community, it is important that community members find ways to make youth feel valued. Most youth feel safe in their schools. Thus, it is important to maintain this status.

At the interpersonal level, it is important that youth have teachers that really care about them and that youth don't feel alone in their lives. More than half of youth surveyed on YRBS feel that their teachers care about them. However, YRBS data also shows that more and more youth are feeling alone in their lives. It is thus important for the community to find ways to be engaged in the youth's lives.

At the intrapersonal or individual level, youth's sex and race/ethnicity matters. Young women and racial/ethnic minorities are at higher risks for being bullied, feeling sad or hopeless, and to seriously consider suicide. Given these risks, it is worth finding ways to specifically target these groups.

Limitations of Secondary Data

While secondary data sources, typically the results of national surveys are very useful to help inform certain aspects of youth behavior, there are inherent limitations associated with these data sources. For example, even when a random sample of participants is initially selected for a survey, the actual survey respondents are ultimately a subset of volunteers who agree to participate. Their attitudes, perceptions, and behaviors may differ from the randomly sampled individuals who declined to participate. In addition, it is well known that self-report information may be intentionally or unintentionally inflated or minimized by respondents for a number of reasons (e.g., a social-desirability effect).

YRBS and other datasets used in the secondary data analysis are all done using a cross-sectional study design. Thus changes within individuals, specifically key behavioral outcomes, are not captured. Conducting secondary data analysis limits us to working with only the variables available in the datasets. Other important concepts that can influence outcomes are not considered, such as gender, sexual orientation, and immigration status, just to name a few.

An important consideration is that significant associations using secondary data are typically based on correlational statistics. Correlation is not evidence of causation.

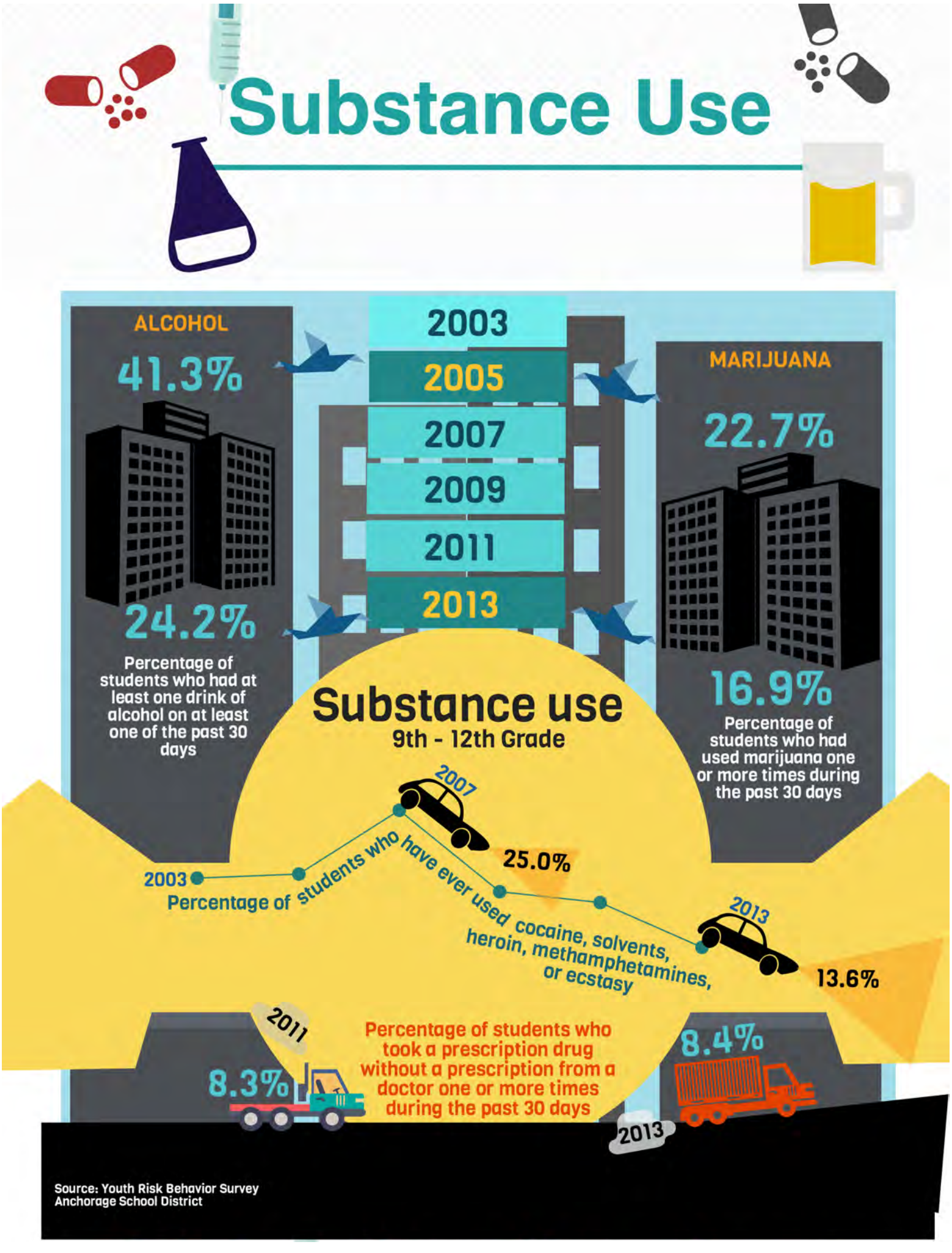
Moreover, trends over time cannot be examined as a result of added or modified questions or changes in operational definitions that impact results or interpretations of them (e.g., changing the reporting of poisoning in suicide attempts; changing the way the reason for school suspensions and expulsions are reported).

Other general limitations are associated with data collection procedures and methods. For example, YRBS data are limited to high school students attending school on the day the survey is administered and for whom parents provided active consent for them to participate in the survey. In other words, the data misses high school age youth who are absent for that class period or that day. The BRFSS survey is administered by telephone so it necessarily misses individuals who do not have a phone, and only recently samples people who only have a cell phone. In 2011, the Alaska Trauma Registry discontinued reporting most poisoning injuries for adults, which had an impact on the number of suicide attempts reported that were due to poisoning.

Despite these gaps and limitations existing incident and survey data are collected to provide the most valid and reliable information possible. They can be used effectively as long as limitations are taken into consideration. Since the data analyses conducted here are based on a sound conceptual framework (i.e., socio-ecological framework), the strong associations reported provide important empirical data to get closer to finding causal relationships between variables.

Infographics of Secondary Data Findings

Substance Use



Substance Use and Dependence

Ages 12 to 17 years
2010 to 2012

USE
- marijuana (13.91%)
- nonmedical use of pain relievers (5.85%)
- cocaine (0.87%)

DEPENDENCE
- illicit drug dependence (2.36%)
- alcohol dependence (1.46%)

USE
- marijuana (16.68%)
- nonmedical use of pain relievers (6.41%)
- cocaine (0.84%)

DEPENDENCE
- illicit drug dependence (2.64%)
- alcohol dependence (1.46%)

USE
- marijuana (16.48%)
- nonmedical use of pain relievers (7.20%)
- cocaine (0.87%)

DEPENDENCE
- illicit drug dependence (2.77%)
- alcohol dependence (1.54%)

Percentage of use/ dependence in the past year

0 10 20 30 40

Source: National Survey on Drug Use and Health (NSDUH)

Ages 18 to 25 years
2010 to 2012

Source: National Survey on Drug Use and Health (NSDUH)

USE
- marijuana (30.66%)
- nonmedical use of pain relievers (10.29%)
- cocaine (4.60%)

DEPENDENCE
- alcohol dependence (6.15%)
- illicit drug dependence (5.40%)

USE
- marijuana (37.66%)
- nonmedical use of pain relievers (11.78%)
- cocaine (5.11%)

DEPENDENCE
- alcohol dependence (7.69%)
- illicit drug dependence (4.78%)

USE
- marijuana (39.50%)
- nonmedical use of pain relievers (12.53%)
- cocaine (5.99%)

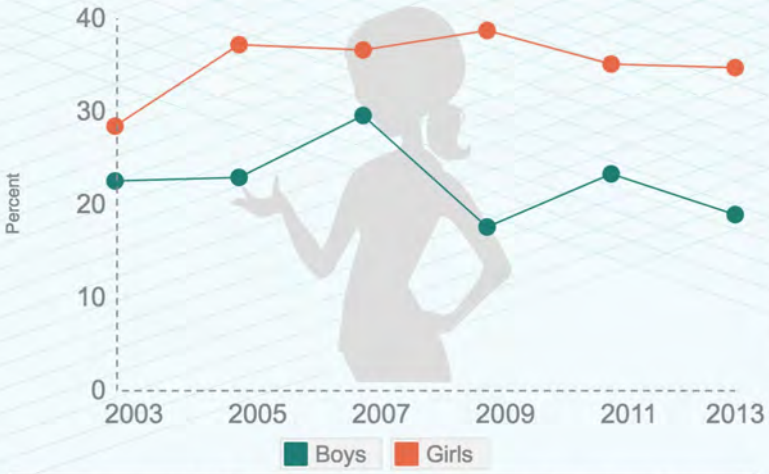
DEPENDENCE
- alcohol dependence (7.26%)
- illicit drug dependence (4.77%)

Percentage of use/ dependence in the past year

0 10 20 30 40

Youth Mental Health

Feelings of sadness, hopelessness, and stress



Percentage of ASD students who felt so sad or hopeless almost everyday or two weeks or more in a row that they stopped doing usual activities during the past twelve months.

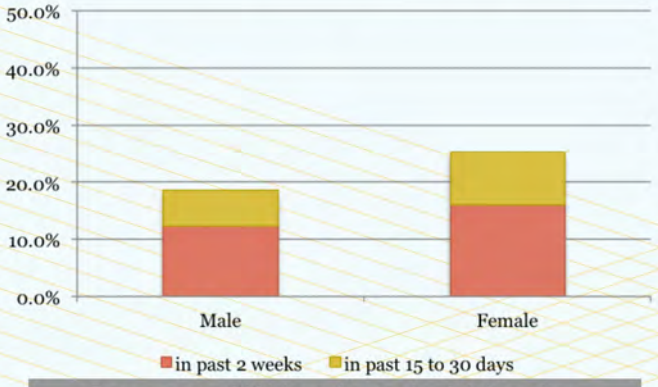
Acronyms

ASD - Anchorage School District
UAA -University of Alaska Anchorage

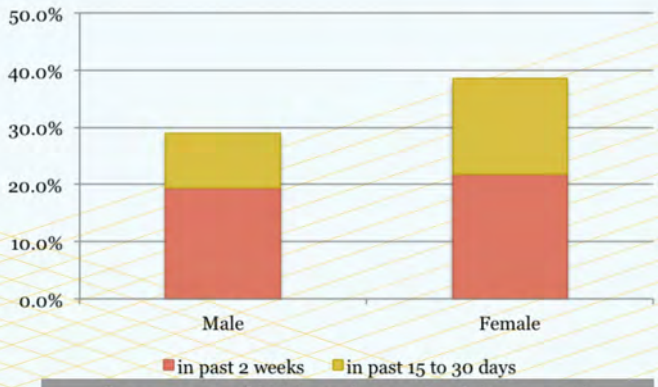
Data Sources

ASD data	Youth Risk Behavior Survey, 2003 to 2013
UAA data	National College Health Assessment, 2009
SAMHSA data	National Survey on Drug Use and Health, 2008 to 2012

From 2003 to 2013, the percentage of high school girls reporting feelings of sadness and hopelessness was on average 12.7% higher than boys.

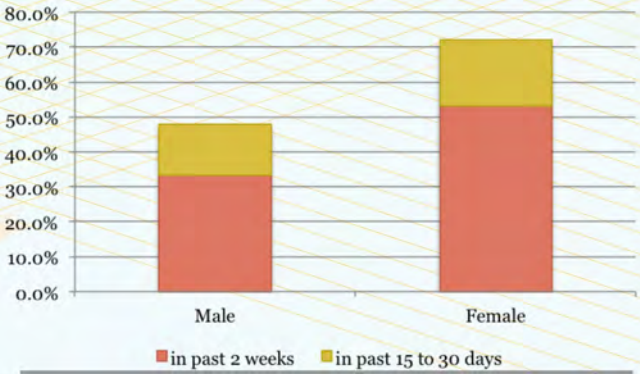


Percentage of UAA students who felt hopeless



Percentage of UAA students who felt very sad

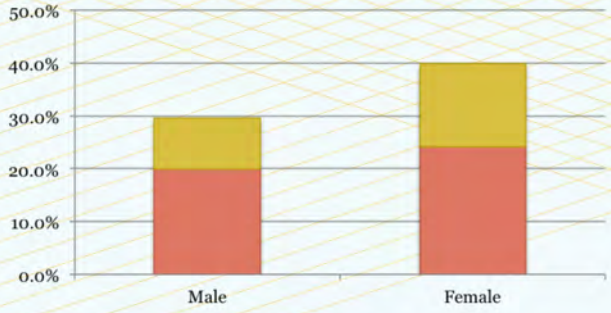
52.1% of female students at UAA reported high stress over the past 12 months.



Percentage of UAA students who felt overwhelmed

Feelings of Loneliness

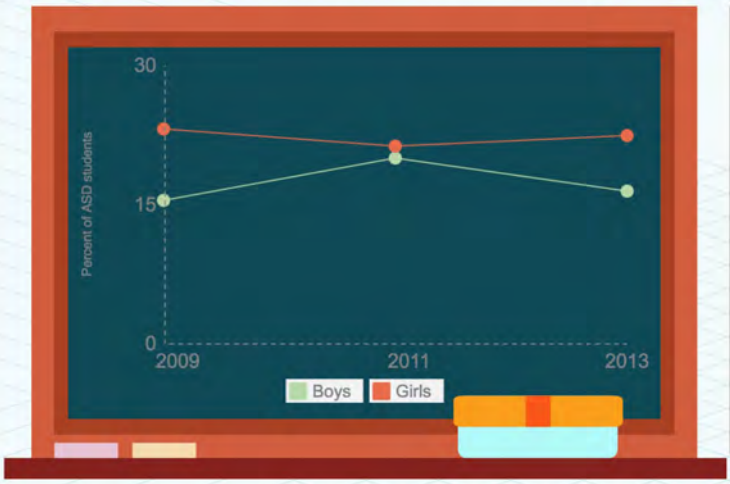
Percentage of ASD students who agree or strongly agree to feeling alone

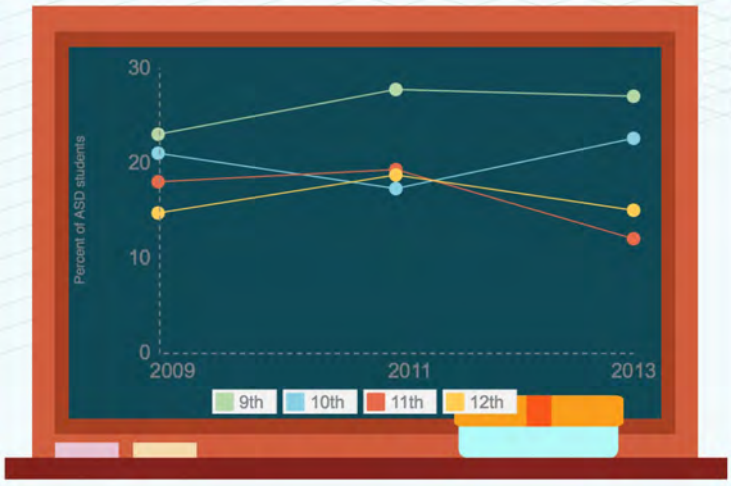


Percentage of UAA students who felt very lonely

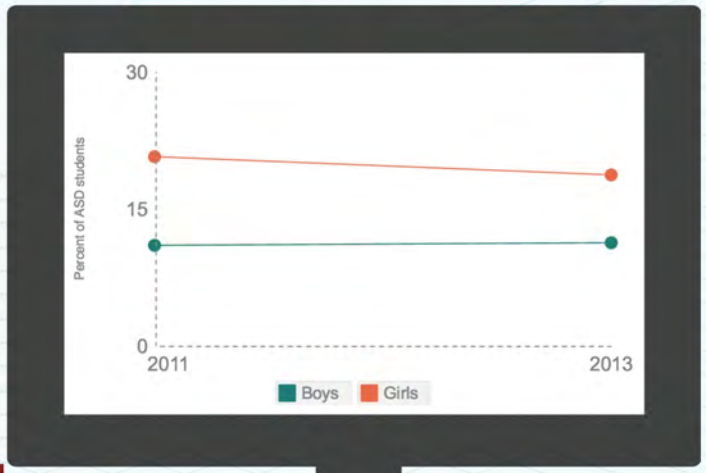
Feelings of being alone have been increasing among ASD students.

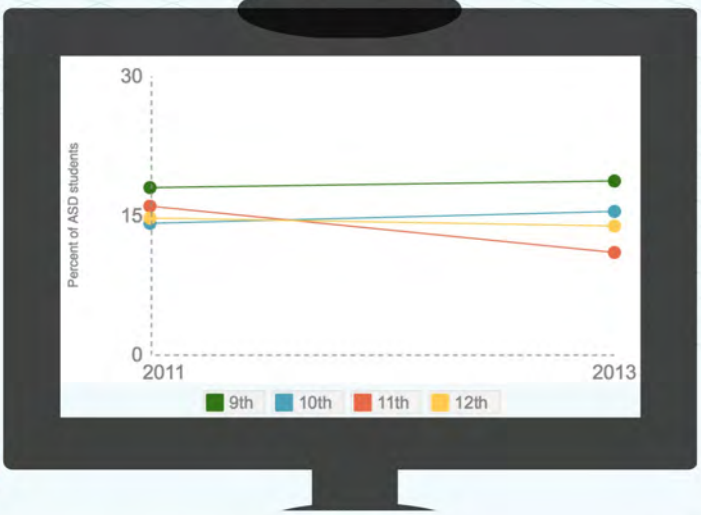
Bullied at School





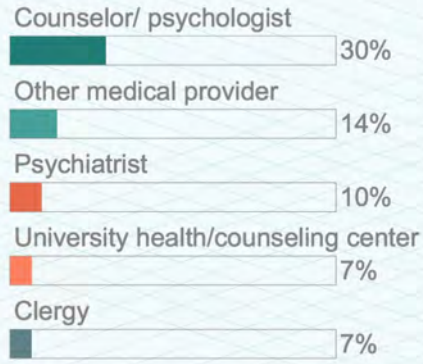
Bullied Electronically





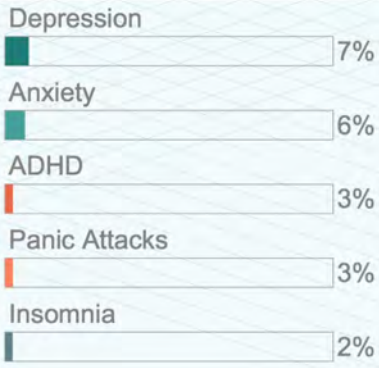
Mental Health Diagnosis and Treatment

Ever received mental health services

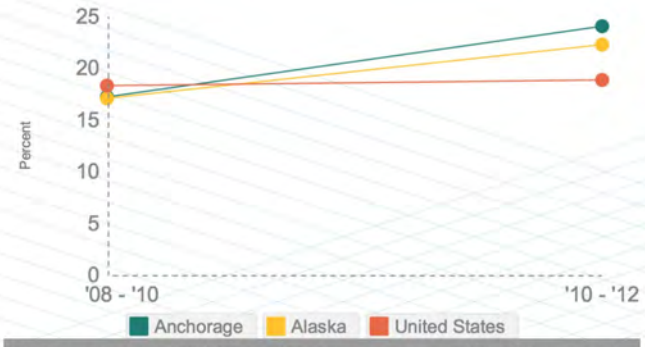


62.1% of students would consider seeking help from a mental health professional in the future.

Current mental health diagnosis in past 12 months

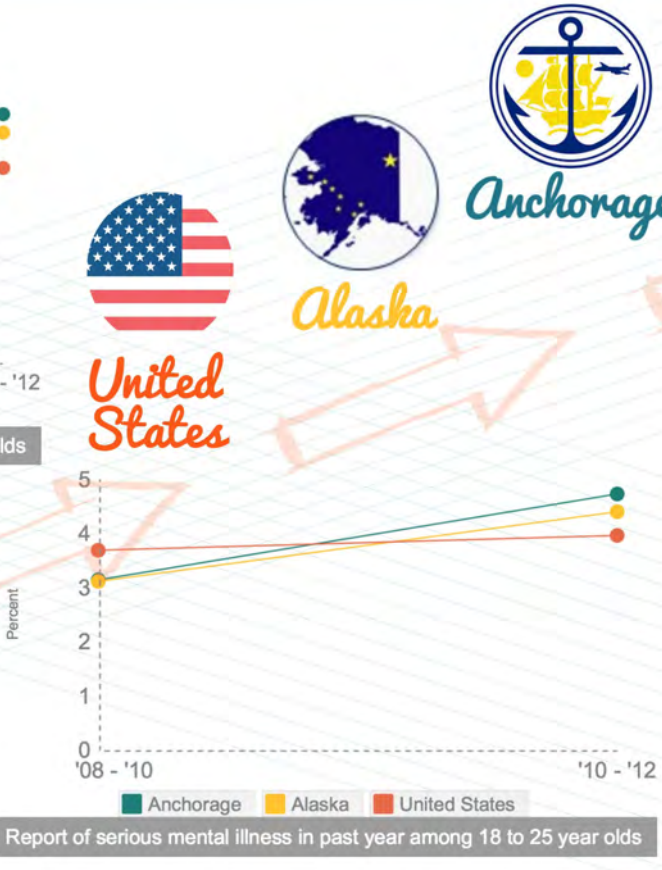


Source: National College Health Assessment, 2009



Any reported mental illness in past year among 18 to 25 year olds

Rates of mental health diagnoses among 18 to 25 year olds are on the rise in Anchorage and Alaska.



Report of serious mental illness in past year among 18 to 25 year olds

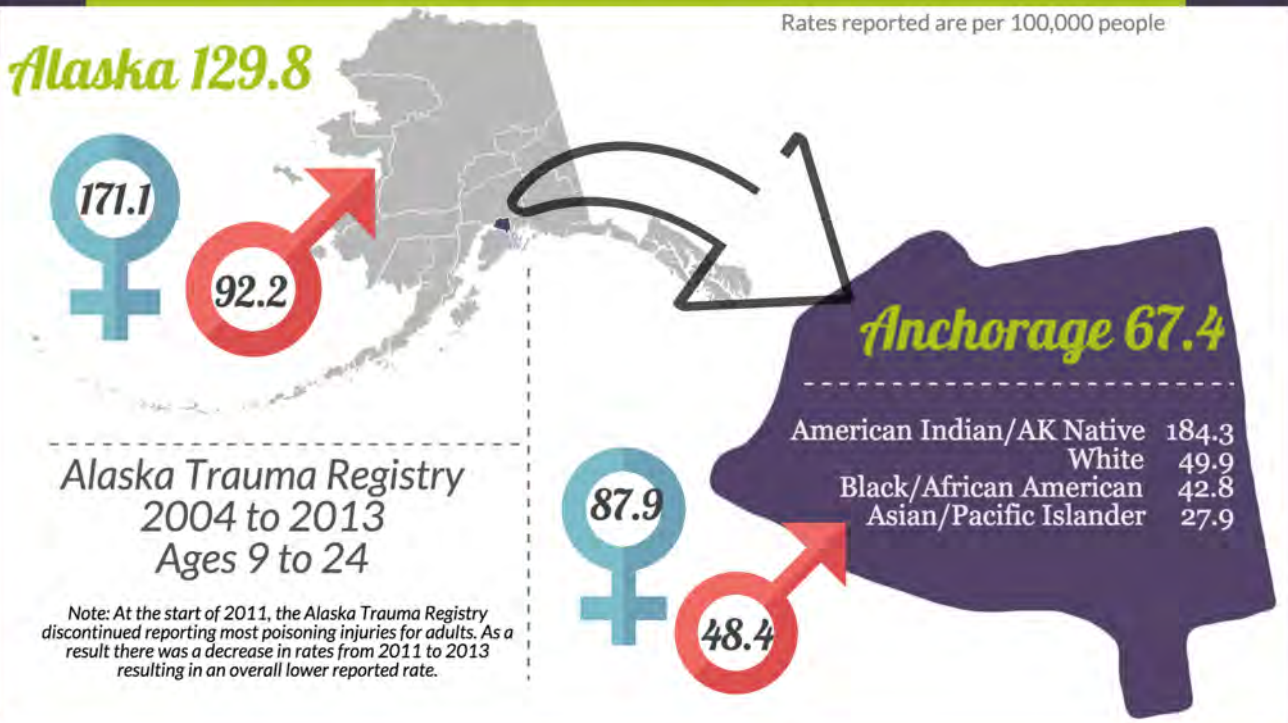
Source: National Survey on Drug Use and Health (NSDUH)

Suicide Prevalence

Alaska and Anchorage

Rates of suicide attempt and self-harm

Rates reported are per 100,000 people



Alaska Trauma Registry
2004 to 2013
Ages 9 to 24

Note: At the start of 2011, the Alaska Trauma Registry discontinued reporting most poisoning injuries for adults. As a result there was a decrease in rates from 2011 to 2013 resulting in an overall lower reported rate.

Rates of death

Rates reported are per 100,000 people

Anchorage 15.0

6.4

23.0

Most Common Means

	Alaska	Anchorage
Firearm	14.5	9.0

9.0

37.0

Alaska 23.6

Bureau of Vital Statistics
2004 to 2013
Ages 9 to 24

Age

	Alaska	Anchorage
9 to 17	8.8	*3.1
18 to 20	37.8	23.2
21 to 24	46.6	33.8

*Based on 10-19 incidents, should be interpreted with caution

Substance Use

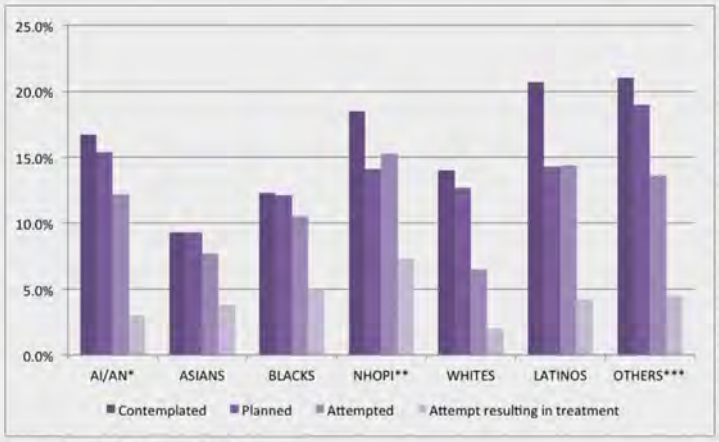
Reported involvement as percent of all cases of intentional self-harm

	Alaska	Anchorage
Alcohol	1.3%	**
Drugs	7.0%	4.7%

** Number not provided

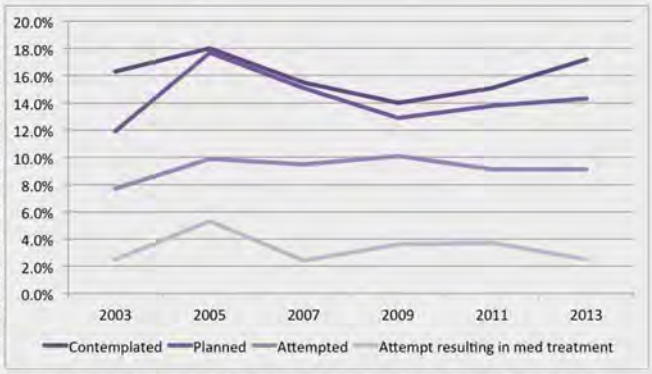
Anchorage School District

By Ethnicity 2009 to 2013



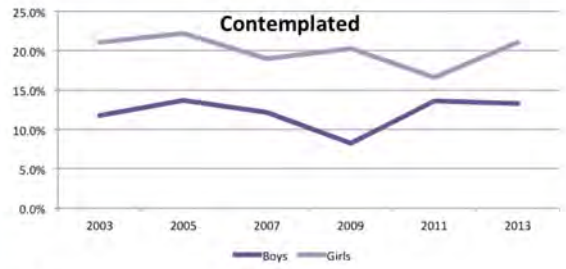
*American Indian/Alaska Native
**Native Hawaiian and Other Pacific Islanders
***Includes mixed race and unidentified race

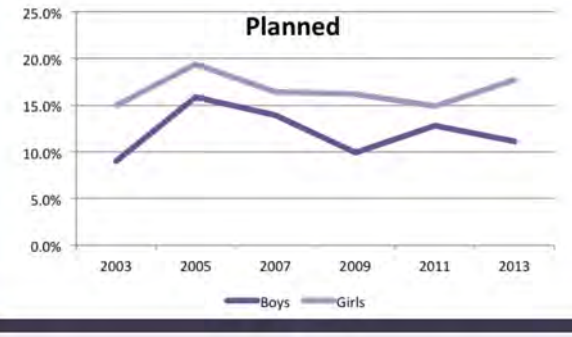
Percent of Anchorage Students



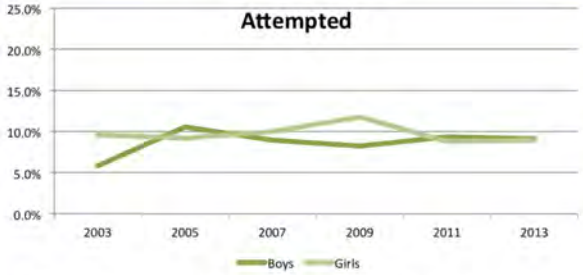
Youth Risk Behavior Survey
2003 to 2013
Anchorage School District
9th through 12th grade

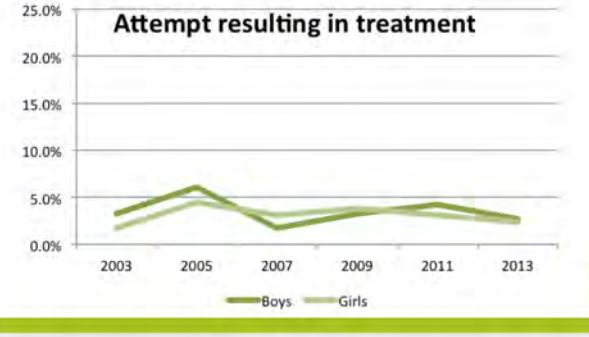
Suicide Ideation





Suicide Attempt





Intermediate Variables

YRBS Protective Factors

Youth Behavior Risk Survey (YRBS) data was collected from 9th through 12th grade students in the Anchorage School District from 2003-2013.

Protective Factors	Seriously considered suicide	Planned a suicide attempt	Feel sad or hopeless	Currently drinking	Binge drinking
Strongly disagree/disagree that they feel alone	**69.7% less likely**	63.1% less likely	67.3% less likely	20.7% less likely	24.0% less likely
Strongly agree/agree they feel they matter to people in their community	**59.4% less likely**	59.3% less likely	54.6% less likely	18.9% less likely	16.7% less likely
Have 1 or more adults comfortable seeking help from	48.0% less likely	**48.9% less likely**	32.7% less likely	Not significant	19.6% less likely
Strongly agree/agree they have teachers that really care about them	47.7% less likely	37.8% less likely	37.4% less likely	**50.8% less likely**	45.8% less likely

Ever bullied at school

Ever bullied electronically

Ever bullied at school		Ever bullied electronically
222% more likely	Seriously considered suicide	199% more likely
183% more likely	Planned an attempt to suicide	194% more likely
175% more likely	Feel sad or hopeless	210% more likely
90% more likely	Currently drinking	169% more likely
65% more likely	Binge drinking	120% more likely

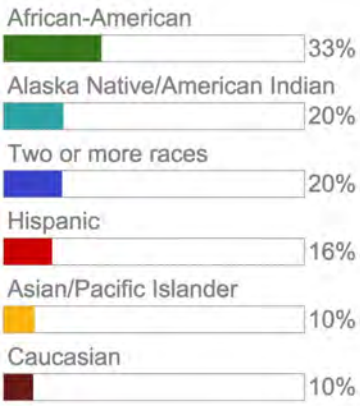
Source: YRBS collected in 2003-2013 from 9th through 12th grade students in the Anchorage School District

SCHOOL SUSPENSIONS

2010-2014

From 2010 - 2014, the Anchorage School District averaged 6,925 suspensions per year in grades 3- 12.

7th and 8th graders accounted for 46.5% of all suspensions.



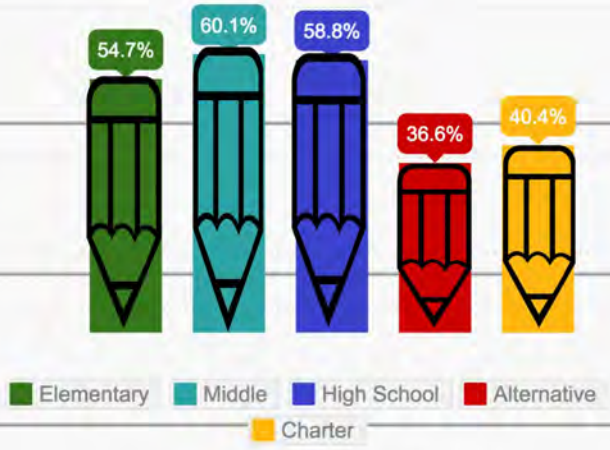
Suspensions within ethnicity

Over 2010 - 2014, the racial groups with the most disproportionate number of suspensions were African Americans, Alaska Native/American Indian, and two or more races.

Source: Alaska Department of Education and Early Development

Bullying at school

More students in Anchorage high schools and middle schools reported seeing one or more instances of bullying at school or a school event than elementary school, alternative school, and charter school students.



Source: SCCS, averages for 2008-2014

Graduation Rates

Graduation rates for Anchorage School District averaged from 2009-2014.

Lowest five graduation rates within categories are represented.

4-Year Cohort

Limited English Proficient	34.2%
Students with Disabilities	41.7%
Alaska Native/ American Indian	47.3%
Native Hawaiian/ Other Pacific Islander	55.5%
Economically Disadvantaged Students	59.9%
All Students	73.5%

5-Year Cohort

Students with Disabilities	50.9%
Limited English Proficient	54.6%
Alaska Native/ American Indian	56.9%
Native Hawaiian/ Other Pacific Islander	67.5%
African American	68.2%
All Students	78.4%

Source: Alaska Department of Education and Early Development

Dropout Rates

Dropout rates for Anchorage School District averaged from 2009-2014.

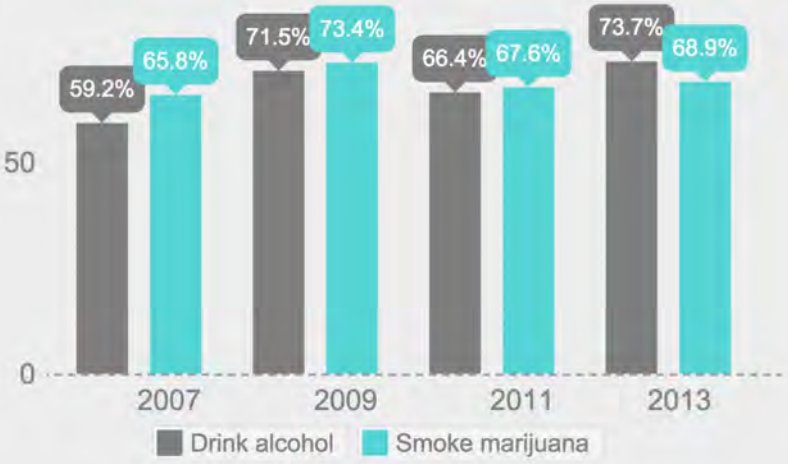
Highest five dropout rates within categories are represented.

Grade 12	9.7%
Alaska Native/ American Indian	7.6%
Limited English Proficient	5.5%
Students with Disabilities	5.2%
Native Hawaiian/ Other Pacific Islander	4.8%
All Students	3.4%

Source: Alaska Department of Education and Early Development

How (un)cool is alcohol and marijuana?

Percentage of high school students who think there is little chance or no chance of being seen as cool if they drink alcohol or smoke marijuana.



Source: YRBS

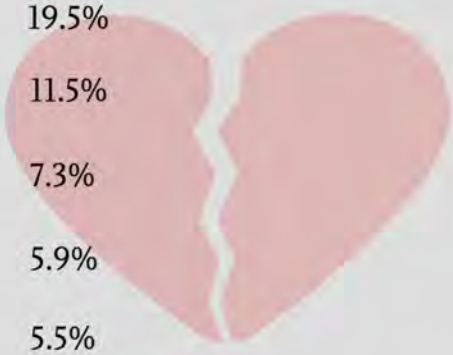
As a consequence of drinking, UAA students who drink reported they:

did something they later regretted	31.6%
forgot what they did	24.9%
had unprotected sex	15.4%
physically injured themselves	14.7%

Source: National College Health Assessment, 2009, students aged 18-24

UAA students 18-24 years old reported in the past 12 months they had been:

verbally threatened	19.5%
in an emotionally abusive relationship	11.5%
stalked	7.3%
physically assaulted	5.9%
sexually touched without consent	5.5%



Source: National College Health Assessment, 2009

Primary Data

Adult Perceptions of Anchorage Youth (APAY): Preliminary Results

The APAY was designed to gather adult perceptions regarding substance use and behavioral health problems of youth, namely bullying, feeling alone, extreme sadness/hopelessness, and suicide. Data from completed and returned surveys as of December 11, 2015 were analyzed and preliminary results are provided here as descriptive statistics, largely percentages and frequencies. Once the survey has closed in January 2016 and all survey data have been entered, the data will be thoroughly cleaned and recoded. In addition, data will be weighted to increase the representativeness of the sample relative to proportions of demographic characteristics in the Anchorage adult population.

Knowledge of issues. The majority of responding adults to date reported that they were not knowledgeable or were only somewhat knowledgeable about behavioral health issues among Anchorage youth such as bullying, extreme sadness/hopelessness, youth feeling alone, and suicide. Forty-six percent of adults reported that they were not knowledgeable and another 36% reported they were only somewhat knowledgeable about the problem of extreme sadness/hopelessness among Anchorage youth. Forty-six percent of adults also reported they were not knowledgeable and another 38% reported they were only somewhat knowledgeable about the problem of Anchorage youth feeling alone in their lives. Similarly, more than 80% of adults reported they were not knowledgeable (38%) or only somewhat knowledgeable (43%) about suicide among Anchorage youth. Adults were slightly more knowledgeable about bullying among Anchorage youth. Seventy-five percent of adults reported they were not knowledgeable (36%) or only somewhat knowledgeable (39%) about bullying while 25% reported they were very knowledgeable or knowledgeable.

Knowledge of Youth Behavioral Health Issues

The majority of adults reported that they were not knowledgeable or were only somewhat knowledgeable about behavioral health issues among youth.

Behavioral Health Issues	*Very Knowledgeable*		*Knowledgeable*		*Somewhat Knowledgeable*		*Not Knowledgeable*		*Total*
	N	*%*	*N*	*%*	*N*	*%*	*N*	*%*	*N*
About bullying among Anchorage youth	11	6.4%	32	18.7%	66	38.6%	62	36.3%	171
About extreme sadness/ hopelessness among Anchorage youth	10	5.8%	21	12.3%	61	35.7%	79	46.2%	171
About Anchorage youth feeling alone in their lives	10	5.8%	18	10.5%	65	38.0%	78	45.6%	171
About suicide among Anchorage youth	10	5.8%	22	12.9%	74	43.3%	65	38.0%	171

Concern about issues. Adults reported a great deal of concern about behavioral health issues among youth, especially suicide. Eighty-four percent of adults reported they were concerned or very concerned about suicide among Anchorage youth. Seventy-one percent reported that they were concerned or very concerned about each of the following youth behavioral issues: bullying, extreme sadness/hopelessness, and feeling alone. Between one and four percent of adults reported that they were not at all concerned about the various behavioral health issues among youth.

Concern Regarding Youth Behavioral Health Issues

Adults reported a great deal of concern about behavioral health issues among youth, especially suicide.

Behavioral Health Issues	Very Concerned		Concerned		Somewhat Concerned		Not Concerned		Total
	N	%	N	%	N	%	N	%	N
About bullying among Anchorage youth	55	32.2%	67	39.2%	43	25.1%	6	3.5%	171
About extreme sadness/ hopelessness among Anchorage youth	53	31.2%	67	39.4%	47	27.6%	3	1.8%	170
About Anchorage youth feeling alone in their lives	53	31.0%	68	39.8%	48	28.1%	2	1.2%	171
About suicide among Anchorage youth	87	50.9%	56	32.7%	25	14.6%	3	1.8%	171

Efforts to address issues. Anchorage adults reported most frequently that there was only a little or some community efforts in place to address various behavioral health issues among youth. Eighty-seven percent of adults report at least a little or some community efforts to address extreme sadness/hopelessness among Anchorage youth and 86% reported a little or some community efforts to address Anchorage youth feeling alone. Eighty percent of adults reported at least a little or some efforts to address suicide among Anchorage youth.

Few adults reported either extensive efforts or a lack of efforts in the community to address behavioral health issues among youth. Fifteen percent of adults reported knowledge of a lot of efforts to address suicide among Anchorage youth. Eleven percent of adults reported knowledge of no efforts addressing Anchorage youth feeling alone.

Engagement in youth's lives. The majority of Anchorage adults are likely or very likely to engage in youths' lives. More than two-thirds of adults surveyed indicated that they are likely or very

Degree of Effort to Address Youth Behavioral Health Issues

Adults reported most frequently that there was only a little or some community efforts in place to address various behavioral health issues among youth.

Behavioral Health Issues	A Lot		Some		A Little		Nothing		Total
	N	%	N	%	N	%	N	%	N
For bullying among Anchorage youth	22	13.0%	84	49.7%	48	28.4%	15	8.9%	169
For extreme sadness/ hopelessness among Anchorage youth	8	4.8%	82	48.8%	64	38.1%	14	8.3%	168
For feeling alone among Anchorage youth	5	3.0%	77	46.1%	66	39.5%	19	11.4%	167
For suicide among Anchorage youth	25	14.9%	97	57.7%	38	22.6%	8	4.8%	168

likely to help a youth address important questions about their lives (68%), make youth feel like they are not alone (68%), and make youth feel like they matter in the community (67%). Just under two-thirds of adults surveyed indicated that they talk to youth about how they are doing in school every day (65%) and encourage youth to take part in organized activities (63%).

Adult Engagement in Youth's Lives

The majority of adults are likely or very likely to engage in youth's lives.

Circumstances	*Very Likely*		*Likely*		*Somewhat Likely*		*Not Likely*		*Total*
	N	*%*	*N*	*%*	*N*	*%*	*N*	*%*	*N*
Talk to youth about how they are doing in school every day	85	50.3%	24	14.2%	20	11.8%	40	23.7%	169
Help youth seeking help from you in addressing important questions about their lives	89	52.7%	26	15.4%	17	10.1%	37	21.9%	169
Help make youth feel that they are not alone in their lives	87	51.5%	28	16.6%	16	9.5%	38	22.5%	169
Help make youth feel like they matter in your community	77	45.8%	35	20.8%	21	12.5%	35	20.8%	168
Encorage youth to take part in organized after school, evening, or weekend activities	87	51.5%	20	11.8%	26	15.4%	36	21.3%	169

Perceptions of school environment. Over 65% of surveyed adults in Anchorage agreed or strongly agreed and another 32% somewhat agreed that Anchorage teachers care about and give encouragement to youth. Only 3% of adults disagreed. There was less agreement that junior high and high schools in Anchorage have clear rules and consequences for youth behavior. Just over 50% of surveyed adults strongly agreed or agreed and other 36% somewhat agreed that junior high and high schools in Anchorage have clear rules and consequences. Nearly 13% of surveyed adults disagreed that junior high and high schools in Anchorage have clear rules and consequences for youth behavior.

Perceptions of School Environment

Most adults agreed that teachers care about and encourage youth, but had less agreement on clear rules and consequences in junior and high schools.

Circumstances	*Strongly Agree*		*Agree*		*Somewhat Agree*		*Disagree*		*Total*
	N	*%*	*N*	*%*	*N*	*%*	*N*	*%*	*N*
Teachers in Anchorge really care and give a lot of encouragement to youth	41	24.3%	69	40.8%	54	32.0%	5	3.0%	169
Junior high and high schools in Anchorage have clear rules and consequences for youth behavior	27	16.1%	59	35.1%	61	36.3%	21	12.5%	168

Summary. Adults responding to the APAY survey to date reported being engaged in youths' lives based on several indicators. Engagement with adults, particularly parents, is an important protective factor for several behavioral health issues. Anchorage adults reported being concerned about the behavioral health issues of bullying, extreme sadness/hopelessness, youth feeling alone, and suicide, but these adults did not feel particularly knowledgeable about the issues. From a community readiness perspective, this creates an opportunity to educate and inform parents and adults about these behavioral health issues among youth in the Anchorage community. The surveyed adults felt that there are few or only some community efforts in place to address these behavioral health issues. This may suggest that more can be done to address these issues in the Anchorage community and that parents and adults need to be informed about current and new efforts, and other resources.

Young Adult Survey (YAS)

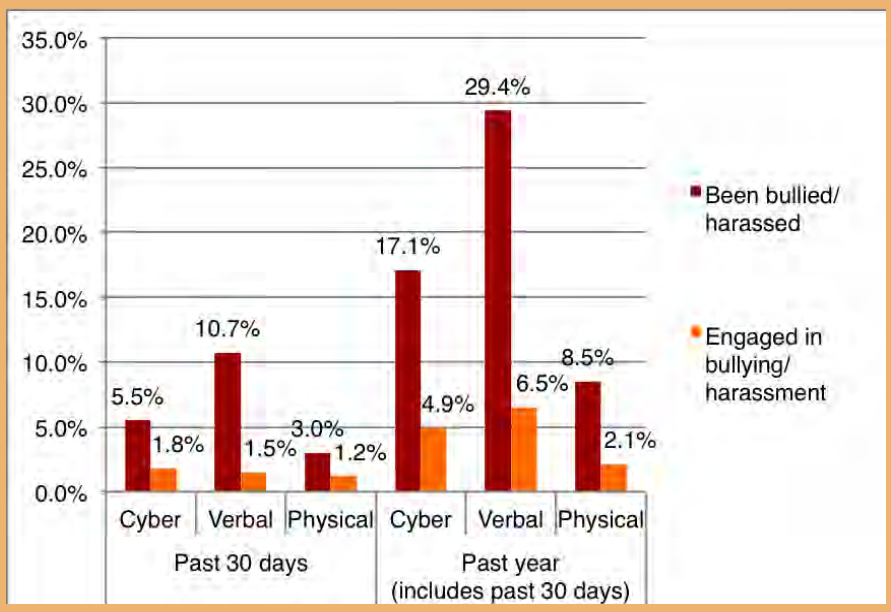
The YAS was designed to gather data from young adults (age 18-24) on social support, community perception and involvement, substance use, stress, bullying and/or harassment experiences, psychological well-being, and help-seeking behaviors and perceptions.

All quantitative data management and statistical analyses of YAS data were conducted in SPSS (IBM Statistical Package for the Social Sciences, v21). Data were reviewed and cleaned. Reliability for multi-item scales was confirmed (Cronbach's alpha > .75 for all). Quantitative analyses included descriptive statistics, frequency analysis, and multiple linear regression. In the latter, a predictive model is developed to determine which variables, in combination, best predict a dependent (or outcome) variable of interest. Multiple linear regression is appropriate when the dependent variable is continuous and was conducted to predict mental health scores. Analyses including gender were limited to comparing men to women, as the small sample size of other gender responses prevented comparison of those groups. Similarly, analyses including race and sexual orientation were limited to comparing the majority groups (i.e. Caucasian and heterosexual) to all other groups.

Qualitative responses to open-ended questions were free-coded for content and grouped by theme. Comments were not limited to one group; rather, each comment was included in as many groups as appropriate given its content.

Bullying. Respondents reported if they had experienced bullying or harassment within the past year and also if they had engaged in

Bullying/Harassment Experiences



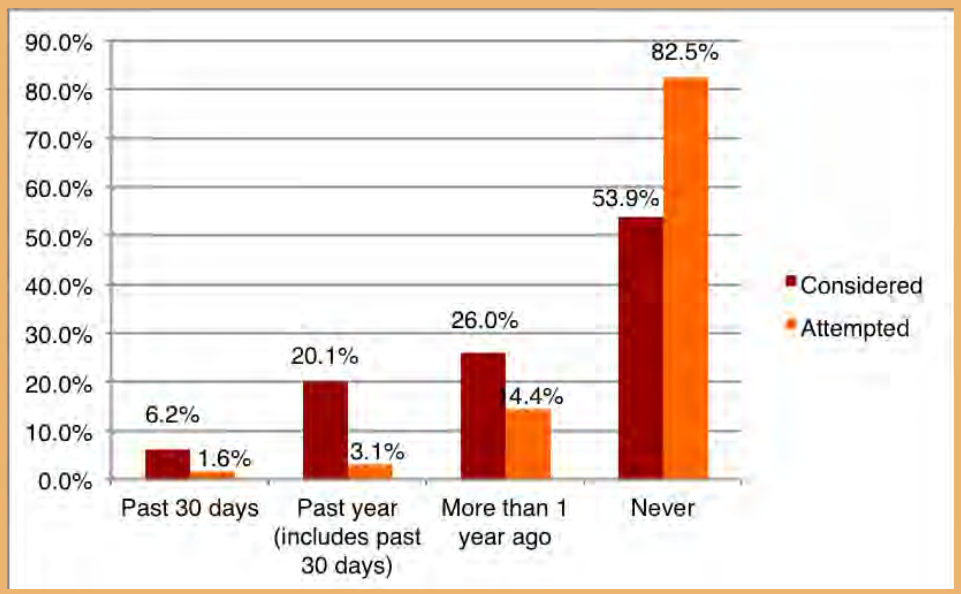
bullying or harassing behaviors. More than a quarter of respondents (29.4%) had experienced verbal bullying within the past year; 10.7% had experienced verbal bullying within the last 30 days. Fewer reported experiencing cyber bullying/harassment (17.1%) or physical harassment (8.5%) within the past year. Overall, more than a third (36.2%) reported experiencing at least one kind of bullying or harassment over the past year.

Among reports of engaging in bullying or harassment, verbal was the most common type (6.5%). Cyber bullying or harassment was reported by slightly fewer respondents (4.9%), with physical bullying or harassment least common (2.1%). Overall, 9.4% of respondents reported engaging in at least one kind of bullying or harassment over the past year.

Respondents were also asked to describe their most recent experience of engaging in bullying or harassment. Comments provided limited insight into the motivations behind the behavior. Participants often described cyber bullying in online forums, on social media, and via text message. Some participants described their behaviors (both cyber and verbal) light-heartedly, such as "I harass people a lot but never maliciously" or describing it as "teasing." A few participants justified the behavior, describing traits or actions of the other individual(s) as deserving of the response. Justification occurred for all three types of bullying or harassment (i.e. cyber, verbal, and physical). Many participants described experiences from more than one year ago (i.e. "in elementary school" or "10 years ago").

Suicide. About 20% of respondents reported seriously considering suicide within the past year, with 6.2% considering within the last 30 days. Three percent had attempted suicide within the past year, with 1.6% attempting within the last 30 days. Women reported considering suicide slightly more often than men, and men reported attempting suicide slightly more often than women.

Suicide Considerations & Attempts



Help seeking. More than half of respondents (61.1%) indicated that they have had a problem for which they thought psychological or mental health services would be helpful. Among these individuals, for those who reported problems as minors, approximately three-quarters did receive services. For those who reported problems as adults, approximately 60% received services.

Respondents who reported experiencing an issue for which services would have been helpful but did not report receiving any such services were asked to explain why they did not seek services. Four primary themes emerged in the responses: cost, lack of resources, stigma, and skepticism.

In describing cost, participants described their own lack of economic resources as well as perceiving the cost of seeking services as quite high. Representative comments:

"I have no health insurance and seeking services is costly."

"At the time I could not afford it."

Participants also described a lack of knowledge regarding available services and how to obtain services. For example:

"As an adult, I didn't know where to even begin to find help."

"Because I wasn't sure how to ask for help."

Respondents described stigma surrounding seeking mental health services as a barrier. Representative comments:

"I felt like...I would be judged by everyone around me tremendously."

"It seemed like a weird thing to do."

Respondents described skepticism about mental health services in two major ways. First, some individuals indicated doubtfulness that professional help is or would be effective. For example, one individual commented that though he/she knew of specific resources,...

"I had not heard good things about the mental health professionals."

Another respondent commented that...

"I didn't think it was worth the money."

Other respondent comments reflected skepticism that their problem or issue was severe enough to warrant mental health services. For example:

"I thought I would eventually get over it."

"I have a mindset that says to just deal with it - never seemed serious enough to really seek help."

Despite these barriers, the majority of respondents (63.9%) indicated they would consider seeking professional help services in the future if they experienced a serious personal problem.

Predictors of mental health. Respondents indicated their experiences of mental health issues over the past year through seven indicators: hopeless, overwhelmed, lonely, very sad, depressed (so much so that it was difficult to function), consideration of suicide, and suicide attempt. Responses to each variable were summed to create an overall mental health score ranging from 0 (no endorsement of mental health issues over the past year) to 7 (endorsement of all seven issues over the past year). On average, participants endorsed half of the mental health indicators (M = 3.6, SD = 2.0). Most participants (91.1%) endorsed at least one mental health issue over the past year, while few participants (2.9%) indicated experiencing all seven indicators.

Multiple linear regression was conducted to determine which other personal and interpersonal factors were associated with experiencing mental health issues. A variety of variables were considered for inclusion:

- Psychosocial variables: stress, optimism, social support, and feeling like one matters to community
- Substance use: alcohol and marijuana use

- Bullying experience
- Work/volunteer
- Demographic variables: gender, sexual orientation, race, and years lived in Anchorage

Psychosocial Factors

	M	*SD*
Feeling like matter to community	3.5	1.0
Social support	4.1	0.9
Optimism	4.0	0.7
Stress	3.6	0.9
Note: Scale is 1-5 for each, with higher scores indicating greater experiences of each.		

The final model significantly predicted mental health, $F(12) = 13.64$, $p < .01$, and included the following variables as significant predictors, in decreasing order of strength: stress, bullying experience, optimism, years lived in Anchorage, gender, and sexual orientation. The directional relationship for each significant predictor is described below. The other considered variables were not significant predictors of mental health.

Predictors of Mental Health

Overall	R^2	*p*
Model	0.34	0.00
Included Variables	β	*p*
Stress	0.24	0.00
Bullied or harassed	0.20	0.00
Optimism	-0.20	0.00
Years lived in Anchorage	0.14	0.00
Gender	0.13	0.01
Sexual orientation	0.12	0.02
Excluded Variables	β	*p*
Social support	-0.11	0.09
Alcohol use	0.09	0.08
Marijuana use	0.09	0.08
Feeling like matter to community	-0.03	0.53
Work/volunteer	0.01	0.80
Race	-0.01	0.92

Greater stress was associated with greater endorsement of mental health issues. Similarly, having experienced bullying over the past year was also associated with greater mental health issues. Greater optimism (i.e., "I believe that my future will work out") was associated with fewer mental health issues. Living in Anchorage longer was associated with more mental health issues, while fewer years living in Anchorage was associated with fewer mental health issues. Finally, identifying as a woman (as opposed to a man) was associated with greater mental health issues while identifying as a heterosexual (as opposed to any other sexual identity group) was associated with fewer mental health issues.

Limitations of data. Because the sample was obtained by convenience, results may not be representative of the population of interest (i.e., all 18-24 year olds in Anchorage). In particular, estimates of rates or frequency should be interpreted cautiously. Similarly, any observed differences between subgroups (i.e. men and women) may be invalid. The results of that type that are reported should be taken with caution and understanding of the limitation. Comparatively, analyses of relationships between variables (i.e., such as those described in the model predicting mental health) are less problematic with a convenience sample.

Summary. As anticipated, the young adults surveyed reported a variety of experiences with bullying and a variety of mental health concerns. Respondents' experience of mental health issues over the past year was significantly predicted by a number of individual and interpersonal factors. Greater endorsement of mental health issues was associated with (in order of strength of association): experiencing greater stress, having been bullied or harassed, being less optimistic, having lived in Anchorage for more years, identifying as woman (as opposed to a man), and identifying as a sexual minority (as opposed to heterosexual).

The majority of participants indicated a willingness to seek professional mental health services in the future if needed. At the same time, respondents described a variety of barriers to seeking services in the past, including cost, lack of resources, stigma, and skepticism about the usefulness of services.

Cooperating
Supporting
Celebrating

Focus Groups

Analysis

Focus group screening. Focus group participants completed a screening questionnaire prior to the focus group discussion. The questionnaire focused on participant demographics; experience being bullied and engaging in bullying behavior; and experience with loneliness, sadness, hopelessness, and stress. The primary intent of the focus group screening was to describe the focus group population and to allow focus group participants to be divided into high and low-risk groups for the discussion.

First, frequencies were calculated for all of the variables on the questionnaire. Second, a correlational analysis was conducted to identify if specific demographic populations were more likely to ever experience or engage in bullying; feel hopeless, lonely, sad, or depressed; or experience stress. Not all focus group participants who completed the screening survey attended the focus group discussion. Participant demographics are described in the Assessment Methodology section of this report for all 68 individuals who attended a focus group and completed a screening questionnaire. Only those individuals who participated in the focus group discussion were included in the correlational analysis (N = 63). Considering the small convenience sample for this analysis, the results cannot be generalized.

In the correlational analysis, the demographic characteristics assessed included the following:

- *Gender* (young man, young woman, and something else);
- *Race/ethnicity* (Whites/Caucasian and racial/ethnic minorities);
- *Age group* (12-18 years and 18-24 years);
- Educational level (currently in high school, high school graduate or equivalent and some college, college graduate or more)
- *Homeless status* (homeless or not homeless in the past 12 months)

Each of the above demographic characteristics were compared in terms of the bullying and mental health outcomes mentioned previously. In comparing these outcomes, each was scored based on the participants' degree of response. The table below shows how the bullying and mental health outcomes were scored.

Scoring Guide for Health-Related Outcomes

Bullying & Mental Health Outcomes	*Scoring Guide*	*Total Possible Score*
Ever Experiencing Bullying		
Been cyber bullied	No Never = 0 Yes, but not in the last 12 months = 1 Yes, in the last 12 months = 2	0 to 6
Been verbally bullied		
Been physically bullied		
Engaged in Bullying		
Engaged in cyberbullying	No Never = 0 Yes, but not in the last 12 months = 1 Yes, in the last 12 months = 2	0 to 6
Engaged in verbal bullying		
Engaged in physical bullying		
Total overall bullying score	0 to 12	0 to 12
Mental Health Condition		
Felt things were hopeless	No Never = 0 Yes, but not in the last 12 months = 1 Yes, in the last 12 months = 2	0 to 8
Felt very lonely		
Felt very sad		
Felt so depressed		
Stress		
Level of stress experienced in the past 12 months	No stress = 0 Less than average stress = 1 Average stress = 2 More than average stress = 3 Tremendous stress = 4	0 to 4

Qualitative coding process. Focus groups were analyzed using the Consensual Qualitative Research (CQR) model, which is a methodology that attempts to minimize interpretive bias by using multiple researchers to cross check and reach agreement on meanings derived from the data (Hill, Thompson and Williams 1997; Hill et al. 2005). Assessment team members, coalition leaders, and coalition members/community partners who assisted with focus group facilitation were invited to participate in the focus group analysis (a.k.a analysis team). Hill et al. (2005) recommend to define a primary team and an

auditor for the purpose of managing the analysis. In this case the primary team consisted of three faculty/researchers from the UAA assessment team and three coalition members, most of whom had participated in a large number of focus groups. A separate researcher from the UAA assessment team served as the auditor, and this individual did not facilitate focus groups but had read all focus group transcripts.

Each member of the analysis team completed an initial review of transcripts for focus groups they co-facilitated to determine common themes. Members of the analysis team gathered together based on focus groups they co-facilitated to discuss and to agree on a list of domains. Domains, according to Hill et al. (2005), "topics used to group or cluster data" (p. 200). The end result of these individual meetings was a codebook (i.e., list of primary domains and subdomains) for each of the 13 focus groups. After initial codebooks were developed for each focus group, the primary team met to identify shared domains and subdomains across focus groups by topic (i.e., bullying and mental health) resulting in a master codebook for each topic. The consensually agreed upon primary domains and definitions are in the following exhibits. Findings from the focus groups and quotes that support each of the primary domains are expanded upon in subsequent subsections.

Primary Bullying Domains and Descriptions

Behaviors/Types of Bullying/Definitions/Other Terms

This domain provides a description of what bullying looks like regarding the types of behavior (e.g., name calling, making fun) and types of bullying that occur (e.g., physical, verbal, cyber), as well as how youth define bullying and what types of words they use to describe bullying.

Where it Happens/Context

Youth and young adults described various settings where bullying takes place (e.g., in school, online) as well as the context in which bullying happens (e.g., between friends, when there is a power differential).

Reasons/Risk Factors

This domain describes youth and young adults' perceptions and experiences regarding why people bully (e.g., social status, as a reaction to being bullied) and what puts youth at risk for bullying either as a perpetrator or victim.

How Bullying Makes a Person Feel/Outcomes

Youth and young adults discussed what happens to youth when they've been bullied and how it makes them feel (e.g., depression, self-harm, missed activities), as well as how it feels to be a bully (e.g., it feels good at first, remorse for the hurt they caused).

Protective Factors/Coping Strategies

This domain helps define the question "What helps Anchorage youth to thrive?" as well as what are the less healthy ways youth are coping with bullying. Youth and young adults were able to describe factors that help them get through bullying (e.g., peer support, trusted adults) and ways in which they cope with the hurt (e.g., music, religion, drugs).

Solutions

This domain describes the insightful ways youth and young adults proposed to solve the issue of bullying in their schools and community.

Primary Mental Health Domains and Descriptions

Signs/Outcomes of Loneliness, Sadness, Hopelessness

Youth and young adults described what it looks like when either they or their friends are showing signs of depression or depression like symptoms (e.g., withdrawn, body language, self-harm).

Causes/Risks

This domain identifies what youth and young adults perceived and experienced were the causes (e.g., social isolation, feeling like they don't matter) of loneliness, sadness, and hopelessness, as well as what put youth more at risk to have these feelings (e.g., technology use, not knowing how to get help). This domain helps address the question, "Why do youth and young adults feel lonely, sad, and hopeless?"

Stigma/Misconceptions

Youth and young adults described how stigma and misconceptions around mental health contribute to the problem and act as a barrier to seeking help.

Protective Factors

This domain helps define the question "What helps Anchorage youth to thrive?" Youth and young adults were able to describe factors that help them and/or peers work through mental health issues (e.g., trusted relationships, meaningful activities, community connectedness).

Solutions

This domain describes the insightful ways youth and young adults proposed to address mental health issues among Anchorage youth.

Significant Findings from Focus Group Screening*

- 18-24 year olds had significantly higher mean stress score compared to 12-18 year olds
- High school graduates without a college degree had significantly higher mean bullying scores compared to participants who either received a college degree or had not received a high school diploma
- There were significantly higher reported means of engaging in bullying behavior among participants who were homeless in the past 12 months as compared to participants who were not homeless

** Results from the screening questionnaire are descriptors of the focus group population. Considering the small convenience sample for this analysis, the results cannot be generalized.*

Findings: Bullying

Behaviors/types of bullying/definitions/other terms. Bullying behavior was a common domain across transcripts. Bullying behaviors were either explicitly described in response to the question, "When I say 'bullying', what do you think of?" or were more subtly mentioned throughout the discussion as participants shared experiences and stories. Behaviors took a variety of forms and included such actions as *verbal provocations* (e.g., name calling, teasing, cursing, threats, put downs and other instances where a person is "made fun of"); *behaviors intended to leverage social capital or status* (e.g., socially excluding someone else, engaging in stereotyping behavior, including labeling, judging, spreading rumors and gossiping); *physical behaviors* including pushing, shoving or fighting; and *online or cyber behaviors*, including the use of social media or gaming technologies to harass another person. Other terms participants used to describe bullying included, "punishing", "tormenting" or "harassing" someone else. For example, one participant, in response to the question, "when I say bullying what do you think of", responded, "People tormenting someone or a group of people…torment, that's about it" (12-14 year old). A commonly described characteristic of bullying is that it is repetitive, a finding that is also reinforced in the literature. Among 18-24 year olds, bullying was described as having potential to escalate to the level of criminal behavior (e.g., physical assault).

Descriptions of bullying behavior varied in terms of individual lived experience, perceived backgrounds of the victim and bully, and social context. For example, one participant describing "what bullying looks like", explained,

> *"I think of someone who is getting picked on because they might be different from other people or maybe somebody who's bullying kids because they probably just feel like it—it makes them feel like they're better than other kids and stuff."- 12-14 year old*

Verbal or cyber bullying were the most commonly cited bullying behaviors but physical threats were also discussed. As related by another participant, "there are a lot of kids who still get bullied at my school like physically" (12-14 year old). Another participant reinforced the diverse forms bullying can take and explained,

> *"There's some physical bullying at my school and there's also more verbal bullying. Recently, people got in trouble at my school because they were sending threats to people through the Internet." - 12-14 year old*

Cyber bullying can be one of the more dangerous and hurtful types of bullying behaviors because the person who bullies has the benefit of anonymity. For example, one participant described the increase in social media use as both a context in which new kinds of social interaction occur, and an opportunity for bullies to target people's perceived weaknesses while remaining hidden from view. She explained, "Now that we have social media, it's easier to hide behind a screen and say all those things without saying it face to face. So then more people get hurt" (14-18 year old). Another participant, in reference to the anonymity of online gaming environments stated,

> *"There's some people who say some things on there that are sort of inappropriate and then there are also some things that they say that are really mean to the people too." - 12-14 year old*

Another member of the same focus group reinforced the severity of online bullying in relating her experience,

> *"There were these girls at my school that were giving death threats to people and they were suspended...but the girls who were getting bullied by them they were really scared because a couple of the girls they wouldn't even come to school. They were—that stuff happens to me online too or it used to anyways because I deleted my accounts to stop it." - 12-14 year old*

One participant described cyber bullying as especially hurtful because people use the Internet to express themselves and some bullies see this as a vulnerability to target. Another participant explained,

"It's kind of one of those difficult things because it's kind of sometimes like there's really obvious cyber bullying and then there's sometimes where it's like you're not sure because you can't see the other person's face so you're never sure who's behind the keyboard. You look on YouTube or something and people post comments and someone will put their heart out making a video or something and people will be like, "Oh that's awful." So they're behind the screen."
- 14-18 year old

Taken together, these quotes illustrate not only the types of behaviors commonly witnessed or experienced, but these quotes also allude to the social context in which bullying occurs and some of the underlying factors that may motivate bullies, including a desire to "fit in". This is consistent with the literature on "bully-victims", where a person who bullies oftentimes has also been bullied at some point or experienced difficult circumstances that motivate a desire to deflect emotional pain onto others. As explained by another participant,

"Well yeah. Some of them bully because they get made fun of. So they bully."
-12-14 year old

Where it happens/context. Bullying was described as occurring in a variety of settings and contexts. Participants talked about bullying happening in school (e.g., hallways in between classes, recess and lunchtime), online settings, outside of school settings (e.g., communities or neighborhoods, home, clubs, bus stops, etc.), work settings (most commonly mentioned in 18-24 sample), and social contexts that shift at key transitional ages. Within these settings students vie for social positioning and status, often at the expense of others in their peer groups.

School and online settings were identified and described most frequently, often by school-aged participants or by 18-24 year old participants reflecting on their school years. There was a shift with the 18-24 year old participants, where work and community settings were more frequently mentioned. This is not surprising given the age group is typically no longer in secondary school. Analysis also revealed that there may be school-specific differences in where, how or if bullying occurs. For example, some participants explained that bullying isn't much of a problem at their school due to protective factors such as teachers and administration that respond to and address bullying as well as perceptions of safe neighborhoods. As one participant described,

"There's not really that much bullying at the school. If they see someone getting bullied someone most likely will just tell the teacher and they'll probably get in-school suspension or just regular suspension." - 12-14 year old

Youth had mixed perceptions of how significant of a problem bullying is among their age group. A number of focus group participants said bullying was a big problem, while others said bullying wasn't a problem. However, with regard to the latter, many of those participants who said bullying wasn't a problem went on to give plenty of examples of bullying that they either experienced or witnessed.

While relatively few participants reported that bullying doesn't happen much in their school, it represents an opportunity for further investigation into what elements of a school environment are protective. When asked a follow up question about why their school seems healthier, some participants explained factors such as access to school-based activities, including sports, clubs and opportunities for creative outlets such as music and art. Others discussed structural factors at the community level that may be protective, such as living in a safe neighborhood or having a healthy school climate.

"Well we have it (the school) in a really nice neighborhood. It's not like a really bad neighborhood. We don't – we normally practice fire drills and earthquake drills. We don't really practice the drills where all the kids have to go cowering right next to the sink or something where they have to pull down all the shades and stuff. We don't really practice that much often because our school's in a really nice environment and there's not that many bad things that happen. All the kids are pretty nice to each other. There's not that many name callings or anything going on in the school. It's a very nice school and I really like it there other than the other schools that I used to go to when I was in kindergarten." - 12-14 year old

The experience of being bullied can often be compounded by other life challenges, including lack of supportive family environments. As one participant explained,

"When I was getting bullied when I was a kid – 'cause I have a lot of dysfunction in my family. And me come – going home after, it was hard on me. So getting bullied at school and then going home and getting bullied, as well, it – it's hard. It's hard. So I think you'll have people that don't understand what's going on with someone else's life. They just see them at school, but they don't know what's going on at home or anything else." - 18-24 year old

Bullying can have multiplicative effects across context and social location. While bullying outside of school settings was less commonly cited, most focus group participants had either direct experiences with or firsthand observations of bullying in their schools and in some cases in various community activities such as sports or other extra curricular activities. For example, when asked to reflect on whether bullying was a problem in their school, one participant explained,

"I think it's a big problem because I think that there's always been bullying. You can look and like as people get older and they get to the workplace there's still bullying there but I think more when people are teenagers it's a little more bit resonant there because everyone's trying to figure out who they are and people are sometimes trying to shove people down for finding out who they are. I also think since now more of our generation is being influenced by technology, people are having an easier source to project their opinions onto people and those opinions may – some opinions are great. They help form ideas and everything but some opinions totally shut people down. So I think that bullying has become a little bit different for our age group than past because we've had more access to ways that you can bully someone." - 14-18 year old

This passage suggests that bullying may be a social norm or defining feature of youth culture today in a variety of contexts across age groups. Another participant echoed this notion, further explaining,

"I think it's – it looks cool to talk crap about someone. It looks cool to be – you look stronger when you're unforgiving, when you're not showing mercy to each other. You look stronger when you're dissing someone else who doesn't do what you do. I think it – people are trying to be approved in society right now. I think being different is not really the cool thing, so we're always talking about each other. 'He's doing this and doing that'. Maybe that's why these kids are shooting up schools and whatnot. I don't think people are looking at each other for who they are and whatnot. So..." - 18-24 year old

Another theme that emerged during analysis of focus groups involved the changes in bullying behavior that occur as children transition into middle and high school. One participant described

age-specific types of bullying as progressing from bullying on the basis of individual appearance in younger kids to "what's on the inside", particularly with transition-aged students in middle and high school. She explained,

> *"So one of those things I felt like when I was littler it really was more about appearance that they judged you on because I feel like when you're little you can't necessarily comprehend what exactly like people think. So you're more on what you see. It can be different. Then when you get older it's much more what's underneath because people after awhile like, "Okay, so you look kind of funny; okay, whatever." But they then start going for what's underneath. So I feel like bullying kind of progresses as you age and what people start thinking as which is kind of harsh because it's kind of like it can hurt when people comment about your appearance because you can't change that. People still continually do it. Then when they decide to dive deeper into what you think and how you feel and it's like those are things you can't change either. So it's just one of those progressions of how bullying happens."*
> *- 14-18 year old*

Overall, the contexts in which bullying occur vary but are primarily centered in school-based and online settings. As youth navigate their social worlds, they almost invariably come into contact with bullying in some form. Perceptions of difference strongly influence why people bully and there is also strong agreement that bullies are often themselves experiencing emotional pain of some kind. It occurs both within and between social groups and is sometimes used as a form of social exclusion or a performance to impress and seek approval from peers.

Reasons/risk factors. Focus group participants described several reasons why people are bullied. Discussion focused around perceived differences between the person who is being bullied and the person who is engaging in the bullying behavior. For example, participants mentioned differences in race, disability, weight, religious beliefs or customs, skin color, sexual orientation, as well as physical or mental vulnerability, and/or feelings of inferiority as reasons people are bullied.

Reasons For Bullying

"I get bullied because of my ***weight*** *and then this girl that we were friends in seventh grade she told someone about my* ***sexuality*** *and then she bullied me for that for a while and still does..."*
- 12-14 year old

"I know some kids get bullied at my school because of their ***religion****. My friend, she wears a hijab and people tell her that it looks dumb." - 12-14 year old*

"Last year I was picked on because of my ***race*** *and my* ***skin color****. A boy in my class said that I was brown and all that and he was laughing about it."*
- 12-14 year old

"I think it happens to people who are just quiet, who ***dress differently****, who don't conform to the patterns of everyone else and listen to the same music as everyone else. I think people who are sitting in the back of the room, they are always the one getting bullied. 'Cause I think they're – me, I was thinking that people didn't like me because of how* ***different*** *I was."*
- 18-24 year old

Low social status or low popularity, according to participants, provided a reason as well. The grade or age of the victim also seemed to be a contributing factor. However, there were mixed responses about directionality of the victim/bully relationship. In some cases, the person exhibiting the bullying behavior was older, in some cases younger or the same age. One participant described how the 7th graders were the worst in a middle school (6th-8th grade), while another said it did not make a

difference. Further, individuals who had been bullied before, were also identified as targets, as were 'new kids.'

As to why people engage in bullying behavior, although some participants admitted to having bullied others, responses were typically from the point of view of individuals who did not identify as engaging in bullying behavior, but were projecting why they think someone would. Participants identified several reasons why someone would engage in bullying behavior including having low self-esteem, for attention, to fit in, and to feel better than others. There was also the sense that people may engage in bullying behavior to turn the tables on the person bullying or to stop the bullying. As mentioned above, the bully/victim relationship may be tied to age differences and gender differences. Although some participants indicated girls exhibit bullying behavior more frequently than boys, especially in the 12-14 year old groups, another participant in the 18-24 year old group said that bullying was a result of the 'alpha male' trying to assert dominance. Finally, there was a perception that some individuals bully for the fun of it, or because they had a bad day. For example, one participant described a bully she had encountered and explained,

"She'd just bully people for fun. Then some kids—I don't really know why they bully kids but probably it might also be just for fun maybe because they have—some of my friends also might have problems going on in their life and they don't really know how to handle it and they really have no one to turn to probably. So they're probably just lost." - 12-14 year old

Other participants said,

"I guess for me it would be like mostly between girls, because, you know, people – like a girl doesn't like your outfit, and it's turned into like a big deal. And like girls can just be rude and stuff." - 12-14 year old

"...it looks cool to talk crap about someone. It looks cool to be – you look stronger when you're unforgiving, when you're not showing mercy to each other. You look stronger when you're dissing someone else who doesn't do what you do." - 18-24 year old

"And I started picking on people and saying names about people. Even though I felt in my heart it was wrong, I still did it because I wanted to be cool..." - 18-24 year old

"I think of people who are rude to other people maybe either because they've had something bad happen to them and they want to make themselves feel better by putting others down or someone who thinks they're better than someone else and wants to make someone else feel bad about themselves." - 12-14 year old

"So that's pretty much what a bully is, is a person who's either abused or feels insecure about something in themselves, and so they beat up other people to make themselves feel better." - 18-24 year old

Several participants discussed how they, or someone they knew, engaged in bullying behavior because they were tired of being the victim. Sometimes parents encourage the behavior by telling their children to fight back when bullied. Participants said,

"Some of them bully because they get made fun of. So they bully." - 12-14 year old

"Bullies are just big babies, since they've been bullied themselves. That's why they pick on people." - 18-24 year old

"Like he said, I call myself a bully because I like to be mean to people. It's just fun. But I don't do it to the point where they get sad and stuff, you know." - 18-24 year old

"Because if you don't have a variety of friend groups and you've just been bullied, bullied, bullied and you don't have the understanding about it like, "Yo, they're just..." – like they're just – those are the truly weak people, you know, weak-minded ones – then you're going to start bullying. You're going to find people in your life to pick on. Because I've done it before in my life, man. I'm not going to lie. There was points when I was just like, "Dang, man, I'm so tired of being judged and shit," so that the way I would get friends was to judge other people. And that's how I would try to get friends." - 18-24 year old

Focus group participants thought life trauma, or something bad happening in the past may lead some people to bully. Additionally, multiple adversities such as domestic violence, homelessness, addiction, divorce, and family problems may be, according to participants, risk factors for individuals and drive them to engage in bullying behavior. One participant discussed how negative music that glorified violent behavior is infecting people his age (18-24). There was also discussion about a power differential with intimidation being a method of bullying behavior. As an example, a couple of participants in the 18-24 year old group, talked about bullies in the drug world. Finally, there was discussion about the drive to have power over someone, to intimidate.

How bullying makes a person feel/outcomes. The impact of bullying can be extremely hurtful and lead to a number of deleterious effects, many of which were identified and described by focus group participants. Youth and young adults described anything from hurt feelings to suicide as outcomes they have observed in others or experienced themselves as a result of bullying. Youth often described a moment in time and did not necessarily describe the effects as a trajectory that starts with less severe and progresses to more severe. One youth who had been bullied for a long time expressed signs of apathy,

"I've been bullied so long that I just – I never really noticed. I've noticed people who get bullied people too, but I never really paid attention to it. You know? Because for me, I just feel like – because I get judged every day. People think certain things about me. Or, somebody will make a joke or something. But I've gotten so used to this that I've realized that that's such a waste of a thought of mind to even think about it, or let it get to me, or put energy on it." - 18-24 year old

Most of the feelings and outcomes described by youth were connected to mental health signs and symptoms. Youth described feelings of depression and trying to pretend everything was okay when they were around others.

"For me, I always had a time in my life that like I was really depressed, and like everything was going wrong. It's like – it's either you're going to forget about it, and just like, whatever it, or not. And I whatevered it, and it wasn't good, because holding on is the hardest thing to do." - 18- 24 year old

"Yeah. They take it – they take it okay, but like – in front of people, but behind closed doors, they can like be having a tough time ... trying to put on a brave face for other people." - 14-18 year old

Participants described how people would withdraw or stop participating in their usual activities. Youth also talked about how they noticed people have lower self-esteem when they are bullied.

"[Bullying] just makes people very depressed, lowers self-esteem. I don't think it would make them go suicide and stuff at my school, but it lowers their self-esteem a lot." - 12-14 year old

While the previous youth said people don't turn to suicide at their school, there were plenty of other examples from focus group participants regarding the connection between bullying and suicide ideation, attempt, and completions. In fact some of the more severe outcomes described by the participants included suicide, death threats, and violent or criminal behavior. Participants talked about fear or expressed fear regarding bullies or how people might react to being bullied. One participant described how some girls in her middle school were receiving death threats from another student. Another participant said,

"...other people can do like really crazy things, like hold people hostage, or like bring dangerous weapons to school and threaten people. So it could be really – it's a really bad problem" - 14-18 year old

Participants spoke about their experiences with suicide both with regard to losing classmates and friends to suicide,

"I had a friend about six months ago commit suicide because she was bullied so bad at my school. There are a lot of kids who still get bullied at my school like physically." - 12-14 year old

And with regard to their own suicide attempt,

"Because I've also been bullied... Tried jumping off a bridge once" - 18-24 year old

Youth also commonly expressed suicidal ideation in connection with nobody caring about them or their situation,

"And there were times when I thought that suicide was the only option, because I didn't think anybody cared." - 18-24 year old

"I think it can be a really big problem, because some people turn to suicide, and to – because they think no one cares about them..." - 14-18 year old

"Well, speaking from personal experience, because of how hard my life was as a child, you know, growing up, I can say that it is a pretty big issue, because there have been times in my life where I've had nothing but bullying happen to me. Nobody cared. Nobody cared enough to show it." - 18-24 year old

According to the focus group screening questionnaire, participants who had been homeless in the past 12 months had significantly higher means with respect to ever engaging in bullying behaviors as compared to youth who had not been homeless. Some youth, especially those in an 18-24 high-risk group, spoke about how the bully feels and why they decided to stop bullying. This group spoke about how it feels good in the moment to bully someone, and later expressed remorse for their actions.

"To be honest, you know, when you – when you bully someone, it feels good for the moment, but then if you're a real good – I mean, not – but if you're a person and you have feelings, you get to understand like what am I doing? Some people stop at that point, or some people keep going, because it makes them feel good. But I know that there's not one person on earth that will – that will bully someone and like it. They're just doing it – some people, like she said, for attention sometimes." - 18-24 year old

Some participants who self-identified as a bully talked about why they stopped, saying they stopped because of the hurt they were causing. One person in particular talked about how losing a friend to suicide really impacted her and other people in her school,

"I used to like bully some people around, you know. And one thing that got me to really like calm down on my stuff was one of my friends, she kept getting bullied, and then she ended up killing herself that year. And then that impacted a lot of people at my school. And it was just like, yo, it's not – it wasn't worth it." - 18-24 year old

"Well, I stopped because – I stopped, I didn't want to hurt anybody else. I got tired of pretty much the consequences, and I got tired of leaving people crying home, and black eyes. I just got tired of that, and I couldn't deal with it anymore, so I was like, I'm done. I'm not going to bully any – so then what I did was every person that I bullied, it was maybe like nine people, I had money back then, I'd go and go buy them something to eat and talk to them and be like, I'm sorry for what I did before. Yeah. That's why I don't like bullying, because it follows you. And when you break those barriers and you try to bring it all together and you try to change it, it takes a while." - 18-24 year old

"I've been bullied all my life and look where I am. Tomorrow I'm turning in job applications. Tomorrow I'm also going over to [name of program] and getting enrolled in school, going to get a job, going to get my ID." - 18-24 year old

"...they're [the person being bullied] just like – they get stronger or something, so they know that it is going to be okay. So they keep their heads high." - 12-14 year old

For some, part of that process was being able to either empathize with the bully and/or forgive them. Empathizing with the bully was often a way for individuals to look at the life of the person bullying them and say they are doing this because of trauma in their own life. This strategy was helpful for the person being bullied because suddenly it was no longer about them; it wasn't that there was something wrong with them it was that the person doing the bullying needed help. It was a similar idea regarding forgiveness, where one participant said,

"You don't forgive them because they need it. You forgive them because it'll help you in the long run, because in the long run, you don't want to be carrying that around on your shoulders, like, oh, my goodness, this person, he did such and such and such and such and such. And then 30 years down the line, they're not hurting at all, and you're still carrying around that baggage."
- 18-24 year old

Protective factors/coping strategies. The ACC was particularly interested in resiliency of youth and "What helps Anchorage youth to thrive?" Throughout the focus groups and across ages participants identified a number of protective factors and strategies that helped them or others to cope. The majority of protective factors and coping strategies could be broken down into the following subcategories: a) individual factors, b) environment/school climate, c) trusted adults, d) peer support, and e) activities.

When participants spoke about individual factors it related to something internal to that person, for example self-awareness or mental resiliency, as one participant said, "…mental strength is key." (18-24 year old). Participants also spoke about the process or the individual journey they took to better themselves or move on.

For some youth, the school climate or environment was a protective factor. Mainly youth mentioned an environment that did not tolerate bullying. As one youth said,

"So normally yeah, the teachers do do something about it. Also a lot of kids there – it's a pretty nice, healthy school. It's pretty rarely that some kids will get bullied but sometimes they do get bullied. You know sometimes we – we do something about it." - 12-14 year old

Youth often saw themselves or their peers as the first line of defense against bullying. There are many examples when youth would say they would go to their friends first, or that they would help their friend before going to an adult, like a teacher. Participants talked about situations where they would stand up to the bully maybe because they said something offensive and they would call them out or maybe they were protecting another youth.

"Maybe we might be able to go up and just say, "Hey stop picking on this person. What did they ever do to you?" Then if it starts to get worse then maybe more kids should help stand up. Maybe we should all surround the person who is getting bullied and we sort of make a wall between them so that the two people won't be able to make contact and then it won't be that bad with each other." - 12-14 year old

"If they don't, then you should just leave them alone, like well, if you're going to keep acting like this, I'm not going to be your friend, or something like that." - 18-24 year old

Youth and young adults also mentioned trusted adults, such as parents, teachers, and counselors, as a resource, though they were often mentioned second to peers. As one youth said, "Friends… Or supportive people in their life like parents or teachers or something, someone that they feel comfortable talking to about it." (12-14 year old) Also it seemed the higher risk youth were less likely to mention trusted adults and often would say they had no one to turn to.

"Like maybe if like the kids around them would talk to them about it or maybe if the teachers knew and if the teachers maybe later on would talk to them or if they got counseling or something like that. Something that where they're able to tell the people how they feel and what might make them feel better and all that. Maybe if we all just like say – go up to them and say, "Hey, it's okay. We'll be your friend. Whatever's going on it's going to be okay." Maybe if we give them hope and maybe some support and say that whatever's going on in their life or whatever's happening that it's going to be okay and that we're going to be their friends." - 12-14 year old

Youth also mentioned specific activities as protective or as ways of coping with the hurt from bullying. Some youth mentioned religion or spiritual practices as a way to find meaning in their life and to cope. Some youth turned to music with positive messaging as a way to cope.

Sometimes youth and young adults would find less healthy methods of coping, such as addiction and drugs. One individual in particular turned to drugs when bullied and explained how they had no one to go to. In fact, this participant mentioned that at one point the only person they would talk to was their drug dealer. This individual also brought to light the complexities of peer relationships. While some participants said their friends would be their first line of defense, others spoke about not wanting to look weak in front of their friends and so they would hide their feelings as evidenced in the following passage.

"I did a lot of drugs. I did a lot of drugs and stayed quiet. And I just - I told people I was okay, but really inside I wasn't. 'Cause it's hard to kind of be honest to other people. "Hey how's it going?" "I'm doing good." It's hard. "Hey how's it going?" "You know what, I feel weak today. I feel kind of crappy today so they're making fun of me…

If I did that, somebody else would probably say, "Man up, man. Be strong. Don't be a pussy." Stuff like that, I think. Those kind of words, it prevented me from actually going to my friend and saying "Hey. Well I just feel like crap today." I didn't want to look weak, I guess. But I think it takes more strength to be weak than it does to be lying to yourself and staying around feeling hopeless and angry and shame." - 18-24 year old

Solutions. The youth voice was invaluable with respect to understanding the youth and young adults' experience, it was even more invaluable with respect to solutions. There is nothing more valuable than to have the end user engaged in defining the intervention. Focus group participants offered various ideas about ways to intervene in bullying behaviors. Their suggestions broadly fell into two categories: actions focused on youth being bullied, and actions focused on youth engaging in bullying behavior. There were numerous examples of how these two groups overlap i.e. how youth being bullied and youth engaging in bullying can be the same people. Below are ideas participants offered about how youth, teachers, administrators, parents, other professionals, and trusted adults in general might intervene.

Intervening with youth engaging in bullying. Participants across focus groups mentioned bullies as youth who are themselves hurting, lonely, and disengaged. Several people mentioned the need to support the introspection of youth engaging in bullying behaviors:

"To help the bully we could see why they're so mean to other people or why they're so upset and help them through that"
- 12-14 year old

One participant thought it might help to interrupt bullying by putting an emphasis on how if youth stop bullying, "you'll make more friends. So be gentle" (12-14 year old). The need to offer comfort to youth engaging in bullying behaviors also came up:

"You can just say 'you're not alone'. They are – if they're doing it because they're hurt it's probably because they're alone"
- 14-18 year old

Several participants thought it might help as a deterrent to explicitly teach youth engaging in bullying behavior the effects that bullying can have, e.g., statistics about how cyber bullying is linked to suicide.

A participant in one of the 18-24 year old focus groups wanted to encourage youth engaging in bullying behavior to find meaningful activities in their lives, as alternatives to bullying:

"Finding something you're really good at and just sticking to it. So, just find a hobby. Something in – that boosts your ego just as much as bullying. Something that makes you feel as good as putting someone else down."
– 18-24 year old

Another one of the older participants believed that critical, non-judgmental listening should be taught in schools as an antidote to bullying behavior:

"I think speaking and listening and thinking skills are well – are malnourished... So it's important to respect everybody and to develop speaking and understanding and thinking skills and putting yourself – and putting each other in each other's shoes rather than judging each other. Teach each other how to just cope with these problems... There wasn't a class about life coping skills and treating each other with respect."
- 18-24 year old

Several youth mentioned the importance of adult interventions at school. For example, the principal or assistant principal could make appearances at lunch, or at pep assemblies, to talk about rates of suicide and connections to bullying. Several

participants also mentioned focus groups like the ones in this project as a possible way to intervene.

Intervening with youth experiencing bullying. The importance of youth supporting youth was an overarching theme. A common suggestion was for friends to offer "comfort" to youth being bullied, such as talking with the person, and generally being "nice" and "kind" to them, both in person and through social media. Participants also thought other youth can and should intervene more directly in bullying behavior, by "standing up" to the bully:

> *"...like when a group of friends come over and say, "Well nobody likes you because you're bullying them," that also helps, too. Us like going together as a group and supporting the other person sort of lowers the limit of bullying that happens at our school." - 12-14 year old*

Just as it was suggested for youth engaging in bullying behaviors, participants advised youth being bullied to process the experiences through communication:

> *"I think talking to someone and facing your problems is healthy because it doesn't break you. It builds you. And I think we need to teach people how to look at themselves and look at these problems, look at how they're treating each other, and really be honest about it and develop and learn." - 18-24 year old*

At the same time, participants recognized that whether or not someone being bullied wants to handle their problems with social support, introspectively, or a combination of these, "really depend[s] on the person".

People in different focus groups talked about individuals taking control of their situations, such as by ignoring bullying, and "deciding, 'I'm not going to deal with you anymore. I'm not going to care what you say'" (14-18 year old). However, several youth that actually shared personal stories of bullying experiences placed less emphasis on an individual change of attitude, and more on social support e.g. friends "standing up" to a bully, or a focus on changing the bully, not the one being bullied.

Similar to an intervention suggestion for youth engaging in bullying, one participant shared, "it's good to do the thing that you love to get your mind off of it" (14-18 year old), although this participant and several others were ambivalent about the magnitude of help this would provide. As there was tension between some of the intervention ideas suggested, a variety of approaches in making final decisions about bullying interventions (e.g., combinations of a focus on the person bullying/focus on the person being bullied, focus on changing individual attitudes/ focus on social support, focus on individual youth introspection/ focus on group processing) should be considered.

Findings: Mental Health

Signs/outcomes of loneliness, sadness, hopelessness. Participants across focus groups shared how it's possible to know that a youth is feeling lonely, sad, and/or hopeless by noticing changes in previous patterns of behavior. For example, if a youth stops engaging in activities they used to enjoy, becomes more "negative" than they were before, or increasingly isolates themselves. One participant noted that, "when you know someone really well," you may be in the best position to judge if changes indicate their mental well being is under threat. Changes in behavior may include: "talking a lot different"; "a change in their attitude towards things"; "they hate that, they hate this, they dislike everything"; "stop talking to people, and maybe they stop responding to your texts"; no longer participating in social media; and withdrawing from extracurricular activities the youth formerly loved e.g. card games, sports.

Several participants mentioned particular body language to pay attention to for signs of loneliness, sadness, and/or hopelessness, such as youth acting "bored" or "tired" even in the midst of formerly meaningful activities. One participant said: "Usually their posture tends to like get more sloggy. Tends to be more gloomy. Just more down" (14-18 year old).Similarly, a participant in another group described a youth feeling lonely,

sad or hopeless as having: "shoulders slumped, eyes down, not talking to anyone, headphones in, kind of just closing out the rest of the world" (14-18 year old). One participant talked about how she became physically ill:

"I got so depressed that I actually got anxiety. And it made me so sick that I had to drop out of school and stop doing my things. So it also takes a physical toll, not just emotional" -14-18 year old

Participants mentioned that youth might actually express feelings of loneliness/sadness/hopelessness explicitly, such as through social media postings.

While participants were able to describe outward signs to look for in youth who might be feeling lonely/sad/hopeless, they also frequently mentioned concealing feelings. One person in a 12-14 year old group claimed that admitting those feelings could hurt the person's "reputation" at their school, and that this might be a reason to conceal. Youth in both high and low groups, from various age ranges, and in multiple focus groups talked about how signs of these feelings may not be socially obvious. As one participant shared:

"You don't really know when someone is lonely, sad, or hopeless. You can't know. A lot of the times you can't just look at someone and say they're depressed. Depression doesn't have a face...And a lot of times people can have everything in their life going right and you won't – And so you wouldn't think that they'd be depressed or sad at all because they don't really have a reason to. But that's not really how it works." - 14-18 year old

Many participants shared the belief that youth may actively try to cover up evidence of feeling lonely/sad/hopeless. The people who mentioned this said youth may not want to "bother" or "burden" the trusted people in their lives with these feelings. Several people talked about "distancing" from social networks as an attempt to conceal feelings, perhaps until the youth experiencing loneliness/sadness/hopelessness could "fix" the feelings on their own:

"I think they feel like they could fix it themselves. They think it's just all by themselves. So they're going to try to fix it themselves, seclude themselves from other people so they can focus on themselves, make things better. Until then, they don't want to hang out with other people. Maybe they don't feel like themselves, so they don't want to show people that side of themselves." - 14-18 year old

Substance use came up throughout various focus groups, but the data is unclear on how use is connected to signs of loneliness, sadness, and hopelessness. Is problematic use a sign of these feelings, a cause of them, and/or a way of coping? The word "drug" appears twenty-five times throughout the 369 pages of transcripts (across both the mental wellbeing, and the bullying domains); "alcohol" appears a total of ten times. However, only three of these comments relate to feelings of loneliness/sadness/hopelessness, and signs or outcomes of drug and alcohol use, for example:

"I did a lot of drugs. I did a lot of drugs and stayed quiet. And I just – I told people I was okay, but really inside I wasn't. 'Cause it's harder to kind of be honest to other people. "Hey, how's it going?" "I'm doing good." It's hard. "Hey, how's it going?" "You know what, I feel kind of weak today. I feel kind of crappy today so they're making fun of me." - 18-24 year old

While the connections between problematic substance use and feelings of loneliness/sadness/hopelessness were not apparent, the connections between these feelings and self-harm were more clear. Several participants mentioned self-harm through cutting, such as one high school participant:

"I have a friend – she goes to my school and everything and we're really close now, but over the summer and throughout the school year... she was talking about how she was hurt by her brother, and she did a lot of cutting and stuff because of that...she finally opened up to her parents about it, and then they talked about it, and now they're getting through it." - 14-18 year old

Importantly, participants across all focus groups shared about how signs of sadness, loneliness, and hopelessness, can be "very personal". Multiple people shared that the expression or concealing of these emotions, as well as the degree to which people withdraw or seek connections with others, really "depends" on the individual.

Causes/risks. According to the secondary data Anchorage youth report high rates of feeling alone, sad, and hopeless. The youth who participated in the focus groups really brought to light the reasons why Anchorage youth and young adults might be experiencing these feelings. Throughout the mental well-being focus groups participants talked about several causes/risk factors for feeling alone, sad, or hopeless: *a) individual-level factors* (e.g., social isolation, withdrawal, not knowing where to go for help, poor sense of self and self worth, not seeking help, experiencing transitions or major life changes, and feeling unsafe in the community), *b) family-level factors* (e.g., trauma, people at home who don't care, parents not around, family far away, family unsupportive, etc.), *c) geographical factors* (e.g., long winter, cold and dark, possible seasonal affective disorder, Anchorage specific challenges such as poor transportation), and *d) community or social factors* (e.g., lacking opportunities for connection to others, unsupportive peer group, bullying, feeling like you don't matter to your community, lack of trusted adults, social media, youth culture, racial, cultural, and/or gendered norms, and perceived societal expectations).

One of the most commonly cited reasons for poor mental health outcomes, including loneliness, sadness and hopelessness, was bullying. This is an important finding as it suggests the two main variables the team examined are inextricably linked. Being bullied by peers in social contexts was frequently mentioned as a direct cause or reason for poor mental wellbeing. Lack of opportunities to connect with peers, both in school and in the community, and lack of family members or trusted adults to talk to were also commonly cited as reasons for feeling lonely, sad or hopeless. Lack of connection to others was also brought up in the context of social media, where new technologies have in many instances increased feelings of social isolation for many. For example, one participant described the increase in social media that youth participate in and consume as a contributing factor to why youth may report feeling sad, hopeless or depressed. The participant explained,

"Spending more time on [social] media...has caused us to have less human interaction for the brain to build up those walls on how to empathize and help ourselves and just be happier overall." - 14-18 year old

The notion that social media has made us less connected was reiterated by another participant, who despite being in a focus group for mental well being, linked technology to bullying. As the participant explained,

"I think it's probably social media and online interactions that are causing it. Go back ten years. Wasn't that much in the way of online anything. Social media, gaming, you name it. So people kind of got themselves out there more, especially kids, and if they were bullied, it would be a more direct source of bullying. Not like nowadays, if you get targeted by a bully, a lot of people just jump on the bandwagon on any social media thing. And it's just way harder for the kid to not—to avoid that." - 14-18 year old

Lack of availability of parents or other trusted adults was another commonly cited theme and a key finding across focus group. Oftentimes, this was positioned as parents not being present due

to working late hours, being too stressed or overly occupied with work, and not taking the time to check in. This oftentimes led to distrust of parents and many participants expressed that they would prefer to speak to a peer rather than either a family member or a trusted adult. As one participant explained,

"Yeah, like sometimes that's why I kind of don't want to go to [my parents] for help because sometimes they're too busy so we just find other trustful adults that you can use." - 12-14 year old

A similar comment was made by another participant, who said that stress at her parents' work resulted in her feeling like they didn't have time for her. She commented,

"[My mom] quit her job because she thought she needed to spend more time with us. So she did but then now she's just really stressed out because this is her week just of work. So she's like really stressed out because she's staying up late on her laptop doing things that she needs to and she's having a lot of trouble with it. So if I'm trying to play my flute and ask her, "look at this mom for my concert coming up" she's like 'honey, I really want to be right now but I just can't. I've got too much work.' So sometimes I have to show my sister or [friend]." - 12-14 year old

Loneliness, sadness and hopelessness are often associated with grief and trauma at the family level. In many of these instances, peer support, family support (if available) and community support proved to be important factors in managing the grieving process. One participant described a circumstance where her friend lost a close family member.

"Yeah. So two of my really good friends, they're siblings, they're two brothers, and they're a few years apart, and recently, in like August, the older brother committed suicide. And they were both very in – they are both like very involved in the community. They both did a lot of things with folk festival. Different music groups. And community service. No one expected the older brother would do something that he did. And the brothers were really, really close. So the younger brother didn't know what to do. He was just lost. His older brother was his best friend. His like – they were super close. So all of our friends we made sure to take care of him, and made sure he was okay, and constantly were checking up on him, making sure he felt safe, and well, because we didn't want to lose him as well, since they were both extremely close. So he had a lot of trouble in the first week. And then we tried to help him. We would take him hiking, take him to movies. We would take turns taking care of him, and tell him that he's a great person, and make him feel good, and feel strong, so he could keep on going." - 14-18 year old

This quote suggests that while community participation and engagement may be protective factors in some contexts, there is often pain a person experiences on the inside that may not be immediately visible. Another participant elaborated,

"I don't think this is really just Anchorage, but when somebody experiences something tragic or devastating, they just kind of focus on that and it's hard to get your mind off of something that's sad." - 14-18 year old

While tragedy was viewed as unavoidable in many cases, opportunities for connecting with peers, getting involved in events or activities in school or in the community (including involvement in a church or faith-based group), or simply acknowledging

that a person has worth and value were viewed to be protective. As one participant explained in the context of school,

"It's kind of like a teacher when they ask you all the time, like let's say you don't really do your homework in a class, and teacher's always like, where's your homework, where's your homework. They care about you, that's why they always ask. So it's kind of like you may not like it but in your mind you're like they're always asking me about my homework, they must really want me to succeed. They care about me. Or it's like your parents are like 'what are you doing, what are you doing', always ask you what you're doing, and you're like, leave me alone. But then if they don't, it's like they don't care about you. Your parents always ask you what you're doing and stuff because they really care about you. And I think you might not realize that but deep down it kind of gives you positive reinforcement, the way you feel." - 14-18 year old

Other participants cited opportunities to participate in activities that involve interaction with peers or others less fortunate in the community as potentially helpful to youth who may be struggling with feelings of loneliness, sadness or hopelessness. One participant further explains,

"I think sports are one of the main activities that a lot of people go to. And some activities – like, helping with your community and seeing activities to help people – like, the less fortunate – that's good for some people. But sports are the main one that I can think of." - 12-14 year old

Quotes from participants highlight the delicate balance of what support looks like, whether it's coming from parents, friends, teachers or school officials or other trusted adults in the community, including coaches and pastors. On the one hand, checking in can be viewed as a form of nagging or bugging and may actually push someone further away towards social isolation if they are feeling lonely, sad or hopeless. However, that check in was also viewed as a visible expression that someone cares and values the person.

Eighteen to 24 year olds specifically spoke to being in an age of transition and how that impacts their mental well-being. Much of their experiences related to societal expectations (e.g., graduating college, finding a job, being happy) as well as moving away from close family and friends. As one participant said, "And everybody's kind of scattered when you're in your 20s. So that's what I imagine can contribute to loneliness" (18-24 year old).

"When you move to a new place you kind of have to find your people, especially if you're far away from your family if you know a very few people who live here. And if you don't find your people or your community you can feel kind of left out and lonely and like you're seeking maybe that support that you found in other places that you've lived or childhood friends or college friends." - 18-24 year old

"I was just thinking the times when I felt most helpless were when I felt stuck and like I wasn't transitioning. I had these huge expectations on me and I didn't know how to - I just felt paralyzed and not able to go or have - I'm trying to say that there's a huge economic component of like how many people in our age group realistically think that they can have a meaningful job that also pays them well?" - 18-24 year old

Stigma and misconceptions. Stigma and misconceptions around mental health can be very damaging. Youth and young adults spoke how stigma and misconceptions might exacerbate mental health symptoms, make it difficult for youth to identify mental health issues, and create barriers for youth in trying to find help. Youth spoke about stigma among the general population, for example that mental health isn't talked about and that adults set the example for youth. As one youth stated,

"The counselors came in and talked about bullying, and they're always there. And we learned about it a little in health. Mental illness, and where to go if you're sad and stuff. But it's just not talked about that much. And it needs to be." - 14-18 year old

Youth also spoke how people have misconceptions about treatment centers.

"...like North Star, I think that the general population who hasn't been there probably thinks of it as a prison where mental asylum people go..." - 14-18 year old

"Because you try to teach kids to not be judgmental and be open-minded, but when you see adults judging people, not only kids that go to North Star but just judging a homeless person on the street or all that, it's harder to teach kids 'Do what I say, not as I do.' It should be 'Do as I do.' And so, I just think teaching not only kids but adults not to be so judgmental of kids that are going through hard times, and anyone who's going through a hard time." - 14-18 year old

Participants also cited examples of stigma and misconceptions among their peers. One participant recalled when a peer had gone to North Star and how the other students in her class were spreading rumors that the individual was "bullying herself for popularity" or "faking the whole cutting thing," which would be equivalent to victim blaming. Among the 18 to 24 year olds there was a sentiment of having to "make it on your own." Meaning they had this misconception that they are adults now and should be able to solve these issues on their own.

"How something like you have a problem and thinking in your head like, 'I should be able to figure this out. I'm an adult. I'm a young adult. I should be able to figure this out but I can't really go to my parents in that situation.' And grappling with all of those bigger life questions all at the same time." - 18-24 year old

Additionally, youth and young adults admitted they were reluctant to seek help because of stigma, "... maybe when they are feeling lonely they don't feel like they can seek higher help - like professional help - in that situation just because I think especially for our age group that stigma could affect us more than other age groups." (18-24 year old). And one youth specifically mentioned that stigma was what was holding their friend back and when they could get past the stigma they were better able to move forward.

"It's just the way I was raised. I don't really like to talk to professionals about it. Because then in my mind I wouldn't need a professional, because then I have family there. I have family and friends. I wouldn't need to call a crisis hotline. And I'm just like I don't really like to tell people I don't know over the line about that. You know? Even though they're supposed to help me. I like to keep myself private, to people I do know." - 14-18 year old

"I guess the person that I'm thinking of, what really helped them was when they were able to kind of get past the stigma of no it's okay that you're feeling this way. That doesn't mean there's anything wrong with you. And there are definitely places you can get help. And when they were able to talk about it that's what really helped get them through. But I know that it was largely a self-journey for them to be okay with the fact that they were feeling this way." - 18-24 year old

Protective factors. As is described in the literature, focus group participants noted several protective factors for favorable mental well-being, or, to put another way, as a deterrent to feeling sad, lonely and/or hopeless. Having trusted relationships and being able to seek support when needed was discussed by most youth and young adults as important. Participants listed both *a) peer support* (friends, siblings, teammates) and *b) adult support* (parents/adult family members, school professionals, community members, helping professionals). "Trusted" relationships, especially when it came to seeking support from adults, was emphasized, as was the preference to seek

support from friends or family over someone from the helping profession. Additionally, participants noted they preferred face-to-face interaction over other types of communication.

There appeared to be a continuum from the low risk groups where they sought out support from any trusted person, to the high risk groups where they tended to seek support from friends or peers first, and finally to the highest risk group, primarily homeless youth in the 18-24 year old group, where they tended to have less trust and relied more on themselves.

Several participants in the high risk groups, indicated a preference for seeking support from friends over adults, including parents. One youth in a high risk group said when describing why someone would go to their friends for support, "... because their friends give them support when they need it. And they're there for them (14-18 year old). While another said, "If they talked to someone it's probably one of their friends because most people trust their friends more than their family I think." (14-18 year old).

"I know personally if I'm feeling sad or lonely I definitely reach out to my mom and friends that I feel like know me on a very deep level - more than maybe acquaintances or even like counselors or adults like in a college setting, like a health center. I would first go to my parents and close friends." - 18-24 year old

"Yeah like trust is a big thing. I know my school nurse for example is really chill and I'm pretty sure she wouldn't – Like a lot of times it's really hard for kids to talk to adults about things that are going wrong in their life because if you talk to adults they're going to be like, "Here is the politically correct way to deal with this." And it's really hard to talk to them because it's like I don't need a uniform. I don't need a counselor. I just want to talk to you. And I feel like I can talk to my school nurse and she won't go telling all these other adults that, '[Participant's name] is not feeling safe.'" - 14-18 year old

"I think my friends – I mean I don't think anyone really knows how to deal with it when like out of nowhere just starts sobbing in the middle of class. But I know that my friends have kind of learned to understand that going like, "Hey are you okay? What happened? What's wrong?' That doesn't always – Nothing always happened. It's just like I think my friends have kind of come to terms to realize sometimes I just feel upset and I don't really – It's not really anything that triggered it. It just kind of came out of nowhere." - 14-18 year old

"I think it would be more common for people to go to their friends just because it's kind of like "The blood of the covenant is thicker than water of the womb." You know just like stuff where it's like you trust your friends sometimes more than you trust your family." - 14-18 year old

"I guess that really depends on the person whether or not they go to a friend or a family member or if they just keep it to themselves. I know a lot of people that would go to a close friend and talk to their friend about it. Or I also know people that'll just keep it to themselves." - 14-18 year old

Focus group participants also described meaningful activities as a way to allay feelings of sadness, hopelessness, or loneliness, or to improve their mental well-being. Meaningful activities fell into two categories, either *a) social engagement* or *b) introspective/individual*. Some activities fell into both categories. Participants emphasized these activities really depended on the individual and that there was not one activity that would serve as a protective factor for all.

Social engagement included a variety of meaningful activities including sports/exercise, volunteering or helping others, clubs, and school based activities. An example of sports/exercise included playing basketball to relieve stress. Examples of volunteering or helping others included working with children, volunteering within the school or

church community, or tutoring. One participant described how volunteering made her feel,

"And just knowing that I'm helping other people and I can make someone else feel a little better just makes me feel good and makes me feel like I matter and that I'm here for a reason, for a purpose" - 14-18 year old

One participant indicated how the community could help:

"[The community] can help youth and young adults by just continuing to do organizations like this [focus group]. I think this is really great. They can have just a lot of involvement by starting organizations, groups, just a lot of volunteer stuff that has a lot to do with giving time and self-sacrificing their time." - 14-18 year old

Examples of clubs and/or school-based activities included Change of Heart—a school-based group focused on mental well-being, and the "waffle club" a school club focused on making waffles and socializing. One participant described the power of school-based activities as, "I think school activities is a great way because you get to communicate and be around people that you are around every day most of the time" (14-18 year old). Another youth described feeling better when considering others who were less fortunate, "I look at other people's worst situations and it's not nice but it helps me. I think, 'I'm not going through that so I should start being happy and appreciate what I don't have to go through'" (12-14 year old).

Introspective activities included expressing themselves through social media or writing, setting goals for themselves and practicing positive thinking and gratitude.

"I think that addressing the issue of being lonely I would – Or for me I would just focus on myself, figure out what I need to do to not feel so lonely. What I would do is I would go drive around and look at the scenery and just enjoy what I have instead of being so lonely and just being in a dark place. So that's why – Just being thankful of what I have as of right now whereas not, and being surrounded by positive people." - 14-18 year old

Three additional activities that fell under both categories were being outside in nature, participating in religious or spiritual activities, and listening to music. Several participants described the natural environment in and around Anchorage as peaceful and calming. Some described how they enjoy going for walks while others said they just enjoy the scenery. Examples of spiritual or religious activities included participating in organized religion, such as attending church or a religious youth group, or individual spiritual activities such as meditating. Listening to music was mentioned by several youth as a way to relax and to get their minds off their worries. Two participants described it as,

"...just meditate, relax your mind from overthinking, from worrying too much, and just have self-peace, inner peace. Or blast music, anything that helps" - 14-18 year old

"I'll call a friend and we'll just go on a walk – just complete silence walking. It's the fresh air and the sunlight and just complete silence" - 14-18 year old

Having safe spaces was an overarching theme the youth emphasized when talking about ensuring mental well-being. Safe schools, and safe places to hang out with friends was seen as important by several of the youth we listened to. Safe places to hang out were described as locations that had space for both active participation (such as a gym), and for quiet and relaxation (with comfortable chairs and places to listen to music, study, or talk

quietly with friends). There was also an emphasis on the safety of the place, including a place that you would not be 'judged.'

"I don't know if there's a set group activity that the community could do. More as just like a safe place that someone could go and just sit or talk or do whatever they need to do without being judged." - 14-18 year old

Feeling connected to the community and to the people who live here, was seen as important to several youth. Youth described several ways they felt or could feel connected to the community including through acknowledgement and value in the community, giving back to the community through volunteering, or participating in a faith community. Participants described feeling connected as,

"It takes time. A lot – it takes a lot of time, and it takes a lot of guts, and it takes a lot of work, but I think just – you have to not give up hope. And they just keep going. And having people around you that care about you – really care about you and want to help you helps a lot." - 14-18 year old

"Seeing people that you kind of know. Smiling. Asking how your day is. Reassuring. Stuff like that. Also, school. They care about your grades and getting you into college. They care about your future.They care that they want to make sure you do good in your life." - 14-18 year old

"Just know that there's someone around who would ask how I'm doing and would genuinely care what the answer is. That makes me feel like I matter to at least that person or those around me who I'm most connected to. And you know more easily I can then want to give back. It's a circle." - 14-18 year old

"...I think it's tough to know whether you know you matter. But I think giving back a little bit helps you feel like you're a little more part of the community and then in that way you feel like you matter a little bit more if you're able to make a little bit more of difference, whether that's giving back through your job or if you're just participating with other people. Or just interactions I think. Being involved is an important part." - 18-24 year old

Youth also described a community where they felt connected because of racial and cultural diversity. One participant described this as,

"I think the diversity helps, too. Like because you get like different cultures point of view. And different like perspectives from different types of people on how they were raised" - 14-18 year old

There was also a sense of community, when individuals faced common struggles. For example, one 12-14 year old youth described feeling connected to the community because the ethnic group, of which she was a part, faced similar challenges.

Solutions: Intervening in loneliness, sadness, and hopelessness. Youth participant suggestions for how to intervene in loneliness, sadness, and hopelessness fell into broad categories of intervention including: a) interpersonal, b) personal, c) community, d) school, and e) professional interventions. The largest subdomain that emerged was the interpersonal category, primarily between peers, followed by family, and then teachers, amongst others. Teachers, security guards, school counselors, and professional counselors were mentioned in terms of being well positioned for interpersonal interventions, however, youth groups and community based groups were brought up more frequently. Participants across groups expressed a preference for interpersonal interventions by people with many different roles in

their lives, as long as the person is chosen, trusted, non-judgmental, compassionate, practices being present, and is an active listener. Community based interventions brought up focused on peer support groups and community centers.

Solutions: Interpersonal and personal interventions. According to participants, small, interpersonal things people can do to support youth feeling lonely, sad, or hopeless include: a) asking the youth to help with something important so they feel they are making a contribution; b) validating the youth's feelings, rather than encouraging their concealment, or denying the importance of those feelings; c) expressing an interest in the youth's interests; and e) expressing appreciation by saying thank you when youth help in different capacities. Below are quotes from three different focus groups, and four different youth describing useful interpersonal interventions:

"I think validation is huge. Like either giving yourself or this other person the opportunity to feel okay with being really sad or depressed or feeling hopeless. The safe space is really important." -18-24 year old

"...if people ask you to do something, [it] lets you know that they trust you and have faith in you to get something done which kind of makes you feel better." -14-18 year old

"And a lot of the times people will always say that they understand. But sometimes the best thing for it is for people to understand that they don't understand. And you don't need to understand to make it better. You just need to kind of be there." -14-18 year old

"For short term I think humor helps a lot. Two, just being there for them, just staying by their side through bad times and good times. And three, just listening. Sometimes people don't need a response or advice. They just need someone to listen to them. Sometimes if you can't understand. If you can't then just listen." -14-18 year old

Participants talked about the importance of meaningful activities as a way to intervene in loneliness, sadness, and hopelessness. The importance of meaningful activities also came up in focus groups around bullying, both as a way of coping with being bullied, and as a way to help youth stop engaging in bullying behaviors. Youth reported that meaningful activities included safe spaces, and safe people, and often entailed giving back in order to receive, such as with tutoring, and volunteering through youth groups. Engaging in meaningful activities was described as protective of extreme loneliness/sadness/hopelessness, a way to cope with such feelings, as well as a way to conceal such feelings.

Meaningful activities were considered both an interpersonal and personal way of intervening in loneliness/sadness/hopelessness. They were interpersonal when done socially, to create meaning in relationships with others; and they were personal where they happen individually, when youth are alone, such as through writing, listening to music, dancing, or walking a dog. While the majority of participants talked about interpersonal ways of intervening, several youth distinctly countered this by arguing that some people prefer to process alone i.e. that "giving space" is imperative. One 14-18 year old participant reflected:

"...a lot of people are saying important things to do or to do activities and stuff. But a lot of times when you're sad and lonely it's hard to motivate to get to these activities. So it's kind of just like you have to do something that you can do just by yourself anywhere."
– 14-18 year old

As with interventions in bullying, the idea came up repeatedly that experiences of, and interventions in loneliness/sadness/hopelessness are very personal and depend on the person:

"...it's different for every single person out there. Like what makes me happy and bring me out of my depression might not bring the person in a room next to me doing that. It's very individualized for each person. And I think their friend group or the people that are closest to them know..." -14-18 year old

Solutions: Community based interventions. One older participant mentioned: "it can be hard to know where to go to get help for mental health" (18-24 year old). While other youth did not share this explicitly, specific names of mental health resources were also not brought up. When asked about interventions, another youth responded: "as a community making sure we remove stigma" (18-24 year old).

There seemed to be consensus across focus groups that peers were of primary importance when it comes to community level interventions in loneliness/sadness/hopelessness, as well as in bullying. Participants mentioned volunteering as a way to feel like they matter to the community, such as by tutoring, or working with youth groups. In intervention efforts, youth emphasized that it's possible to help youth feel like they matter to the community by doing something that matters:

"I think when you feel that you matter if your self-worth but I feel like you won't matter until you do something worthwhile." - 12-14 year old

"...giving back a little bit helps you feel like you're a little more part of the community." - 18-24 year old

As with personal and interpersonal interventions, it was clear that youth thought a variety of community based interventions was necessary. While most participants talked about social, group interventions, at least two participants wanted to remind us that not all youth benefit from group work:

"I feel that people who are sad and lonely won't really come to groups – youth groups. I feel like youth groups or people that are concerned for them should come to them because I feel like they won't really reach out." - 14-18 year old

That being said, by far the most commonly mentioned community level intervention ideas had to do with youth groups. Several participants mentioned that groups should be based on common experiences so that youth can "relate" to others in the group. Most participants shared that groups should be activities based, such as with volunteering, gaming, and rotating activities, rather than primarily discussion based groups.

"I think that you can also have like your personal interest communities and then that's how you also kind of build off of that community. Like here specifically there are a lot of people that are involved in outdoor activities. And then you bond more with those people. There's a lot of skiing and that whole area. And I think that creates a sense of you kind of belong to your own little community. Even if you don't know anyone you just kind of have things in common with those people and I think that builds a network for you." - 18-24 year old

Participants frequently mentioned community centers, with an emphasis on affordable entry fees, and accessible transportation to them. Here are quotes from two different participants about the use of community centers in possible future interventions:

"Like have activities that involves everybody and not just like adults but also kids. So have just like a little neighborhood thing even just like go to the park. My parents can talk and kids can play. So just have activities that everybody can go to and enjoy, not just certain people." -12-14 year old

"Kind of like community centers but more diverse. Like if they had a place where you could – We touched on this a lot. A lot of people require different things to make them feel better about themselves. And so if you had a more diverse community center, like maybe just one place where you can just chill and be quiet, but the other places where there are activities that you can do. And then there are places that you can also go to do homework." -14-18 year old

Additionally, several mentioned the usefulness of the focus groups themselves as an intervention. While recommendations for interpersonal, and support group interventions were prominent findings in this project's primary data collection, additional focus groups explicitly seeking youth feedback about intervention ideas should be considered.

Finally, participants in a 14-18 year old focus group had rich ideas about community support groups as a possible intervention, including:

- regularly meeting youth groups centered around both activities, and social support through discussions:

"...If anyone has a problem, they can kind of bring it to their group, and everyone can kind of help them out about it. So like let's say these things two hours – they last around two hours – and you can hang out and do stuff for the first hour and a half. But for the last half hour, if anyone has any problems, people can go like, does anyone have anything they want to talk about?" - 14-18 year old

- bringing together the youth groups once a year as a convention or just a celebration with dancing, to learn from each other about activities and topics discussed throughout the year e.g. activities like bowling, sports, anime, movies, video games, role play, skiing, hiking, writing; and topics like bullying, problem solving, and sadness:

"...having an annual get together to combine some really popular things together, so people could go and try new things. Have a part of it like anime and sports, just kind of bring all those things that don't normally go together all that well kind of into one area so people can learn" - 14-18 year old

- having youth groups meeting throughout the year, as well as the annual convention/celebration meet at a common building, or a set of buildings across town, so that youth become familiar with what's going on where.

Moving Playing Enjoying

Synthesis & Recommendations

Considering the results of the secondary and primary data as they are discussed throughout this report and synthesized here, it is recommended for the next steps that the ACC focus on the following three intermediate variables for youth aged 12 to 24: **a) feeling alone, b) trusted relationships, and c) youth feeling they matter to the community. These three intermediate variables as evidenced** throughout this report and data analysis are key variables for having an impact on bullying, sadness/hopelessness, and suicide and thus improving the mental health of Anchorage youth. Below is a summary of how the ACC community assessment process led to this recommendation.

The community assessment began with a broad analysis of behavioral health indicators among Anchorage youth by thoroughly reviewing data from multiple sources (i.e., YRBS, BRFSS, NSDUH, PRAMS, SCCS, TR, NCHA, BVS, ADEED, OCS). This early phase of assessment was intended to identify the highest priority among the behavioral health indicators of suicide, substance use, and mental health. The secondary data results were presented to the ACC and community partners. Based on a careful review of the data, the coalitions and community partners prioritized mental health along with the intermediate variables of feeling alone, sadness, hopeless, and bullying. These behavioral health indicators and intermediate variables were prioritized due to increasing or static trends in the data, while substance use was not included as trends generally appeared to be decreasing over time.

The second phase of the assessment included primary data collection using various methods (i.e., APAY survey, YAS, and focus groups) to further investigate the priority area (mental health) and associated intermediate variables (feeling alone, sadness, hopeless, and bullying). Secondary and primary data methods, analyses, and key findings are thoroughly described in prior sections of this report. It is evidenced in both the secondary and primary data outcomes that there are critical relationships between suicide, mental health (i.e., feeling alone, sad, and hopeless), and bullying. Although, substance use was not considered a priority area it is worth noting that substance use was significantly correlated with bullying in the YRBS data and focus group participants also identified substance use as a mechanism for coping with negative feelings from being bullied. Other outcomes from being bullied that were identified by focus group participants included bullying (i.e., bullying as a result of being bullied) and violence/crime. Both secondary data analysis and primary data support the relationship that being bullied leads to poor mental health and suicide, as well as the relationship that poor mental health is a precursor to suicide. That poor mental health may be a precursor to suicide was evidenced in quantitative YRBS data, and supported through qualitative evidence in focus groups.

Several risk factors map onto at least two, if not all three variables of bullying, mental health/depression, and suicide. These crossovers further support the relationships among variables described above. For example, having been bullied is a risk factor for suicide and for feelings of sadness/hopelessness, as evidenced in focus groups and YRBS data. According to the YRBS data analysis, feeling alone is the highest risk factor for sadness/hopeless and suicide. Mixed-race was a risk factor for both bullying and sadness/hopelessness. Risk factors that crossed bullying, sadness/hopelessness, and suicidal ideation, as evidenced in YRBS, included unsafe schools and being female.

The primary data was also intended to supplement the secondary data by filling data gaps. One of the primary gaps in the secondary data was the limited amount of information regarding the behavioral health of young adults aged 18 to 24 in the Municipality of Anchorage. The secondary data (i.e., National College Health Assessment, 2009) indicated that 45.9% of University of Alaska Anchorage students aged 18 to 24 reported high stress during the previous 12 months. During the

screening process for focus groups, which included 18-24 year olds who had not engaged in higher education, stress was found to be significantly higher in 18-24 year olds when compared to school ages youth 12-18. The results of the Young Adult Survey indicated stress as a risk factor for sadness/hopeless among 18 to 24 year olds.

As with risk factors, there were several similar protective factors for the variables of bullying, sadness/hopelessness, and suicide. As evidenced by both focus groups and the Young Adult Survey, individual factors such as optimism, self-esteem, self-awareness are protective for bullying and sadness/hopelessness. That is, youth perceived individuals with higher self-esteem and self-awareness to be less impacted by bullying and also less likely to be bullied. With regard to the Young Adult Survey, being more optimistic was associated with better mental health. The protective factors of most significance that crossed over all three variables included youth feeling like they matter to their community and youth having trusted relationships, both peer and adult.

According to YRBS strength of association findings, youth feeling like they matter to their community is the second ranked protective factor against bullying, feeling sad/hopeless, suicide ideation, and a planned attempt at suicide. This was also evidenced in the focus group discussion, where youth elaborated on what it meant to matter in their community and the importance of feeling engaged in one's community. Regarding trusted relationships, YRBS data indicated the highest ranked protective factor against being bullied was having a teacher who cares. Having a teacher who cares also meant youth were less likely to feel sad or hopeless and less likely to consider or plan a suicide attempt. While trusted adults were mentioned in focus groups as a resource and support, it was only second to peer relationships. Peers were highly regarded across focus groups as the first line of defense for bullying and mental health concerns. Individuals often said they would talk to and rely on their peers first before seeking adult or professional help. It is important to note that while youth in focus groups refer to peer relationships, there is no measure of peer relationships in YRBS.

In summary, it is demonstrated through a variety of means (i.e., secondary data, primary data, quantitative and qualitative data) that bullying, mental health, and suicide are not independent constructs. As a result, there are a number of risk and protective factors that are associated with at least two if not all three of these variables. Therefore, it would be highly beneficial and efficient to focus interventions and next steps on intermediate variables that cross the main variables of focus, thereby increasing the potential impact of the intervention. For example, having trusted relationships is a protective factor for bullying, sadness/hopelessness, and suicide, and therefore an intervention focused on establishing trusted relationships would potentially reduce bullying behaviors, feelings of depression, and suicide ideation/attempts.

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Secondary Data Sources Cited

Alaska Department of Education and Early Development (ADEED)

Note: For this report, data was only analyzed on suspensions/expulsions, dropout, and graduation rates in the Anchorage School District

Purpose: to collect relevant school information (e.g., attendance, graduation rates, suspensions/expulsions) on Alaska public school students

Dates Collected: On-going data collection

Participants: Data collected on students attending Alaska's public schools.

Limitations: Data are presented by counts instead of percentages (in the absence of total student population for each year). ASD graduation and dropout rates were calculated differently prior to the 2009-2010 school year.

Website: http://www.eed.state.ak.us/

UAA Assessment Team Rating: Validity-2 Consistency-1 Sensitivity-1

Behavioral Risk Factor Surveillance System (BRFSS)

Purpose: to collect data on preventive health practices and risk behaviors linked to chronic diseases, injuries, and preventable infectious diseases.

Dates Collected: Yearly since 1984. Computer Assisted telephone interviewing began in 2005.

Participants: Nationwide survey. Participants are non-institutionalized civilian adults 18 and older.

Website: http://www.hss.state.ak.us/dph/chronic/hsl/brfss/default.htm

UAA Assessment Team Rating: Validity-2 Consistency-2 Sensitivity-1

Bureau of Vital Statistics (BVS)

Purpose: to collect information on infant mortality, cancer and chronic disease deaths, other leading causes of death, unintentional injuries, pregnancy rates, marriage and divorce rates.

Dates Collected: On-going data collection

Participants: Data collected from all birth, death, marriage and divorce statistics (vital statistics) in state of Alaska.

Limitations: The data includes all vital statistic information occurring in the state and the data can be used to assess trends over time.

Website: http://www.hss.state.ak.us/dph/bvs/

UAA Assessment Team Rating: Validity-2 Consistency-2 Sensitivity-1

National College Health Assessment (NCHA)

Purpose: to collect information on college students' health habits, behaviors and perceptions.

Dates Collected: UAA collected in 2009

Participants: Students enrolled in university participating in the survey

Limitations: Only one year of data so trend data not available

Websites: http://www.acha-ncha.org/overview.html

http://www.achancha.org/

UAA Assessment Team Rating: Validity-1 Consistency-2 Sensitivity-1

National Survey of Drug Use and Health (NSDUH)

Purpose: to collect US national and state-level data on the use of tobacco, alcohol, illicit drugs, and mental health. Used to assess and monitor drug and alcohol use and consequences of abuse.

Dates Collected: 1990-present conducted every year. 1972-1990 conducted every two-three years.

Participants: Randomly selected individuals age 12 and older

Limitations: Excludes individuals without households (i.e, homeless, military, living in dorms, living in institutions like jails, prisons, and hospitals).

Website: http://www.oas.samhsa.gov/nsduh.htm

UAA Assessment Team Rating: Validity-2 Consistency-2 Sensitivity-1

Office of Children's Services (OCS)

Purpose: to collect information on children and families utilizing OCS and on providers for out-of-home placements.

Dates Collected: on-going

Participants: Participants using Office of Children's Services

Limitations: Not all data is publically available.

Website: http://dhss.alaska.gov/ocs/Pages/default.aspx

UAA Assessment Team Rating: Validity-1 Consistency-1 Sensitivity-1

Pregnancy Risk Assessment Monitoring System (PRAMS)

Purpose: to collect information on state-specific population-based maternal attitudes and experiences before, during, and after pregnancy.

Dates Collected: 1990 to present. On-going data collection

Participants: Stratified random sample of approximately 1 in 6 mothers of live births in Alaska (minimum of two months and a maximum of six months have passed since the date of birth). Stratification is on both race (native and non-native) and birth weight (<2500 g and ≥ 2500 g).

Limitations: Only collected from mothers with live births, therefore pregnancy issues generalized to that population.

Websites: http://www.epi.hss.state.ak.us/mchepi/PRAMS/default.stm

http://www.cdc.gov/prams/

UAA Assessment Team Rating: Validity-2 Consistency-2 Sensitivity-1

School Climate and Connectedness Survey (SCCS)

Purpose: to measure student and staff perceptions of school climate and connectedness

Dates Collected: Yearly since 2005; ASD--2007-present

Participants: Survey offered to Alaska school districts. Additional questions included in Anchorage School district (ASD) survey to address issues unique to ASD. Participants are public school staff with student contact and students. For the ASD the grades are 3-12.

Limitations: self-reported which is subject to recall bias and social desirability; less than 10 years data

which limits availability of trend data

Website: http://alaskaice.org/wordpress/wp-content/uploads/2010/11/SCCS-2014-Statewide-Report-combined.pdf)

http://www.alaskaice.org/material.php?matID=529

UAA Assessment Team Rating: Validity-2 Consistency-2 Sensitivity-1

Trauma Registry (TR)

Purpose: to collect information on trauma patient injury and treatment from Alaska's acute care hospitals

Dates Collected: 1991-present

Participants: 24 of Alaska's acute care hospitals contribute to the registry

Limitations: The Trauma Registry includes all poisoning injuries reported for children (patients under age 18), but limits the reporting of poisoning injuries for adults. Initially the Trauma Registry included unintentional occupational, unintentional inhalational and self-inflicted poisoning injuries for adults. As of January 1, 2011, the Trauma Registry no longer included self-inflicted poisoning injuries for adults age 18 and older. This includes drug-related suicide attempts, which account for the majority of suicide attempts in Alaska.

Website: http://dhss.alaska.gov/dph/Emergency/Pages/trauma/registry.aspx

UAA Assessment Team Rating: Validity-2 Consistency-1 Sensitivity-2

Youth Risk Behavior Survey (YRBS)

Purpose: to measure the prevalence of behaviors and protective factors that most influence the health of youth in grades 9-12.

Dates Collected: 1990, but Alaska first participated in 1995. Conducted every other year.

Participants: Nationwide survey established by CDC. Participants are public high school students in grades 9-12.

Limitations: Cross-sectional survey which does not allow for researchers to establish causation; self-reported which is subject to recall bias and social desirability; conducted only in English (Anchorage School District reported 99 languages in 2014); does not collect information on socioeconomic status, gender identity/sexual orientation, and neighborhood environment; in Alaska, it cannot be administered without written parent permission (active parental consent beginning in 2001).

Websites: http://www.hss.state.ak.us/press/2007/YRBS_2007_fact_sheet.pdf

http://www.hss.state.ak.us/dph/chronic/school/YRBS.htm

UAA Assessment Team Rating: Validity-2 Consistency-2 Sensitivity-2

Appendix A:
Data Review & Prioritization Tool

Data Review and Prioritization Tool

Based on your review of the data, select two (2) issues that you feel are the top behavioral health priorities (of most concern) for Anchorage youth ages 12 – 24. These may be protective factors or risk factors.

To help you in prioritizing, please focus on these three considerations:

1) Prevalence of the issue
2) Trends over time
3) Urgency

Also, please consider these questions:

- For each of the issues you have identified, which population seems most at risk?
- If the issue you have prioritized is a risk factor, do you see a protective factor that you feel correlates with or influences that risk factor?
- As you reviewed the data and went through the prioritization process, did any additional questions pop up for you? Is there anything else you wish you knew that the data didn't tell you? ***(Please record this information on the back of this sheet)***

Issue #1:
1) What is the prevalence of this issue?
2) What is the trend?
3) What is the urgency?
4) Which population seems most at risk?
5) Risk Factor or Protective Factor?
6) If Risk Factor, is there a related protective factor that appears to be an influence? (Please identify the protective factor)

Issue #2:
1) What is the prevalence of this issue?
2) What is the trend?
3) What is the urgency?
4) Which population seems most at risk?
5) Risk Factor or Protective Factor?
6) If Risk Factor, is there a related protective factor that appears to be an influence? (Please identify the protective factor)

Appendix B:
Survey & Focus Group Instruments

UAA Justice Center
UNIVERSITY of ALASKA ANCHORAGE

Adult Perceptions of Anchorage Youth: 2015 Survey

Your answers are completely confidential. When you submit your completed questionnaire, your name will be deleted from the mailing list and never connected to your answers in any way. When the data is made public, no names or addresses will be connected to your answers, and handwritten answers will not be included in the public data file. This survey is voluntary. However, you can help us very much by taking a few minutes to share your experiences and opinions about underage use of alcohol, marijuana, and prescription drugs in Anchorage.

If you would prefer to take this survey online please use the following link to log in to the survey. You will be asked for a password and a PIN. Your individual PIN number is on the back cover of this survey. Once you have logged in please follow the directions for completing the survey. The questions on either the online or this paper version are the same, and for either version your answers to the survey are completely voluntary and confidential. Again, only compete the survey (online or paper form) if you are an adult, over the age of 18.

Website URL: **http://tinyurl.com/nbb74uj**

If you have questions about the research project, please call Dr. Cory Lepage at the UAA Justice Center (907-786-4302). If you have questions regarding participation in the research project, please call Sharilyn Mumaw at the Office of Research Integrity and Compliance at (907-786-1099).

_____

Signature indicating consent to participate.

Would you like a copy of this signed consent form returned to you? ☐Yes ☐No

If you are a minor, under the age of 18, please do not complete the survey. Simply return the survey in the enclosed return envelope, and feel free to keep the $2 gift.

Underage Substance Use Problem

1. **How concerned are you about the problem of...**

	Very concerned	Somewhat concerned	Not at all concerned	Don't know
…drunk driving	○	○	○	○
...youth under 21 drinking alcohol	○	○	○	○
...youth under 21 smoking tobacco	○	○	○	○
...marijuana use by youth 18 or younger	○	○	○	○
...use of prescription drugs without a prescription by youth 18 or younger	○	○	○	○
…use of spice by youth 18 or younger	○	○	○	○

2. **Please answer the following questions about underage drinking:**

	No	Yes	Don't know
Do you think it's ever okay for a person who is 12-14 years old to drink alcohol?	○	○	○
Do you think it's ever okay for a person who is 15-17 years old to drink alcohol?	○	○	○
Do you think it's ever okay for a person who is 18-20 years old to drink alcohol?	○	○	○
Do you think it's ever okay for a person who is 25 years old to drink alcohol?	○	○	○

3. **Please indicate your level of agreement with the following statements:**

	Strongly agree	Agree	Disagree	Strongly disagree	Don't know
It is okay for youth under 21 to drink at parties if they don't get drunk.	○	○	○	○	○
Youth under 21 should be able to drink as long as they don't drive afterwards.	○	○	○	○	○
In my community, there is a lot of social pressure for youth under 21 to drink.	○	○	○	○	○
In my community, drinking among youth under 21 is acceptable.	○	○	○	○	○
With marijuana legalized for use by those 21 and older, use of marijuana by teens will likely increase.	○	○	○	○	○

4. **How easy is it for youth in your community to…**

	Very easy	Sort of easy	Sort of hard	Very hard	Don't know
…get an older person to buy alcohol for them?	○	○	○	○	○
…sneak alcohol from their home or their friend's home?	○	○	○	○	○
…get their parents to give alcohol to them?	○	○	○	○	○
…get alcohol at a party at someone's house?	○	○	○	○	○
…get alcohol at a public or community event like a festival?	○	○	○	○	○
…get alcohol at a family celebration such as a wedding, barbecue, or birthday?	○	○	○	○	○
…steal alcohol from a retailer (i.e. restaurant, bar, or liquor store)?	○	○	○	○	○
…purchase alcohol from a retailer (i.e. restaurant, bar, or liquor store)?	○	○	○	○	○
…get marijuana from a friend?	○	○	○	○	○
…buy marijuana?	○	○	○	○	○
…get their parents to give marijuana to them?	○	○	○	○	○
… sneak prescription drugs that are not prescribed to them from their home?	○	○	○	○	○
…get their parents to give youth prescription drugs that are not prescribed to the youth?	○	○	○	○	○

5. **Please share your personal knowledge of youth access to alcohol and drugs:**

	No	Yes	Don't know
Would youth under 21 that you know be able to access any alcohol that you have purchased without your knowledge?	○	○	○
Would youth under 21 that you know be able to access any marijuana that you have grown or purchased without your knowledge?	○	○	○
Would youth under 21 that you know be able to access any of your prescription drugs without your knowledge?	○	○	○

6. **What percentage of students in your local high school do you think used the following substances in the last month?**

	%
Alcohol	_____
Prescription drugs to get high	_____
Marijuana	_____

7. **How much do you think youth under 21 risk harming themselves (physically or in other ways) if they:**

	No Risk	Slight Risk	Moderate Risk	Great Risk
Take one or two drinks of an alcoholic beverage nearly every day.	○	○	○	○
Have five or more drinks of an alcoholic beverage once or twice a week.	○	○	○	○
Try marijuana once or twice.	○	○	○	○
Smoke marijuana once or twice a week.	○	○	○	○
Smoke marijuana once or more a day.	○	○	○	○
Try prescription drugs (painkillers, sedatives, stimulants, etc.) that are not prescribed to them once or twice.	○	○	○	○
Use prescription drugs not prescribed to them at least once a month	○	○	○	○
Try spice once or twice	○	○	○	○

8. **Please indicate your level of agreement with the following statements about the relative safety of various substances used by youth:**

	Strongly agree	Agree	Disagree	Strongly disagree	Don't know
Marijuana use by youth is safer than alcohol use by youth under 21.	○	○	○	○	○
Youth use of prescription drugs to get high is safer than alcohol use by youth under 21.	○	○	○	○	○
Alcohol use by youth under 21 is safer than youth marijuana use.	○	○	○	○	○
Youth use of prescription drugs to get high is safer than youth marijuana use.	○	○	○	○	○

9. **Following are some consequences associated with youth substance use. Please indicate your level of concern for each of the risks listed below:**

		Not at all concerned	Not very concerned	Somewhat concerned	Very concerned	Don't know
Alcohol	Youth might drink to excess or become addicted to alcohol	○	○	○	○	○
	Youth might drink and drive	○	○	○	○	○
	Youth's brain development might be adversely affected	○	○	○	○	○
	Youth might be involved in unwanted and/or unprotected sexual behavior	○	○	○	○	○
	Youth's drinking could lead to depression or suicide	○	○	○	○	○
	Youth could lose out on scholarship or some other opportunity	○	○	○	○	○
	Youth's grades might suffer	○	○	○	○	○
	Youth might end up in trouble with the police	○	○	○	○	○
	Youth might move on to other drugs	○	○	○	○	○
Prescription Drugs	Depressed breathing from prescription drug use without a prescription	○	○	○	○	○
	Death due to overdose by prescription drug use without a prescription	○	○	○	○	○
Marijuana	That marijuana use will lead to use of other more dangerous drugs	○	○	○	○	○
	That marijuana use will lead to a decrease in grades	○	○	○	○	○

Adult Influences on Underage Substance Use

10. At what age (in years) is it appropriate to begin talking to a child about underage alcohol use? _____
    At what age (in years) is it appropriate to begin talking to a child about youth marijuana use? _____
    At what age (in years) is it appropriate to begin talking to a child about youth prescription drug use to get high? _____

11. At what age (in years) is it appropriate to begin monitoring a child's behavior with regard to alcohol? _____
    At what age (in years) is it appropriate to begin monitoring a child's behavior with regard to youth marijuana use? _____
    At what age (in years) is it appropriate to begin monitoring a child's behavior with regard to youth prescription drug use to get high? _____

12. **How much influence do you think each parental example would have on the drinking decisions of their youth under 21:**

	Not at all influential	Not very influential	Somewhat influential	Very influential	Don't know
Occasionally joke or tell a funny story about their past drinking behavior in front of their youth under 21.	○	○	○	○	○
Use alcohol to relieve stress or anxiety, saying things such as “I’ve had a tough week; I need a beer.”	○	○	○	○	○
Have 5 or more drinks in one evening in front of their youth under 21.	○	○	○	○	○
Ask their youth under 21 to get alcoholic beverages for them, such as getting a beer from the refrigerator.	○	○	○	○	○
Have alcohol at youth-centered events (i.e. kids' birthday parties, spiritual celebrations, sporting events, etc.).	○	○	○	○	○
Pressuring other adults to consume alcoholic beverages in front of their youth under 21.	○	○	○	○	○

13. **Please indicate your level of agreement with the following statements:**

	Strongly agree	Agree	Disagree	Strongly disagree	Don't know
Parents’ use of alcohol has no influence on a youth under 21’s use of alcohol.	○	○	○	○	○
Parents should know where their youth are when not at home.	○	○	○	○	○
Parents should know whom youth are with when not at home.	○	○	○	○	○
Parents should have specific rules about youth alcohol use.	○	○	○	○	○
Parents should have specific consequences for youth who break family rules about alcohol use.	○	○	○	○	○

14. **Please share your personal knowledge of or belief about the following:**

	No	Yes	Don't know
Do you know of parents or adults who permit their own children under the age of 21 to consume alcohol under their supervision?	○	○	○
Do you think it's ever okay for parents to offer their own children under 21 alcohol in their home?	○	○	○
Do you know of parents or adults who permit anyone under the age of 21 (other than their own children) to consume alcohol under their supervision?	○	○	○
Do you think it's ever okay for parents to offer anyone under 21 (other than their own children) alcohol in their home?	○	○	○
Do you think it's ever okay for youth to attend a party where youth under 21 are drinking as long as a parent is present?	○	○	○
Do you know anyone under the age of 21 who uses alcohol?	○	○	○

15. **Please share the following regarding prescription drugs (pain relievers, tranquilizers, stimulants, or sedatives) in the home:**

	No	Yes	Don't know
Are there prescription drugs in your home?	○	○	○
If there are prescription drugs in your home, do any children in your home know that prescription drugs are kept in your home?	○	○	○
Is it necessary for parents or guardians to take steps to keep children and youth from having access to prescription drugs in the home?	○	○	○

16. **If you have prescription drugs in your home (pain relievers, tranquilizers, stimulants, or sedatives) do you take any of the following steps to keep youth in your home from having access to these prescriptions?:**

	No	Yes	Don't know
Keep track of the number of pills	○	○	○
Lock the pills up	○	○	○
Hide the pills	○	○	○
Keep the pills with you when you leave home	○	○	○
Other: _____ _____	○	○	○

Substance Use

17. **Please answer the following questions about your substance use as a youth:**

	No	Yes	Don't know
As a youth under 21, was there ever a time when you drank alcoholic beverages at least once a week?	○	○	○
As a youth under 21, was there ever a time when you drank five or more alcoholic beverages in one day?	○	○	○
As a youth under 18, was there ever a time when you smoked marijuana once per week or more frequently?	○	○	○

18. **How long has it been since you last drank an alcoholic beverage?**

- ○ Within the past 30 days
- ○ More than 30 days ago but within the past 12 months
- ○ More than 12 months ago

19 **During the past 30 days, on how many days during did you use**

	None	1 or 2 days	3 to 5 days	6 to 9 days	10 to 19 days	20 to 29 days	All 30 days
Alcohol	○	○	○	○	○	○	○
Marijuana	○	○	○	○	○	○	○
Prescription Drugs to get high	○	○	○	○	○	○	○

Community Readiness

20. **Please answer how knowledgeable you are...**

	Very knowledgeable	Knowledgeable	Somewhat knowledgeable	Not knowledgeable
….. about bullying among Anchorage's youth?	○	○	○	○
... about extreme sadness/hopelessness among Anchorage's youth?	○	○	○	○
... about Anchorage youth feeling alone in their lives?	○	○	○	○
... about suicide among Anchorage's youth?	○	○	○	○

Community Climate

21. **Please answer how concerned you are...**

	Very concerned	Concerned	Somewhat concerned	Not concerned
….. about bullying among Anchorage's youth?	○	○	○	○
... about extreme sadness/hopelessness among Anchorage's youth?	○	○	○	○
... about Anchorage youth feeling alone in their lives?	○	○	○	○
... about suicide among Anchorage's youth?	○	○	○	○

Knowledge of Efforts

22. **Efforts mean any programs, activities, or services in the community. To what degree would you say there are efforts in the community to address…**

	A lot	Some	A little	Nothing
….. the bullying among Anchorage's youth?	○	○	○	○
... the extreme sadness/hopelessness among Anchorage's youth?	○	○	○	○
... feeling alone among Anchorage's youth?	○	○	○	○
... suicide among Anchorage's youth?	○	○	○	○

The next set of questions ask about your engagement in youths' lives as a parent and/or community member. If you are not currently parenting youth or do not have regular interaction with any youth who are at least 12 years old, please answer the following questions as you would if you were parenting or had regular interaction with one or more youth age 12 or older.

23. **How likely are you/would you be to…**

	Very likely	Likely	Somewhat likely	Not likely
… talk to youth about how they are doing in school every day?	○	○	○	○
... help youth seeking help from you in addressing important questions affecting their life?	○	○	○	○
... help make youth feel that they are not alone in their life?	○	○	○	○
... help make youth feel like they matter in your community?	○	○	○	○
… encourage youth to take part in organized after school, evening, or weekend activities	○	○	○	○

School Environment

The next set of questions asks you about your perception of youths' school environment.

24. **To what degree would you say that in general…**

	Strongly agree	Agree	Somewhat agree	Disagree
… teachers in Anchorage really care and give a lot of encouragement to youth?	○	○	○	○
... junior high and high schools in Anchorage have clear rules and consequences for youth behavior?	○	○	○	○

Respondent Background Information

This demographic information helps researchers at the university to better understand features of community and civic attitudes as they relate to individual characteristics. These responses will be kept confidential, and your answers to these and all of the questions in this survey will not be traceable to you.

Nonetheless, if there are any questions that you do not wish to answer, please simply skip those items and move onto the next question in the survey. Your answers remain valuable whether you choose to answer every question or not.

25. **How old were you on your last birthday?** ____

26. **What is your gender?** ○ Female ○ Male

27. **Are you of Hispanic or Latino background or origin?** ○ No ○ Yes ○ Don't know

28. **What race or ethnicity would you say best describes you?** (Please mark all that apply.)

- ○ Alaska Native or American Indian
- ○ Asian
- ○ Black or African American
- ○ Native Hawaiian, Samoan, or Other Pacific Islander
- ○ White or Caucasian
- ○ Other (please specify) _____

29. **What is your current marital status?**

- ○ Single, Never Married
- ○ Married
- ○ Separated
- ○ Divorced
- ○ Widowed

School Environment

30. **What is the highest degree or level of school you have completed?**

- ○ A graduate or professional degree
- ○ A bachelor degree
- ○ An associate degree
- ○ One or more years of college, but no degree
- ○ High school diploma or GED
- ○ No degree - specify last grade **completed** _____

31. **Which of the following best describes your current primary employment status?** (Please select one.)

- ○ Currently on active military status
- ○ Working full-time, that is 35 or more hours per week in one or more jobs, including self-employment
- ○ Working part-time
- ○ Have a job, but out due to illness/leave/furlough/or strike
- ○ Have seasonal work, but currently not working
- ○ Unemployed or laid off and looking for work
- ○ Unemployed and not looking for work
- ○ Full-time homemaker
- ○ In school only
- ○ Retired
- ○ Disabled for work
- ○ Don't know/Not applicable
- ○ Other (please specify) _____

32. **Household composition**

Including yourself, how many people currently live in your home?	____
How many people under the age of 21 currently live in your home?	____
How many people between the ages of 13-17 currently live in your home?	____

Interaction with Youth

33. Are you currently parenting one or more youth who are 12 to 24 years old? ○ Yes ○ No

34. Do you have regular interaction with any youth who are 12 to 24 years old? ○ Yes ○ No

35. **Is there anything else that you would like to tell us about underage substance use in Anchorage, or things that you think we should have asked but didn't?** Please share your feedback.

[PLEASE WRITE YOUR RESPONSE IN THIS BOX.]

Please return your completed questionnaire in the envelope provided to:
Justice Center
University of Alaska Anchorage
3211 Providence Drive
LIB 213
Anchorage, AK 99508

Anchorage Young Adult Survey

1. What is your current age? _____

2. What is your biological sex? Male Female Intersex

3. Do you currently live in the Municipality of Anchorage (includes Anchorage Bowl, JBER, Indian, Girdwood, Eagle River, Birchwood, Peters Creek, Chugiak, Eklutna)? Yes No

3a. How long have you lived in Anchorage? (If you have lived in Anchorage more than one time, please list only the number of years during this current period of time.) _____ years

3b. Have you lived in Anchorage previously? Yes No

3c. How many total years did you previously live in Anchorage? ____ years

["Please indicate the extent to which you agree or disagree with the following statement:"]

4. In my community, I feel like I matter to people.

Strongly agree Not sure Disagree
Agree Strongly Disagree

["For each statement below, indicate your response using the provided scale"]

5a. I have chances to talk to someone I trust about my problems.
5b. I receive love and affection.
5c. I have people who care about me.
5d. I spend time with family and/or friends.

1	2	3	4	5
Much less than I would like				As much as I would like

6. During an average week, on how many days do you take part in organized activities, such as clubs; community center groups; music, art, or dance lessons; church; or cultural or other organized activities?

I do not take part in organized activities.
I take part in organized activities occasionally, but not regularly.
I take part in organized activities regularly, but less than 1 day per week.
1 day/week
2 days/week
3 days/week
4 days/week
5 days/week
6 days/week
7 days/week

["Please indicate the extent to which you agree or disagree with each of the following statements:"]

7a. I have important goals for my life.
7b. I believe I have what it takes to succeed in my life.
7c. I believe that somebody will take care of me when I am old.

7d. I believe that my future will work out.
7e. I believe that if you work hard enough, you can accomplish anything.

Always agree	Agree half the time	Rarely agree
Usually agree		Never agree

8. What is the highest level of education that you plan to attain?

Less than high school diploma	Associate degree
High school diploma or GED	Bachelor's degree
Trade/technical/vocational training	Graduate or professional degree
Some college, no degree	

9. Within the last 30 days, on how many days did you use:

a. Alcohol
b. Marijuana
c. Illicit drugs (including cocaine, methamphetamines, hallucinogens, opiates)
d. Prescription drugs not prescribed to you

{Matrix table with same choices for all:}

Never used	6-9 days
Have used, but not in last 30 days	10-19 days
1-2 days	20-29 days
3-5 days	Used daily

{Only for those that selected some alcohol use in last 30 days}

10. Over the last two weeks, how many times have you had *five/four* or more drinks of alcohol at a sitting? *five for men; four for women

N/A; I don't drink	3 times	7 times
None	4 times	8 times
1 time	5 times	9 times
2 times	6 times	10 or more times

11. Within the last 12 months, how would you rate the overall level of stress you have experienced?

No stress	Average stress	Tremendous stress
Less than average stress	More than average stress	

The next few questions are about bullying and/or harassment. When answering these questions, please think about aggressive behavior that is intended to hurt, humiliate, or harm another person either physically or emotionally. Please do not include instances of domestic violence or aggressive behavior by or toward an intimate partner.

12. In the past 12 months, have you ever:

a. Been cyber bullied or harassed (such as via text, Facebook, Snapchat, or other electronic methods).
b. Been verbally bullied or harassed.
c. Been physically bullied or harassed.

{Matrix table with same choices for all:}

No, never
No, not in the last 12 months
Yes, in the last 2 weeks
Yes, in the last 30 days
Yes, in the last 12 months

{if yes} Please describe your most recent experience of being bullied or harassed. [open-ended]

13. In the past 12 months, have you ever:

a. Engaged in cyber bullying or harassment toward someone else (such as via text, Facebook, Snapchat, or other electronic methods).
b. Engaged in verbal bullying or harassment toward someone else.
c. Engaged in physical bullying or harassment toward someone else.

{Matrix table with same choices for all:}

No, never
No, not in the last 12 months
Yes, in the last 2 weeks
Yes, in the last 30 days
Yes, in the last 12 months

{if yes} Please describe your most recent experience of engaging in bullying or harassment.

14. In the past 12 months, have you ever:

a. Felt things were hopeless
b. Felt overwhelmed by all you had to do
c. Felt very lonely
d. Felt very sad
e. Felt so depressed that it was difficult to function
f. Seriously considered suicide
g. Attempted suicide

{Matrix table with same choices for all:}

No, never
No, not in the last 12 months
Yes, in the last 2 weeks
Yes, in the last 30 days
Yes, in the last 12 month

15. Have you ever had a problem or issue for which you thought psychological or mental health services would be helpful?

Yes, as a minor (<18 years old)
Yes, as an adult (18+)
Yes, both as a minor and an adult
No, never

16. Have you ever received psychological or mental health services… (Select all that apply.)

	Yes, as a minor (<18 years old)	Yes, as an adult (18+)	No
a. from a counselor, therapist, and/or psychologist?			
b. from a psychiatrist?			
c. from a medical provider other than a psychiatrist (e.g. pediatrician, family physician, nurse practitioner)?			
d. from a minister, priest, rabbi, or other clergy?			
e. from someone else? Please specify:			

*{if 15=yes AND 16=no}*You indicated that you once had a problem or issue for which you thought psychological or mental health services would be helpful and that you have never received such services.

17. Why did you not seek services? {open-ended}

18. If in the future you were having a personal problem that was really bothering you, would you consider seeking help from a mental health professional? Yes No

18a. Why or why not? {open-ended}

19. When was the last time you visited a medical provider (e.g. physician, physician's assistant, nurse practitioner, public health nurse) for any reason?

Within the last week
Within the last month
1-3 months ago
4-6 months ago
7-12 months ago
More than one year ago

20. During the average week, how many hours do you work for pay?

0 hours
1-9 hours
10-19 hours
20-29 hours
30-39 hours
40 hours
More than 40 hours

21. During the average week, how many hours do you volunteer?

I do not volunteer.
I volunteer occasionally, but not regularly.
I volunteer regularly, but less than 1 hour per week.
1 hour/week
2 hours/week
3-5 hours/week
6-10 hours/week
11 or more hours/week

22. In the past 6 months, where have you been living most of the time?

Apartment, house, or room that I rent or own
Parent or relative's apartment, house, or room
Apartment, house, or room of someone unrelated to you
Dormitory/college residence
Halfway house
Institution (residential treatment, hospital, jail/prison)
Shelter
Street/outdoors (sidewalk, park, public or abandoned building)

23. What is the highest level of education that you have completed?

Less than high school diploma
High school diploma or GED
Trade/technical/vocational training
Some college, no degree
Associate degree
Bachelor's degree
Graduate or professional degree

24. Are you currently enrolled as a student?

Yes, part-time
Yes, full-time
No

25. Do you have health insurance? Yes No Unsure

26. I identify as…
A man
A woman
Transgender
Gender non-conforming
_____

27. Which best describes your sexual orientation?
Asexual
Bisexual
Gay/Lesbian/homosexual
Pansexual
Straight/heterosexual
_____

28. What is your race? (Select all that apply.)
Alaska Native
American Indian/Native American
Asian/Asian American
Black/African American
Native Hawaiian/Other Pacific Islander
White/Caucasian
Other. Please specify: _____

29. Are you Hispanic or Latino/a? Yes No

30. Are you a refugee? Yes No

31. Have you served in the Armed Forces, the Reserves, or the National Guard?
Yes, I am currently serving.
Yes, I have previously served but am separated or retired.
No, I have not served in the Armed Forces, the Reserves, or the National Guard.
{if yes} **31a. Have you ever been deployed to a combat zone?** Yes No

32. What is your marital status?
Single
Married
Unmarried, living with partner
Divorced/Separated
Widowed

33. Do you have children?
Yes, I have one or more children and one or more lives with me at least part-time.
Yes, I have one or more children and none live with me.
No.

34. Do you currently qualify for or receive public assistance such as WIC, SNAP, and/or Medicaid due to your income? Yes No Unsure

ACC Youth Focus Groups (ages 12 - 18)
Background Survey

You are being asked to complete a survey before participating in the focus group. Your participation in this survey and focus group are voluntary. You can choose to skip questions you do not want to answer. You have the right to change your mind and leave at any time. You will receive a $20 gift card for participating in the survey and focus group. This is yours to keep even if you decide to leave.

Your responses to this survey are confidential. You will get an Alaska place nametag and we will only call you by your place name. Please do not put your real name on this survey. After completing the survey, return it to one of the facilitators. Other focus group participants will not see your survey responses.

We will use this information and focus group responses to write a report for the ACC. We may also use the information to write journal articles and give presentations. Identifying information will not be used.

We will read the focus group consent out loud after everyone completes the survey. You will be divided into smaller groups for the focus group discussion.

Questions about this focus group, contact:
Danielle Reed
University of Alaska Anchorage
Center for Human Development
907-272-8270
danielle@alaskachd.org

Questions about your rights as a research participant, contact:
Sharilyn Mumaw
Compliance Officer
UAA Office of Research & Graduate studies
907-786-1099
simumaw@uaa.alaska.edu

☐ Check the box if you have read the above information, you agree to participate, and you agree to have your answer included with others.

Alaska Place Name: _____

Age: _____ *If under 12, stop here and see the facilitator.*

What grade are you in? _____
If you are not in grades 6th to 12th, stop here and see the facilitator.

Have you lived in Anchorage for at least 6 months in your lifetime? ☐ Yes ☐ No
If no, stop here and see the facilitator.

Have you ever:

Select only one answer to each statement.

	No, never.	Yes, but not in the last 12 months	Yes, in the last 12 months.
Been cyber bullied (such as via text, Facebook, Snapchat, or other electronic methods).	▫	▫	▫
Been verbally bullied.	▫	▫	▫
Been physically bullied.	▫	▫	▫

Have you ever:

Select only one answer to each statement.

	No, never.	Yes, but not in the last 12 months	Yes, in the last 12 months.
Engaged in cyber bullying toward someone else (such as via text, Facebook, Snapchat, or other electronic methods).	▫	▫	▫
Engaged in verbal bullying toward someone else.	▫	▫	▫
Engaged in physical bullying toward someone else.	▫	▫	▫

Have you ever:

Select only one answer to each statement.

	No, never.	Yes, but not in the last 12 months	Yes, in the last 12 months.
Felt things were hopeless.	▫	▫	▫
Felt very lonely.	▫	▫	▫
Felt very sad.	▫	▫	▫
Felt so depressed that it was difficult to function.	▫	▫	▫

Within the last 12 months, how would you rate the overall level of stress you have experienced?
Circle only one answer.

No stress	Less than average stress	Average stress	More than average stress	Tremendous stress

Gender: ▫ Young Man ▫ Young Woman ▫ Something else _____

What is your race/ethnicity? *Select all that apply.*

▫ Alaska Native

▫ American Indian/Native American

▫ Asian/Asian American

▫ Black/African American

▫ White/Caucasian

▫ Native Hawaiian/Other Pacific Islander

▫ Hispanic

▫ Latino/a

▫ _____

Are you a refugee? ▫ Yes ▫ No

In the past 12 months, were you homeless or did you have to sleep outside, in a car, or in a shelter? ▫ Yes ▫ No

Have your parent(s) served in the Armed Forces, the Reserves, or the National Guard?

▫ Yes, currently serving.

▫ Yes, previously served but are separated or retired.

▫ No, my parent(s) have not served in the Armed Forces, the Reserves, or the National Guard.

Thank You! Please make sure your Alaska place name is on this form and return it to the facilitator.

ACC Young Adult Focus Groups (ages 18 – 24)
Background Survey

You are being asked to complete a survey before participating in the focus group. Your participation in this survey and focus group are voluntary. You can choose to skip questions you do not want to answer. You have the right to change your mind and leave at any time. You will receive a $20 gift card for participating in the survey and focus group. This is yours to keep even if you decide to leave.

Your responses to this survey are confidential. You will get an Alaska place nametag and we will only call you by your place name. Please do not put your real name on this survey. After completing the survey, return it to one of the facilitators. Other focus group participants will not see your survey responses.

We will use this information and focus group responses to write a report for the ACC. We may also use the information to write journal articles and give presentations. Identifying information will not be used.

We will read the focus group consent out loud after everyone completes the survey. You will be divided into smaller groups for the focus group discussion.

Questions about this focus group, contact:
Danielle Reed
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Questions about your rights as a research participant, contact:
Sharilyn Mumaw
Compliance Officer
UAA Office of Research & Graduate studies
907-786-1099
simumaw@uaa.alaska.edu

☐ Check the box if you have read the above information, you agree to participate, and you agree to have your answer included with others.

Alaska Place Name: _____

Age: _____ *If under 18, stop here and see the facilitator.*

Have you lived in Anchorage for at least 6 months in your lifetime? ☐ Yes ☐ No
If no, stop here and see the facilitator.

Have you ever:

Select only one answer to each statement.	No, never.	Yes, but not in the last 12 months	Yes, in the last 12 months.
Been cyber bullied or harassed (such as via text, Facebook, Snapchat, or other electronic methods).	▫	▫	▫
Been verbally bullied or harassed.	▫	▫	▫
Been physically bullied or harassed.	▫	▫	▫

Have you ever:

Select only one answer to each statement.	No, never.	Yes, but not in the last 12 months	Yes, in the last 12 months.
Engaged in cyber bullying or harassment toward someone else (such as via text, Facebook, Snapchat, or other electronic methods).	▫	▫	▫
Engaged in verbal bullying or harassment toward someone else.	▫	▫	▫
Engaged in physical bullying or harassment toward someone else.	▫	▫	▫

Have you ever:

Select only one answer to each statement.	No, never.	Yes, but not in the last 12 months	Yes, in the last 12 months.
Felt things were hopeless.	▫	▫	▫
Felt very lonely.	▫	▫	▫
Felt very sad.	▫	▫	▫
Felt so depressed that it was difficult to function.	▫	▫	▫

Within the last 12 months, how would you rate the overall level of stress you have experienced? *Circle only one answer.*

No stress	Less than average stress	Average stress	More than average stress	Tremendous stress

What is the highest level of education that you have completed?

- ☐ Currently in high school
- ☐ Less than high school diploma
- ☐ High school diploma or GED
- ☐ Trade/Technical/Vocational training
- ☐ Some college, no degree
- ☐ Associate's degree
- ☐ Bachelor's degree
- ☐ Graduate or professional degree

Are you currently enrolled as a student? ☐ Yes ☐ No

Gender: ☐ Man ☐ Woman

Which best describes your sexual orientation?

- ☐ Asexual
- ☐ Bisexual
- ☐ Gay/Lesbian/homosexual
- ☐ Pansexual
- ☐ Straight/heterosexual

What is your race/ethnicity? *Select all that apply.*

- ☐ Alaska Native
- ☐ American Indian/Native American
- ☐ Asian/Asian American
- ☐ Black/African American
- ☐ White/Caucasian
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Hispanic
- ☐ Latino/a
- ☐ _____

Are you a refugee? ☐ Yes ☐ No

In the past 12 months, were you homeless or did you have to sleep outside, in a car, or in a shelter? ☐ Yes ☐ No

In the past 12 months, have you been involved with the criminal justice system? ☐ Yes ☐ No

Have you served in the Armed Forces, the Reserves, or the National Guard?

- ☐ Yes, I am currently serving.
- ☐ Yes, I have previously served but I am separated.
- ☐ No, I have not served in the Armed Forces, the Reserves, or the National Guard.

Thank You! Please make sure your Alaska place name is on this form and return it to the facilitator.

Focus Group Questions (12-18):

Bullying

Opening warm-up question

1. How long have you lived in Anchorage and what is one thing you like about living here?

Define bullying

2. When I say "bullying", what do you think of?
    a. What other words would you use for "bullying"?
    b. How would you define bullying type behavior for your age group?
    c. What are some examples of bullying or bullying behavior?
3. Now thinking about your age group and the behavior you all described,
    a. For your age group, where does bullying take place?
    b. For your age group, who does it happen between?
    c. For your age group, why do some people bully?

Impact of bullying

4. How much of a problem is bullying for people in your age group?

Support

5. Think of someone who experienced bullying and during that time seemed to be ok. It might be you, a friend, or an acquaintance.
    a. What helps them to cope with it?
    b. What is it about the individuals involved?
    c. What is it about that situation?
6. What can we do to address bullying among your age group?
    a. What would help young adults/youth to not bully?

Focus Group Questions (12-18):
Feeling lonely, sad, and hopeless

Opening warm-up questions

1. How long have you lived in Anchorage and what is one thing you like about living here?

Definition

2. How do you know when someone your age is lonely, sad, or hopeless?
    a. What do they do?
    b. Who or where do they go to for support? Why?

Why youth/young adults feel lonely, sad, and/or hopeless

3. Feelings of loneliness have been increasing among youth in Anchorage over the past 10 years. Why do you think this is happening?
4. Around 30% of youth in Anchorage report feeling so sad or hopeless every day for two weeks or more that they stopped doing usual activities. Why do you think so many youth feel sad and hopeless?

Support

5. What helps Anchorage young adults/youth who feel lonely, sad, or hopeless?
    a. What kind of activities might help?
    b. How do young adults/youth help their peers?
    c. How does the community help?
6. Think of someone who has felt lonely, sad, or hopeless and is now doing ok. It might be you, a friend, or an acquaintance.
    a. What helped them to get through it?
7. Feeling like you matter to your community promotes wellbeing.
    a. How do you know you matter to your community?
    b. How can the Anchorage Community help young adults/youth feel like they matter?

Wrap-up

8. The ACC is interested in the mental wellness of Anchorage youth. They are looking to create programs to support young adults'/youth's mental wellbeing.
    a. What kinds of programs or activities could they do that would be helpful and would engage young adults/youth your age?

Focus Group Questions:
Bullying

Opening warm-up question

1. How long have you lived in Anchorage and what is one thing you like about living here?

Define bullying

2. When I say "bullying", what do you think of?
    a. What other words would you use for "bullying"?
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3. Now thinking about your age group and the behavior you all described,
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    b. For your age group, who does it happen between?
    c. For your age group, why do some people bully?

Impact of bullying

4. How much of a problem is bullying for people in your age group?

Support

5. Think of someone who experienced bullying and during that time seemed to be ok. It might be you, a friend, or an acquaintance. If you can't think of a current situation think back to high school.
    a. What helps them to be ok?
    b. What is it about the individuals involved?
    c. What is it about that situation?
6. What can we do to address bullying among your age group?
    a. What would help young adults/youth to not bully?

Focus Group Questions:
Feeling lonely, sad, and hopeless

Opening warm-up questions

1. How long have you lived in Anchorage and what is one thing you like about living here?

Definition

2. How do you know when someone your age is lonely, sad, or hopeless?
    a. What do they do?
    b. Who or where do they go to for support? Why?

Why youth/young adults feel lonely, sad, and/or hopeless

3. Among a sample of 18-24 year olds in Anchorage more than 35% reported feeling very lonely in the past month. Why do you think so many young adults feel lonely?
4. Among a sample of 18-24 year olds in Anchorage over 35% reported feeling very sad and over 20% reported feeling hopeless. Why do you think so many young adults feel sad or hopeless?

Support

5. What helps Anchorage young adults/youth who feel lonely, sad, or hopeless?
    a. What kind of activities might help?
    b. How do young adults/youth help their peers?
    c. How does the community help?
6. Think of someone who has felt lonely, sad, or hopeless and is now doing ok. It might be you, a friend, or an acquaintance.
    a. What helped them to get through it?
7. Feeling like you matter to your community promotes wellbeing.
    a. How do you know you matter to your community?
    b. How can the Anchorage Community help young adults/youth feel like they matter?

Wrap-up

8. The ACC is interested in the mental wellness of Anchorage youth. They are looking to create programs to support young adults'/youth's mental wellbeing.
    a. What kinds of programs or activities could they do that would be helpful and would engage young adults/youth your age?

UAA Center for Human Development
UNIVERSITY of ALASKA ANCHORAGE

UAA Center for Behavioral Health Research & Services
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UAA Department of Health Sciences
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UAA Justice Center
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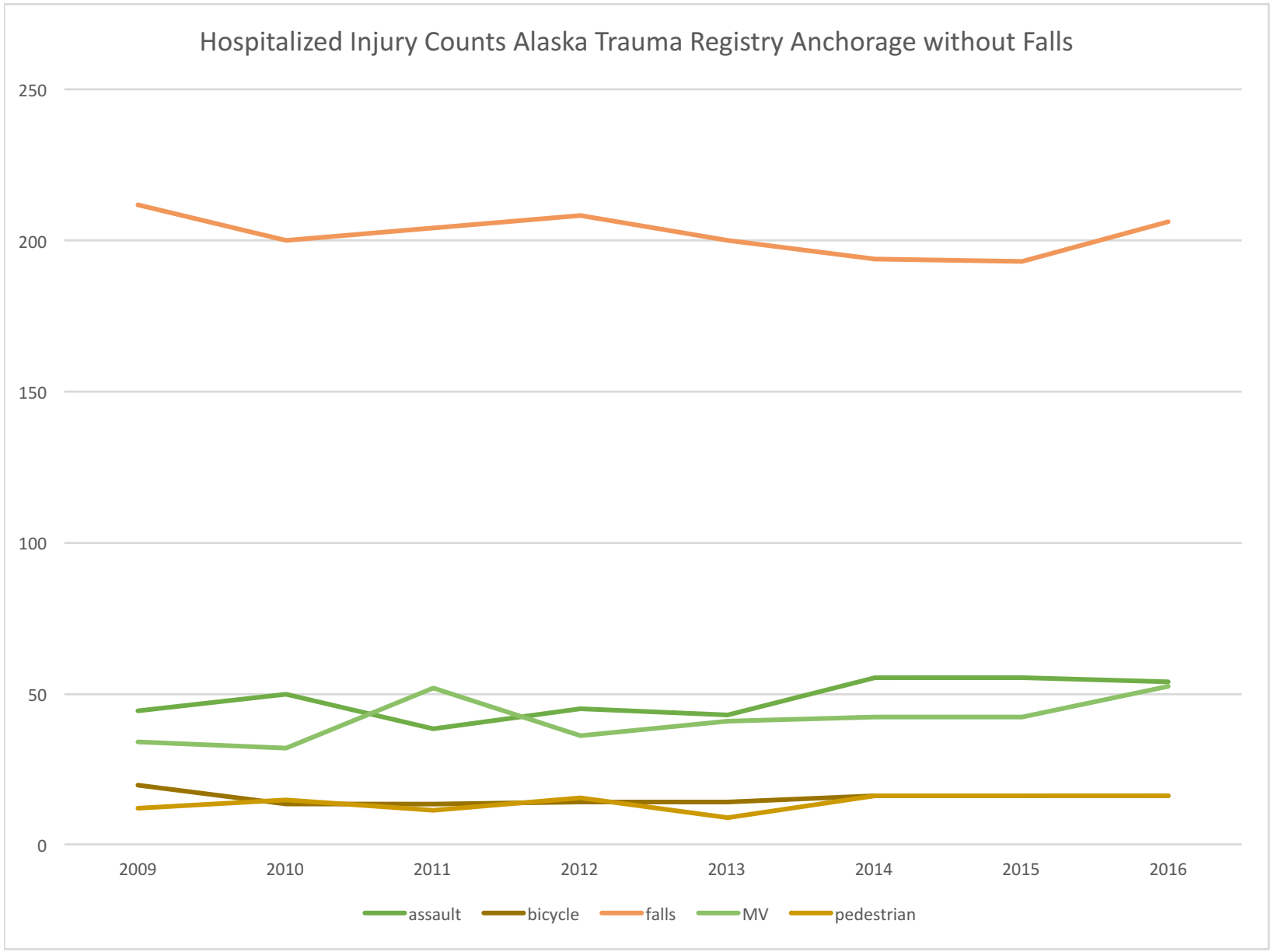
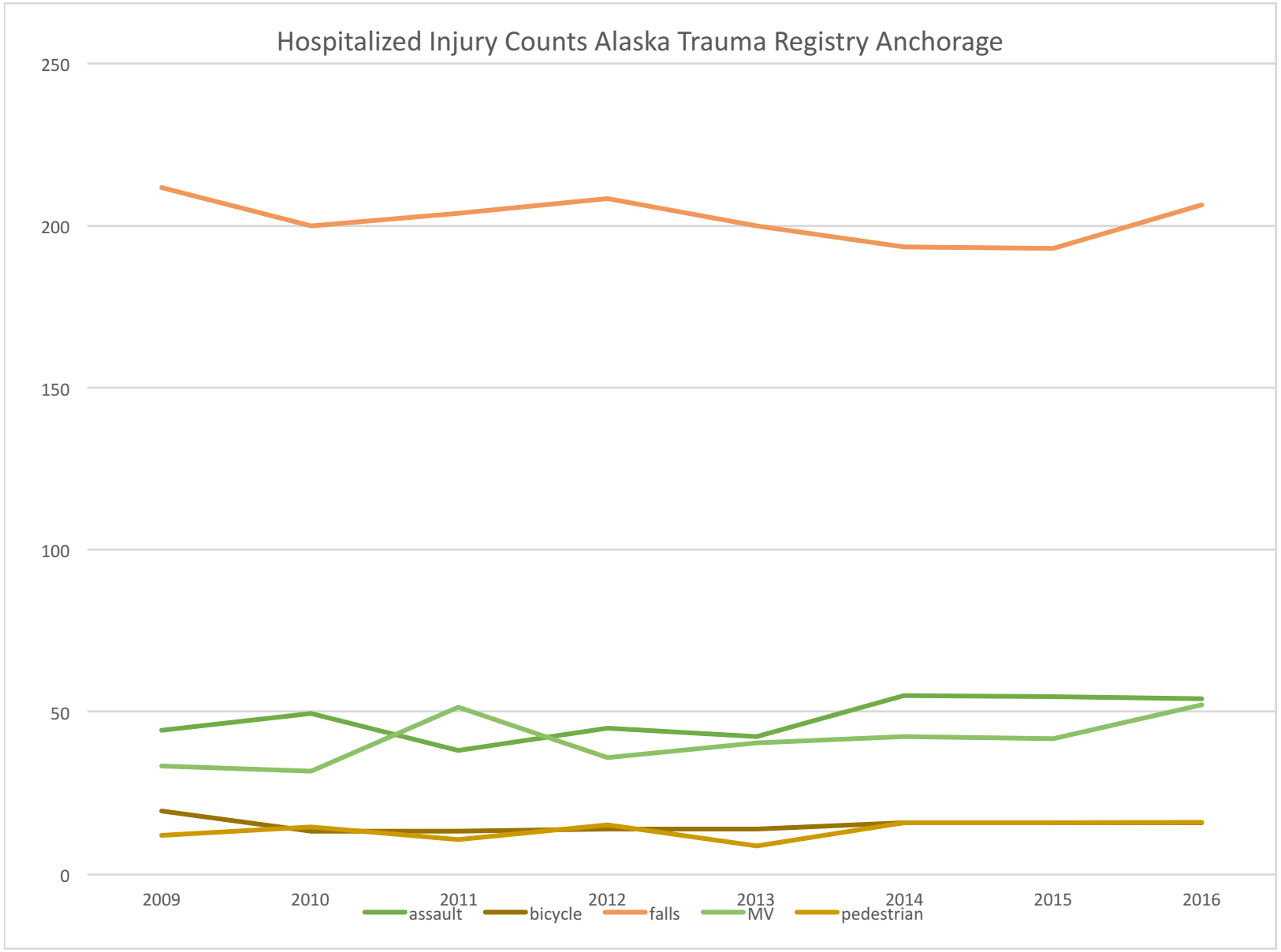

Hospitalized Injury Counts Alaska Trauma Registry Anchorage without Falls
250
200
150
100
50
0
2009
2010
2011
2012
2013
2014
2015
2016
assault
bicycle
falls
MV
pedestrian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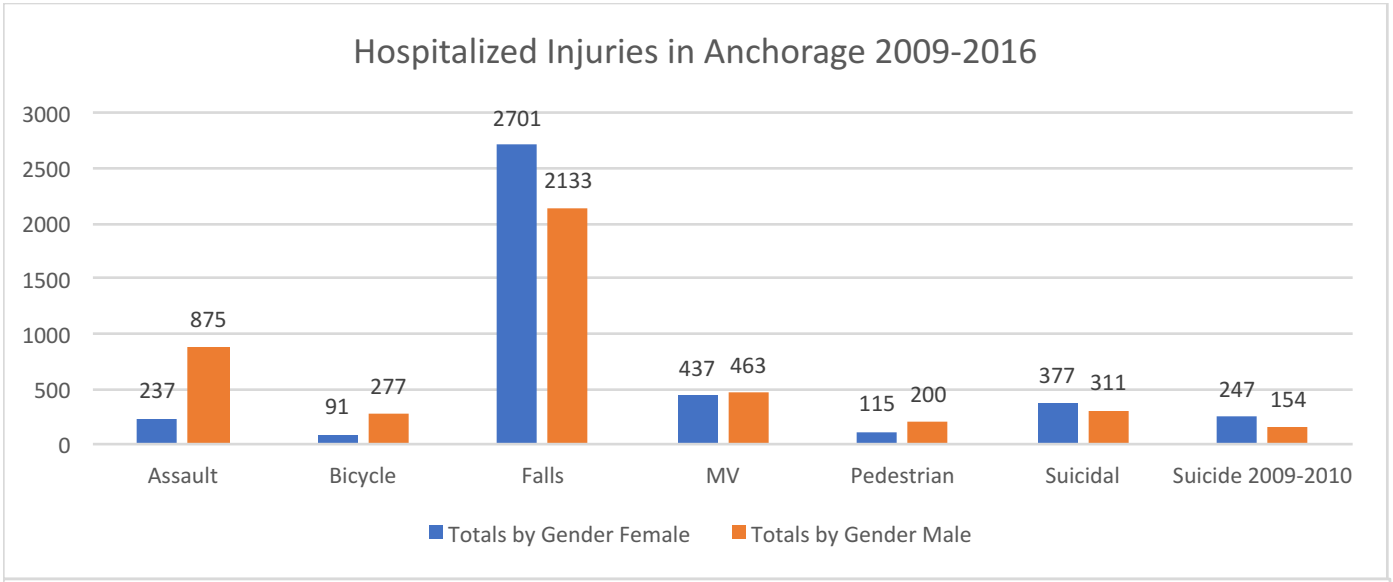
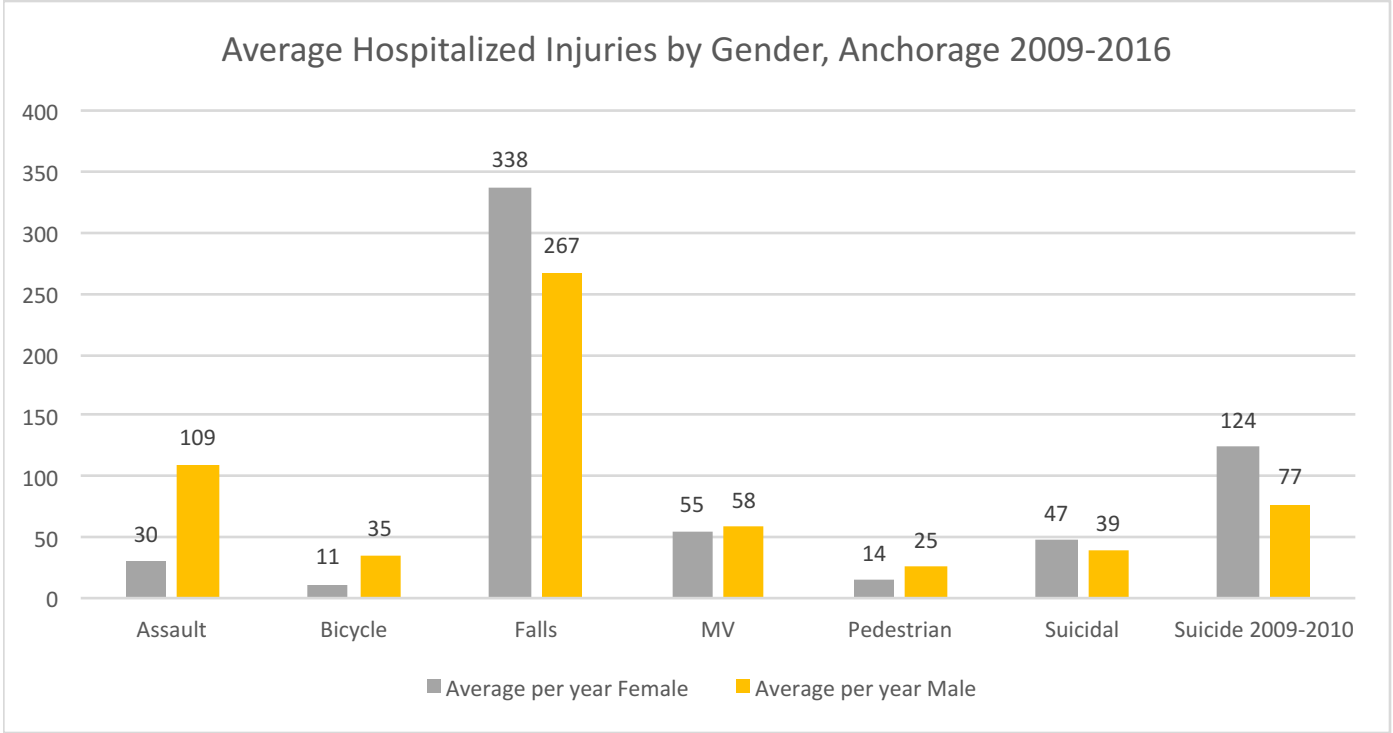
250
200
150
100
50
0
2009
2010
2011
2012
2013
2014
2015
2016
assault
bicycle
falls
MV
pedestrian

Anchorage Injury Hospitalized Counts and Rates per 100,000

	2009	2010	2011	2012	2013	2014	2015	2016
assault #	129	145	112	132	126	163	163	161
assault rate	44.3	49.7	38.3	45.0	42.8	55.2	55.0	54.0
bicycle #	57	39	40	42	41	47	47	48
bicycle rate	19.6	13.4	13.7	14.3	13.9	15.9	15.9	16.1
falls #	616	583	597	612	589	572	572	615
falls rate	211.7	199.8	203.9	208.4	200.0	193.6	193.0	206.2
MV #	98	93	151	106	120	125	125	156
MV rate	33.7	31.9	51.6	36.1	40.7	42.3	42.2	52.3
pedestrian #	35	42	32	45	26	47	47	48
pedestrian rate	12.0	14.4	10.9	15.3	8.8	15.9	15.9	16.1
suicidal #	176	224	35	37	44	61	55	55
suicidal rate	60.5	76.8	12.0	12.6	14.9	20.6	18.6	18.4


Hospitalized Injuries in Anchorage 2009-2016
3000
2500
2000
1500
1000
500
0
237
875
91
277
2701
2133
437
463
115
200
377
311
247
154
Assault
Bicycle
Falls
MV
Pedestrian
Suicidal
Suicide 2009-2010
Totals by Gender Female
Totals by Gender Male


Average Hospitalized Injuries by Gender, Anchorage 2009-2016
400
350
300
250
200
150
100
50
0
30
109
11
35
338
267
55
58
14
25
47
39
124
77
Assault
Bicycle
Falls
MV
Pedestrian
Suicidal
Suicide 2009-2010
Average per year Female
Average per year Male

Prescription Opioid Misuse and Heroin Use Among Youth and Young Adults in Anchorage, Alaska, Needs Assessment

Healthy Voices Healthy Choices & Alaska Injury Prevention Center

Healthy Voices Healthy Choices

Prescription Opioid Misuse and Heroin Use Among Youth and Young Adults in Anchorage, Alaska, Needs Assessment

April 15, 2017

Prepared for

Healthy Voices Healthy Choices coalition
Volunteers of America
Charlie Daniels
Phone: 907-265-1912
Email: cdaniels@voaak.org
Website: www.voaak.org/healthy-voices-healthy-choices

Prepared by

Alaska Injury Prevention Center
Marcia Howell, Lindsey Hajduk and Sylvia Craig
Phone: 907-929-3939
Email: Marcia.Howell@alaska-ipc.org
Website: www.alaskainjurypreventioncenter.org

Acknowledgements

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The Healthy Voices Healthy Choices coalition would like to thank to all its coalition members for the oversight and feedback throughout the needs assessment process. In particular, we would like to thank Amanda Lenhard with the American Lung Association, the Alaska Counter Drug Support Program, Matt Keith with Geneva Woods, Eydie Flygare with Tutan Recovery Services, Will Hurr with Boys and Girls Clubs of Alaska, Chris Kosinski with Anchorage Water and Waterwaste Utility, and the Anchorage Police Department. We would also like to thank our key informant interview experts.

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We would like to thank Alaskan AIDS Assistance Association for the collection of open-ended survey information from their clients. We would also like to thank the following agencies for providing primary and secondary data for this report, including: the State of Alaska Division of Behavioral Health, the Anchorage School District, Alaska Trauma Registry, other local agencies, and Volunteer's of America Alaska's PRIME For Life program. We would like to thank Adriene Active for support on the resource assessment and Marny Rivera for evaluation support.

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I. Table of Figures

II. Table of Tables

III. Introduction

The State of Alaska's Department of Health and Social Services, Division of Behavioral Health (DBH) issued the Strategic Prevention Framework Partnerships for Success Grant (SPF PFS) to coalitions across the state of Alaska to prevent the non-medical use of prescription opioids (NMUPO) among 12-25 year olds and heroin use among 18-25 year olds. Within Anchorage, the Volunteers of America Alaska's Healthy Voices Healthy Choices coalition (HVHC) was awarded funding. HVHC contracted with Alaska Injury Prevention Center (AIPC) to conduct this assessment.

Purpose of Assessment

The DBH tasked grantees with collecting data pertaining to NMUPO among 12-25 year olds and heroin use among 18-25 years olds. Through the assessment, grantees were to collect data pertaining to the nature of NMUPO and heroin use and related consequences, including health disparities related to NMUPO and heroin use. Grantees were also asked to assess intervening and community factors. Specifically, grantees were required to assess community factors related to social and retail availability, and perceived risk for harm of NMUPO and heroin use, and an additional intervening variable the coalition identified in this process is regarding harm reduction. PFS grantees were additionally asked to assess the community's capacity and readiness to address NMUPO and heroin use.

Strategic Prevention Framework

The Substance Abuse and Mental Health Services (SAMHSA) funds the Alaska SPF PFS grant. The DBH requires PFS grantees to use the Strategic Prevention Framework (SPF) to approach the prevention of NMUPO and heroin use. The SPF is a prevention model used by community coalitions to improve the behavioral health of their communities.

Figure 1 Strategic Prevention Model

The SPF takes a comprehensive approach to behavioral health and prevention and is rooted in principles of public health and community organizing. Strategies based on the SPF should address both the individual and the environment. The SPF outlines five processes for implementation: 1) Assessment, 2) Capacity Building, 3) Planning, 4) Implementation, and 5) Evaluation. The SPF places Cultural Competency and Sustainability at the core of this process, meaning that at each step of the SPF, coalitions should work to ensure their actions demonstrate cultural competence and that the work being done is sustainable into the future.

Stakeholders

Healthy Voices Healthy Choices

HVHC is a coalition with Volunteers of America Alaska. HVHC brings together various stakeholders to promote healthy choices through public education, outreach, advocacy, and youth-led activities. The vision of HVHC is to educate and promote healthy lifestyle choices related to our community's youth and young adult's mental, physical, and emotional wellness. HVHC actively advocates for a community that:

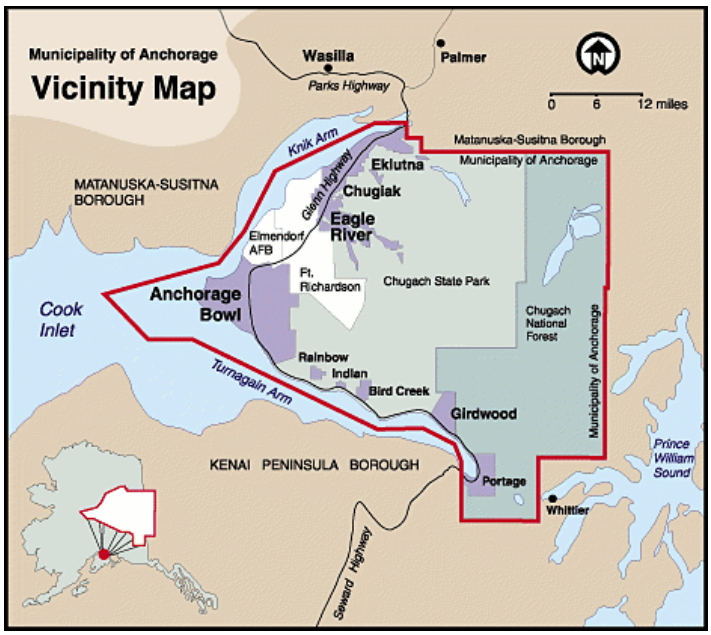
- Prevents access to alcohol, drugs, and tobacco products by youth and young adults.
- Promotes abstinence from alcohol, tobacco, and other drugs in youth and young adults.
- Supports and promotes effective lifestyle choices that build and strengths positive assets in our youth and young adults.

Alaska Injury Prevention Center

The Alaska Injury Prevention Center (AIPC) is a non-profit located in Anchorage, Alaska. AIPC's core purpose is to promote wellness, prevent injury, and improve safety in Alaska. AIPC has a history of collecting primary data and assessing existing datasets. HVHC contracted with AIPC to conduct the assessment. AIPC will also assist HVHC with developing the logic model and strategic plan. AIPC is a member of the HVHC coalition.

Community Description

The Municipality of Anchorage, Alaska includes the communities of Anchorage, Chugiak, Eagle River, Joint Base-Elmendorf Richardson, Girdwood and communities along Turnagain Arm. Located in Southcentral Alaska, the Anchorage metropolitan area sits in a bowl with Cook Inlet to the west, and Chugach State Park to the east. Warmed by Pacific currents, the city has a mild northern climate (Anchorage Convention & Visitors Bureau). The average temperature is 37 F, with an average



annual high of 43.7, and average low of 30.3 F (US Climate Data).

Demographics

The U.S. Census Bureau estimates the July 2016 population of Anchorage to be 299,816. This is a 2.2% increase from 2010 population estimates (Anchorage Economic Development Corporation, 2013). Anchorage is the largest community in the state, with just over 40% of Alaska's population.

Since 2010, Anchorage has added more than 28,000 residents through births, lost 9,400 residents from deaths, and experienced a net loss of 12,400 residents from out-migration. The population peaked in 2013 at 300,957 residents, but has since had a net loss of 1,920 residents since that time (Anchorage Economic Development Corporation, 2017c). In-migration into Anchorage is occurring among individuals in their mid-20's, often from other Alaska communities. Out-migration is occurring among individuals in their late-teens/early-20's as they leave the state for school or work (Anchorage Economic Development Corporation, 2017c).

Population growth in Anchorage will continue to be slowed by an aging demographic. Alaska Department of Labor and Workforce Development long-term projections indicate the population of those over 65 years old are anticipated to increase more than 30% between 2017 and 2022. Over that same period the population of residents between the ages 20 and 64 are anticipated to decrease slightly (Anchorage Economic Development Corporation, 2017c).

Race and Ethnicity

According to 2015 estimates based on 2010 data from the United States Census Bureau, the racial/ethnic makeup of Anchorage is approximately as follows:

- 65.5% White
- 9.6% Asian
- 9.1% Hispanic or Latino
- 8.3% American Indian and Alaska Native
- 7.9% Two or more races
- 6.2% Black or African American
- 2.4% Native Hawaiian and Other Pacific Islander

Anchorage is home to more Alaska Native people than any other city in the United States (Hunsinger & Sandberg, 2013). In 2010, 26% of the state's Alaska Native population lived in Anchorage (Williams, 2010). Today, parts of Anchorage are more than 50% people of color. As reported in the Alaska Dispatch News, Anchorage's Mountain View census area was recently identified as the most racially diverse census tract in the entire United States (McCoy, 2013). Seventeen percent of Anchorage residents speak another language than English in their homes. Approximately 10% of Anchorage residents were not United States citizens at birth.

Education

In 2016, the estimated population at 25 years or older is 192,637. Of this population, approximately 5,244 (2.72%) people have below a 9th grade education level; 7,482 (3.88%) have

a grade 9-12 education level; 46,448 (24.11%) have a high school level; 52,940 (27.48%) have some college; 16,465 (8.55%) have an associate degree; 41,734 (21.66%) have a bachelor's degree; and 22,324 (11.59%) have a graduate degree (Anchorage Economic Development Corporation, 2017b).

The municipality of Anchorage is also home to the University of Alaska Anchorage (UAA), which is Alaska's largest post-secondary institution and is part of the Alaska's statewide university system. UAA serves over 14,000 students and hosts 113 student clubs. UAA offers 151 degree programs, including: associate, certificate, bachelor, masters, and doctoral programs (University of Alaska, Anchorage, 2017)

Gender

In 2015, the population of Anchorage was approximately 145,703 female (48.6%) and 154,113 male (51.4 (United States Census Bureau, 2015).

Age

Table 1 provides a brief profile of the Anchorage youth populations by age. At the time of the 2010 census, there were over 65,000 youth between ages 10 and 24 living in Anchorage.

Table 1 Anchorage Youth and Young Adult Population by Age, 2010 Census

Ages	Number of Youth
20-24	24,379
15-19	21,187
10-14	20,443
5-9	20,618
4 and under	21,961

Note. Adapted from the State of Alaska Department of Labor and Workforce Development, Research and Analysis. (2016). *Demographic Profile for Anchorage Municipality*. Retrieved from: http://live.laborstats.alaska.gov/cen/dppdfs/dem_profile_52.pdf

Military and Veteran Population

The Anchorage population also includes 5,500 military and civilian personnel from the military Joint Base Elmendorf-Richardson (Joint Base Elmendorf-Richardson, n.d.). There are approximately 29,141 veterans living within Anchorage, based on 2011-2015 estimates (United States Census Bureau, 2015).

Socio-Economic Indicators

The median Anchorage household income between 2011-2015 was $78,326 (United States Census Bureau, 2015). An estimated 8.7% of people were recorded as living below poverty level (United States Census Bureau, 2015), with 32,947 people 125% below poverty level (State of Alaska Department of Commerce, Community, and Economic Development, n.d.)

Between October 1, 2013, and September 30, 2014, there were 7,506 people recorded as homeless in Anchorage (Alaska Coalition on Housing and Homelessness, 2014). This includes families and individuals in emergency shelters, transitional housing, and permanent supportive housing. In the same timeframe, 987 children were represented under the same categories. This does not include people using "other programs whose primary mission is to provide services to victims of domestic violence, dating violence, sexual assault, or stalking," such as rape crisis centers or battered women's shelters (Alaska Coalition on Housing and Homelessness, 2014).

Housing

The average Anchorage household size from 2011-2015 was 2.77 persons per household (United States Census Bureau, 2015). Of the estimated 115,461 Anchorage households in 2016, 66,475 were owner-occupied and 44,830 were renter-occupied (Anchorage Economic Development Corporation, 2017). In 2011, there were 40,575 family households and 9,910 single mother households containing people less than 18 years of age in Anchorage (Anchorage Economic Development Corporation, 2013).

In 2016, the average sales price of a home in Anchorage was $363,932. The relative cost of housing in Anchorage has risen every year since 2009, except for 2016 with a 0.23% decrease from 2015. The average rent in Anchorage decreased from $1,312 in 2015 to $1,214 in 2016 for a two-bedroom apartment. The local vacancy rate in 2016 was 3.79% (Anchorage Economic Development Corporation, 2017c).

Employment

As of 2011, the Anchorage labor force was estimated at 157,210 persons, with 147,604 people employed (Anchorage Economic Development Corporation, 2012). Table 2 shows the top ten occupations in Anchorage as of 2012.

Table 2 Top Ten Anchorage Occupations

Occupations	Number of Workers	Female	Male
Retail Salespersons	5,087	2,831	2,256
Cashiers	3,290	2,066	1,223
Office and Administrative Support Workers, All Other	2,864	2,238	626
Combined Food Preparation and Serving Workers, Including Fast Food	2,627	1,513	1,111
Office Clerks, General	2,544	1,930	614
Personal Care Aides	2,256	1,711	542
Registered Nurses	2,233	2,011	221
Janitors and Cleaners, Except Maids and Housekeeping Cleaners	2,014	688	1,323
Bookkeeping, Accounting, and Auditing Clerks	1,869	1,622	247

Occupations	Number of Workers	Female	Male
General and Operations Managers	1,114	677	1,137

Note. Data retrieved from the State of Alaska Department of Labor and Work Force Development, Research and Analysis: Alaska Local and Regional Information, Anchorage Municipality; accessed 4/6/15;

Cost of Living

Anchorage's overall cost of living index is 130.2% of the national average—or 30.2% higher than the national average—ranking the Anchorage the 20th most expensive city to live in in the U.S. (Anchorage Economic Development Corporation, 2017).

In 2013, housing was the top item of expenditure for Anchorage residents. Average distribution of expenditures included 40.6% housing; 16.9% transportation; 15.5% food and beverages; 6.6% medical care; 6.7% recreation; 5.7% education and communication; 5% clothing; and 3.1% other goods and services (Fried, 2014).

Health Care and Coverage

Anchorage is ranked the third highest in the nation for health care costs, preceded by two other Alaska cities: Juneau and Fairbanks. A physician's office visit is 63.7% higher than the national average (Anchorage Economic Development Corporation, 2017).

In 2013, the share of Anchorage residents who were uninsured was 18.5%. In 2012, 14.5% of Anchorage residents were not able to receive the care they needed due to the cost of health care. Also in 2012, 41.7% of Anchorage residents reported not having a primary doctor or provider. In 2012, avoidable hospital admissions, which are hospitalizations due to conditions that could have been avoided with preventive and primary care services, had decreased to 39.9 per 1000 hospitalizations (Providence Medical Center, 2015).

Anchorage has four major hospitals, and a wide range of behavioral and mental health services available. The National Alliance on Mental Illness Anchorage lists 15 community mental health service providers in the Anchorage metro area (NAMI Anchorage). The Anchorage Neighborhood Health Clinic serves uninsured and low-income individuals and families and provided $7.8 million in services to almost 14,500 people in 2013 (Anchorage Neighborhood Health Center, 2014). The Alaska children's health insurance program Denali KidCare pays for healthcare for children and teens through age 18 (Alaska Department of Health and Social Services, 2016)

Governance

The Municipality of Anchorage lists 34 departments, divisions, and offices, including the Department of Health and Human Services, Office of Emergency Management, Fire Department, Police Department, Parks and Recreation Department, Municipal Light and Power,

Library, Anchorage Museum at Rasmuson Center, Solid Waste Services, Port of Anchorage, and Public Transportation, among others (Municipality of Anchorage, 2015).

There are 38 community councils representing Anchorage's neighborhoods that sere as advisories to the Anchorage Assembly (Municipality of Anchorage, 2015). The community councils are private, non-profit associations comprised of volunteer citizens within set geographical neighborhoods designated by the Assembly (Municipality of Anchorage, 2015).

As of 2013, a total of 344 police officers were fulltime law enforcement employees in Anchorage. The Anchorage Police Department is the largest police department in the state of Alaska. It maintains a Crisis Intervention Team of police officers who are educated on mental illness, suicide and crisis interventions, active listening, and de-escalation techniques so that they may respond to calls for persons with mental illness with empathy and respect. More than 90 officers have become APD Crisis Intervention Team members since the program's inception in 2011 (Municipality of Anchorage, 2015).

Legal System

Anchorage's court system is part of the State of Alaska Court system and is comprised of the Anchorage District Court, Anchorage Superior Courts, and the Alaska Supreme Court (State of Alaska, 2015). In addition to the traditional court system, the Anchorage Youth Court "provides the opportunity for youth in grades 7 through 12 who are accused of breaking the law to be judged by their peers. It is a court in which the roles of attorneys, judges, bailiffs, clerks, and jurors are filled by youth" (Anchorage Youth Court, 2015). Anchorage Youth Court allows youth the opportunity to resolve their legal issues without creating a formal criminal record. Defendants are typically first time offenders and are referred to the Anchorage Youth Court through McLaughlin Youth Center's Juvenile Probation Office. There are eight youth facilities operated by the State of Alaska's Division of Juvenile Justice. Anchorage's youth facility, McLaughlin Youth Center, has the capacity to detain or provide treatment for 135 youth (State of Alaska, 2015).

IV. Methods

HVHC and AIPC worked in collaboration to complete the assessment in accordance with the guidance document provided by DBH. This assessment covered four areas of NMUPO and heroin use in compliance with DBH's recommendations. First, HVHC and AIPC assessed consumption and related consequences. Second, the coalition assessed intervening variables and community factors related to NMUPO and heroin use. These key intervening variables are: social availability of prescription opioids and heroin, retail availability of prescription opioids through providers, and perceptions of risk for harm. Third, the assessment looked at community resources and community readiness. Fourth and last, the coalition prioritized community factors related to NMUPO and heroin use.

A combination of primary and secondary data sources and tools were used to capture and analyze both quantitate and qualitative datasets. These various datasets and collection methods are detailed below.

Secondary Data

To measure NMUPO and heroin consumption and its consequences, this assessment relied on data from existing sources. This included data from the Youth Risk Behavior Survey (YRBS), National Survey on Drug Use and Health (NSDUH), Alaska Trauma Registry (ATR), Volunteers of America Alaska, and the State of Alaska Department of Health and Social Services (DHSS). These data sources provided estimates of NMUPO use and heroin use in Anchorage, as well as information about overdose and fatality. HVHC and AIPC also used data from the Alaska Young Adults Substance Use Survey (YASUS).

Youth Risk Behavior Survey

The YRBS is an anonymous school-based survey of high school students that covers six categories of adolescent health and social behaviors (Alaska Division of Behavioral Health, 2012). The survey is administered every other year and the most recent survey was conducted in 2015. In spring 2015, 1,418 students from across the state of Alaska were surveyed. The YRBS contains questions pertaining to current and lifetime prescription drug use (not specific to opioid use/misuse) and heroin use. Data is available at the district level for the Anchorage School District.

Alaska Trauma Registry

The Alaska Trauma Registry collects data from 24 of Alaska's acute care hospitals for patients with serious injuries. Alaska Injury Prevention Center requested data from the Division of Public Health pertaining to opioid and heroin overdose for the appropriate age groups.

State of Alaska Department of Health and Social Services

The DHSS has issued several epidemiology bulletins covering the NMUPO and heroin use issue. In March of 2016, the DHSS issued a bulletin with information about drug overdose deaths in Alaska from 2009-2015. This bulletin relied on mortality data collected by the Alaska Bureau of Vital Statistics.

Alaska Young Adult Substance Use Survey

The Center for Behavioral Health Research and Services at University of Alaska Anchorage conducted a telephone survey to assess young adult substance use in Alaska (J.D. Barnett, personal communication, December 23, 2016). Specifically, the YASUS aimed to establish state-level estimates of opioid and heroin consumption and consequences among 18-27 year olds. The YASUS also contained questions pertaining to social availability, retail availability, and perceived risk of harm. There were a total of 39 questions within the survey.

A total of 7,130 individuals were invited to participate and a total of 1,031 respondents completed the survey. While the research team intended to only invite participants in the 18-27 age range, some participants were older than 25. Of the 1,031 respondents to complete the survey, 779 (75.6%) were within the target age range of 18-27. Of the 7,130 participants invited to participate, 2,100 were residents of Anchorage. Anchorage participants in the 18-27 year range completed a total of 212 surveys.

The UAA research team obtained Institutional Review Board (IRB) approval from the University of Alaska Anchorage and the Alaska Area Institutional Review Board to conduct the YASUS. Per IRB protocol the research team could not provide raw data for further analysis, but did provide data analysis for statewide and Anchorage data as a whole, and by race and gender.

Primary Data Collection

Because of the complexity of opioid misuse and heroin use, HVHC and AIPC jointly decided to gather primary data, both qualitative and quantitative. Qualitative data collection methods allow participants to provide in-depth explanations and rich narrative on a topic. Since NMUPO and heroin prevention are an emerging issue in the Anchorage community, HVHC and AIPC wanted to collect as much information as possible. Giving community members the chance to speak freely on the issue provided HVHC and AIPC with a more comprehensive understanding of the issue. HVHC and AIPC conducted interviews and open-ended surveys with community members and current NMUPO and heroin users to gather more information about the consequences of NMUPO and heroin use in the community. A telephone survey, conducted by Hays Research Group, collected data from Anchorage residents around knowledge of the problem of NMUPO and heroin use, concern about the issues and levels of knowledge of efforts to address the problems.

Key Informant Interviews

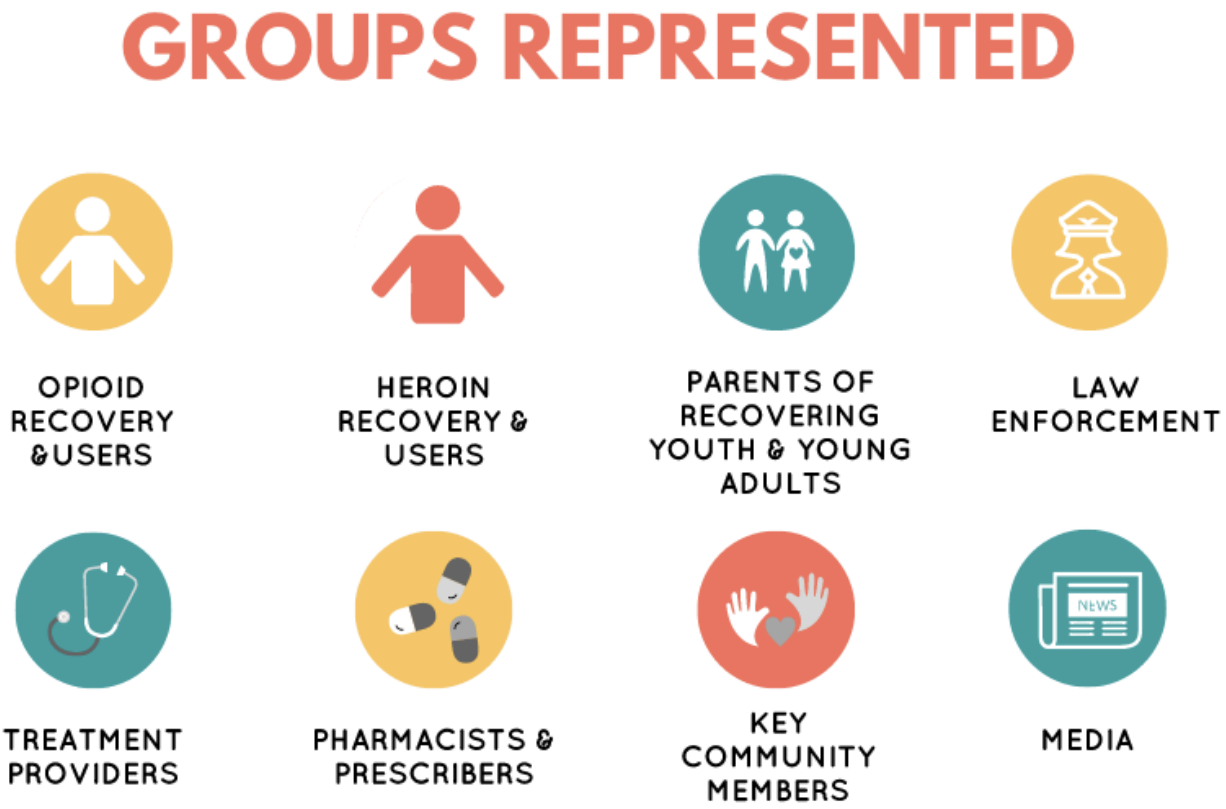
The assessment team first considered conducting focus groups. However, due to the sensitive nature of the topic, the assessment team ultimately decided to conduct one-on-one interviews. The assessment team chose to conduct one-on-one interviews to ensure that all participants were given room to speak freely on the topic and to avoid any discomfort an individual might feel sharing in a group.

The key informant interviews were qualitative, in-depth interviews with people who know what is going on in the community regarding non-medical prescription opioid use and heroin use

within our target population. The key informants provided nature on the insight of the nature of the challenges around the issues as well as provided recommendations for solutions within Anchorage.

HVHC and AIPC worked together to identify individuals to interview. Interviewees included a mix of existing and new contacts. AIPC and HVHC chose to interview parents, individuals in recovery for opioid use, individuals in recovery for heroin use, active users, treatment providers, prescribers, military personnel, corrections/law, and community members representing health care, education, business, and local media. Interviewees were asked to identify others they think might have valuable input or be interested in participating in coalition activities.

Figure 2 Key Informant Interview Sector Representation



HVHC and AIPC staff and volunteers directly contacted respondents to solicit participation. Respondents were offered the option to go through the questions as an interview or provide written responses to each of the questions. A total of 22 key informants were interviewed for this needs assessment. Responses were synthesized based on sector representation. A full synthesis of all 22 interviews by sector is included in Appendix A in this document.

Open-Ended Written Surveys

To collect data from current users, AIPC distributed open-ended written surveys to Alaskan AIDS Assistance Association (Four A's). Four A's coordinates and houses the city's only syringe exchange program. AIPC initially provided Four A's with 25 surveys. After receiving the completed 25 surveys back from Four A's staff, AIPC provided 25 more surveys with a few modifications based on responses from the initial survey distribution. Both surveys are included in the Appendix I of this document.

In total, Four A's staff distributed and collected 50 surveys from current users of either heroin, opioids, or both. In exchange for completing the survey, respondents received a $25 WalMart gift card. Four A's began distributing surveys on February 8, 2017 and had 50 surveys completed by February 13, 2017.

Volunteers of America Alaska PRIME for Life Data

Volunteers of America Alaska, in collaboration with the Anchorage School District, the Boys and Girls Club of Southcentral Alaska, and the First Christian Methodist Episcopal Church offers PRIME for Life to middle and high school students in the greater Anchorage area (Volunteers of America Alaska, 2017). PRIME for Life is a three-day, alternative to suspension course for first-time drug and alcohol offenses. It can also serve as a preventive course for students wishing to avoid suspension. The PRIME for Life program engages students in self-evaluation of their decision to use drugs and alcohol, helps students see the life-long consequences of drug and alcohol use, and equips students with the skills needed to prevent future substance use.

Volunteers of America Alaska coordinates the PRIME for Life program and conducts surveys with participants. The surveys contain questions pertaining to drug and alcohol use, including social availability. AIPC and HVHC analyzed the data from these surveys for this assessment.

Telephone Survey

The Alaska Injury Prevention Center contracted with Hays Research Group LLC to conduct a telephone survey regarding attitudes, opinions, and behaviors related to several behavioral health issues in Anchorage, Alaska. Questions about opioid and heroin use were included. Marcia Howell of AIPC and Adam Hays of Hays Research Group developed the survey instrument. The telephone survey was conducted from August 4, 2016 to August 9, 2016. Each survey averaged approximately eight minutes in length.

A total of 382 residents from Anchorage, Alaska were interviewed. The sample was kept in proportion to state population figures with the margin of error for age groups and gender.

Hays Research Group team used IBM SPSS software to analyze the data. They provided frequency and cross tabulation data. Those results are presented in the Key Findings section of this report.

Community Readiness

A community readiness assessment was conducted following the Tri-Ethnic Center for Prevention Research's model of Community Readiness for Community Change. (Plested, Jumper-Thurman, & Edwards, 2015). The community readiness assessment on the non-medical use of prescription opioids and heroin use measured attitudes, knowledge, resources, and efforts and activities of community members and leadership in order to assess the community's readiness to address five key dimensions: 1) Community knowledge of the issues (how much does the community know about the issues?); 2) Community knowledge of efforts (How much does the community know about current prevention programs and activities?); 3) Community climate (What is the community's attitude toward addressing the issues?); 4) Leadership (What is he leadership's attitude toward addressing the issue?); and 5) Resources (What are the resources being used or that could be used to address the issue?).

Tri-Ethnic Surveys Methodology

AIPC and HVHC developed a group interview protocol to evaluate the levels of community awareness, understanding, and readiness of NMUPO and heroin use in Anchorage. The community readiness protocol is attached in Appendix B.

A selected group of HVHC coalition members and community members was invited to attend one or two community readiness assessment focus groups. These participants were identified and selected as key informants based on their representation of various sectors in the community as well as their knowledge and experience around the issues. Eight participants joined the group focused on non-medical prescription opioid use for 12-17 year olds. Eleven participants joined a group focused on non-medical prescription opioid and heroin use for 18-25 year olds.

The total of 19 key informants joined our two group interviews representing the following community sectors: youth-serving organizations, military, law enforcement, clinical services, medical services, youth, parents, Native American, people in recovery, Hispanic, Alaska Native, faith, and non-profit communities.

The group interviews were conducted, captured, scored, and analyzed by AIPC and HVHC staff. The interview discussions were analyzed for key themes relating to priority community factors related to retail availability, social availability, perception of risk for harm, and harm reduction. All interviews were individually scored on the community readiness scale using the Tri-Ethnic Center Community Readiness Model.

Every key informant scored each community readiness dimension, and then the scores were averaged for each dimension of readiness for the two issues (non-medical prescription opioid use for 12-17 year olds, and non-medical prescription opioid and heroin use for 18-25 year olds). The scores for each dimension were then averaged to arrive at an "overall" community readiness score for each issue.

Table 3 Stages of Community Readiness Scale (Colorado State University, 2014)

Stage of Readiness	Score
No Awareness	1
Denial/Resistance	2
Vague Awareness	3
Preplanning	4
Preparation	5
Initiation	6
Stabilization	7
Confirmation/Expansion	8
High Level of Community Ownership	9

V. Key Findings

Extent of the Problem in the Community

Current Consumption Patterns

Prescription opioid misuse/abuse and heroin use in Anchorage

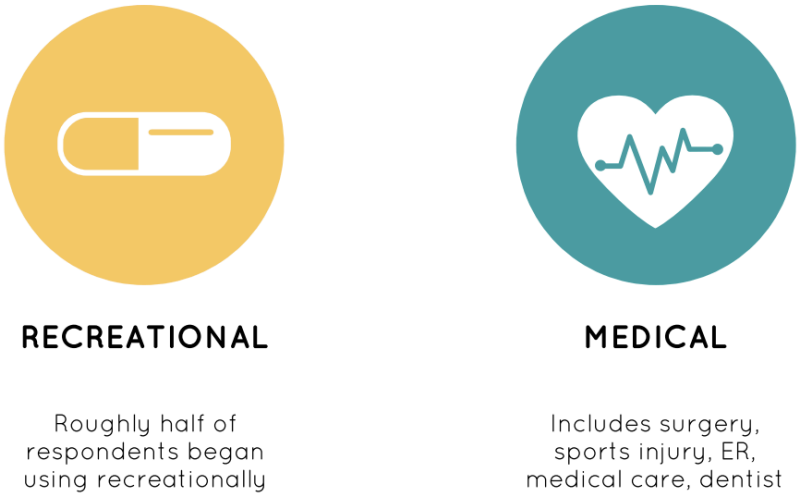
Prescription opioid misuse and heroin use are prevalent throughout the community. Our key informant interviews revealed the far reach the impacts of opioid or heroin addiction have on the community, and that many people are affected.

> *"Most people know opioids are dangerous, that they never wanted loved ones to do it. But many people know someone who does. […] Many people using heroin didn't start there. The community has more sympathy for opioid and heroin users than other drugs because we all know someone." (Key Informant, February 2017)*

Based on our key informant interviews with people in recovery and our open-ended surveys from current users, there was a roughly even split between people being initially introduced to opioids for both recreational and medical purposes. People also shared that if they were using prescription opioids they would often both use and sell them to others.

Figure 3 Introduction to Opioids for Recreational and Medical Use

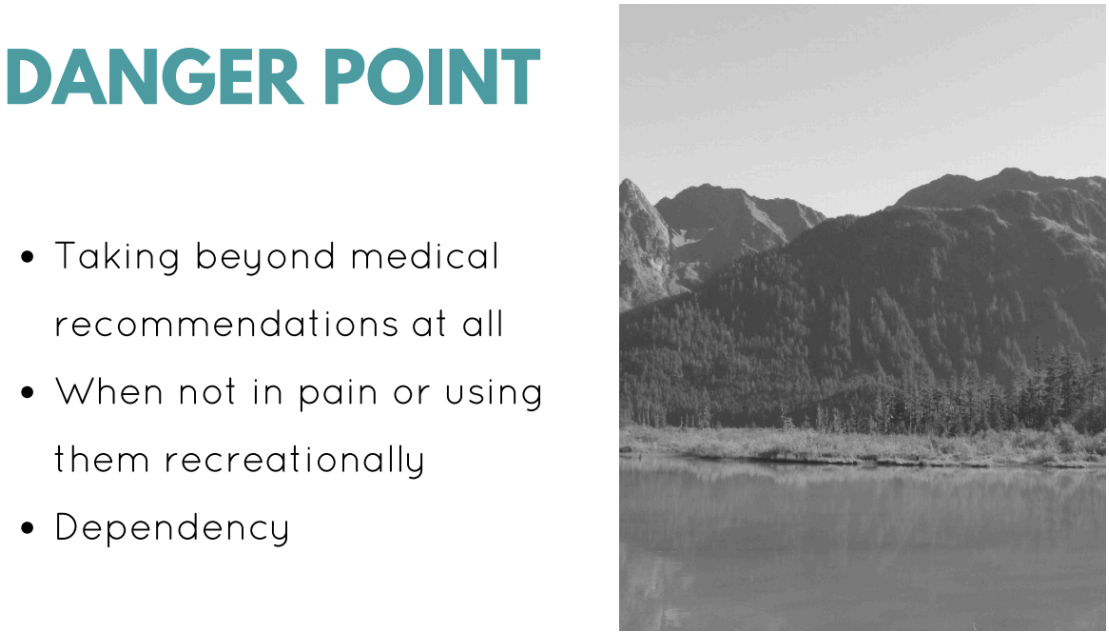
INTRODUCTION TO OPIOIDS



There were varying opinions of what constituted "misusing prescription opioids." Some thought it was when a person first begins to use them beyond medical recommendations, others believed it was when the opioids were not treating pain, and others believed it was as soon as a dependency is established.

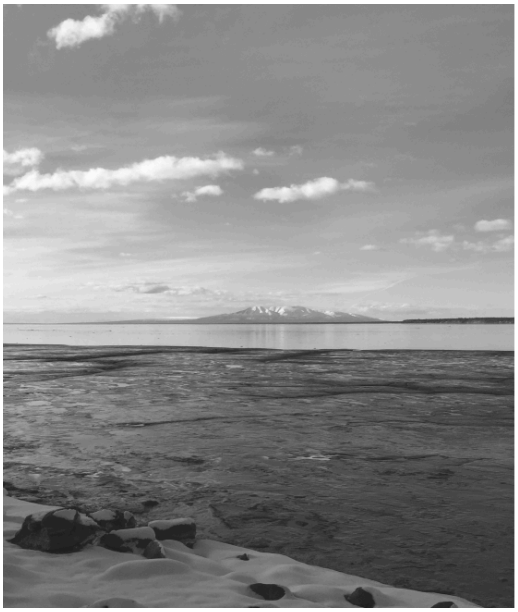
> *"I think it is highly likely that someone who is misusing opioids runs the risk of becoming addicted. This drug is quick to claim its next victim. […] Children don't understand how this drug works and how quickly it can take over their lives. Once they are in the stages of needing it, it's hard to go through the withdrawal." (Key Informant, February 2017)*

Figure 4 Summary of Themes for When Taking Prescription Opioids is Risky



Once a person has access to prescription opioids there is a risk at becoming addicted. Based on our key informant interviews, there were numerous reasons that may lead people within Anchorage to begin overusing prescription opioids.

Figure 5 Summary of Themes for Reasons People Begin Overusing Prescription Opioids

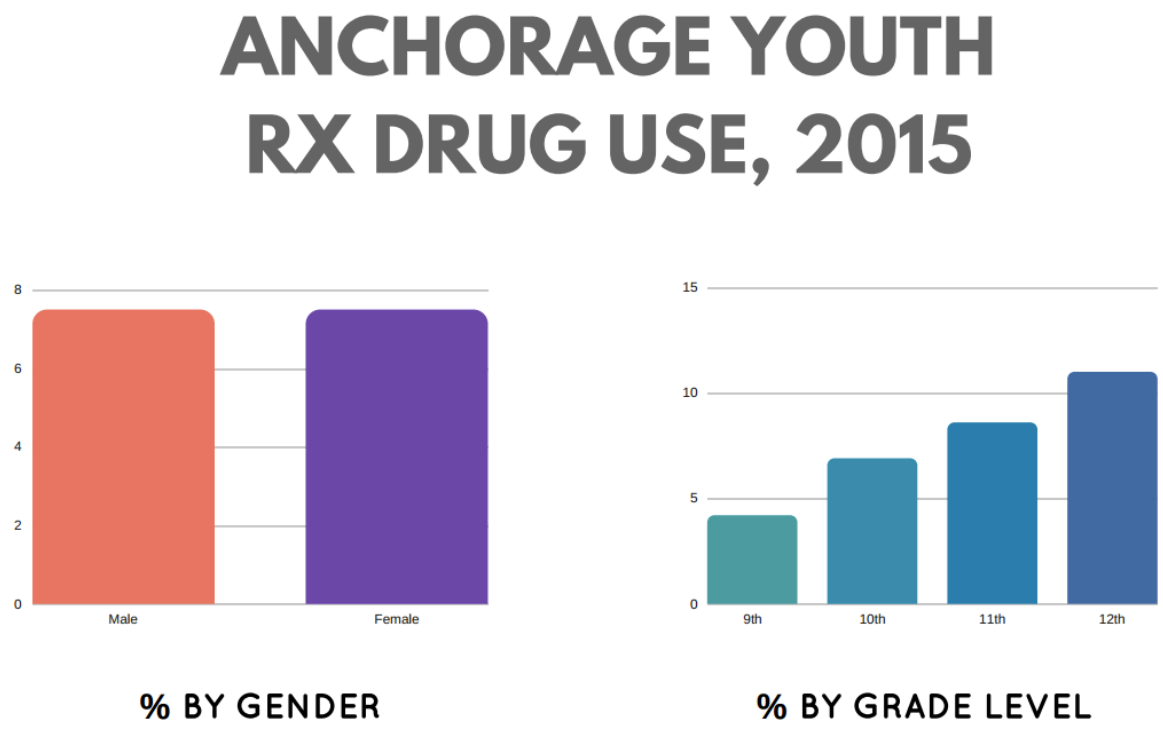


Use of prescription drugs by youth

Data from the YRBS reveals several trends for the use of prescription drugs by youth 12-17 years of age. It is important to note that the question on the YRBS survey does not differentiate between different kinds of prescriptions drugs and may not solely capture opioid use. Figure 6 shows trends in prescription drug use without a prescription over time based on gender and grade level.

Based on gender, there is a near-even percentage of males and females that use prescription drugs at just under 8% for both genders. Based on grade level, use of prescription drugs increases over grade levels and age of youth.

Figure 6 Anchorage Youth Prescription Drug Use



Youth Risk Behavior Surveillance data provided by PFS DETAL.

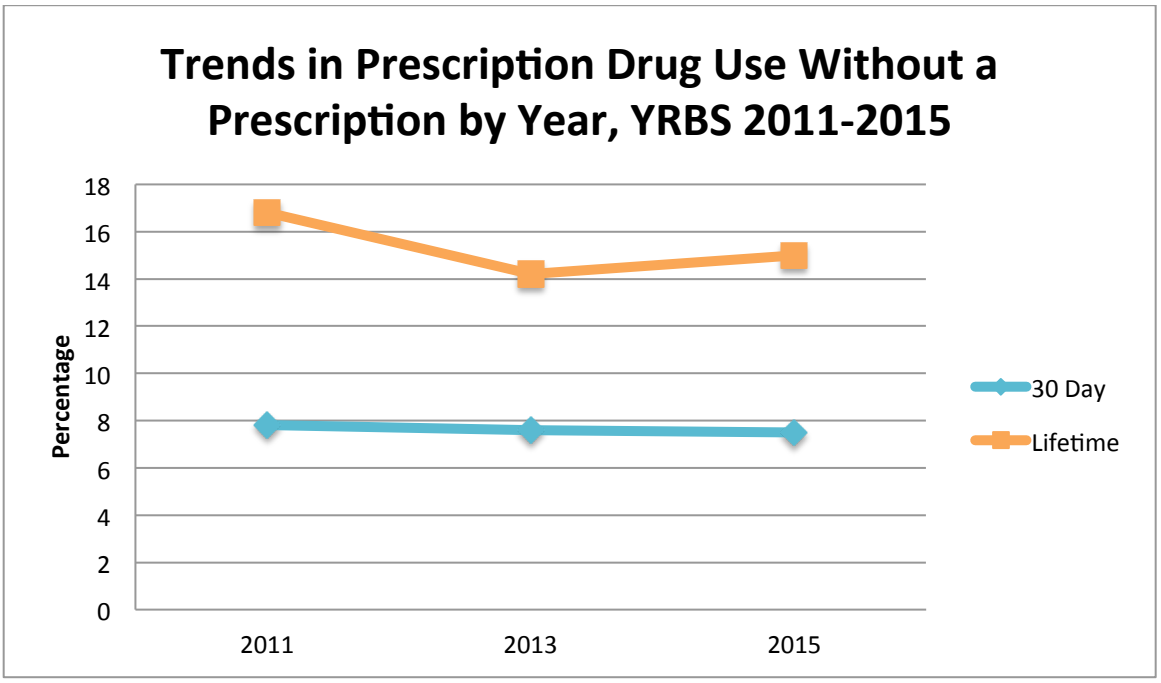
Many of our key informants believe the community has more compassion toward youth who fall victim to addiction.

> *"People have to understand that these kids don't plan on taking these pills to become addicts, and if they could go back and undo the first time they started I don't know of anyone who would have continued to keep taking these pills." (Key Informant, February 2017)*

Use of prescription drugs without a prescription by youth

Data from the YRBS reveals several trends for the use of prescription drugs without a prescription by youth. It is important to note that this question does not differentiate between different kinds of prescriptions drugs and may not solely capture opioid use. Figure # shows trends in prescription drug use without a prescription over time. Use of prescription drugs without a prescription by students in alternative high schools in Alaska was over 40%, in 2011, compared to 16.9% for all Alaskan high school youth (Hull-Jilly & Casto, 2011).

Figure 7 Anchorage Youth Prescription Drug Use



Youth Risk Behavior Surveillance data provided by PFS DETAL.

30 Day Use

An estimated 7.5% of Anchorage high school students had taken a prescription drug without a prescription from a doctor one or more times during the past 30 days. Rates of use in the past 30 days range from 4.2% in 9th grade to more than double that in 12th grade (11.0%). There was no difference in past 30-day use for males and females (7.5%). For this assessment, students who did not identify as white or Alaska Native were categorized as "Other Races." Compared to white and Alaska Native students, the Other Races group saw the highest rate (9.7%) of prescription drug use without a prescription. There were also differing rates of past 30-day use by academic performance. Approximately 12% of students with primarily grades of C, D, or F reported past 30-day use compared to 5.5% of students with grades of primarily A or B. This data shows that there is a greater rate of non-prescription drug use among students not identifying as white or Alaska Native, students primarily receiving grades of C, D, and F, and upperclassmen.

Table 4 Past 30 Day Prescription Drug Use Without a Prescription, YRBS 2015

	Estimate	95% Confidence Interval	
Alaska Total	6.4	5.1	8.0
Anchorage Total	7.5	5.7	9.8
Sex			
Male	7.5	5.1	10.8
Female	7.5	5.4	10.4

Race/Ethnicity			
White (Non-Hispanic, Single Race Only)	5.9	3.9	8.8
Alaska Native	7.4	4.0	13.2
Other Races/Refused/Missing/Unknown	9.7	6.9	12.5
Grade			
9th Grade	4.2	2.7	6.7
10th Grade	6.9	4.1	11.6
11th Grade	8.6	5.3	13.8
12th Grade	11.0	7.0	17.0
Academic Grades			
Mostly As and Bs	5.5	3.8	7.9
Mostly Cs, Ds, and Fs	12.1	8.6	16.8

Lifetime Use

Data from the 2015 YRBS indicate that 15.0% of Anchorage School District students had taken a prescription drug without a prescription from a doctor during their life. According to 2015 YRBS data, the rates for lifetime use by females (15.6%) was not substantially different compared to males (14.3%). There was little difference in prevalence for lifetime use when comparing racial/ethnic groups. Alaska Native and students not identifying as white or Alaska Native each had approximately 16% lifetime use of prescription drugs without a prescription, and 13.7% of white students reported lifetime use. There was a greater rate of lifetime use for upperclassmen compared to underclassmen. Just over 10% of high school freshman and 12% of high school sophomores reported lifetime use. High school juniors had the highest lifetime use rate in 2015 at 19.6% and 18.9% of high school seniors reported lifetime use. Approximately 21.5% of students with primarily grades of C, D, or F reported lifetime use of a non-prescribed prescription drug compared to 12.4% of students with grades of primarily A or B. This data shows that there is little difference in lifetime use between males and females, or students of different racial/ethnic groups. There are, however, differences in lifetime use by grade year as well as by academic performance.

Table 5 Lifetime Prescription Drug Use Without a Prescription, YRBS 2015

	Estimate	95% Confidence Interval	
Alaska Total	14.6	12.5	17.1
Anchorage Total	15.0	12.6	17.7
Sex			
Male	14.3	11.7	17.4
Female	15.6	12.1	19.9
Race/Ethnicity			
White (Non-Hispanic, Single Race Only)	13.7	10.2	18.3
Alaska Native	16.3	11.0	23.4

Other Races/Refused/Missing/Unknown	16.1	12.9	19.9
Grade			
9th Grade	10.3	7.6	13.8
10th Grade	12.3	8.6	17.1
11th Grade	19.6	14.6	25.9
12th Grade	18.9	12.8	26.9
Academic Grades			
Mostly As and Bs	12.4	9.9	15.5
Mostly Cs, Ds, and Fs	21.5	17.2	26.5

Use of heroin by Anchorage youth

The YRBS asks students about lifetime heroin use. An estimated 1.6% of students reported ever having used heroin. Table 5 shows lifetime use of heroin for students in Anchorage high schools by sex, race/ethnicity, grade level, and academic grades.

Table 6 Lifetime Use of Heroin, YRBS 2015

	Estimate	95% Confidence Interval	
Alaska Total	2.2	1.3	3.5
Anchorage Total	1.6	.9	2.9
Sex			
Male	2.6	1.4	4.7
Female	0.6	0.2	1.8
Race/Ethnicity			
White (Non-Hispanic, Single Race Only)	1.1	0.5	2.6
Alaska Native	0.8	0.2	4.3
Other Races/Refused/Missing/Unknown	2.6	1.2	5.4
Grade			
9th Grade	0.8	0.2	2.8
10th Grade	1.7	0.6	4.7
11th Grade	3.1	1.3	7.2
12th Grade	1.1	0.3	3.7
Academic Grades			
Mostly As and Bs	1.0	0.4	2.1
Mostly Cs, Ds, and Fs	2.9	1.3	6.3

Nonmedical use of pain relievers in the past year by youth and young adults

According to the National Survey on Drug Use and Health (NSDUH), there has been an increase in the nonmedical use of pain relievers among 18-25 year olds in Anchorage, from 11.79% to

12.35% from 2006/2008 to 2012/2012 (Heath, et al., 2015). Reported rates of use are greater in Anchorage than Alaska's statewide rate (11.78 in the 2010/2012 survey) and greater than the U.S. rate (10.29 in the 2010/2012 survey). The rates for 12-17 year olds were 7.2% in 2010/2012 in Anchorage. This is greater that the Statewide rate (6.41) and the national rate (5.85) in the 2010/2012 survey.

Table 7 Substance Use and Dependence Amongst Youth by Age Group (2010-2012)

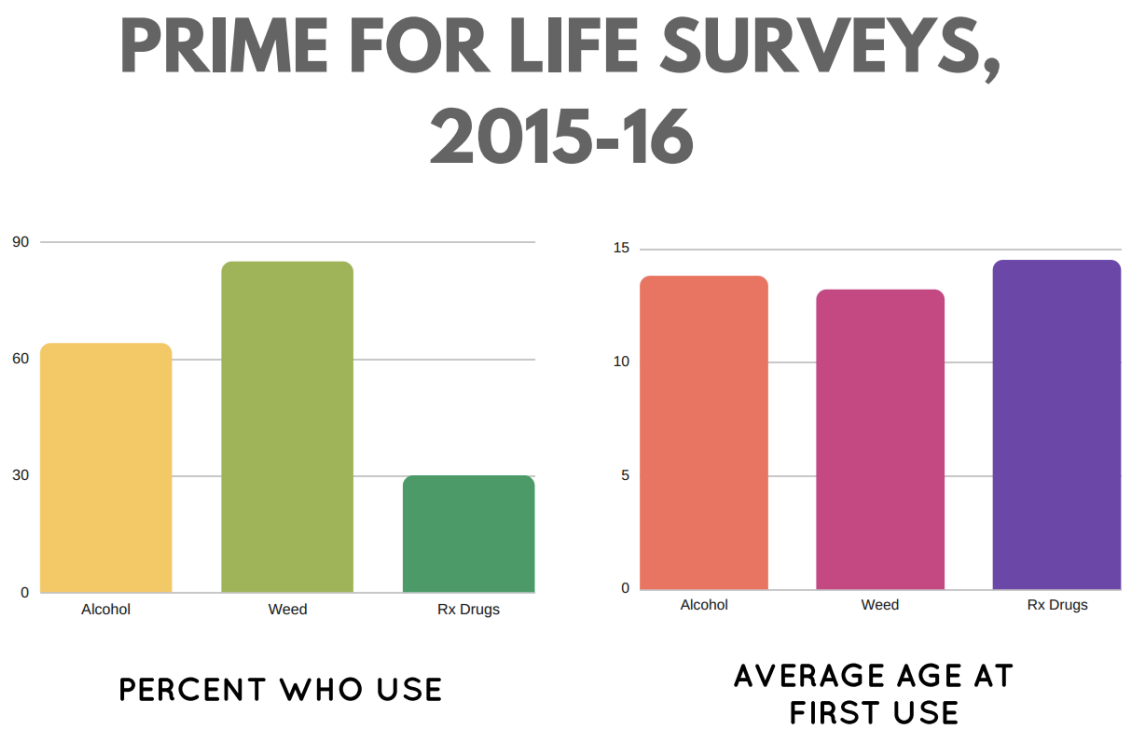
Behavior*	Anchorage	Alaska	United States
Ages 12-17			
Nonmedical Use of Pain Relievers	7.2%	6.41%	5.85%
Ages 18-25			
Nonmedical Use of Pain Relievers	12.53%	11.78%	10.29%

Note. Table created from data retrieved by Heath et al., 2015, from NSDUH.

*Refers to substance use or dependence in the year preceding survey.

With additional information gathered from PRIME for Life participant surveys, it is important to note that prescription drugs are the third most-used substance after marijuana and alcohol. Many of the youth participating in PRIME for Life self-reported that they began using prescription drugs at the average age of 14.

Figure 8 PRIME For Life Summary Data



Data provided by Volunteers of America Healthy Voices Healthy Choices.

Prescription drug misuse and abuse at University of Alaska Anchorage

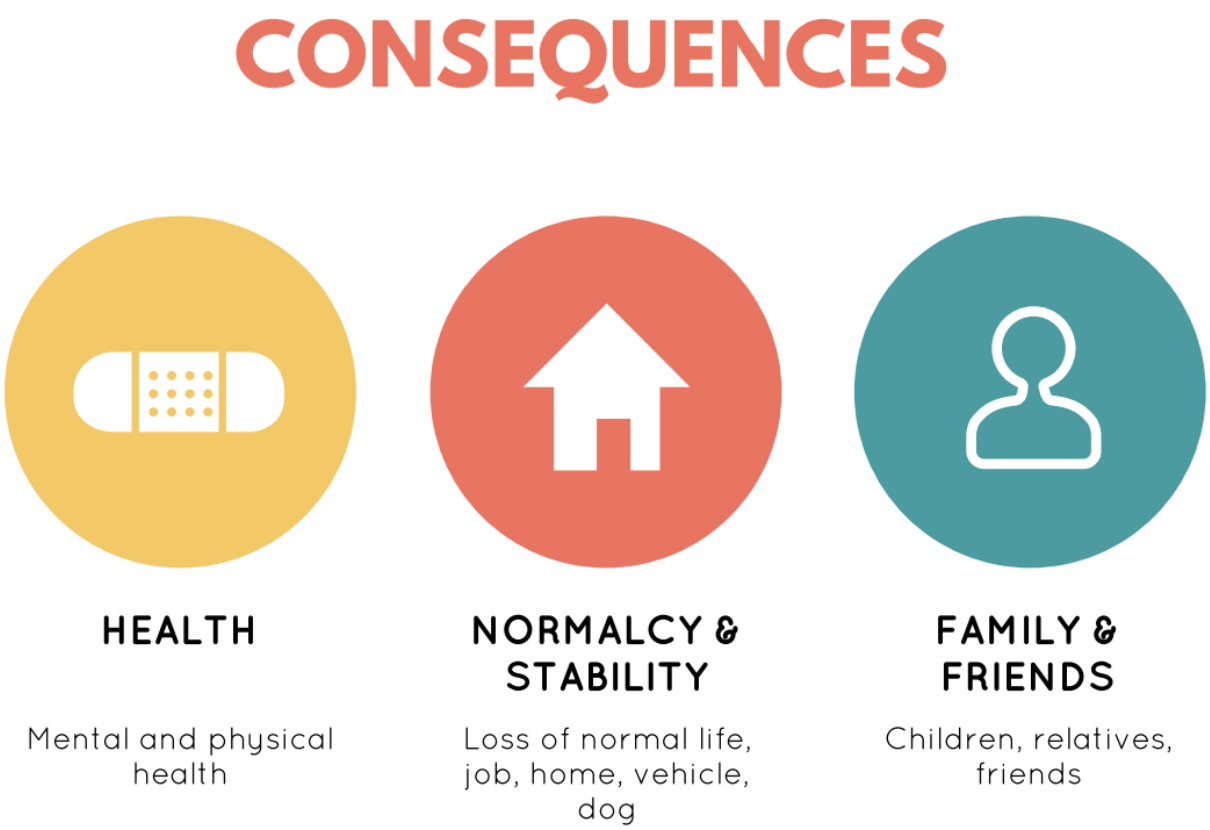
The 2015 UAA Drug and Alcohol survey also shows prescription drug use on the rise on campus. Of the 4,000 students who responded to the survey, 6.6% reported using sedatives once a week and 4.2% reported using sedatives three or more times a week (Heath, et al., 2015). Law enforcement data show illegal use of pharmaceuticals is a growing concern, hydrocodone and OxyContin/oxycodone abuse, in particular.

Consequences of Opioid Misuse and Heroin Use

Community Perceptions of Consequences

> *"I don't know anyone who has started to take this [opioid] medication that began to misuse it but didn't suffer the consequences of their health, family life, friendships, school, and future destroyed by this." (Key Informant, February 2017)*

Figure 9 Summary of Consequences of Opioid Misuse and Heroin Use



Morbidity

From 2004-2013, 40 hospitalized patients, ages 9-24, tested positive, for opiates. This represents 1.3% of all patients in this age group who were tested for drugs (n=2993) and 4.2% (n=954) of all patients in this age group who tested positive. An Epidemiology Bulletin produced by the State of Alaska revealed that the rate of hospitalizations related to heroin poisoning in Alaska nearly doubled from 2008-2012 (Hull-Jilly, Frasene, Gebru, & Boegli, 2015).

Mortality

Data collected from the Alaska Bureau of Vital Statistics mortality database, shows that from 2009-2015, there were 774 drug overdose deaths. 400 of these deaths were from opioid pain relievers and 128 were heroin related. Of the 311the number of accidental poisoning deaths doubled from 66 in 2005 to 133 in 2012 (Strayer, Craig, Asay, Haakenson, & Provost, 2014). Poisoning deaths include, but are not limited to, unintentional overdoses from drugs. The number of heroin overdose deaths in Alaska increased by a factor of four from 2008-2013 (Hull-Jilly, Frasene, Gebru, & Boegli, 2015).

Seventy-five percent of all heroin-associated death in Alaska from 2008-2013 occurred in Anchorage and the Matanuska Susitna regions (Hull-Jilly, Frasene, Gebru, & Boegli, 2015). From 2007-2011, Anchorage had 257 unintentionally drug induced deaths, which was 49% of all such deaths in the State. This is a rate of 17.1 per 100,000 and was 25 percent higher than the national average of 12.9 per 100,000 (Hull-Jilly, Frasene, Gebru, & Boegli, 2015). Poisoning was the leading cause of unintentional injury deaths for Alaska Natives/American Indians in the Anchorage Mat-Su area from 1992-2011 at 21%. The second leading cause of injury death for Alaska Natives/American Indians during this time period were motor vehicle crashes, meaning that there were 20% more poisoning deaths than motor vehicle deaths during this time period (Strayer, Craig, Asay, Haakenson, & Provost, 2014).

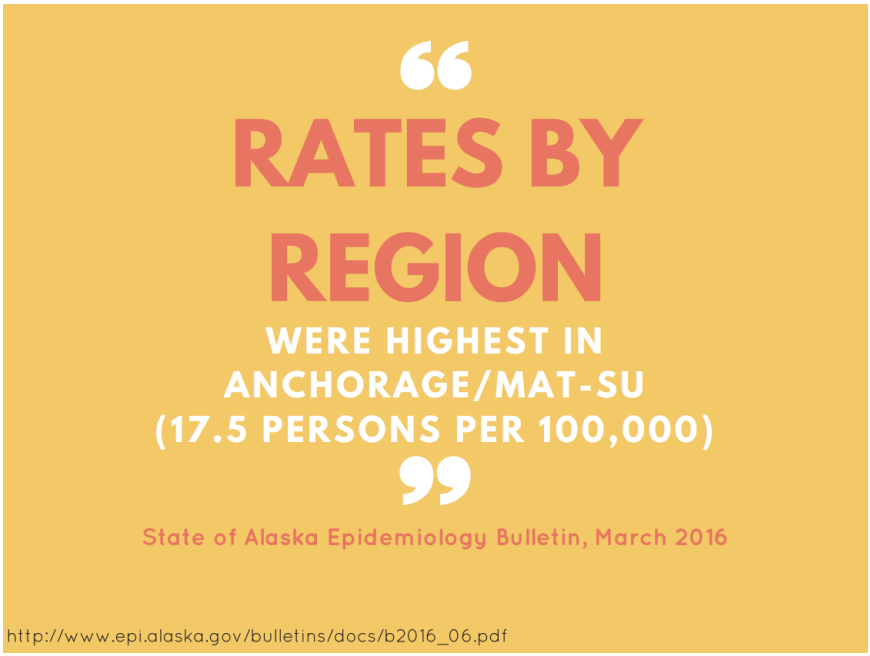
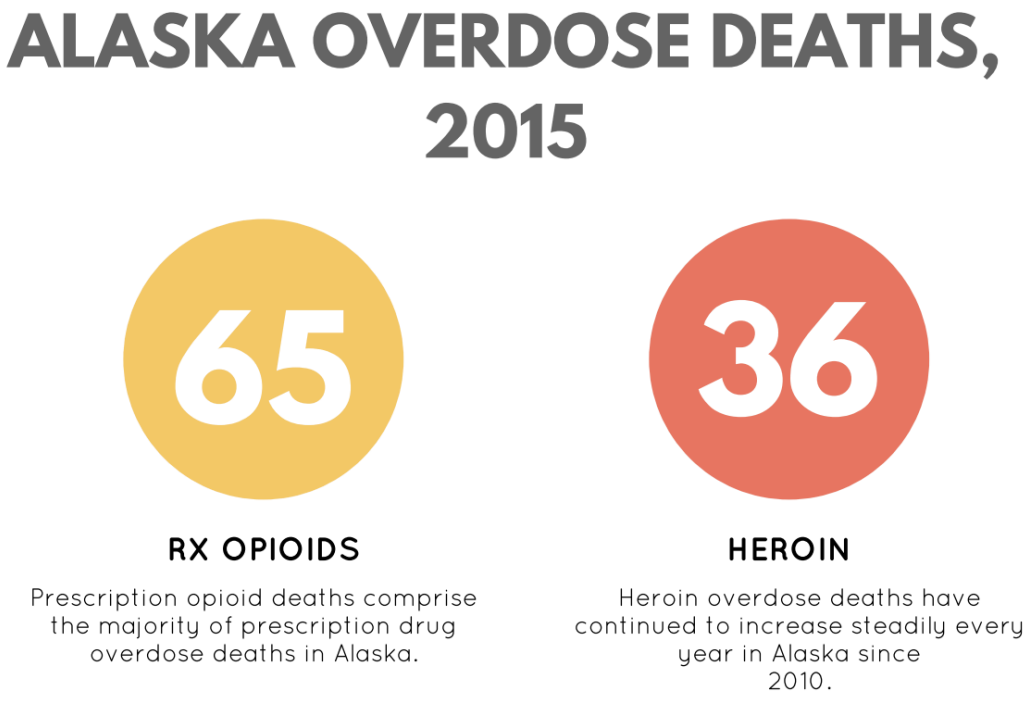


Figure 10 Alaska Heroin Overdose Deaths, 2009-2015

http://www.epi.alaska.gov/bulletins/docs/b2016_06.pdf

Figure 11 Summary of Alaska Overdose Deaths From Prescription Opioids and Heroin, 2015



http://www.epi.alaska.gov/bulletins/docs/b2016_06.pdf

Rates of Hospitalizations related to prescription opioids

Table 8 Prescription Opioid-Related ER Discharges

	N	%
Total ER Discharges	121,232	100.0%
Prescription Opioid-Related ER Discharges	568	0.5%
Poisonings	29	5.1%
Other ER Discharges	539	94.9%
Gender		
Male	271	80.4%
Female	297	19.6%
Age		
12-17 Years Old	7	0.0%
18-25 Years Old	101	33.9%
Other Age	460	66.1%
Race		
White	400	70.4%
AK Native	100	17.6%
All Other Races	55	9.7%
Other	13	4.8%

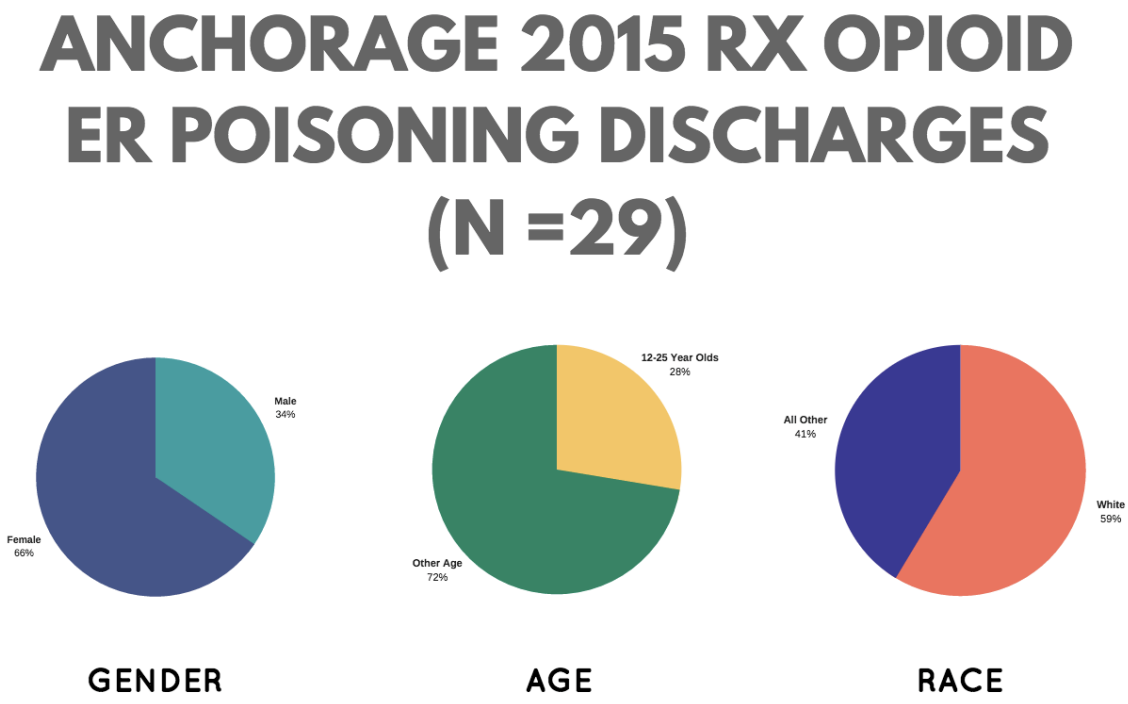
Note. Anchorage Municipality health facilities discharge data provided by DETAL

Table 9 Prescription Opioid-Related ER Discharges

	N	%
Pharmaceutical ER Poisoning Discharges	458	100.0%
Prescription Opioid ER Poisoning Discharges	29	6.3%
Gender		
Male	10	34.5%
Female	19	65.5%
Age		
12-25 Years Old	8	27.6%
Other Age	21	72.4%
Race		
White	17	58.6%
All Other Races	12	41.4%

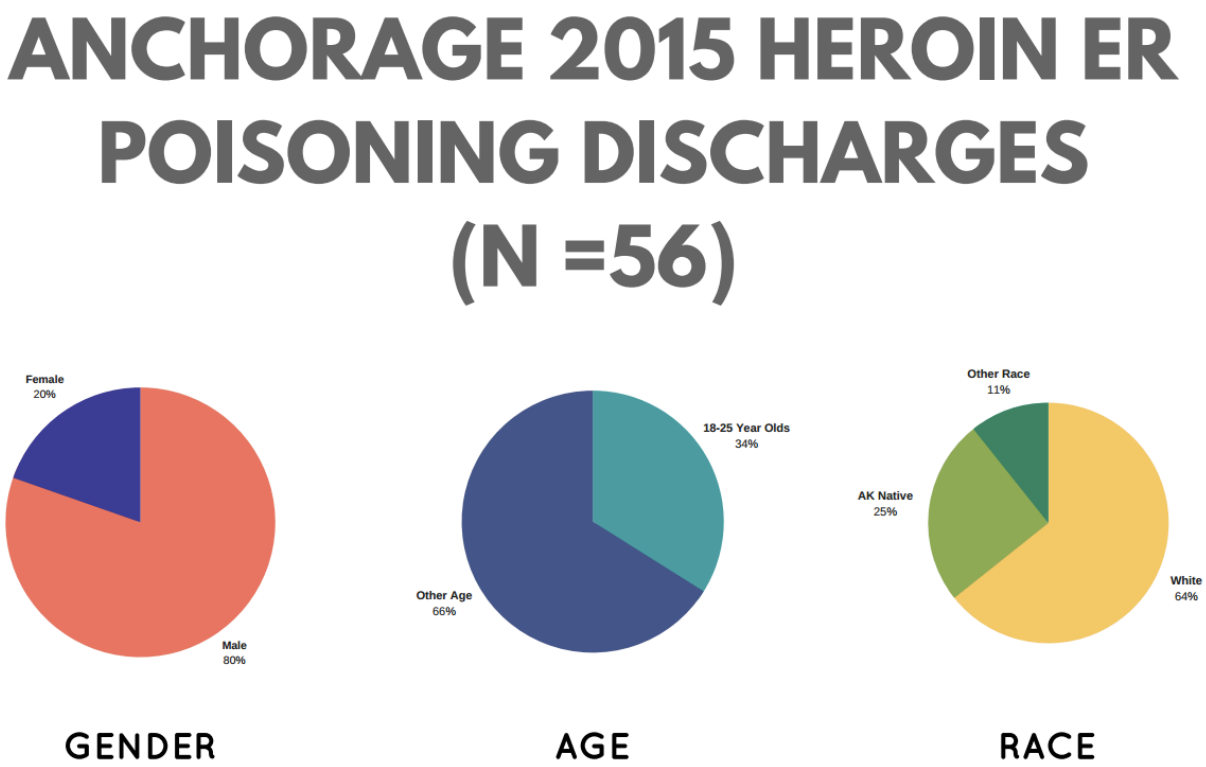
Note. Anchorage Municipality health facilities discharge data provided by DETAL

Figure 12 Summary of Anchorage 2015 Opioid ER Poisoning Discharges



Hospital facility discharge data provided by PFS DETAL.

Figure 13 Summary of Anchorage 2015 Heroin ER Poisoning Discharges



Hospital facility discharge data provided by PFS DETAL.

Hepatitis C Virus

The Hepatitis C virus infection (HCV) is the most common chronic blood borne infection in the United States. Hepatitis C is a contagious liver disease that results from infection with the HCV and can range in severity from a mild illness lasting a few weeks to a serious, lifelong illness. Hepatitis C usually spreads when blood from a person infected with the HCV enters the body of someone not infected, often through the use of sharing needles or other equipment to inject drugs like heroin. There is no vaccine for Hepatitis C so prevention is the best avenue to avoid its spread, like abstaining from injecting drugs (Alaska Department of Health and Social Services, 2016).

The State of Alaska's Section of Epidemiology (SOE) reported a total of 5,888 HCV cases during 2011-2015. The number of HCV cases rose considerably for all age groups in that period, but most significantly for people between the ages 18-29 (from 228 to 459, a 100% increase). Most cases (55%) were male, but among the age range of 18-29 years, most cases (53%) were female (Alaska Department of Health and Social Services, 2016). Within Anchorage, the overall rate of people having the HCV is 161 per 100,000 people; the rate among 18-29 year-olds is 221 per 100,000 people, which is a 100% increase (Alaska Department of Health and Social Services, 2016).

Costs

The average cost for a hospitalized heroin poisoning was approximately $30,000.

Increases in Hepatitis C infections are associated with the sharing of syringes for heroin or other intravenous drug use. The treatment of Hepatitis C for one person costs $81,000 through Medicaid (Four A's, 2017).

Motor Vehicle Impaired Driving

In 2009, just over 10% of DUI citations in which non-alcohol related toxicology tests were conducted were issued due to opiate use (Alaska Highway Safety Office, 2009).

Drug Recognition Expert (DRE) evaluations revealed that 52 drivers out of 299 impaired drivers in 2008 were under the influence of narcotics such as heroin, oxycontin, or other opioids (Alaska Highway Safety Office, 2008). The DRE program is being revitalized. It will be valuable to get updated information when it becomes available.

Juvenile Drug Offenses

The number of juveniles arrested for a drug offense increased from 272 in 2007 to 353 in 2011; this marked a 29% increase in juvenile drug offense arrests in Alaska during this time (Hull-Jilly, Frasene, Gebru, & Boegli, 2015).

Key informant interviews found that there are specific challenges with youth in the justice system and links to drug use. Some youth within the juvenile justice system experience cognitive delays, which then challenges them to understand the long-term consequences of their current actions. For example, it may be challenging to connect that addiction and its consequences can result from taking an opioid pill for short-term relief now. This makes it

challenging for youth to make the best decisions for themselves specifically within this population.

Statewide Seizures, Charges, and Arrests and Crime

From 2009 to 2011 arrests and charges in Alaska related to heroin nearly doubled from 64 to 118 respectively. Statewide, the pounds of heroin seized also nearly doubled from 3.3 pounds in 2009 to 6.4 pounds in 2011 (Hull-Jilly, Frasene, Gebru, & Boegli, 2015). In 2014, the Alaska State Troopers report 209 arrests/charges and 22.4 pounds of heroin seized (Alaska State Troopers, 2015) In 2015 there were 233 heroin related arrests in Alaska. In 2012, 141 Hydrocodone and 609 OxyContin/Oxycodone doses were seized. These numbers saw large increases to 796 and 1183 respectively in 2014 (Alaska State Troopers, 2015).

Locally, the Anchorage Police Department seized 2.78 kilos of heroin in 2011. That number increased to 2.92 in 2012, 5.67 in 2013 and 6.9 in 2014. The 2014 seizure had a street value of $3,441,785 dollars. In 2015 4.2 kilos of heroin were confiscated with a street value of $1,054,997. APD seized 1050 Oxycodone, Oxycontin, and hydrocodone doses in Anchorage, with a street value of $196,900. (Alaska State Troopers, 2015)

Anchorage has seen an increase in all kinds of theft from 2014-2015, as reported by Anchorage Police Department. In 2014 there were 496 reported robberies, 1375 burglaries, 2768 thefts and 939 reports of stolen vehicles. In 2015, those numbers increased to 621 reports of robberies, 1885 burglaries, 8962 thefts and 1154 vehicles reported stolen. Arrests for possession of narcotics rose from 97 in 2014 to 132 in 2015. (McClure & Monfreda, Crime in Alaska 2015, 2015) (McClure & Monfreda, Uniform Crime Reporting Program, 2014).

Impacts to Families

Based on our key informant interviews, there are many personal challenges not only to a person misusing opioids or heroin, but also to their family and close friends. Our key informant interviews shared themes that after addiction people may become homeless, jobless, lose family and friend connections, may lead to jail, sexual exploitation, or death.

One challenge key informants shared was that a person may not know the full extent of the consequences until it is too close, including losing their children to the Office of Children's Services or becoming homeless.

A recent analysis of 2004-2015 data found that the incidence of Neonatal Abstinence Syndrome (NAS) is increasing both nationally and in Alaska (Alaska Department of Health and Social Services, 2016). NAS is primarily associated with prenatal exposure to opiates. Prenatal use of opioids, which include heroin and other prescription drugs, is increasing nationally, resulting in an associated increase in NAS. In Alaska, health care providers are responsible for reporting NAS infants to OCS to assess the safety of the home environment and possibly intervene (Alaska Department of health and Social Services, 2017).

Real Consequences of NMUPO as described by active users

Participants were asked to identify consequences that they had seen from individuals using opioids beyond medical recommendations. Consequences were varied, often serious, and included: addiction, overdose, poor health, losing family and friends, losing jobs, homelessness, loss of normal life, jail, and death.

Did you know about these consequences before you started using?

After being asked to identify consequences they had seen from prescription opioid misuse, participants from the first round of surveys were asked if they had been aware of these consequences before they started using. Over half of those asked indicated that they did not know about the consequences. Of those that said yes, they did know of the consequences before they started using, several indicated that they did not fully understand the depth and impact of the consequences.

Participants from the second round of surveys were asked to identify which consequences they knew about before they started using. Just over half of respondents knew that jail and poor health were consequences of using prescription opioids beyond medical recommendations. Under a half of respondents knew that loss of normal life, losing a job, homelessness, and losing friends were potential consequences. Approximately one third of respondents knew that losing family could be a consequence of misusing prescription opioids.

How likely do you think it is that people who use opioids beyond recommendation will face these consequences?

Almost all respondents indicated that it is very likely or guaranteed that a person who misuses prescription opioids will face consequences.

Which consequences might have persuaded you to not start using?

The majority of respondents indicated that loss of family might have persuaded them from not using. Loss of friends, jail, and homelessness were also common responses.

A few survey participants mentioned that having access to more community events, parks, and activities and a better community environment might have helped prevent opioid misuse. A few respondents also indicated that being more educated about the effects of prescription opioids might have prevented them from misusing them.

Some respondents indicated that none of the consequences could have persuaded them from not using.

Real Consequences of heroin use as described by active users

What consequences have you seen from heroin use?

The consequences of heroin use as described by current users were serious. Consequences included loss of family and friends; lose of job, homelessness, poor health, loss of normal life, dependency, overdose, and death.

Which of these consequences did you know about before you started using?
The original survey contained a question about which consequences they knew of before beginning to use heroin. Responses included loss of family, loss of friends, poor health, overdose, physical dependency, abscess, jail, and loss of possessions and home. The modified survey provided respondents with options to select from. These options included losing family, losing friends, losing jobs, homelessness, poor health, loss of normal life, and jail. The majority of respondents were aware of at least some of the consequences of heroin use before initiating use. Roughly one-fifth of respondents from all 50 surveys were not aware of the consequences of heroin use before they began using heroin. Several respondents indicated that while they had been aware that there were consequences of heroin use, they did not fully realize the extent of the consequences until they had experienced them themselves.

How likely do you think it is that people who use heroin will face these consequences?
Almost all respondents indicated that it is very likely that a person who uses heroin will face consequences like the ones referenced in the previous questions.

Which consequences might have persuaded you to not start using?
When asked which consequences might have persuaded them from not using heroin, loss of family was the most common response, followed by jail. Loss of friends, death, homelessness, and experiencing withdrawal were also frequent responses. A few respondents indicated that loss of normal life might have persuaded them from not using.

Some respondents indicated that none of the consequences could have persuaded them from not using.

> “
> **IF I COULD CHANGE ANY THING IN THE WORLD AT ALL,**
> **IT WOULD BE NOT DOING IT THE FIRST TIME I TRIED IT.**
> ”
>
> Survey Response

What other things that could have prevented your heroin use?
Heroin users were asked what other things might have prevented them from using heroin. Common responses included having family and friends provide support and outreach may

have prevented them from using heroin. Several respondents also pointed to past trauma, family instability, or mental health issues as leading them to heroin use.

Two respondents indicated that they transitioned from opioid use to heroin use. One of these participants responded that being cut off cold turkey from prescription opioids made them seek out heroin.

Community Factors associated with Social Availability of heroin and prescription pain relievers

Access to heroin and prescriptions opioids in Anchorage

Obtaining Prescription Opioids
For current users, the two most frequently mentioned means for obtaining prescription opioids were through the street or through a prescription from doctors. Obtaining drugs from the street was often mentioned as networking, or through word-of-mouth. A few respondents indicated faking scripts. Dealers, friends, and stealing from family and strangers were also common responses.

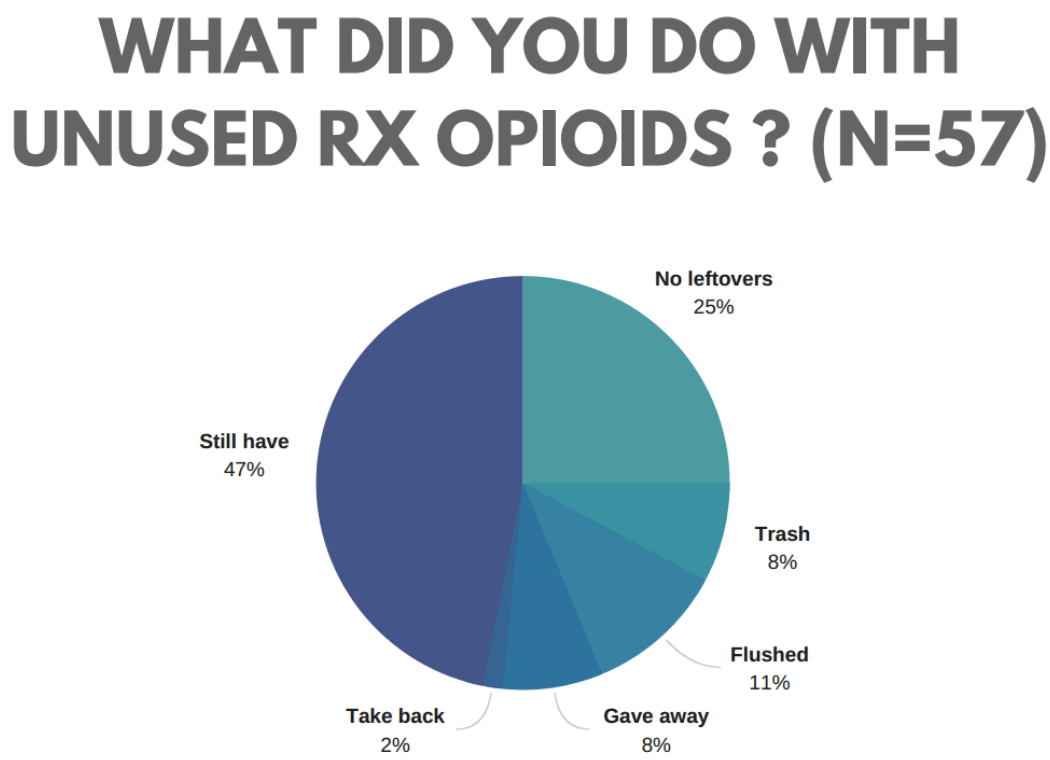
Obtaining Heroin
When asked how current users or people they knew obtained heroin in Anchorage, the majority responded with either a dealer or the street. Other responses included from friends, strangers, and, in a few instances, family members.

Safe Storage

A theme emerged from interviews with key informants that many people do not throw away unused prescription medication. Stockpiling of unused drugs “for another day” is a common practice throughout Anchorage.

From a citywide survey, nearly half (47%) of all community members reported that they still have their unused prescription opioids. A quarter of respondents reported that they did not have any medication remaining so did not have to dispose of them. However, that leaves a remaining 29% of respondents that disposed of them either by throwing them in the trash (8%), flushing them down a toilet (11%), bringing them to a “take back” (2%), and the remainder gave them away (8%).

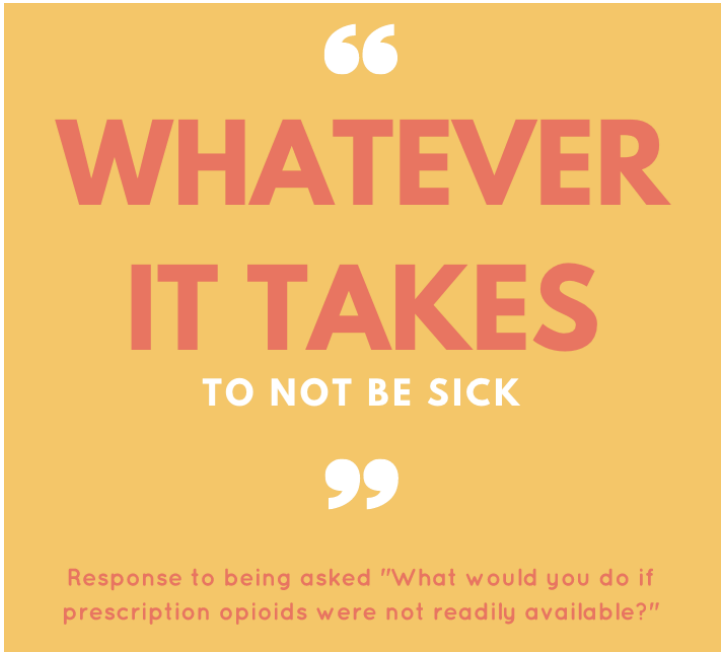
Figure 14 Summary of What People do With Excess Prescription Opioids



Data provided by PFS DETAL. Survey of 212 Anchorage residents aged 18-27.

Current misusers of prescription opioids who participated in the surveys at 4's, discussed what safe storage means to them. The majority of respondents indicated that they needed to be in a safe or lockbox. A few individuals also indicated that they should not tell anyone that they have a prescription for opioids.

When asked what they would do if prescription opioids were unavailable, most respondents said they would move to heroin, another drug, or continue to search for opioids until they could find them. A small number of survey respondents indicated that they would enter detox or try to stop using prescription opioids all together.



Many active heroin users are also misusers of prescription opioids. When asked what they would do if prescription opioids were securely stored, most said they would seek other

drugs. Several pointed out that they would do anything to avoid experiencing withdrawal. A small number said they would detox and get clean.

Interviews with key informants found that adults were also not likely to be deterred if opioids were simply unavailable. Many, including people in opioid recovery, said that if they were addicted and opioids were not available they would simply "find something else to use" (Key Informant, January 2017). Open-ended surveys with active users reinforced this message, that someone with an addiction will do "whatever it takes to not be sick."

In the Adult Perceptions of Anchorage Youth (APAY) a survey initiated by HVHC and with Dr. Marny Rivera at the University of Alaska Anchorage as the principal investigator, adults in Anchorage were asked questions about prescription drugs in their home and youth access to their prescription drugs. Seventy-four percent of adults in Anchorage indicated that they have prescription drugs in the home. While most Anchorage adults have prescription drugs in the home fifty-five percent indicated that children in the home do not know prescription drugs are in the home and another six percent did not know whether children in the home knew there were prescription drugs. The majority of adults (87%) agreed that it is necessary for parents or guardians to take steps to keep children and youth from having access to prescription drugs in the home.

Adults in Anchorage were also asked about several steps that could be taken to reduce youth access to prescription drugs in the home. Less than half of the adults engaged in any of the four activities they were asked about. The most common techniques used by adults in Anchorage for reducing youth access to prescription drugs included hiding the pills (49%) and keeping track of the number of pills (48%). The least common techniques used by adults for reducing youth access to prescription drugs included keeping the pills with them when they leave home (21%) and locking the pills up (35%). "Other" methods for preventing youth access to prescription drugs suggested by survey respondents included educating youth about prescription drug use, making prescription drugs inaccessible to youth, and discarding prescription drugs as soon as the prescription has expired.

A cross-tabulation analysis of Adult Perceptions of Anchorage Youth survey data showed that parents (of 12-24 year olds) were significantly less likely than other adults in Anchorage to take various steps to reduce youth access to prescription drugs in the home. Fifty-two percent of adults hide prescription medications while only 40% of parents did. Whereas 35.6% of adults reported that they lock up their pills, only 26.2% of parents did. Twenty-three percent of adults reported that they kept their prescription medications with them while only 14% of parents did (HVHC data).

How Youth Access Prescription Opioids

Youth who participated in the Prime For Life evaluation survey report accessing prescription opioids from a friend, taking them from a family member and paying someone for them.

Several mentioned getting them at school. The two most common responses were taking them from a family member and giving someone money for them.

Community perception was gathered on drug use and misuse. HVHC's members surveyed 100 community members in 2015 by asking opened ended questions. Questions asked included "How do you think young people are accessing prescription drugs in our community?" The survey found that answers to the question, confirm our assumption that youth are obtaining them from someone they know, especially friends and family members. The most frequently recorded answer was parents' home followed by friends, then followed by parents, siblings, family, and acquaintances in general.

Drug Take-Back Events

Prescription Drug Take-Back efforts have occurred in Anchorage with leadership provided by HVHC. The Anchorage DEA is an active participant in the HVHC's Drug Take Back committee. The prescription take back efforts throughout Alaska have resulted in a significant amount of safe disposal of drugs. HVHC and AIPC staff recently met with DEA staff and HVHC's Take Back work group. There is renewed interest and commitment to conducting Take Back events. The next one will be in late April, followed by a fall event. Take Back efforts are a powerful awareness raising tool, and will help elevate community recognition of the problem as well as readiness to plan and implement prevention strategies.

Table 10 Amount of Drugs Collected Through Anchorage Drug Take Back Events

Event date	*Amount of drugs collected in pounds*
September 25, 2010	1336.00
April 30, 2011	1603.60
October 29, 2011	1877.66
April 28, 2012	2722.41
September 29, 2012	1838.00
April 2013	3931.00
Fall 2013	2763.00

Community Factors that Contribute to Retail Availability

Opioid Use Initiation

Half of the adult survey participants who are actively misusing prescriptions opioids indicated that they began using prescription opioids to get high. The other half responded that use began after receiving a prescription from a doctor for post-surgery pain, a sports injury or an emergency room visit or from a dentist.

How did you start taking opioids?	
	n
Recreational Use	24
Surgery	12
Sports Injury	6
Medical Care	4
Emergency Room	4
Dentist	3

From Use to Misuse

Responses to the question "At what point do you think using prescription opioids, beyond medical recommendations, becomes dangerous?" were varied. Many survey respondents indicated that taking prescription opioids at any point beyond medical recommendations is dangerous. Other respondents referenced dependency as the point at which it becomes dangerous. Taking prescription opioids when not in pain or using them recreationally were also indicated as dangerous.

Misusing Prescription

Common responses for reasons for misusing prescription opioids were enjoying or wanting to experience the high, increased tolerance to prescription opioids, prescribed dosage not being adequate for pain, experiencing persistent pain, and the experience of physical withdrawal symptoms. A few respondents also indicated a traumatic experience as catalyst or underlying reason for abusing prescription opioids.

Lack of Mandatory Prescription Drug Monitoring Program

Voluntary PDMP participation allows unsupervised over prescribing. In a recent conversation, it was reported that doctors are sometimes persuaded to prescribe more than the standard of care amount to help a patient avoid paying the co-pay twice if they need a refill.

Key informants stressed that prescribers may be in the challenging position of not knowing how much prescription opioids a patient is taking, especially if they are seeking multiple prescriptions from different doctors.

Hospital "Satisfaction Scores"

Key informant interviews also revealed that "hospital satisfaction scores" drive many prescribers. The Hospital Consumer Assessment of Healthcare Providers and Systems survey, or HCAHPS, was the first national, standardized, and publically reported survey of patients' perspectives on hospital care. These scores were first used in 2006 by the Centers for Medicare and Medicaid Services (Adams, Bledsoe, & Armstrong, 2016).

The HCAHPS scores are designed to measure patient perceptions of hospital experience as one surrogate for hospital quality. Based on patient satisfaction, many have speculated that higher scores occur with patients that are more satisfied with the hospital's treatment of their levels of pain. Focus centers around:

> *HCAHPS Question 14: "How often did the hospital or provider do everything in their power to control your pain?"* (Centers for Medicare and Medicaid Services, 2016).

Many physicians see their patient satisfaction scores in patient surveys decrease as a result of changes in their prescribing practices, which affect compensation and promotions. The quickest solution to treat pain is with prescription opioids. Some feel this culture has contributed to today's challenges with opioid addiction, and that prescribers may over-prescribe to patients by dosage and duration.

Pain as a Fifth Vital Sign Culture

Key informant interviews with pharmacists and prescribers linked today's epidemic with what they call, "pain as a fifth vital sign" culture. The Joint Commission and Agency for Healthcare Research and Quality promoted the medical practice that no patient should experience pain. (Adams, Bledsoe, & Armstrong, 2016). Prescribers have to trust their patients and prescribe according to the pain; however they may not know when a patient is addicted or breaks trust, putting the prescriber in the unwitting position of supporting dangerous behaviors.

> *"We live in a society of instant fixes, and nobody think's it's OK to experience pain and discomfort from time to time, and that's not true. It's OK to have these feelings and to feel them. I'm just not sure what the answer is, but we have to start doing something different than what we have been doing." (Key Informant, February 2017)*

Alternative or Non-Drug Treatment

Key informant interviews with pharmacists and prescribers stressed that there are alternatives to prescribing opioid medication that potential patients have the right to be educated on before receiving prescription opioids. Various other treatments were raised, including massage therapy, physical therapy or eastern medicines, such as acupuncture.

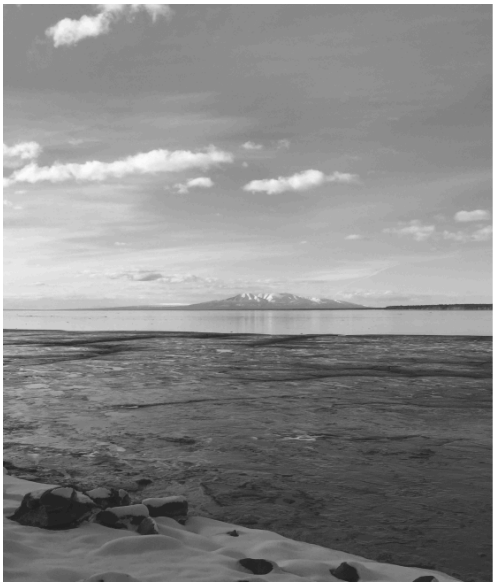
Some key informants also pointed to the use of non-steroidal anti-inflammatory drugs (NSAIDs) rather than prescription opioids. These NSAIDs are a class of drugs that provides analgesic and antipyretic effects, and in higher doses also provide anti-inflammatory effects. These may include Ibuprofen, aspirin, and more. Many community members agree they would like to see prescribers look at other alternatives before prescribing drugs at high-risk for addiction.

> *"I would like to see more natural methods of treatment, physical therapy, ice or heat treatment, diet and exercise therapy, and education for people. […] Focus on the younger generation to grow and build a healthier generation of people who understand the body and how important what you put in affects what you get out." (Key Informant, January 2017)*

Perceptions for Risk of Harm

Based on open-ended surveys of current users, approximately 60% of young adults view trying prescription opioids once or twice as risky. Eighty-seven percent of those surveyed also perceive regularly misusing opioids as physically or otherwise harmful.

Roughly 85% of young adults view trying heroin as risky. Approximately 90% of those surveyed also view using heroin once or twice a week as posing a great physical harm to an individual.



RX TO OVERUSE

- Seeking high
- Increased tolerance
- Rx inadequate for pain
- Persistent pain
- Experiencing withdrawal
- Trauma

Based on our key informant interviews, there is a varying range of when people believe danger exists in taking prescription opioids. Among people in recovery from opioid addiction, some felt risk exists as soon as an opioid prescription is written, while others feel it is only dangerous when a person uses the prescription beyond the doctor's orders.

> *"The first time a person takes medication not as directed they cross a line and become their own doctor, as if they know how much to take, which is dangerous because they don't." (Key Informant, January 2017)*

Interviews with people in recovery for opioid and heroin addiction shared similar stories that though the risks are great, many feel knowing the risks would not deter use. Many felt that the drug use was treating a symptom of trauma, despair, or other life challenges. Many also felt that, "People think it won't happen to them" (Key Informant, January 2017).

Perception of risk of harm among Anchorage high school students

The YRBS asks students about their perception of risk of harm from use of prescription drugs without a prescription. Over 80% of students in Anchorage think there is a moderate or greater risk of harm from use of prescription drugs without a prescription. When assessed by sex, a greater percentage of female students (85.5%) believe there is a moderate or greater risk of

harm as compared to males (79.2%). Compared to Alaska Native students and students of Other Races, a greater percentage of white students perceive a moderate or greater risk of harm from prescription drug misuse. Between 82% and 84% of 10th, 11th, and 12th grade students perceive the risk of harm from prescription drug misuse as moderate or great. In comparison, 79.5% of 9th grade students perceive a moderate or greater risk of harm. A greater percentage (85.4%) of students with mostly A's and B's perceive the risk of harm from prescription drug misuse as moderate or great than students with mostly C's, D's, and F's (74.6%). Low grades should not automatically be assumed to mean that the youth are less intelligent or have always been low achieving students.

Trends in perception match trends in lifetime and 30-day prescription drug misuse.

Table 11 Perception of risk of harm from prescription drug misuse as moderate or greater (%)

	Perception of Risk	
	Moderate or Greater	Great
Alaska Total	78.7	54.4
Anchorage Total	82.2	55.8
Sex		
Male	79.2	53.5
Female	85.5	58.2
Race/Ethnicity		
White (Non-Hispanic, Single Race Only)	88.9	61.2
Alaska Native	77.8	50.2
Other Races/Refused/Missing/Unknown	75.2	50.9
Grade		
9th Grade	79.5	52.3
10th Grade	83.2	58.4
11th Grade	84.0	54.2
12th Grade	82.6	58.4
Academic Grades		
Mostly As and Bs	85.4	59.0
Mostly Cs, Ds, and Fs	74.6	48.1

Our key informant interviews revealed a theme that people think doctor's prescriptions are safe, especially youth who may not have the education around addiction brain chemistry and are misinformed. Youth believe in stereotypes that "addicts" or "heroin users" are junkies and not someone they know. Since opioids are not illegal but prescribed by a doctor that lends to the misperception that prescription opioids are not dangerous.

"There is a perception that those who abuse opioid prescriptions are losers, ill-educated, unhygienic, cannot hold a job, overall bad person rather than 'regular person just like you and I.'" (Key Informant, February 2017)

Many key informants also cited younger people becoming introduced to opioids through sports injuries in middle to high school. Many also cited that youth may be introduced to opioids as "party drugs" and may not know what pills they are exposed to.

Perception of risk of harm among young adults in Anchorage

The YASUS contained several questions to the perception of risk of harm of opioid and heroin use. Table 13 and Table 14 contain data pertaining to perception of risk from misusing opioids once or twice and perception of risk of harm from regular misuse of opioids. Respondents ranked the level of risk on a scale where 1 = no risk and 6 = great risk. Table 13 shows that the majority of survey participants indicated there being some level of risk to misusing opioids once or twice.

Table 12 Perception of risk of harm from trying to misuse opioids once or twice

	Total		Alaska Native		White		All Other Races	
	N	%	*N*	%	*N*	%	*N*	%
1 No Risk	13	6.1	3	10.0	4	3.1	6	11.8
2	25	11.8	2	6.7	18	13.7	5	9.8
3	43	20.3	9	30.0	27	20.6	7	13.7
4	30	14.2	4	13.3	22	16.8	4	7.8
5	40	18.9	4	13.3	27	20.6	9	17.6
6 Great Risk	60	28.3	8	26.7	33	25.2	19	37.3

Note. Table created using data from Hanson, B. L. & Barnett, J. D. (2016)

Table 12 shows that just over half (54.7%) of young adults aged 18-27 that were surveyed found that the regular misuse of opioids once or twice a risk posed a great risk.

Table 13 Perception of risk of harm from regular misuse of opioids once or twice a week

	Total		Alaska Native		White		All Other Races	
	N	%	*N*	%	*N*	%	*N*	%
1 No Risk	10	4.7	4	13.3	1	0.8	5	9.8
2	4	1.9	0	0.0	3	2.3	1	2.0
3	12	5.7	2	6.7	5	3.8	5	9.8
4	22	10.4	3	10.0	12	9.2	7	13.7
5	47	22.2	4	13.3	30	22.9	13	25.5
6 Great Risk	116	54.7	17	56.7	80	61.1	19	37.3

Note. Table created using data from Hanson, B. L. & Barnett, J. D. (2016)

Table 14 and Table 15 show data from the YASUS on young adults in Anchorage perception of risk from trying heroin once or twice and from regularly using heroin. When compared to data for misusing opioids once or twice, a much greater percentage of adults identify using heroin once or twice as posing a great risk. Similarly, a higher percentage of young adults identify regularly using heroin once or twice a week as posing a great risk compared to the same question for opioid misuse.

Table 14 Perception of risk of harm from trying heroin once or twice

	Total		Alaska Native		White		All Other Races	
	N	%	*N*	%	*N*	%	*N*	%
1 No Risk	9	4.2	3	10.0	4	3.1	6	11.8
2	8	3.8	2	6.7	18	13.7	5	9.8
3	10	4.7	9	30.0	27	20.6	7	13.7
4	22	10.4	4	13.3	22	16.8	4	7.8
5	31	14.6	4	13.3	27	20.6	9	17.6
6 Great Risk	131	61.8	8	26.7	33	25.2	19	37.3

Note. Table created using data from Hanson, B. L. & Barnett, J. D. (2016)

Table 15 Perception of risk of harm from regularly using heroin once or twice per week

	Total		Alaska Native		White		All Other Races	
	N	%	*N*	%	*N*	%	*N*	%
1 No Risk	7	3.3	3	10.0	1	0.8	3	5.9
2	5	2.4	1	3.3	2	1.5	2	3.9
3	5	2.4	0	0.0	3	2.3	2	3.9
4	10	4.7	1	3.3	4	3.1	5	9.8
5	24	11.3	3	10.	15	11.5	6	11.8
6 Great Risk	160	75.5	22	73.3	106	80.9	32	62.7

Note. Table created using data from Hanson, B. L. & Barnett, J. D. (2016)

Student perception of parental attitudes

Across all student groups, between 86% and 92% of students felt that their parents consider prescription drug misuse as wrong or very wrong.

Table 16 Student perception that parents consider prescription drug misuse as wrong or very wrong (%)

	Perception of Parental Attitudes		
	Estimate	95% Confidence Interval	
Alaska Total	91.1%	88.9	92.9
Anchorage Total	90.3	88.0	92.2
Sex			
Male	89.5	86.4	92.0
Female	91.1	88.0	93.4
Race/Ethnicity			
White (Non-Hispanic, Single Race Only)	94.6	92.4	96.2
Alaska Native	86.0	79.1	90.9
Other Races/Refused/Missing/Unknown	86.3	81.5	90.0
Grade			
9th Grade	89.2	84.2	92.8
10th Grade	89.9	84.0	93.7
11th Grade	90.6	86.6	93.5
12th Grade	91.6	87.0	94.7
Academic Grades			
Mostly As and Bs	91.9	89.6	93.7
Mostly Cs, Ds, and Fs	87.0	81.9	90.8

Harm Reduction

Stigma

There are misperceptions about who uses heroin, and this creates a stigma. Stigma may cause individuals to not to seek help for themselves, and for others to not recognize the need for help in friends and family members. However, heroin addiction crosses all ethnic and racial lines.

Legislation

The Opioid OD Drugs Dispensing; Immunity Act became law in Alaska on March 15, 2016. Opioid/heroin use and overdose has caught the attention of local politicians. In 2015, Alaska State Senator Johnny Ellis, representing Downtown Anchorage, Fairview, Mountain View, and Airport Heights, introduced Senate Bill 23 to make Narcan more widely available. This will be an invaluable tool for decreasing overdose deaths by increasing access to Naloxone and immunity for prescribing, providing, or administering opioid overdose drugs. Raising awareness of the new law, and reducing stigma that some may feel asking for a prescription for Naloxone are ripe opportunities for the Anchorage coalitions.

Medical Community

There were 28 physicians in Anchorage certified to treat opioid dependence with buprenorphine as of January 6, 2016. Buprenorphine is an opioid partial agonist. It relieves opioid withdrawal symptoms. Initially, certified buprenorphine physicians can only have 30 active patients at a time. After 1 year, they can apply for an increase to 100 patients. There is an increasing number of trainings being provided in Anchorage for prescribers to become certified to prescribe buprenorphine.

Needle Exchange Program

Anchorage has one needle exchange program at Four A's. Needle exchange programs are an effective way to reduce consequences of needle sharing, such as Hepatitis C and HIV. During the 2016 calendar year, participants came to the needle exchange program 21,316 times. Four A's distributed 438,578 syringes and collected and incinerated 523,245 syringes.

Given the increase in cases of people infected with the Hepatitis C virus both nationally and locally in Anchorage, many national efforts include expanding syringe exchange programs as well as expanding efforts to allow access to sterile syringe supplies.

Lack of Medically Monitored Detox Beds

Anchorage has only 13 medically monitored detox beds at Ernie Turner. Generally, drug treatment programs require that a person has detoxed prior to admission. Medically monitored detox is the safest way to stop using heroin. People with addictions can hit an extreme low, generating a desire to quit using and seek treatment. It is critical that this option be available immediately. In Anchorage, the wait is often 30 or more days until a bed is available. This creates a situation where someone seeking recovery services may continue using, and when their name pops up on a list for an available bed, the moment of desiring help has passed.

One challenge our key informant interviews revealed was that a person needs to be sober in order to enter a detox or treatment program. That can be a major barrier for people to receive the treatment they need. Many stressed that immediate action needs to be taken as soon as a person is willing to seek help. Otherwise, the window of opportunity may quickly close, especially if a person is denied from a program, insurance challenges the coverage, or childcare cannot be secured.

Many key informants raised the need for more community resources to support a comprehensive treatment center, including detox beds, a hospital, in-patient recovery services, job and life skills coaching, and courses to teach independence. Unfortunately, there was also an acknowledgement at the lack of resources and leadership to move this forward.

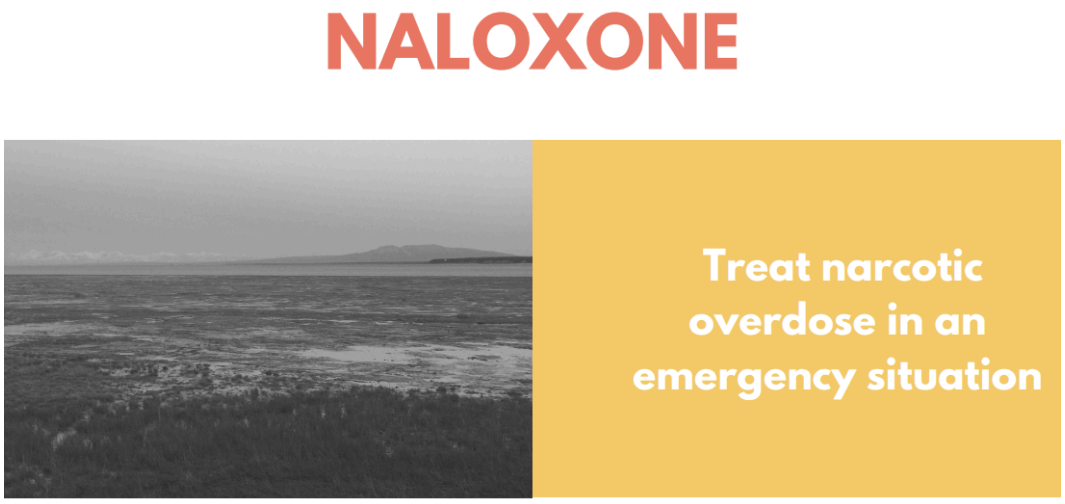
Access to Naloxone

Key informants spoke highly of the need for more access to Naloxone, sometimes known as Narcan. Many recommended distributing them throughout the community.

Interviews with key informants also uncovered that there is misinformation about the use of Naloxone. Many people did not know that medical care after its use must be sought.

Some also felt that Naloxone is good, but it does not treat the root of the problem. Some key informants also had warnings regarding Naloxone. Some felt that offering Naloxone may enable users to ignore consequences of overdosing and continue using. Without adequate detox or treatment facilities, a person in recovery after overdosing and using Naloxone may end up in the same situation. One key informant called it a "very vicious cycle."

Out of the 50 4A's survey participants who are current users of opioids, just over half (n =29) had some knowledge about Naloxone or had heard of it. From the 25 participants that were asked about how long Naloxone remains effective after being administered, none of the participants correctly identified that it lasts roughly 30 minutes. Responses varied from a few minutes to over a month. Many respondents did not answer the question or wrote "Don't Know."



When asked where Naloxone should be distributed, many respondents indicated that it should be available at the needle exchanges. Other suggestions included in vending machines, at low cost over the counter, for free at clinics, at all doctor's offices, and in Emergency Rooms.

Other Community Factors

Coordinated Apolitical Advocacy

Anchorage has a strong and dedicated field of people interested in reducing drug use and consequences. While there are multiple factors that encourage use and abuse, there are even greater opportunities to discourage them. What has been lacking is a centralized, apolitical and

staffed force to gather the stakeholders. This was echoed at the Alaska Health Summit during the session discussing the heroin and opioid issues in February 2016.

Involvement of Schools

In December 2015, South Anchorage High School Principal Dr. Kersten Johnson-Struempler wrote a letter to parents titled "Prescription Drugs: Please talk to your student." In the letter, Dr. Johnson-Struempler shed light on the growing issue of illegal prescription drug use at South Anchorage High School and urged parents to speak with their children about prescription drug use and monitor their own medications.

Improved Access to Data

There is a need to improve data collection regarding prescription opioid and heroin use. This should include increasing the number of toxicology tests done for violent death victims, in motor vehicle crashes and to reinstate surveillance of poisoning in the trauma registry. This will provide more thorough data to fully understand the severity of the heroin and opioid problems and assist with defining baselines from which to measure change.

Growing Community Awareness Through the Local Media

In recent years, there has been a growing national discussion around the increase of opioid and heroin overdoses and related deaths in the United States. The Alaska Dispatch News has been covering the rise in opioid and heroin overdoses and deaths and the online conversations on these articles reflect the community's concern, level of awareness, and personal connections to the issue. Several high profile fatalities related to opioid/heroin use have captured the local media and public's attention. A list of local news stories is detailed in Appendix G.

Community Norms and Perceptions

Community norms are a factor that discourages risk behaviors. Alaska's Strategies to Prevent Underage Drinking states that "Individuals and communities must model positive behaviors in order to prevent future generations from developing substance use disorders. Things as simple as dining together as a family create positive norms for youth." HVHC and AYDC/AIPC actively partner promoting healthy norms in Anchorage. Research locally and nationally supports the concept that family support, monitoring and communication have an impact on youth alcohol behaviors. Anchorage School District YRBS analysis showed youth talking to their parents nearly every day about school is a significant protective factor for 30-day use and binge use of alcohol.

Other factors that are correlated with decreased substance abuse by Anchorage youth include: Parent and role model behavior and community norms that discourage substance use, School, home, and community environments that discourage both substance use and alcohol advertising, Individuals and communities that model positive behaviors, family support, monitoring and communication and strong cultural identity and support.

Insufficient Coordinated Efforts to Address the Problem

There are quite a few organizations in Anchorage with an interest in the opioid and heroin problem. However, they lack the leadership in collaborative involvement. The newly formed Anchorage Opioid Taskforce will also be a strong partner in the community.

Synthetic Opioids

Our key informants also noted national trends are being felt within Anchorage, noting three waves: 1) opioid painkillers, 2) heroin use, and 3) synthetic opioids. Synthetic opioids are more potent, such as fentanyl, which is 50-100 times more potent than morphine. As the prevalence of synthetic opioids becomes more mainstream, there may be more overdoses and deaths.

Community Readiness Assessment

HVHC and AIPC held two group key informant interviews to determine the community readiness in Anchorage to address non-medical use of prescription opioids for 12-17 year olds, and the non-medical use of prescription opioids and heroin use in 18-25 year olds. Group interviews followed the Tri-Ethnic Community Readiness Assessment model, developed by Colorado State University.

A total of 8 individuals were interviewed in the group regarding 12-17 year olds, and 11 individuals were interviewed in the group regarding the 18-25 year olds. The total of 19 key informants joined our two group interviews representing the following community sectors: youth-serving organizations, military, law enforcement, clinical services, medical services, youth, parents, Native American, people in recovery, Hispanic, Alaska Native, faith, and non-profit communities.

The Tri-Ethnic Center for Prevention Research's model of Community Readiness for Community Change measures five key dimensions: 1) Community knowledge of the issues (how much does the community know about the issues?); 2) Community knowledge of efforts (How much does the community know about current prevention programs and activities?); 3) Community climate (What is the community's attitude toward addressing the issues?); 4) Leadership (What is he leadership's attitude toward addressing the issue?); and 5) Resources (What are the resources being used or that could be used to address the issue?).

Every key informant scored each community readiness dimension, and then the scores were averaged for each dimension of readiness for the two issues (non-medical prescription opioid use for 12-17 year olds, and non-medical prescription opioid and heroin use for 18-25 year olds). The scores for each dimension were then averaged to arrive at an "overall" community readiness score for each issue.

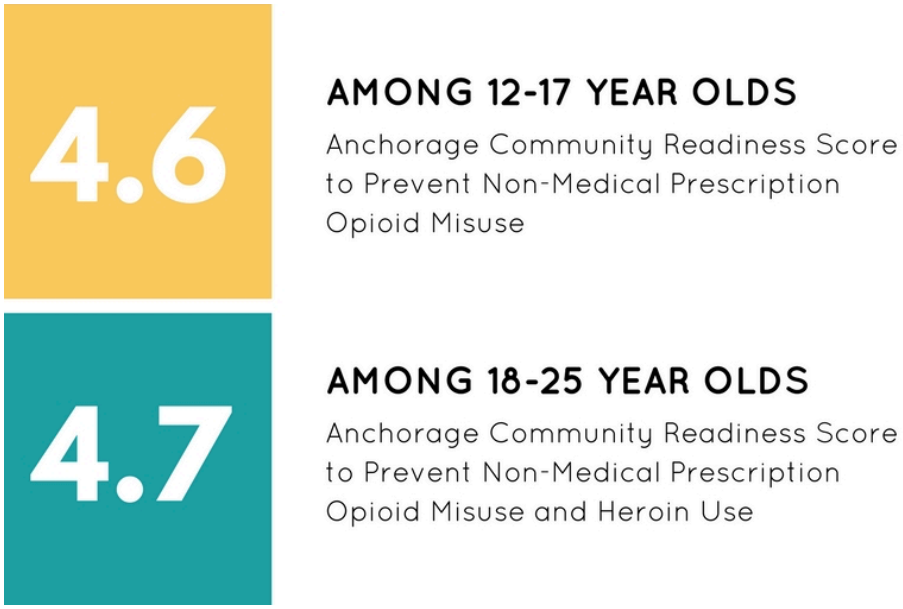
Table 17 Stages of Community Readiness Scale

Stage of Readiness	Score
No Awareness	1
Denial/Resistance	2
Vague Awareness	3
Preplanning	4
Preparation	5
Initiation	6

Stabilization	7
Confirmation/Expansion	8
High Level of Community Ownership	9

Based on the Tri-Ethnic Community Readiness Assessment model, the overall community readiness score for prescription opioid misuse prevention for ages 12-17 was 4.6 (on a scale of 1 to 9). This indicates a level of community readiness that is above "Stage 4: Preplanning," meaning there is some concern and acknowledgement of concern of the problem and stigma around the issue, but little known of the issue or of local efforts, and that there are limited resources to further the efforts.

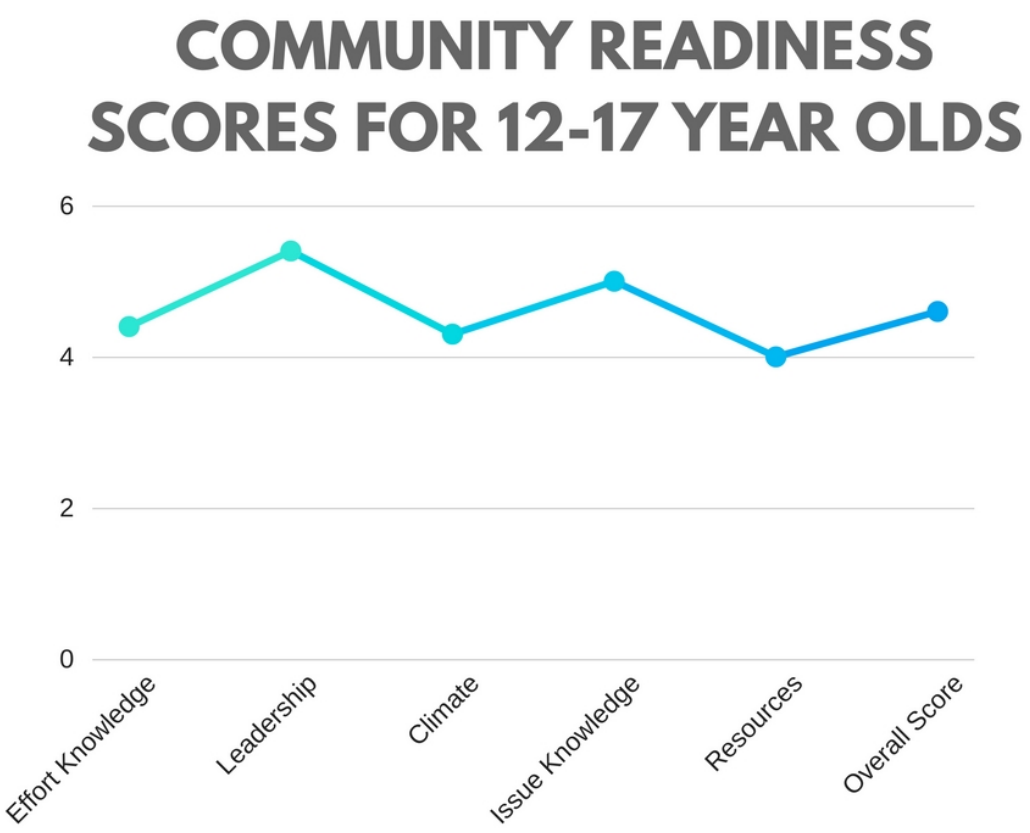
The overall community readiness score for prescription opioid misuse and heroin use prevention for ages 18-25 was 4.7. This also indicates a level of community readiness that is above "Stage 4: Preplanning," meaning there is some concern and acknowledgement of concern but little known of the issue or of local efforts, and that there are limited resources to further the efforts.



Both community readiness scores for both age groups are on the higher end of the Stage 4 scale, nearing “Stage 5: Preparation,” which would indicate that most community members have heard of local efforts, leadership actively supports continuing and improving current efforts, there is basic knowledge about the issues, and there are some resources identified to further efforts.

The overall community readiness scores are illustrated in the following figures, as well as a brief narrative describing some of the findings based on community sectors.

Figure 15 Community Readiness Scores for Non-Medical Prescription Opioid Misuse among 12-17 Year-Olds in Anchorage (2017)



Community Readiness Scores varied based on sector. For the key informants discussing non-medical prescription opioid use for 12-17 year-olds, overall community readiness scores ranged from 3.3 to 5.4 across sectors. The military and non-profit community had some of the lowest readiness scores overall at 3.6 and 3.3 respectively. The clinical and medical service sectors had the highest readiness scores for leadership at 7.5 and 7 respectively. The Native American youth representative's leadership readiness score was 9; however, there may be limitations based on having only one representative from this and other sectors.

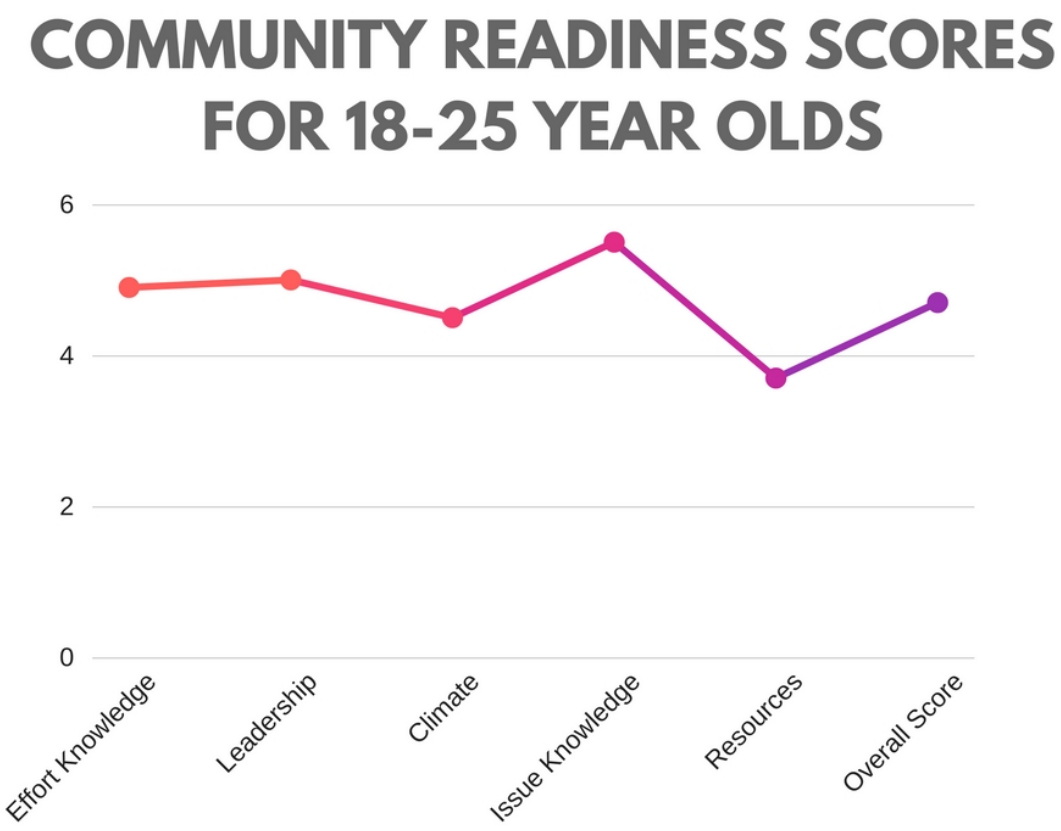
> *"I do see advocates on this issue, but having advocates and community member leadership are two different things. Folks would say they support expanded efforts, but whether you have the people to make the movement towards a solution is also two different things." (Key Informant, April 6, 2017)*

Additional policy related questions were asked regarding prevention efforts around alternative treatment to prescription opioids, safe storage and disposal of prescription opioids, and social stigma. The sectors with the lowest community readiness scores for these policy proposals were the clinical and youth-serving organizations with scores of 2.7 and 3.7 respectively. Both

the military and medical sectors had the highest community readiness scores for these policies at scores of 6 and 5.7 respectively.

> *"If something happens close to you, you want to work on solving it, but you get burned out when you realize how big the issues are before you get to the solution. A lot of times community members know there is a problem, but there's still that social stigma not only on users but also on family and friends." (Key Informant, April 6, 2017)*

Figure 16 Community Readiness Scores for Non-Medical Prescription Opioid Misuse and Heroin Use among 18-25 Year-Olds in Anchorage (2017)



Community Readiness Scores varied based on sector. For the key informants discussing non-medical prescription opioid use and heroin use for 18-25 year-olds, overall community readiness scores ranged from 3 to 5.8 across sectors. The Alaska Native and Hispanic recovery service provider communities had some of the lowest readiness scores overall at 3 and 3.4 respectively. The law enforcement (score 5.8), clinical (score 5.4), and Native American Youth (score 5.4) had the highest overall community readiness scores.

> *"In Anchorage the population is in a lot of survival mode because of drinking and drugs. These issues impact families so much, but knowing about resources is difficult. It's hard to even admit there is a problem, especially for grandparents that are raising the grandkids. Lots of families have secretive problems. There is lots of healing to do. […] There are lots of programs, but to know you already need to be looking for help so you generally have to be in a lot of trouble to begin with. If you're not in trouble people don't tend to know about it." (Key Informant, April 6, 2017)*

Additional policy related questions were asked regarding prevention efforts around alternative treatment to prescription opioids, safe storage and disposal of prescription opioids, social stigma for opioid and heroin use, and needle exchanges. The sectors with the lowest community readiness scores for these policy proposals were the medical and Alaska Native communities with scores of 4.4 and 4.2 respectively. The clinical (score 8.8), Native American Youth (score 8.6), and law enforcement (score 8) had the highest community readiness scores for these policies. These overall scores are rather high for the community and may be due to the selection of key informants who have extensive experience and networking into prevention efforts.

> "The military is very reactive and not proactive. It's all commander-dependent. There are a few commanders that are vocal about this, and we have a lot of resources are available, but they're not used unless there is a problem. […] If you have a prescription, no one will think twice about it or make that big of a deal about it. But until someone gets in trouble, that's when it becomes an issue." (Key Informant, April 6, 2017)

Through the group key informant interviews, themes arose around leadership and community members, including various organizations, understanding and taking action on opioid and heroin use. However, a lack of resources and enough funding to expand existing resources was raised as a common barrier.

Through the group key informant interviews, there were themes that arose around cultural responsiveness. Generally, the Alaska Native and Hispanic populations scored lower community readiness scores. Many of these challenges centered on social stigma holding families back from seeking support services. There is also a language barrier that may exist in education efforts on the dangers of prescription opioid addiction, especially from the medical field to the Hispanic community.

Many of the themes from the group key informant interviews reinforced the priority community factors prioritized from community members. These themes from the group interviews are summarized below.

Figure 17 Summary of themes from Community Readiness Assessment group interviews (2017)

Intermediate Variable	Priority Community Factors	Comments from Community Readiness Assessment meetings	"Youth" Group (n=8)	Percent	"Young Adult" Group (n=11)	Percent
Retail Availability						
	Alternative pain management not commonly discussed with patient		6	75	4	36
		Alternative forms of pain control may cost more than opioids due to insurers.				
		Not many people know what alternative pain control is, especially youth.				
		Maybe alternative or non-drug opioids should be preferences in treatment.				
		Doctors tend to offer prescription opioids as the first line of pain treatment.				
	Inadequate patient/parent education at time of initial prescription		2	25	6	55
		Families often seek information or programs after they are severely impacted by addiction and its consequences.				
		There is no standard warning to give to patients.				
		Very few prescribers or pharmacies have pain agreements with patients explicitly stating proper medication use.				
		The military community and culture tends to accept use of prescription opioids without question.				
		Language may also be a barrier in communicating information about prescription opioids.				
	Lack of Prescription Drug Monitoring (PDMP) participation		6	75	9	82
		The Alaska Native Medical Hospital and Southcentral Foundation led community on prescription drug monitoring and pain contracts.				
		There are too few efforts to combat prescription opioid misuse.				
		The Governor is leading efforts and has offered bills to address prescription drug monitoring efforts.				
Social Availability						
	Secure storage and safe disposal		4	50	7	64
		There are overall too few efforts to combat opioid and heroin use, and too few resources to support existing efforts.				
		Pharmacies or providers seem to be unwilling to take back all prescription drugs.				
		Families want to play their part to make a difference, but they may not know the best practices for safe storage.				

		Community members, including the military, do not tend to throw away prescription drugs.			
	Social circle	2	25	2	18
		Grandparents raising grandchildren do not have accurate information on opioids, and may not use proper storage or teach best behaviors.			
		Military structure offers reactive, rather than proactive, punishment of behavior.			
Perception of Risk					
	Lack of understanding of what opioids do to the brain and body and how quickly dependence can occur	8	100	11	100
		There is vast misinformation about opioid addiction in youth.			
		There is a lack of understanding that misuse of prescription opioids may lead to heroin use.			
		There is a misconception that doctors can tell who will be at risk for misuse and abuse.			
		People believe in stereotypes of families so believe youth may or may not tend to misuse prescription opioids.			
	Opioids are prescribed from a doctor and presumed to be safe. There is less stigma surrounding opioid use than other drugs such as heroin	4	50	2	18
		People believe there are fewer risks in prescribed medication.			
		Treating pain as a vital sign has led to over-prescribing, and patients now request it.			
		There is more potential for conversations around stigma for 12-17 year-olds, but may be harder for 18-25 year-olds.			
	Not understanding the vast consequences of using and misusing	8	100	10	91
		Most youth-service workers do not know how to address opioid addiction in youth.			
		There is misinformation about who can become addicted to misusing prescription opioids.			
		Leadership in the community are not activated unless the consequences of addiction impact their lives directly.			
Harm Reduction					
	Access to needle exchange	N/A		1	9
		There is a lack of understanding of how a needle exchange addresses heroin addiction.			
	De-stigmatize addiction	4	50	3	27
		Families are still secretive when addiction is impacting them. Stigma can hold them back from seeking support services.			

		There is a racial issue that some people of color might be at a disadvantage or receiving treatment.				
		Stigma is prevalent and different in various cultures.				
	Lack of coping skills		1	13	0	0
		Alternative treatment could involve discussing other pain management skills with patients.				

Perception of the Problem in the Community

The YASUS asked survey respondents about their perception of the problem of prescription opioid misuse and heroin use in the community. The following two tables are the results for these perceptions of the problem questions for Anchorage residents. The question was asked as a scale with one reflecting that the individual found it to be a not a problem at all, and six to be a very large problem. The tables show results of the scores for all Anchorage residents, Alaska Native respondents only, White respondents, and respondents of all other races.

Table 18 Perception of prescription opioid misuse problem in community

	Total		Alaska Native		White		All Other Races	
	N	%	*N*	%	*N*	%	*N*	%
1 Not a problem at all	26	12.3%	3	10.0	13	9.9	10	19.6
2	26	12.3%	4	13.3	18	13.7	4	7.8
3	51	24.1%	11	36.7	29	22.1	11	21.6
4	37	17.5%	4	13.3	25	19.1	8	15.7
5	28	13.2%	4	13.3	18	13.7	6	11.8
6 A very large problem	41	19.3%	3	3.3	27	20.6	11	21.6

Table 19 Perception of heroin problem in community

	Total		Alaska Native		White		All Other Races	
	N	%	*N*	%	*N*	%	*N*	%
1 Not a problem at all	31	14.6	3	10.0	18	13.7	10	19.6
2	28	13.2	7	23.3	17	13.0	4	7.8
3	42	19.8	6	20.0	25	19.1	11	21.6
4	25	11.8	1	3.3	18	13.7	6	11.8
5	30	14.2	7	23.3	19	14.5	4	7.8
6 A very large problem	53	25.0	5	16.7	33	25.2	15	29.4

Knowledge of the Issue

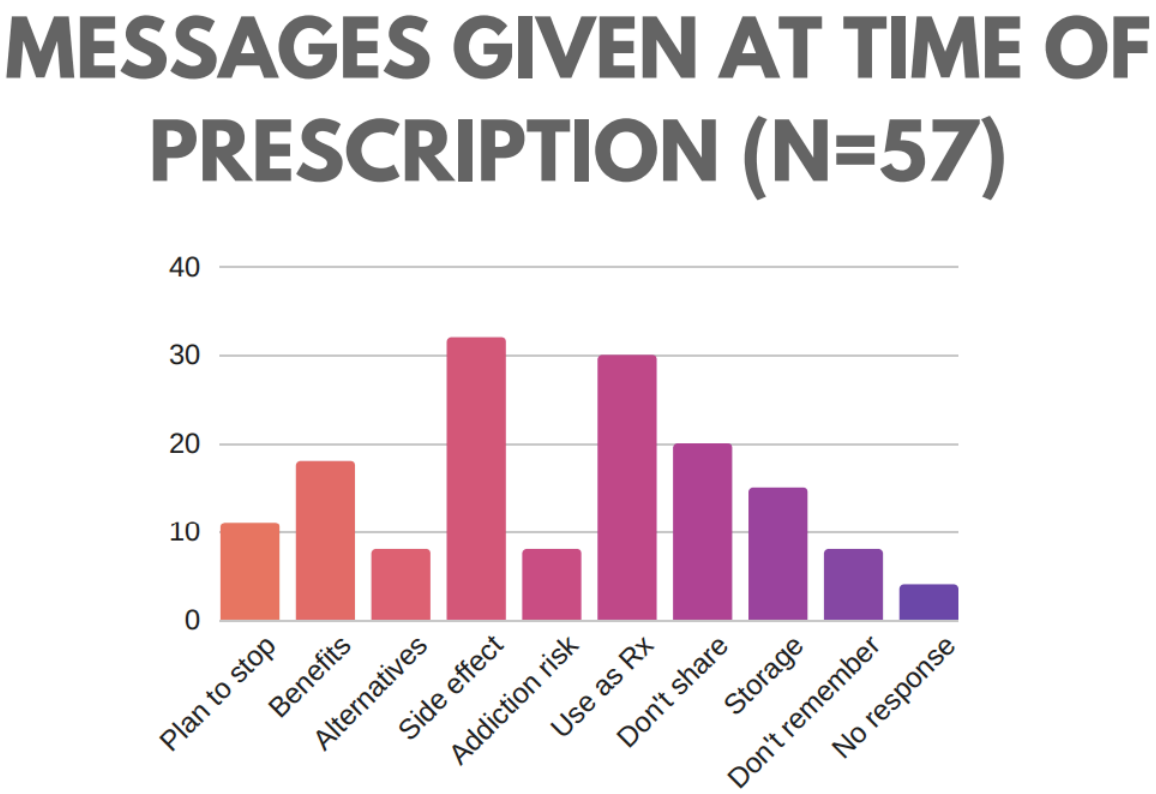
The Adult Telephone Survey of opioid misuse/abuse and heroin use in Anchorage asked adults about their knowledge of opioid use among youth age 12-17, young adults age 18-25, and heroin use among young adults age 18-25. The results for those three questions from the survey can be seen in the table below.

Table 20 Percentage of Anchorage Adults Knowledgeable about Opioid Abuse and Heroin Use (*n* = 382)

Knowledge about opioid abuse among kids 12-17	
Very knowledgeable	10%
Knowledgeable	10%
Somewhat knowledgeable	31%
Not knowledgeable	46%
Don't know	3%
Refused	0%
Knowledge about opioid abuse among young adults 18-25	
Very knowledgeable	17%
Knowledgeable	13%
Somewhat knowledgeable	36%
Not knowledgeable	32%
Don't know	2%
Refused	0%
Knowledge about heroin use among young adults 18-25	
Very knowledgeable	18%
Knowledgeable	11%
Somewhat knowledgeable	31%
Not knowledgeable	39%
Don't know	1%
Refused	0%

It is also clear that people are not given adequate information at the time of receiving an opioid prescription, including creating a plan to stop, alternatives, and risk of addiction. Based on a survey of Anchorage residents, the summary is displayed in Figure 18.

Figure 18 Summary of Messages From Prescribers to Patients at Time of Prescription



Data provided by PFS DETAL. Survey of 212 Anchorage residents aged 18-27.

Concern of Prescription Opioid Misuse and Heroin Use

The Adult Telephone Survey of opioid misuse/abuse and heroin use in Anchorage asked adults about their level of concern of opioid use among kids age 12-17, young adults age 18-25, and heroin use among young adults age 18-25. The results for these three questions are shown in the table below.

Table 21 Percentage of Anchorage Adults Concerned about Opioid Abuse and Heroin Use (*n* = 382)

Concern about opioid abuse among kids 12-17	
Very Concerned	63%
Concerned	15%
Somewhat concerned	15%
Not concerned	4%
Don't know	1%
Refused	0%
Concern about opioid abuse among young adults 18-25	
Very Concerned	57%
Concerned	16%

Somewhat concerned	18%
Not concerned	7%
Don't know	1%
Refused	0%
Concern about heroin use among young adults 18-25	
Very Concerned	63%
Concerned	16%
Somewhat concerned	13%
Not concerned	6%
Don't know	1%
Refused	0%

Knowledge of Efforts to Address Issues

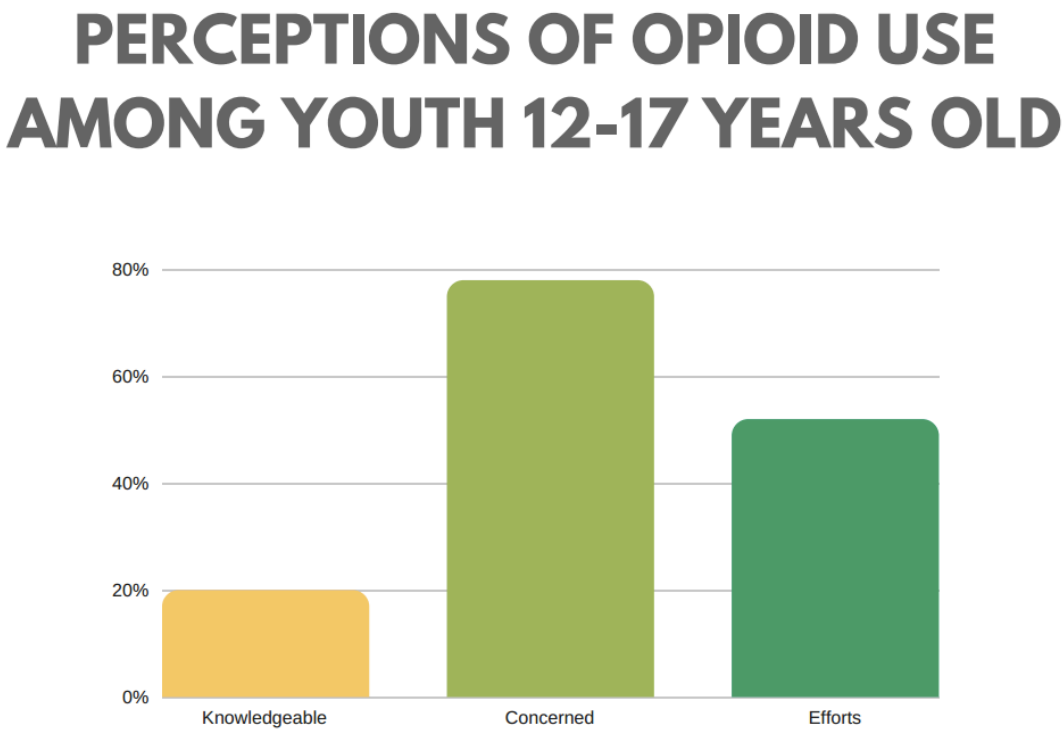
The Adult Telephone Survey of opioid misuse/abuse and heroin use in Anchorage asked adults about their knowledge of efforts in the community to address opioid use among kids age 12-17, young adults age 18-25, and heroin use among young adults age 18-25.

Table 22 Percentage of Anchorage Adults Knowledgeable about Efforts in Community to Address Opioid Abuse and Heroin Use (*n* = 382)

Efforts in community to address opioid use among kids 12-17	
A lot	15%
Some	37%
A little	19%
Nothing	11%
Don't know	16%
Refused	1%
Efforts in community to address opioid use among young adults 18-25	
A lot	16%
Some	35%
A little	24%
Nothing	10%
Don't know	15%
Refused	0%
Efforts in community to address opioid use among young adults 18-25	
A lot	19%
Some	32%
A little	21%
Nothing	14%
Don't know	15%
Refused	0%

Overall, community members who were concerned or very concerned regarding youth ages 12-17 misuse of prescription opioids was 78%. However, their knowledge of community efforts and the issue were lower. People who felt they had “a lot” or “some” knowledge of efforts was 52% of respondents. Their knowledge of the issue itself was lower still at 20%.

Figure 19 Summary of Perceptions of Opioid Use Among Youth 12-17 Years-Olds



Data collected by Hays Research Group LLC for AIPC. N-382.

Overall, community members who were concerned or very concerned for young adults ages 18-25 misuse of prescription opioids was 73%. However, their knowledge of community efforts and the issue were lower. People who felt they had “a lot” or “some” knowledge of efforts was 51% of respondents. Their knowledge of the issue itself was at 30%.

Overall, community members who were concerned or very concerned regarding young adults ages 18-25 for heroin use was at 79%. However, their knowledge of community efforts and the issue were lower. People who felt they had “a lot” or “some” knowledge of efforts was 51% of respondents. Their knowledge of the issue itself was lower still at 29%.

Figure 20 Summary of Perceptions of Opioid Use Among 18-24 Years Old

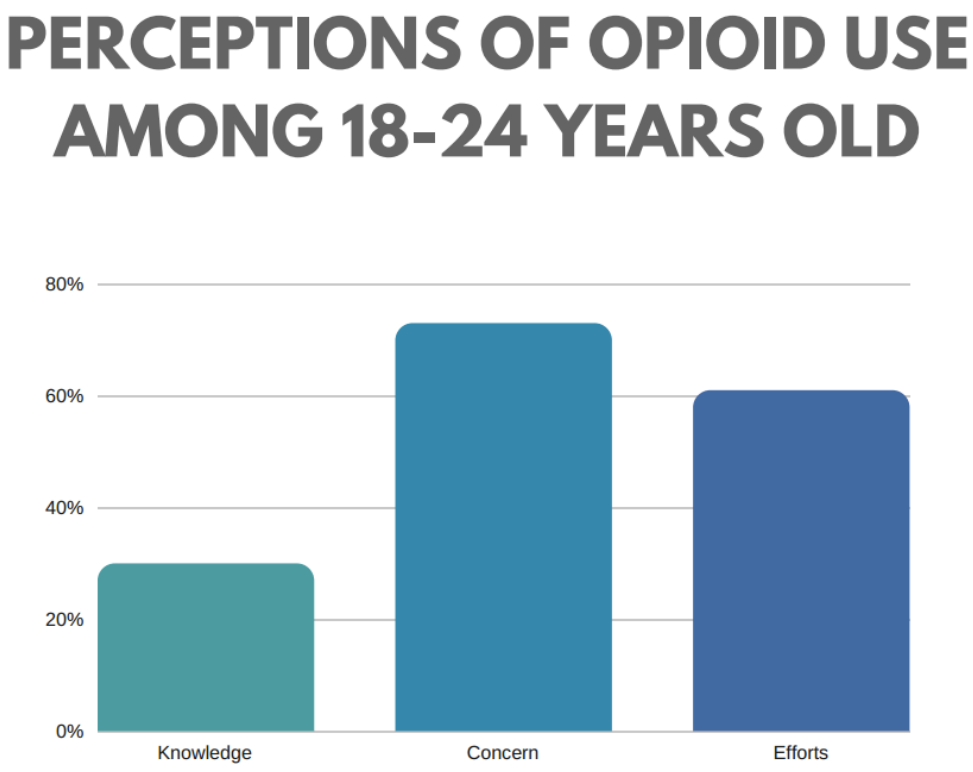


Figure 21 Summary of Perceptions of Heroin Use Among Youth 18-24 Years Old

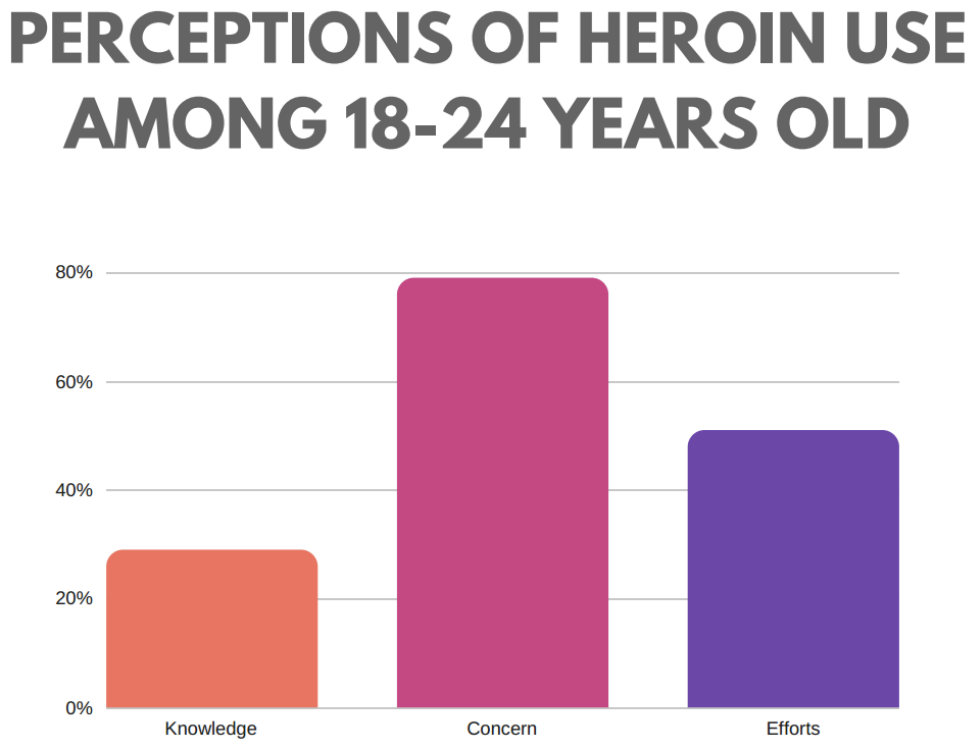


Figure 20 and 21 data collected by Hays Research Group LLC for AIPC. N-382.

The combination of high levels of concern, but lower levels of knowledge of efforts and knowledge of issue were themes throughout all primary data collection, including in key informant interviews.

> *"When we went down this path we didn't know where to go or who to turn to for help. […] Once your kid is in crisis it's assumed it's because you are a bad parent and that's just not the case. This can happen to anyone. Parents need to know the warning signs because they can be so easily hidden and explained away." (Key Informant, February 2017)*

Community Resource Assessment

A three-tiered resource assessment was conducted. First, current NMUPO and heroin users were asked what resources are available in Anchorage addressing both prevention and treatment. Treatment questions were included knowing that successful treatment will lead to fewer users, overdoses and other harmful consequences. Users were also asked what resources they wish were available. Secondly, an assessment was conducted of resources that could provide assistance with the intervening variables provided by the State. The list of potential partners is provided as Appendix D and E. Appendix F lines out which resources are available to address each of the proscribed intervening variables. Finally, an assessment of available treatment resources in Anchorage was provided.

User perceptions of available and needed resources

Survey participants who are actively misusing opioids and/or using heroin were asked about the resources available for those who want help with opioid addiction. Responses included both general and specific resources. General resources included treatment, detox, counseling, hotlines, rehab, clinics, hospitals, family and friends, and churches. More specific resources named included the Ernie Turner Center, the methadone clinic, Suboxone, Vivitrol, Narcotics Anonymous and Alcoholics Anonymous, and the Salvation Army Clitheroe Center.

Several respondents pointed out inadequacies with the resource options in Anchorage. Criticisms included that there aren't enough resources, that resources can be expensive, that there are often waitlists, and that there is a lack of empathy for those experiencing opioid addiction.

After being asked about resources currently available, survey participants were asked about resources that they wished were available. Some of the more frequent responses included greater access to methadone and Suboxone. There were also pleas for more detox centers and rehabs with shorter waitlists. A few respondents also wished for harm reduction resources such as more needle exchanges locations and supervised injection sites.

Resources available to address intervening variables:

Opioid Availability

Social and Retail Availability of Prescription Opioids are inextricably linked. A reduction in retail availability will necessarily reduce social access. Anchorage has a number of agencies and individuals who are well poised to help reduce retail availability through education to patients seeking pain relief, physicians about alternatives to opioids to reduce pain as well as improvements to the AKPDMD. The list of resources includes people who work or volunteer in opioid misuse prevention as well as prescribers and pharmacists. See Appendices D, E, and F.

Currently participation in the Alaskan Prescription Drug Monitoring Program is voluntary. Key informants described the broad range of levels in which prescribers and pharmacists are participating. Currently, only 22% of statewide potential professionals are registered. However, implementation of SB 74 will result in positive changes. The Bill is scheduled to roll out with a series of mandates over the next few years. As components become compulsory, retail access to prescription opioids will decrease.

Once opioids are prescribed they have the potential to become socially available. Anchorage has two year-round medication drop locations at Providence Pharmacy and Alaska Native Tribal Health Consortium. Additionally, HVHC in conjunction with multiple partners including the DEA host two National Prescription Drug Take-Back Days in April and October. This is an opportunity for people to safely dispose of prescription medication. In addition to Take-Back events, safe storage is another method of reducing social availability. HVHC is distributing “pillpods” to raise awareness of safe storage of all medication.

Heroin Availability

Reducing heroin availability is primarily a law enforcement function. Law enforcement in Anchorage has continually increased the amount of heroin confiscated each year and is fully onboard to continue to do so. However, reducing availability of heroin is not a cure-all for the ultimate goals of reducing morbidity and mortality associated with heroin.

Most active heroin users said that if heroin were not available they would switch to another drug. Simply reducing access is not a viable stand-alone option. A complementary community level approach is the reduction of the desire for heroin. Half of current heroin users said they began using opioids with a legitimate prescription for pain. They then progressed to using heroin when prescription opioids became unaffordable or inaccessible. Reducing the desire for heroin can start with reducing initial retail availability of prescription opioids.

Perception of Risk and Harm Reduction

Resources for increasing the perception of the risk of both prescription opioids and heroin and reducing harm from use come from many of the same places. Appendices D, E, and F describe multiple organizations and individuals who are resources for these issues. They fit into two categories. The first falls into the primary prevention scope. These are prescribers who can educate potential users about the true risks of musing opioids for pain, as well as providing improved information about what constitutes appropriate use and how to taper off. The

second category is those organizations and individuals who can help with harm reduction. This includes providing access to and information regarding Narcan, clean needles and referrals and information about treatment options and resources.

Reducing stigma regarding addiction and increasing willingness to seek help are two more efforts the above-listed resources can assist with providing. Additional resources for these endeavors include the news media, who have covered the opioid issues with several articles a month for the past two years.

Community strengths, gaps, assets, and weaknesses

Partners in Anchorage have a long history of working together on substance abuse issues. This includes treatment providers, members of multiple coalitions, youth serving organizations, and the Anchorage School District. Some relationships that are in the development phase include medical professionals not involved in treatment services and law enforcement. Most collaborative substance abuse efforts have been geared towards underage drinking. In underage drinking prevention efforts, law enforcement was a key partner. The new direction of opioid misuse and heroin use prevention can work to re-invigorate relationships from prior collaborative efforts. As with all collaborative work, relationships are the key starting point. Anchorage is a relatively small community, and many of the necessary relationships are well formed. A final strength, that is also a weakness, is that Anchorage now has several groups working on this issue. Work towards planning and developing strategies will provide an opportunity for the various partners and coalitions to come together and strategically use their strengths moving forward.

VI. Prioritization

Prioritization Process

AIPC and HVHC coordinated two prioritization meetings with members of the HVHC leadership team, as well as members of the HVHC coalition as a whole and general community members.

On March 8, 2017, the HVHC leadership team met for two hours to name and prioritize community factors related to NMUPO and heroin use based on local primary and secondary data shared with them. To start the process, AIPC staff presented data related to NMUPO and heroin use to the leadership team. The leadership team then broke out into groups based on their interest in four intervening variables: retail availability, social availability, perception of risk, and harm reduction. The DBH required coalitions to consider retail availability, social availability, and perception of risk. HVHC and AIPC included harm reduction as an intervening variable based on the community's efforts around Narcan distribution and feedback from NMUPO and heroin users.

Through small group discussions, the groups brainstormed a list of community factors contributing to each of the four intervening variables. AIPC used the Community Factor

Prioritization worksheet provided by the DBH to guide and frame this process. After brainstorming community factors, the groups were asked to place factors on a chart based on whether or not there was the potential for change on that factor, and the importance of that factor. AIPC staff facilitated each group through the process and was available to take notes and answer questions. A detailed protocol for the prioritization process, work sheets, and summaries are available in Appendix C.

At the conclusion of the first prioritization meeting, AIPC staff summarized the group's work. AIPC then met with HVHC to further interpret and organize the factors brainstormed and develop a list of community factors for each intervening variable. Below is the list of community factors developed at the first meeting.

Retail Availability

Community Factors

- Lack of knowledge of new pain management recommendations from the CDC
- Lack of Prescription Drug Monitoring Program (PDMP) participation
- Inadequate patient/parent education at time of initial prescription
- Alternative pain management not commonly discussed with patient
- Need for ongoing training for prescribers
- Inadequate patient screening for pain contracts or addiction risk
- Pharmaceutical pain management is cheaper than physical therapy

Social Availability

Community Factors

- Prescription drug stockpiles
- Giving away, trading, stealing, selling excess
- Social status of having pills
- Social circle
- Inadequate policing capacity and lack of enforcement consequences
- Drugs aren't stored securely
- Social host/ parent/caregiver enabling

Perceived Risk

Community Factors

- Opioids are prescribed from a doctor and presumed to be safe (even is misused)
- Less stigma around using opioids than heroin
- Trust that heroin is heroin and not cut with fentanyl, etc.
- Lack of understanding of what opioids do to the brain and body and how quickly dependence can occur
- Not understanding vast consequences of using and misusing
- It won't happen to me
- Risk of mixing substances is misunderstood

Harm Reduction

Community Factors

- Access to and knowledge of Narcan/Naloxone
- Access to needle exchange
- Lack of community connectedness and bystander involvement
- Intervention available at the moment people decide they want to quit using
- Need to increase coping skills: Reduce need for quick fix of any ailments, and seeing opioids as cure all
- Need for ongoing post treatment/recovery services and opportunities
- De-stigmatize addiction
    - Perception that addiction is a moral issue
    - Perception that the drug use is only an issue for "them" not "us"
    - Increase help-seeking

The second prioritization meeting was open to all members of the HVHC coalition and stakeholders throughout the community. That meeting took place on March 28, 2017. At the second prioritization meeting, AIPC staff again presented data related to NMUPO and heroin use. AIPC staff then led the group through a prioritization process using the community factors brainstormed by the HVHC leadership team at the first prioritization meeting.

AIPC asked attendees to prioritize the variables based on their importance and changeability. AIPC placed several large graphs on the walls around the room for each of the intervening variables. The graphs were drawn with changeability on the x-axis and importance on the y-axis. Participants were given a set of colored and numbered post-it notes that corresponded with a community factor related to the intervening variables. Participants were asked to chart the community factors according to their level of importance and changeability using their colored and numbered post-it notes. At the conclusion of the meeting, AIPC collected the graphs to assess the group's input to further narrow the community factors. See Appendix C.

To assess the graphs and determine the factors of highest priority to the coalition, AIPC developed a method to assign numerical value to each factor's placement on the graphs. AIPC took photos of each graph and printed the graph on lined graph paper. AIPC then assigned numeric values to each hash mark of the graph both on the x-axis and y-axis. A score was calculated and given to each factor. The community factors were ranked for each of the four intervening variables. Once the factors were ranked, HVHC and AIPC met to select a highest priority community factors of focus for each of the intervening variables.

Based on the data and the coalition's input, the following community factors were prioritized for each intervening variable:

Retail Availability

Priority Community Factors

- Alternative pain management not commonly discussed with patient
- Inadequate patient/parent education at time of initial prescription
- Lack of Prescription Drug Monitoring (PDMP) participation

Social Availability

Priority Community Factors

- Secure storage and safe disposal
- Changes in social circle
- Safe Disposal

Perceived Risk

Priority Community Factors

- Lack of understanding of what opioids do to the brain and body and how quickly dependence can occur
- Opioids are prescribed from a doctor and presumed to be safe. There is less stigma surrounding opioid use than other drugs such as heroin.
- Not understanding the vast consequences of using and misusing

Harm Reduction

Priority Community Factors

- Access to needle exchange
- De-stigmatize addiction
- Lack of coping skills

VII. Discussion and Recommendations

Through the data collection and prioritization processes, paths for making change have become clear. This however, does not mean it will be easy. The good news is there are many overlapping issues and potential solutions that will allow future prevention efforts to make greater impact.

Four key findings will assist with strategically moving forward.

- First, at least half of the current heroin users who responded to the surveys started using prescription opioids for pain. Of them, many were not aware of alternatives to prescription opioids, the risks of using opioids, nor the importance of tapering use.
- Second, misperceptions and stigma around addiction result in misuse leading to dependence, a disinclination to recognize when someone develops a problem and an unwillingness to seek help.
- Third, many people in Anchorage are unwilling to discard opioids and other unused medications.
- And finally, once a person develops an opioid dependence, there are methods to reduce risks that will reduce the consequences of use.

Reduce Retail Availability

Reducing retail availability of prescription opioids is one of the first steps to take to prevent both opioid and heroin addiction. This action will reduce the number of people who start using opioids not as prescribed, and who later may develop dependence.

The data show the community is ready to embark on multiple methods to make this happen. The medical profession, through new PDMP mandates, will receive more training regarding pain management and engage in more conservative prescribing practices. Increasing prospective patient awareness of both the risks of and alternatives to opioid use for pain management was recommended by the community to decrease initial demand for opioid prescriptions. Both of these actions will decrease prevalence of opioid dependence and have wide community support.

Reduce Stigma

In Anchorage there are stigmas and misperceptions regarding opioid addiction. These include perceptions that opioid addicts (both prescription and illicit opioids) are primarily homeless, live in poverty, and that it is an Alaska Native community problem. The data show that none of these are the case.

Opioid addiction reaches across cultures and socioeconomic levels. Addicts are also thought to be bad people who rob and steal to access drugs. While this can be true, what is often misunderstood is that many people addicted to opioids do not want to be addicted and do want help. The stigmas and misperceptions result in families not wanting to admit that a member has an addiction issue, and the subject is hushed and hidden. Members of the community showed readiness to begin confronting the stigmas surrounding addiction, and believe it is an important step towards reducing the harms of NUMPO and heroin use.

Increase Safe Disposal

Many people in Anchorage expressed an unwillingness to discard prescription drugs, including opioids when a course of treatment has ended. For those who are willing to do so, the Drug Take-Back events are a valuable service. The events can also serve as an opportunity to raise awareness of the risks of stockpiling drugs.

For those unwilling to discard drugs, safe storage is critical. Users recommended several options. First, don't let anyone know about having the prescription in the first place. Second, lock the drugs in a safe, just like you would a gun.

NMUPO and heroin users described the degrees to which they will go to access their next high. These include stealing drugs from family and friends. The power of addiction and the horrors of withdrawal lead these actions. Safe storage will reduce social availability of prescription opioids. For some, this will help reduce nonprescription use of prescription opioids. This is not a cure-all. It is important to note that people that use heroin and misuse prescription opioids have a strong proclivity to switch to a different drug if one becomes unavailable.

Reduce Harm

Finally, an often mentioned and much needed resource is increased access to in- and out-patient detox and treatment options. Because this grant will not solve those issues, harm reduction for users was recognized as important. Harm reduction comes in various flavors.

One form of harm reduction is the increased access to and knowledge about Naloxone (Narcan). Most current heroin users were not familiar with Naloxone. Of those who were familiar with it, many did not have accurate understandings about how long it works for and the need for medical attention after one receives it. There were also concerns that Naloxone can lead to pushing the limits for a high. These are important considerations for the planning phase.

Another harm reduction effort includes access to the Alaskan AIDS Assistance Association's (Four A's) syringe exchange. Some people were confused by how this helps. Syringe exchanges serve several functions. One, clean needles protect against many blood borne diseases and infections, like Hepatitis C. Second, and at least as important, the needle exchange is a trusted place where many users go to get information about treatment, Narcan, HIV/AIDS and more. A final harm reduction idea is to improve coping skills, social and emotional skills, and life skills. These are longer-term recommendations but will eventually help to reduce the need for immediate relief of both physical and emotional pain through drugs.


THANK YOU
Anchorage!

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IX. Appendices

APPENDIX A – Summary of Key Informant Interviews

Summary of Key Informant Interviews based on sector responses.

Key Informant - Opioid Recovery Community		
	1. What drugs do you think of when you hear about prescription opioids?	Both individuals identified higher potent pain medications as prescription opioids.
	2. At what point do you think the using opioids beyond the medical recommendation is dangerous?	The individuals differed in their responses. One individual felt any time an opioid prescription is written the risk exists, while the other individual felt it is at the point when the person begin to use the prescribed drug outside the doctor's orders
	3. How did you start taking prescription opioids? What led to your use beyond recommendations? Thinking about other people you know, how did they start and what led to their use beyond recommendations?	Both individuals referenced how the drugs made them feel as the reason for using them beyond what the doctor prescribed, such as the relief from chronic pain.
	4. How do (did) you, or people you know obtain prescription opioids?	Most get opioids from doctor, some forged prescriptions, stole, or borrowed/bought from a friend.
	5. What consequences have you seen from opioid use beyond recommendations? Did you know about these consequences before you started using?	Both referenced death. "Becoming lost in life addicted."

	6. How likely do you think it is that people who use opioids beyond recommendation will face these consequences? And which ones might have persuaded you to not start using?	It depends with opioids because there are other non-lethal uses for them. People think it won't happen to them.
	7. What other things that could have prevented or intervened?	Both are unsure. One thought "maybe" a mother or father figure.
	8. What are safe ways to store opioids and how likely would you be to use them?	Locked up. Use them as directed.
	9. What would you have done if opioids weren't readily available?	If using for pain, use alternatives like tramadol or ibuprofen. If addicted, likely find something else to use.
	10. What resources are there for people who want help with opioid addiction?	Both said treatment centers, but one acknowledged you have to be sober to enter but that doesn't make sense.
	11. What resources do you wish were available? Tell me what you know about Naloxone, sometimes know as Narcan? How do you think it could be distributed to make it more readily available?	Distribute Narcan through soup kitchens or homeless shelters. Comprehensive treatment center with detox, hospital, recovery, job/life skills, to be independent again.
	12. Is there anything you'd like to add?	Narcan may enable users to continue using. Once Narcan saves you, there's no detox or treatment, so the "very vicious cycle" continues.
Key Informant - Heroin Recovery Community		
	1. Tell me about how you started using heroin? Thinking about other people you know, how did they start?	One was already using opioids. One started smoking heroin, then IV, then with other drugs (cocaine).

	2. How do (did) you, or people you know obtain heroin?	From other people, including drug dealers.
	3. What consequences have you seen from heroin use? Did you know about these consequences before you started using?	After addiction, become homeless, jobless, lose family, and may include jail, sexual exploitation, or death. Did not know consequences beforehand.
	4. How likely do you think it is that people who use heroin will face these consequences? And which ones might have persuaded you to not start using?	It's just a matter of time. Knowing the consequences may not deter use, "it won't be me" or will use other drugs.
	5. What other things that could have prevented or intervened?	Doctors not prescribe opioids. People have to make a decision to quit; have to treat their illness (maybe life challenges) in a healthy way instead of drugs.
	6. What would you have done if heroin wasn't readily available?	Use another drug.
	7. What resources are there for people who want help with heroin use?	Narcotics Anonymous or Alcoholics Anonymous (12 step program)
	8. What resources do you wish were available?	Comprehensive detox, hospital, treatment (drug-free) center that teaches life skills.
	9. Tell me what you know about Naloxone, sometimes know as Narcan? How do you think it could be distributed to make it more readily available?	Naloxone save lives but make sure medical care is sought. Distribute from needle exchange and homeless shelters.

	10. Do you know of community programs that offer detox or treatment programs?	Few, must be sober to enter.
	11. Where do you get information about heroin use or recovery?	Alcoholics Anonymous or Volunteers of America.
	12. Is there anything you'd like to add?	(no response)
Key Informant - Parents		
	1. At what point do you think the misuse of prescription opioids is dangerous?	Prescription medicine that is not prescribed to them, or if it is they're not following doctor's orders.
	2. What are some of the risks or consequences of associated with misusing opioids that you have seen? How likely is it that someone misusing opioids will suffer these consequences?	Family, health, and future all impacted from addiction. Consequences are highly likely to occur.
	3. How or what causes people in Anchorage to begin taking prescription opioids? What happens that ends up leading to addiction?	For youth, sports injuries, peer pressure, and get drugs from families. Kids with mental health issues may use opioids to self-medicate (anxiety), then build tolerance, and may become addicted. Parents may be naive and not lock up drugs. Kids often do not know the long-term consequences of taking prescription opioids.
	4. Had your doctor or pharmacist discussed the risks of addiction with you?	Doctors did not share the risks of prescription opioid addiction, and when the youth was in crisis over it the doctor's office did not help. Doctors need to know where to send people for treatment.
	5. For people who are misusing opioids, how do you think they obtain them? What do you think could be done to limit this access?	Demographics may lead to more opioid prescriptions. This person's experience is with white middle-class families where doctors may more freely prescribe opioids to private insurance.

	6. What are safe ways to store opioids?	Count pills and lock them out of reach of children. Educate parents and children on alternative ways to manage pain and proper use of prescription drugs.
	7. What would you be willing to do to limit access to prescription opioids? (storage, drop off, pill pod)	Lock opioids up, have more drug take-back events.
	8. Did you know where to find support and services for your child? What supports do you wish were available to you, and to your child?	No, we did not know. Commercials to advertise local help. Eliminate the stigma of drug use, don't be afraid to talk to your kids about drugs. Parents should learn warning signs.
	9. Tell me what you know about Naloxone, sometimes know as Narcan? How do you think it could be distributed to make it more readily available?	(no responses)
	10. What thoughts or messages would you like to share with other parents?	Share your story to become part of the solution. Work together to educate our community and our kids to learn to accept different ways to deal with pain management or ways to feel better.
Key Informant Treatment Providers		
	1. What does it mean, to the medical profession, to misuse prescription opioids?	To get high, leads to addiction and overdose, repeated ER visits. Some doctors get it and offer alternative treatment, others just keep prescribing.
	2. How concerned are you about opioid misuse in Anchorage? What about heroin? What is it about opioid misuse and heroin use that concerns you?	All are very concerned. Opioid use may lead to heroin use, which is cheaper, or another drug. Need more enforcement to police street dealers.

	3. Tell me about stories you hear about how people started using opioids misusing opioids, and started using heroin. (sports injuries, start to get high…)	Sports injuries. Work injury that leads to prescription, then heroin is cheaper.Pain doctor.Closing Palmer Correctional Facility meant people could not receive treatment, then dealers targeted them again.
	4. What risks do your clients perceive with misusing opioids? What about heroin? (addiction, death, losing kids, jobs, homelessness…)	Youth clients don't care about risks, just about getting a high. Clients don't see the risks until it's too late. It can be losing kids to OCS or homelessness. Hospitals receive higher funding based on "satisfaction scores" if prescribing opioids over prolonged periods.
	5. With your patients, what do you think could have been done to prevent their initial use and eventual addiction? What information might have caused them to hesitate before starting?	Prevention education helps, including high schools. Peer intervention would be key. Hospital database that flags repeat visits, so they can be educated.
	6. What would help after treatment to keep them from using again?	Continuing Care groups, structured sober support groups. Build up resiliency. Learning basic life skills (job), healthier habits and hobbies.
	7. Who are the people most affected by opioid misuse? Heroin?	Teens, young adults and middle age adults. Especially 18-25 or 20-30 year olds.
	8. What trends are you seeing with prescription opioid and heroin use in Anchorage?	Both opioid and heroin use rising. Doctor shopping for pills. Heroin is cheaper. People masking their addictions.

	9. What can you recommend to address the opioid misuse problem in Anchorage? Heroin?	Train teens to intervene with peers. Get rid of "patient satisfaction score" pain contracts. Better education, affordable and accessible detox and rehab.
	10. Is there anything else you'd like to add?	Education and support system in place.ER's treat addiction and have facility to transport patient to immediately.
Key Informant - Pharmacists and Prescribers		
	1. What does it mean, to the medical profession, to misuse prescription opioids?	Prescriber has to trust their patient and prescribe according to the pain. Use beyond medical recommendations. Or providing opioids to someone whom they were not prescribed.
	2. How concerned are you about opioid misuse in Anchorage? What about heroin? What is it about opioid misuse and heroin use that concerns you?	Yes, concerned. Prescribers may not know how much a patient is taking. If prescriber has to help patient using heroin, they have to go to them often in a dangerous environment. Public safety. Negative effects on family.
	3. How do you think most people in Anchorage obtain prescription opioids that are misusing them?	From someone else. False prescriptions, over prescribing, pharmacy robberies, or purchasing from someone who obtained them in that way.
	4. From what you've seen, what do you think causes people to start misusing prescription opioids? How about using Heroin?	Teens lack knowledge and think of it as party drug. Misuse of opioids may lead to heroin use. Recreational use. self-medication, overuse with poor oversight of practitioner, unrealistic expectation of pain control, poor awareness of alternatives, not following after care plan (physical therapy).

	5. What risks do your clients perceive with misusing opioids? What about heroin?	Heroin users may mark which vein for medical professionals to use. Patients don't share sense of risk. Either unconcerned, unaware, or benefit outweighs risks. Patients underappreciate risk.
	6. What was the likelihood you think people think they are at risk of becoming addicted to opioids? Heroin?	Not sure.Low for opiates, high for heroin.
	7. Who are the people most affected by opioid misuse? Heroin?	Community suffers most through economics and perception of safety. User is most affected, then immediate family and friends, then community.
	8. What trends are you seeing with prescription opioid and heroin use in Anchorage?	Shooting up morphine, taking Dilaudid. Hospitals advertise when they're out of Dilaudid to minimize seekers. Heroin and opioid use on the rise in overdose/deaths. Increased provider awareness, but no change in prescribing or prescription volume. Possible greater sense of patient demand for opioids.
	9. What can you recommend to address the opioid misuse problem in Anchorage? Heroin?	Tracking system for prescribers. Use NSAID's before opioids. (non-steroidal anti-inflammatory drugs)
	10. Is there anything else you'd like to add?	Education for kids.
Key Informant Law Enforcement		

	1. In your experience, how are people obtaining prescription opioids? What about heroin?	People get opioids from legitimate prescriptions, maybe buying or stealing from friends/family. Then addiction and heroin use might follow. Youth tend to use more marijuana and smoke with Xanax, than opioids or heroin. For heroin, from a drug dealer, a friend, family member, or using/sharing heroin.
	2. What are some of the consequences you are seeing from opioid misuse in Anchorage? What about heroin?	Higher property crime, overdose deaths, dysfunctional families, jail time, loss of job, divorce/separation, loss of trust, financial burden, loss of child custody, poor judgment, violent crimes, stealing, domestic violence. For both. Heroin and fentanyl lead to more overdoses. Youth don't know long-term consequences.
	3. What are you hearing about how people start misusing prescription opioids? Heroin?	Doctors over-prescribed by dosage or duration. Keep excess medication for future use to self medicate, thinking it's "safe."Opioid addicts may turn to heroin since it's cheaper and easier to find.Kids in single parent, low-income families, with mental health or trauma issues tend to more likely lead to full habit or addiction.Start by managing pain, then build a tolerance, and not realize they're addicted until it's too late.
	4. What trends are you seeing with prescription opioid misuse in Anchorage? Heroin use?	Prescription pad theft and the diversion of pharmaceutical opioids. Use of the mail service to order opioids and heroin. Youth are getting less prescriptions written for themselves now, so tend to take from others. Parents naive that child would use pills. Higher potency heroin is available so people are overdosing more easily. Fentanyl mixed with heroin.

	5. What are people in your profession doing to combat the heroin/opioid problem in Anchorage? What would you like to see change?	DEA's 360 strategy: 1. Law Enforcement action against heroin traffickers. 2. Diversion Control a) Enforcement actions against DEA registrants which include doctors, pharmacists, veterinarians and nurses operating outside the law. b) Long-term engagement with pharmaceutical drug manufacturers, wholesalers, pharmacies and practitioners to come up with reasonable safeguards against the dangers of opioid treatment and addiction. 3. Community Outreach Support youth on "front-end" in probation (not institutionalized) to do "Seven Challenges" substance abuse program, and Prime for Life. Job urinalysis, awareness, prevention & treatment, education.
	6. What other recommends do you have on how to address the opioid misuse problem in Anchorage? Heroin?	Treat opioid use as an epidemic. State put into practice reasonable measures to curtail the use by providers. Educate the public, including in schools. Retain effective penalties for those that possess and distribute heroin.
	7. What challenges do you see to making those things happen?	Challenges include State rules surrounding SB91 in relation to heroin or opioid distribution and penalties. State database in the limiting of opioid prescriptions in quantity and duration. Youth with cognitive delays have trouble understanding the long-term consequences of opioid use and cannot make the best decisions for themselves. Parents using drugs models that behavior, and if OCS gets involved the cycle continues. Funding for treatment, law enforcement, prevention, coalitions, social workers, therapists, public health, etc. Community buy-in to support people in recovery.
Key Informant - Key Community Members		

	1. How do most people in Anchorage view using prescriptions opioids to get high? What about heroin?	Pill form or injecting. There is a perception that those who abuse opioid prescriptions are losers, ill-educated, unhygienic, cannot hold a job, overall bad person rather than "regular person just like you and I." Increases crime and safety concerns. Although both are bad, opioid abuse is more "forgivable / overlooked" than heroin. Prescription drugs are addictive especially when used in a manner not consistent with the labeling or used someone other than the patient. Based on the news, heroin use seems to be on the rise.
	2. How do you think most people obtain prescription opioids? What about heroin?	Multiple visits to medical facilities like the doctors office & ER to obtain opioid prescription.Give it away or sell to/from family/friendsBuying from drug dealers."Black market" for opioids and heroin. Can be brought in from other states.Youth get from peers in school, parent's medicine cabinets, stealing other people's prescriptions.
	3. What are some of the consequences you are seeing from opioid misuse in Anchorage? What about heroin?	Higher Crime rates and safety concerns. Overdoses Taking resources away from APD and AFD. Addiction & dependency. Quick-paying jobs, like serving to prostitution, to buy more drugs. Increase of deceptive behavior like lying and stealing. Unhealthy weight loss in heroin users. Opened syringes in public parks and parking lots.

	4. What causes people to start misusing prescription opioids? Heroin?	Pain management. Lack of knowledge of addiction when beginning opioid use. Depression. Other Drug use. Economic/Financial impacts such as losing a job or house. Curiosity - learning from users/dealers in high-risk areas, rather than safer education. Compulsive drug seeking for heroin. Heroin can be cut/mixed with other drugs/poisons or white substances such as sugar, starch or powered milk, causing more danger.
	5. What trends are you seeing with prescription opioid misuse and heroin use in Anchorage?	Epidemic is regularly in the news. It's "not in the dark" anymore. Used syringes left in public areas.I feel that use is increasing. Opioid misuse is common amongst teens and young adults. According to news stories many Heroin addicts started with Opioid misuse.
	6. What are people in your profession doing to combat the heroin/opioid problem in Anchorage? What would you like to see change?	Coming together to brainstorm solutions & strategies. Making the community aware of the level of seriousness, and that everyone has the potential to become an addict. My profession does not combat this problem. We tie in facts about drugs to nicotine while promoting drug-free society. I would like to see more education from schools & parents to kids on the importance of following doctors orders with prescription meds. Offering preventative measures/ services, treatment services and transition to independence services among other services to adolescents and adults.

	7. What do you recommend to address the opioid misuse problem in Anchorage? Heroin?	Community awareness and education, in the general community and the school district. More and better resources for those in need of help. Education/awareness, talking about it openly, address that there is a problem, not to stereotype it as low SES people only. Reduce stigma. Sharing knowledge with those closest to us. Helping others deal with the pressures of life with alternative positive, healthy ways, like exercising and volunteering. Medical help for those suffering with mental illness and substance abuse such as anxiety, depression & post-traumatic stress disorder. People use when life is not working out. Help intervene by helping set healthy priorities, including balanced diets.
	8. What are challenges to what you'd like to see happening?	People will seek a high, and addicts have to want to quit. Education may not be enough. Low or lack of city/state budget. Not enough professionals in the field.Drug lords are dangerous people and may kill when people interfere with their business. (Something can be done about this if we all join efforts)Parent using while their children are in recovery and are using around them. (Children with poor support system.)
Key Informant - Media		

	1. How do most people in Anchorage view using prescriptions opioids to get high? What about heroin?	Generally people view using opioids in a negative way or as dangerous. May start with opioid prescription or recreationally leading to addiction; then maybe into heroin use. Need to see abuse as an illness rather than judging. Most people know opioids are dangerous. Parents know more now, but we don't know who is newly getting addicted. In Juneau, the whole class of 2007 had rampant addiction. Kenai has high heroin use. Community has more sympathy for heroin users than other drugs because we all know someone. Heroin is public health crisis now, which has racial undertones.
	2. How do you think most people obtain prescription opioids? What about heroin?	DoctorsThe Street, or black market, and easily in Town Square Park. Drugs are easy to get in halfway houses or corrections system.Pill mills - how many in Anc? People get heroin from a network of low-level dealers connected to CA and WA States. Even moms with kids in withdrawal will sometimes go buy heroin to help lessen their kids' withdrawal symptoms.
	3. What are some of the consequences you are seeing from opioid misuse in Anchorage? What about heroin?	Lose custody of kids to OCS. If parents trying to get clean, dealing with OCS makes that harder. Babies born addicted, then OCS. Death Loss of Job. It's not a problem of awareness. People know the risks.

	4. What causes people to start misusing prescription opioids? Heroin?	Heroin is cheaper, and there is a community built around drug use. People are self-medicating around traumas in their lives. People are self-treating other trauma, aimlessness, depression, etc., that leads to heroin and opioid use. Give people more options, like job corps.
	5. What trends are you seeing with prescription opioid misuse and heroin use in Anchorage?	Jay Butler said there are three waves: 1. Prescription painkillers, 2. Heroin, 3. Synthetic drugs (like Fentanyl). "We need more detox" is too simplistic. Replacement therapy is more effective (vivitrol, methadone, soboxone). Methadone has worked for some people, but there is a stigma.
	6. What are people in your profession doing to combat the heroin/opioid problem in Anchorage? What would you like to see change?	In the media we're not doing enough solutions reporting. Reporting personal stories can reduce stigma. The Anchorage Press has done some good in-depth reporting. Now it's recognized as a national problem because of race and economics. This is a topic of interest to editors. Things that work, not what is broken is the angle we prefer. But, our readers tend to like the tragedies that people can relate to, more than the solutions stories.
	7. What do you recommend to address the opioid misuse problem in Anchorage? Heroin?	More needle exchanges, like Four A's. Treating this problem like a public health crisis. Criminal Justice Reform for the long-term impact. More resources for treatment. Like an immediate help/action center or an emergency mental health center or crisis number. Change in public perception of those using as bad people; it's not a moral issue. Prevention measures, such as giving 17-25 year olds alternatives to make their lives better, to care for them and build their self-worth's. Have real people share their story.

	8. What are challenges to what you'd like to see happening?	Not enough treatment options that work, like Partners Reentry System. Support for addicts that are in jails, more training for guards and more resources to withdrawals. Treat withdrawals like emergency, opportunity to intervene. Restrict availability of drugs to those in Halfway Houses by increasing the quality of guards. Naloxone. Good but doesn't get at the root. Awareness. People know drugs are bad. Ads, radios, etc. don't work. Young people consume media better and are savvier than those ads.
Key Informant - Additional Key Community Members		
	1. How do most people in Anchorage view using prescriptions opioids to get high? What about heroin?	People think doctor's prescriptions are safe. May lead to chronic addiction, and possibly going to the street for heroin.People think heroin users are junkies or rock stars and not someone they know, but now they're learning neighbors or housewife down the street are "pill popping" to get high.They view opioids as easy to get since they're not illegal and are prescribed by a doctor. Heroin is illegal because the government says so.
	2. How do you think most people obtain prescription opioids? What about heroin?	"Doctor hop" to get opioid prescriptions. (There needs to be some mechanism to stop prescription abuse.) People start with prescriptions for legitimate pain. Buy or steal from people they know have prescriptions. Hurt themselves purposely in order to go to the ER and get a couple day's supply. People are buying heroin on the streets from drug dealers.

	3. What are some of the consequences you are seeing from opioid misuse in Anchorage? What about heroin?	Domestic violence Children in need of aid due to abuse or neglect. Petty crimes to support their habit. Overcrowded jails. Over use of and full ERs/Hospitals. Lack of enough treatment facilities. Poor health of those addicted. Death. Heartbreak. Average middle class people with opioid addictions. It's cheaper to get heroin, so more use it.
	4. What causes people to start misusing prescription opioids? Heroin?	Pain from workers' compensation injuries, car accident injuries, etc. Prescription opioids might lead people to turn to the street for illegal heroin. It feels good/like the feeling. It becomes a way to cope with things like depression, frustration, anger, trauma, etc. Over-prescribed opioid medication. Heroin - because it is cheaper and easier to obtain than a prescription med.

	5. What trends are you seeing with prescription opioid misuse and heroin use in Anchorage?	The people using sent to jail, so more people in prisons. Over-use of ER and Police. Increase of overdoses. Increase of child abuse & neglect. Younger people using and getting hooked; like athletes, good students, & middle school-ers. Rural communities exposed at an earlier age. Using is considered cool by performers & entertainers, they call it "lean" or "sizzurp" which is codeine I think mixed with juice or pop. Influences younger people. Heroin not as popular with mainstream entertainers. Increased in transfer of STD HIV/AIDS through unprotected sex and needle sharing.
	6. What are people in your profession doing to combat the heroin/opioid problem in Anchorage? What would you like to see change?	Most prefer addicts to be put back out on the street (from jail) because they perceive nothing wrong is being done. Promote longer jail sentences with mandatory drug rehabilitation programs while in jail. People are more aware of warning signs of drug abuse. Prescribers aren't so quick to give opioid prescriptions.Discussed opening a treatment center but logistically it is not possible due to lack of funding. Consider natural methods of treatment; physical therapy, ice or heat treatment, diet and exercise therapy, and education for people. Focus on the younger generation to grow and build a healthier generation.Limit the number of pills prescribed at a time. Meds should be distributed by dose through a third party. People being prescribed should be held accountable and told of consequences. They should also be tested to have pills in their system to ensure they are

	7. What do you recommend to address the opioid misuse problem in Anchorage? Heroin?	More police on the street. Stiffer penalties for repeat offenders; 2nd offense for selling/using any opioid or heroin, sent to jail for the rest of your life. Get to the root of why people use through therapy & treatment that is affordable and easy to access. More detox beds and treatment. Consider other pain treatments before opioid use. Limit amount prescribed. Education on treating the body better at an early age to avoid pain later in life. "Take care of the old person you are going to become."
	8. What are challenges to what you'd like to see happening?	Shut down the court system's "revolving door" problem with the same people in and out of the jail system for the same crimes.Money/ResourcesAnchorage municipality leadership to be active in finding solution. Getting local agencies to campaign for funds; such as Alaska Native Corporations in villages. Doctors to stop over-prescribing Hold patients accountable to using medication responsibly, and using safe storage, like locking them up and not selling them.Parents and families model better, healthier, and substance-free lifestyles to youth, especially Alaska Native youth.

APPENDIX B – Summary of Community Readiness Assessment

Healthy Voices Healthy Choices Community Readiness Assessment
Partnerships for Success: Opioid and Heroin Prevention

Non-medical prescription opioid and heroin use for 18-25 year-olds

Purpose (for interviewer to read)

Thank you for joining the Healthy Voices Healthy Choices coalition today for our community readiness assessment interviews. We are conducting a needs assessment for Anchorage to prevent and reduce the non-medical use of prescription opioids and heroin for 18-25 year-olds, as well as the non-medical use of prescription opioids for 12-17 year-olds.

The purpose for today's survey is to better understand the level of community readiness in preventing non-medical use of prescription opioids and heroin in Anchorage. This model of assessment uses key informant interviews with stakeholders who are knowledgeable and represent various sectors in the community. You have been invited to participate because you represent an important community sector and are also knowledgeable about the issue, community, and resources.

I will ask a series of questions on five areas: 1) community knowledge, 2) leadership, 3) community climate, 4) knowledge about the issue, and 5) resources for efforts.

Today, when I refer to "the issue," I am referring to:

> **Today's "Issue**:" the non-medical use of prescription opioids and heroin for 18-25 year-olds in Anchorage.

Let's get started!

Introductions

Inclusion activity: talk to a partner and share your story of how you've gotten to where you are now (2 minutes) while your partner listens. Then your partner will give you feedback on what you learned about them. Repeat and switch so the other partner for sharing and listening.

Community Readiness Interview Questions

Community Knowledge

1. Everyone score the community level of community concern for their sector.
2. Are there efforts in Anchorage that address issue?
3. Can you briefly describe each of these?
4. About how many community members are aware of each of the following aspects of the efforts? (None, a few, some, many, or most)
    a. Have heard of efforts?

    b. Can name efforts?
    c. Know the purpose of efforts?
    d. Know who the efforts are for?
    e. Know how the efforts work (e.g. activities or how they're implemented)?
    f. Know the effectiveness of the efforts?
5. Based on that, why do you think your community members have this amount of knowledge?
6. Are there misconceptions or incorrect information among community members about the current efforts.
7. Is anyone in the community trying to get something started to address the issues? Can you tell me about that?

Leadership

1. Everyone score the community level of community concern for their sector. Explain.
2. How much of a priority is addressing this issue to leadership? Can you explain why you say this?
3. I'm going to read a list of ways that leadership might show its support or lack of support for efforts to address issue. Can you please tell me whether none, a few, some, many or most leaders would or do show support in this way? Also, feel free to explain your responses as we move through the list. How many leaders…
    a. At least passively support efforts without necessarily being active in that support?
    b. Participate in developing, improving or implementing efforts, for example by being a member of a group that is working toward these efforts?
    c. Support allocating resources to fund community efforts?
    d. Play a key role as a leader or driving force in planning, developing or implementing efforts? (prompt: How do they do that?)
    e. Play a key role in ensuring the long-term viability of community efforts, for example by allocating long-term funding?
4. Does the leadership support expanded efforts in the community to address issue?
5. How much of a priority is addressing this issue to leadership? Can you explain why you say this?

Community Climate

1. Everyone score the community level of community concern for their sector. Explain.
2. How much of a priority is addressing this issue to community members? Can you explain your answer?
3. I'm going to read a list of ways that community members might show their support or their lack of support for community efforts to address issue. Can you please tell me whether none, a few, some, many or most community members would or do show their support in this way? Also, feel free to explain your responses as we move through the list. How many community members…

    a. At least passively support community efforts without being active in that support?
    b. Participate in developing, improving or implementing efforts, for example by attending group meetings that are working toward these efforts?
    c. Play a key role as a leader or driving force in planning, developing or implementing efforts? (prompt: How do they do that?)
    d. Are willing to pay more (for example, in taxes) to help fund community efforts?
4. About how many community members would support expanding efforts in the community to address issue? Would you say none, a few, some, many or most? If more how might they show this support?

Knowledge About the Issue

1. Everyone score the community level of knowledge for their sector. Explain.
2. Would you say that community members know nothing, a little, some or a lot about each of the following as they pertain to the issue? (Nothing, a little, some or a lot)
    a. issue, in general
    b. the signs and symptoms
    c. the causes
    d. the consequences
    e. how much issue occurs locally
    f. what can be done to prevent or treat issue
    g. the effects of issue on family and friends?
3. What are the misconceptions among community members about the issue?

Resources for Efforts

1. Everyone score the community level of knowledge for their sector. Explain.
2. How are current efforts funded? Is this funding likely to continue into the future?
3. I'm now going to read you a list of resources that could be used to address issue in your community. For each of these, please indicate whether there is none, a little, some or a lot of that resource available in your community that could be used to address issue?
    a. Volunteers?
    b. Financial donations from organizations and/or businesses?
    c. Grant funding?
    d. Experts?
    e. Space?
4. Would community members and leadership support using these resources to address issue? Please explain.
5. On a scale of 1 to 5, where 1 is no effort and 5 is a great effort, how much effort are community members and/or leadership putting into doing each of the following things to increase the resources going toward addressing issue in your community?
    a. Seeking volunteers for current or future efforts to address issue in the community.

b. Soliciting donations from businesses or other organizations to fund current or expanded community efforts.
c. Writing grant proposals to obtain funding to address issue in the community.
d. Training community members to become experts.
e. Recruiting experts to the community.

6. Are you aware of any proposals or action plans that have been submitted for funding to address issue in community?

Additional Policy-Related Questions:

For your sector…

1. How ready is your community with promoting alternatives to opioid use?
2. How ready do you think Anchorage is to start storing properly in a safe and discarding once they're expired or no longer needed?
3. What do you think the level of readiness are people ready to start talking about stigma for opioids?
4. What do you think the level of readiness are people ready to start talking about stigma for heroin?
5. How willing do you think your sector is to thinking the needle exchange is a good idea?

Healthy Voices Healthy Choices Community Readiness Assessment
Partnerships for Success: Opioid and Heroin Prevention

Non-medical prescription opioid use for 12-17 year-olds

Purpose (for interviewer to read)

Thank you for joining the Healthy Voices Healthy Choices coalition today for our community readiness assessment interviews. We are conducting a needs assessment for Anchorage to prevent and reduce the non-medical use of prescription opioids for 12-17 year-olds, as well as the non-medical use of prescription opioids and heroin for 18-25 year-olds.

The purpose for today's survey is to better understand the level of community readiness in preventing non-medical use of prescription opioids and heroin in Anchorage. This model of assessment uses key informant interviews with stakeholders who are knowledgeable and represent various sectors in the community. You have been invited to participate because you represent an important community sector and are also knowledgeable about the issue, community, and resources.

I will ask a series of questions on five areas: 1) community knowledge, 2) leadership, 3) community climate, 4) knowledge about the issue, and 5) resources for efforts.

Today, when I refer to "the issue," I am referring to:

> **Today's "Issue**:" the non-medical use of prescription opioids for 12-17 year-olds in Anchorage.

Let's get started!

Introductions

Inclusion activity: talk to a partner and share your story of how you've gotten to where you are now (2 minutes) while your partner listens. Then your partner will give you feedback on what you learned about them. Switch so the other

Community Readiness Interview Questions

Community Knowledge

1. Everyone score the community level of community concern for their sector.
2. Are there efforts in Anchorage that address issue?
3. Can you briefly describe each of these?
4. About how many community members are aware of each of the following aspects of the efforts? (None, a few, some, many, or most)
    a. Have heard of efforts?
    b. Can name efforts?

    c. Know the purpose of efforts?
    d. Know who the efforts are for?
    e. Know how the efforts work (e.g. activities or how they're implemented)?
    f. Know the effectiveness of the efforts?
5. Based on that, why do you think your community members have this amount of knowledge?
6. Are there misconceptions or incorrect information among community members about the current efforts.
7. Is anyone in the community trying to get something started to address the issues? Can you tell me about that?

Leadership

1. Everyone score the community level of community concern for their sector. Explain.
2. How much of a priority is addressing this issue to leadership? Can you explain why you say this?
3. I'm going to read a list of ways that leadership might show its support or lack of support for efforts to address issue. Can you please tell me whether none, a few, some, many or most leaders would or do show support in this way? Also, feel free to explain your responses as we move through the list. How many leaders…
    a. At least passively support efforts without necessarily being active in that support?
    b. Participate in developing, improving or implementing efforts, for example by being a member of a group that is working toward these efforts?
    c. Support allocating resources to fund community efforts?
    d. Play a key role as a leader or driving force in planning, developing or implementing efforts? (prompt: How do they do that?)
    e. Play a key role in ensuring the long-term viability of community efforts, for example by allocating long-term funding?
4. Does the leadership support expanded efforts in the community to address issue?
5. How much of a priority is addressing this issue to leadership? Can you explain why you say this?

Community Climate

1. Everyone score the community level of community concern for their sector. Explain.
2. How much of a priority is addressing this issue to community members? Can you explain your answer?
3. I'm going to read a list of ways that community members might show their support or their lack of support for community efforts to address issue. Can you please tell me whether none, a few, some, many or most community members would or do show their support in this way? Also, feel free to explain your responses as we move through the list. How many community members…

    a. At least passively support community efforts without being active in that support?
    b. Participate in developing, improving or implementing efforts, for example by attending group meetings that are working toward these efforts?
    c. Play a key role as a leader or driving force in planning, developing or implementing efforts? (prompt: How do they do that?)
    d. Are willing to pay more (for example, in taxes) to help fund community efforts?
4. About how many community members would support expanding efforts in the community to address issue? Would you say none, a few, some, many or most? If more How might they show this support?

Knowledge About the Issue

1. Everyone score the community level of knowledge for their sector. Explain.
2. Would you say that community members know nothing, a little, some or a lot about each of the following as they pertain to the issue? (Nothing, a little, some or a lot)
    a. issue, in general
    b. the signs and symptoms
    c. the causes
    d. the consequences
    e. how much issue occurs locally
    f. what can be done to prevent or treat issue
    g. the effects of issue on family and friends?
3. What are the misconceptions among community members about the issue?

Resources for Efforts

1. Everyone score the community level of knowledge for their sector. Explain.
2. How are current efforts funded? Is this funding likely to continue into the future?
3. I'm now going to read you a list of resources that could be used to address issue in your community. For each of these, please indicate whether there is none, a little, some or a lot of that resource available in your community that could be used to address issue?
    a. Volunteers?
    b. Financial donations from organizations and/or businesses?
    c. Grant funding?
    d. Experts?
    e. Space?
4. Would community members and leadership support using these resources to address issue? Please explain.
5. On a scale of 1 to 5, where 1 is no effort and 5 is a great effort, how much effort are community members and/or leadership putting into doing each of the following things to increase the resources going toward addressing issue in your community?
    a. Seeking volunteers for current or future efforts to address issue in the community.

b. Soliciting donations from businesses or other organizations to fund current or expanded community efforts.
c. Writing grant proposals to obtain funding to address issue in the community.
d. Training community members to become experts.
e. Recruiting experts to the community.

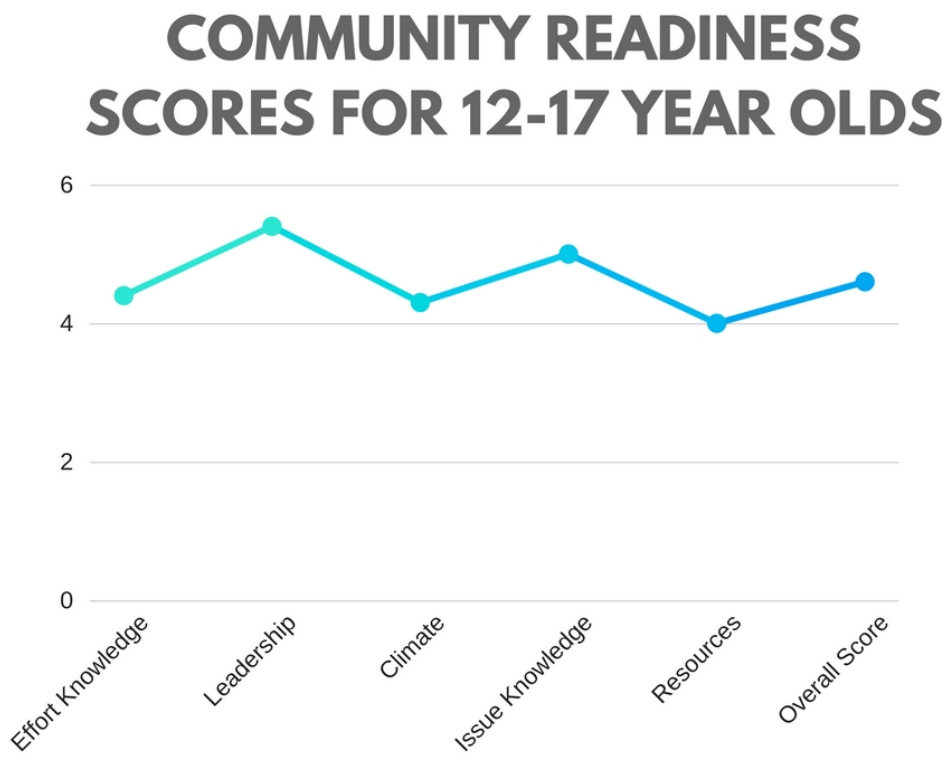
6. Are you aware of any proposals or action plans that have been submitted for funding to address issue in community?

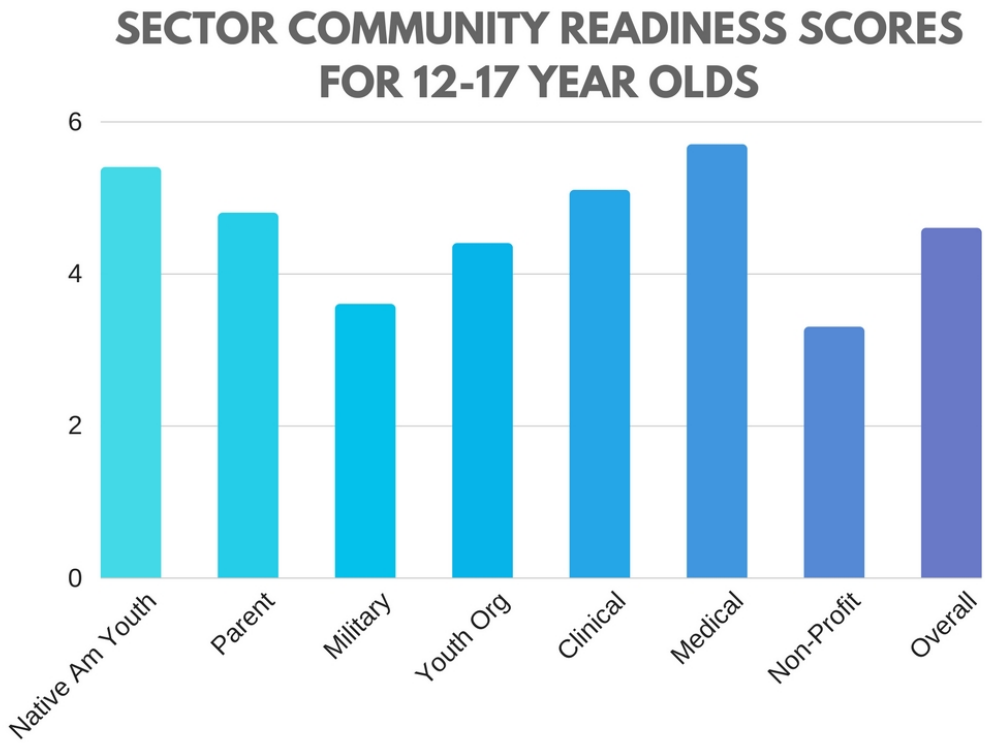
Additional Policy-Related Questions:

For your sector…

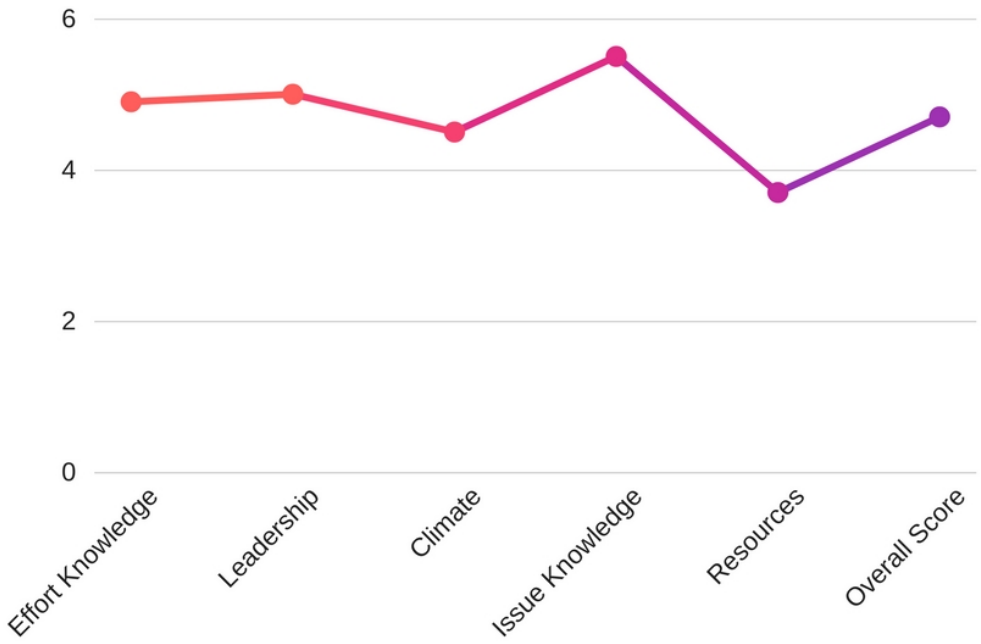
1. How ready is Anchorage to hear about alternatives to pain medication? Changing the perception of instant gratification.
2. How ready do you think Anchorage is to start storing properly in a safe or discarding once they're expired or no longer needed?
3. What do you think the level of readiness are people ready to start talking about stigma?

Summary of Community Readiness Assessment Scores

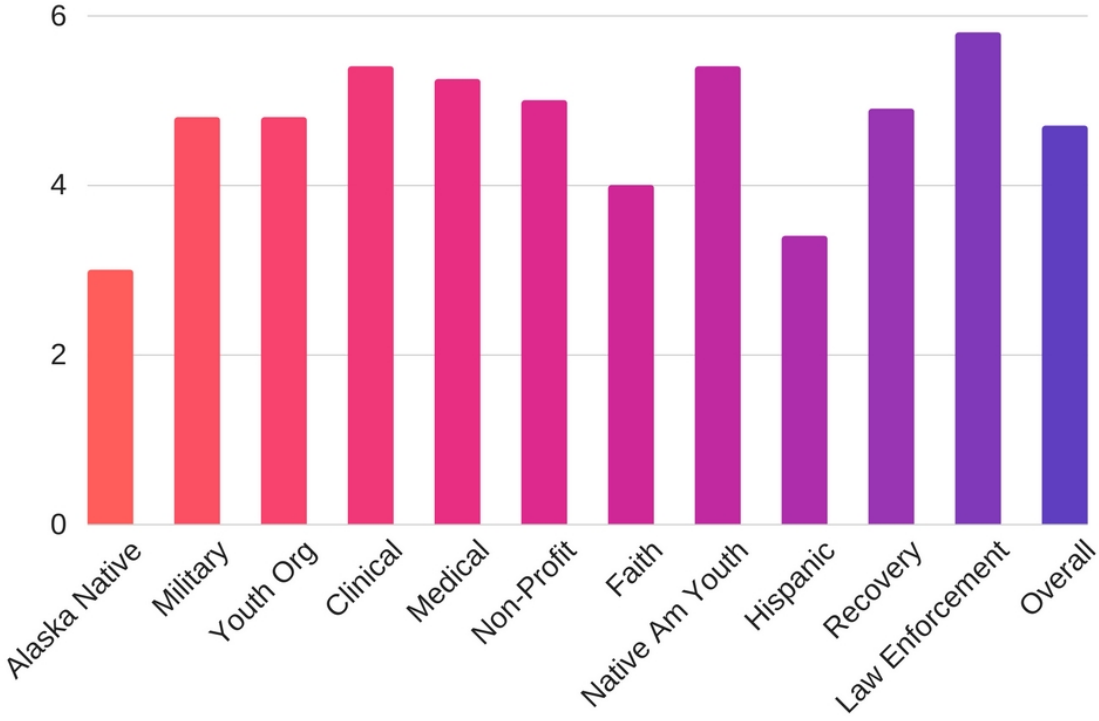




COMMUNITY READINESS SCORES FOR 18-25 YEAR OLDS



SECTOR COMMUNITY READINESS SCORES FOR 18-25 YEAR OLDS



Summary of themes from Community Readiness Assessment group interviews

Intermediate Variable	Priority Community Factors	Comments from Community Readiness Assessment meetings	"Youth" Group (n=8)	Percent	"Young Adult" Group (n=11)	Percent
Retail Availability						
	Alternative pain management not commonly discussed with patient		6	75	4	36
		Alternative forms of pain control may cost more than opioids due to insurers.				
		Not many people know what alternative pain control is, especially youth.				
		Maybe alternative or non-drug opioids should be preferences in treatment.				
		Doctors tend to offer prescription opioids as the first line of pain treatment.				
	Inadequate patient/parent education at time of initial prescription		2	25	6	55
		Families often seek information or programs after they are severely impacted by addiction and its consequences.				
		There is no standard warning to give to patients.				
		Very few prescribers or pharmacies have pain agreements with patients explicitly stating proper medication use.				
		The military community and culture tends to accept use of prescription opioids without question.				
		Language may also be a barrier in communicating information about prescription opioids.				
	Lack of Prescription Drug Monitoring (PDMP) participation		6	75	9	82
		The Alaska Native Medical Hospital and Southcentral Foundation led community on prescription drug monitoring and pain contracts.				
		There are too few efforts to combat prescription opioid misuse.				
		The Governor is leading efforts and has offered bills to address prescription drug monitoring efforts.				
Social Availability						
	Secure storage and safe disposal		4	50	7	64
		There are overall too few efforts to combat opioid and heroin use, and too few resources to support existing efforts.				
		Pharmacies or providers seem to be unwilling to take back all prescription drugs.				
		Families want to play their part to make a difference, but they may not know the best practices for safe storage.				
		Community members, including the military, do not tend to throw away prescription drugs.				
	Social circle		2	25	2	18

		Grandparents raising grandchildren do not have accurate information on opioids, and may not use proper storage or teach best behaviors.				
		Military structure offers reactive, rather than proactive, punishment of behavior.				
Perception of Risk						
	Lack of understanding of what opioids do to the brain and body and how quickly dependence can occur		8	100	11	100
		There is vast misinformation about opioid addiction in youth.				
		There is a lack of understanding that misuse of prescription opioids may lead to heroin use.				
		There is a misconception that doctors can tell who will be at risk for misuse and abuse.				
		People believe in stereotypes of families so believe youth may or may not tend to misuse prescription opioids.				
	Opioids are prescribed from a doctor and presumed to be safe. There is less stigma surrounding opioid use than other drugs such as heroin		4	50	2	18
		People believe there are fewer risks in prescribed medication.				
		Treating pain as a vital sign has led to over-prescribing, and patients now request it.				
		There is more potential for conversations around stigma for 12-17 year-olds, but may be harder for 18-25 year-olds.				
	Not understanding the vast consequences of using and misusing		8	100	10	91
		Most youth-service workers do not know how to address opioid addiction in youth.				
		There is misinformation about who can become addicted to misusing prescription opioids.				
		Leadership in the community are not activated unless the consequences of addiction impact their lives directly.				
Harm Reduction						
	Access to needle exchange		N/A		1	9
		There is a lack of understanding of how a needle exchange addresses heroin addiction.				
	De-stigmatize addiction		4	50	3	27
		Families are still secretive when addiction is impacting them. Stigma can hold them back from seeking support services.				
		There is a racial issue that some people of color might be at a disadvantage or receiving treatment.				
		Stigma is prevalent and different in various cultures.				
	Lack of coping skills		1	13	0	0
		Alternative treatment could involve discussing other pain management skills with patients.				

APPENDIX C –Community Prioritization Process

Community Prioritization Meeting Protocol

Partnerships for Success – Opioid and Heroin Prevention

Healthy Voices Healthy Choices

COMMUNITY FACTORS

We're looking to find what factors in our community lead to trends around opioid and heroin use. For example, if there are few disposal sites for prescription opioids, it can make it easier for someone to get their hands on them who was not prescribed to use them. We'll discuss some of the trends we've seen in Anchorage based on local data, surveys, interviews, and local media, and we'll identify what factors may lead to those trends.

Then we will see what community factors we come up with and prioritize them in how important they are and how much we could change them with new programs going forward.

PRIORITIZATION

Criteria to prioritize other community factors:

Now that we have an idea of community factors that lead to trends of opioid and heroin use in Anchorage, we need to prioritize what factors we want to address going forward.

We should prioritize and select community factors that are high in both *importance* and *changeability:*

- **Importance**
  - If the factor changed, how much of a difference will it make on the problem?
    - Example: If doctors change the way they prescribe (vs) Storage
  - Does the community factor impact other behavioral health issues or other identified problems for opioid and heroin use?
- **Changeability**
  - Does the community have the capacity—the readiness, resources, and funding—to change a particular community factor?
  - Can change occur in a reasonable time frame? (within next two years?)
  - Can the change be sustained over time?

WORKSHEET DIRECTIONS

Community Factors - Step 1 Directions: In a small group, brainstorm some of community factors that influence prescription opioid and heroin use and consequences in the following areas. We will then discuss this as a large group before moving to Step 2.

Prioritization - Step 2 Directions: Fill in this chart placing community factors from Step 1 based on the criteria of changeability and importance, and taking other considerations into account. Factors that land in the "high importance and high changeability" quadrant will likely have most priority for our work going forward.

Community Factor Prioritization – Group Worksheet

Organization/Member: _____

Step 1:

Step 2:

RETAIL AVAILABILITY	High Changeability	Low Changeability
High Importance		
Low Importance		

Community Factor Prioritization – Group Worksheet

Organization/Member: _____

Step 1:

Step 2:

RETAIL AVAILABILITY	High Changeability	Low Changeability
High Importance		
Low Importance		

Community Factor Prioritization – Group Worksheet

Organization/Member: _____

Step 1:

Step 2:

Perceived Harm Risk	High Changeability	Low Changeability
High Importance		
Low Importance		

Community Factor Prioritization – Group Worksheet

Organization/Member: _____

Step 1:

Step 2:

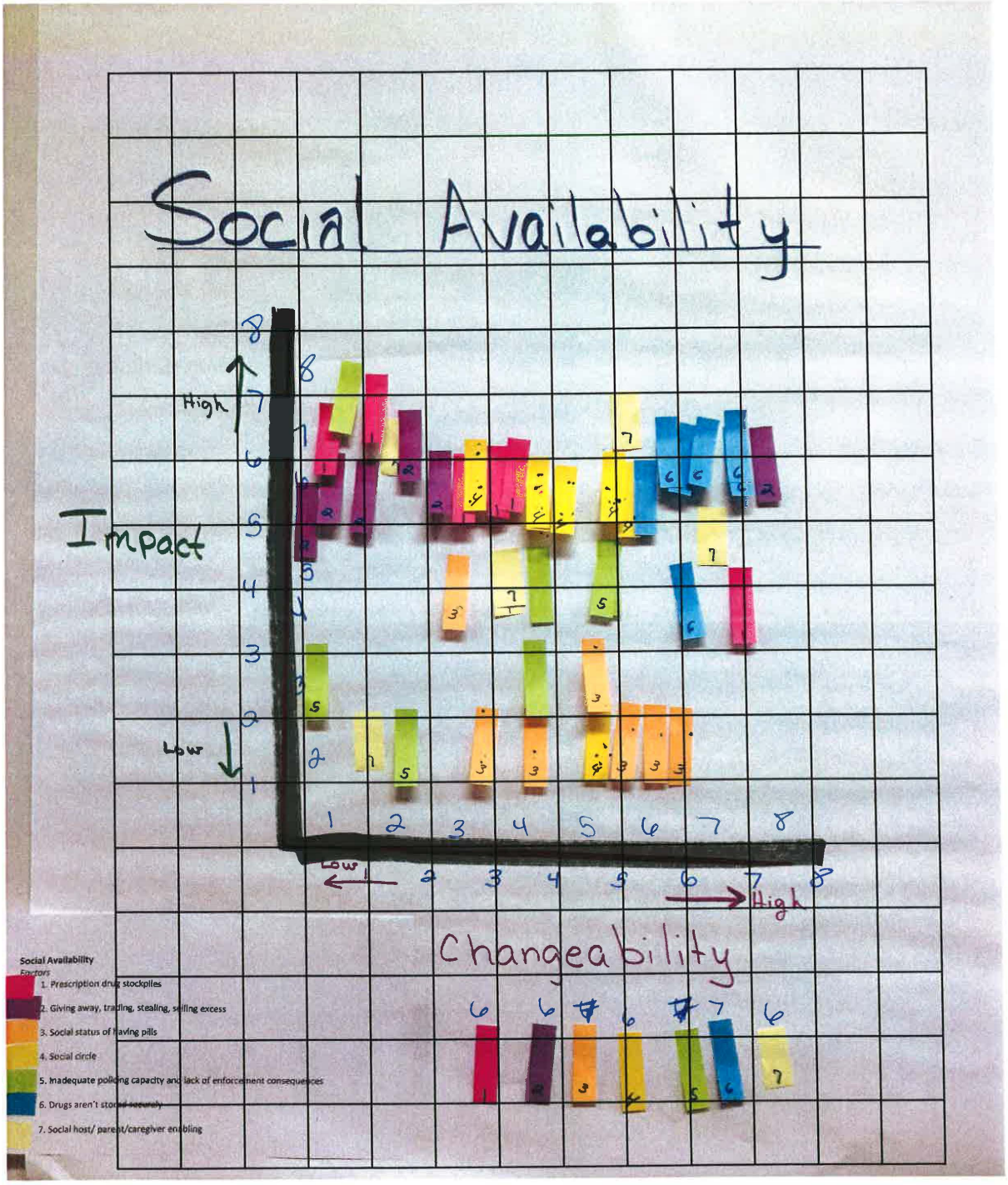
Harm Reduction	High Changeability	Low Changeability
High Importance		
Low Importance		

Community factors from round 1 of HVHC community prioritization meetings

The HVHC coalition held a series of two community prioritization meetings. Below are the results of the first community prioritization meeting of possible community factors. These community factors were refined further at the second community prioritization meeting.

Intermediate Variable	Priority Community Factors
Retail Availability	
	1. Lack of knowledge of new pain management recommendations from the CDC
	2. Lack of Prescription Drug Monitoring Program (PDMP) participation
	3. Inadequate patient/parent education at time of initial prescription
	4. Alternative pain management not commonly discussed with patient
	5. Need for ongoing training for prescribers
	6. Inadequate patient screening for pain contracts or addiction risk
	7. Pharmaceutical pain management is cheaper than physical therapy
Social Availability	
	1. Prescription drug stockpiles
	2. Giving away, trading, stealing, selling excess
	3. Social status of having pills
	4. Social circle
	5. Inadequate policing capacity and lack of enforcement consequences
	6. Drugs aren't stored securely
	7. Social host/ parent/caregiver enabling
Perception of Risk	
	1. Opioids are prescribed from a doctor and presumed to be safe (even is misused)
	2. Less stigma around using opioids than heroin
	3. Trust that heroin is heroin and not cut with fentanyl, etc.
	4. Lack of understanding of what opioids do to the brain and body and how quickly dependence can occur
	5. Not understanding vast consequences of using and misusing
	6. It won't happen to me
	7. Risk of mixing substances is misunderstood
Harm Reduction	

	1. Access to and knowledge of Narcan/Naloxone
	2. Access to needle exchange
	3. Lack of community connectedness and bystander involvement
	4. Intervention available at the moment people decide they want to quit using
	5. Need to increase coping skills: Reduce need for quick fix of any ailments, and seeing opioids as cure all
	6. Need for ongoing post treatment/recovery services and opportunities
	7. De-stigmatize addiction
	o Perception that addiction is a moral issue
	o Perception that the drug use is only an issue for “them” not “us”
	o Increase help-seeking


Social Availability
High
Impact
Low
1 2 3 4 5 6 7 8
Low
High
Changeability
Social Availability
Factors
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2. Giving away, trading, stealing, selling excess
3. Social status of having pills
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5. Inadequate policing capacity and lack of enforcement consequences
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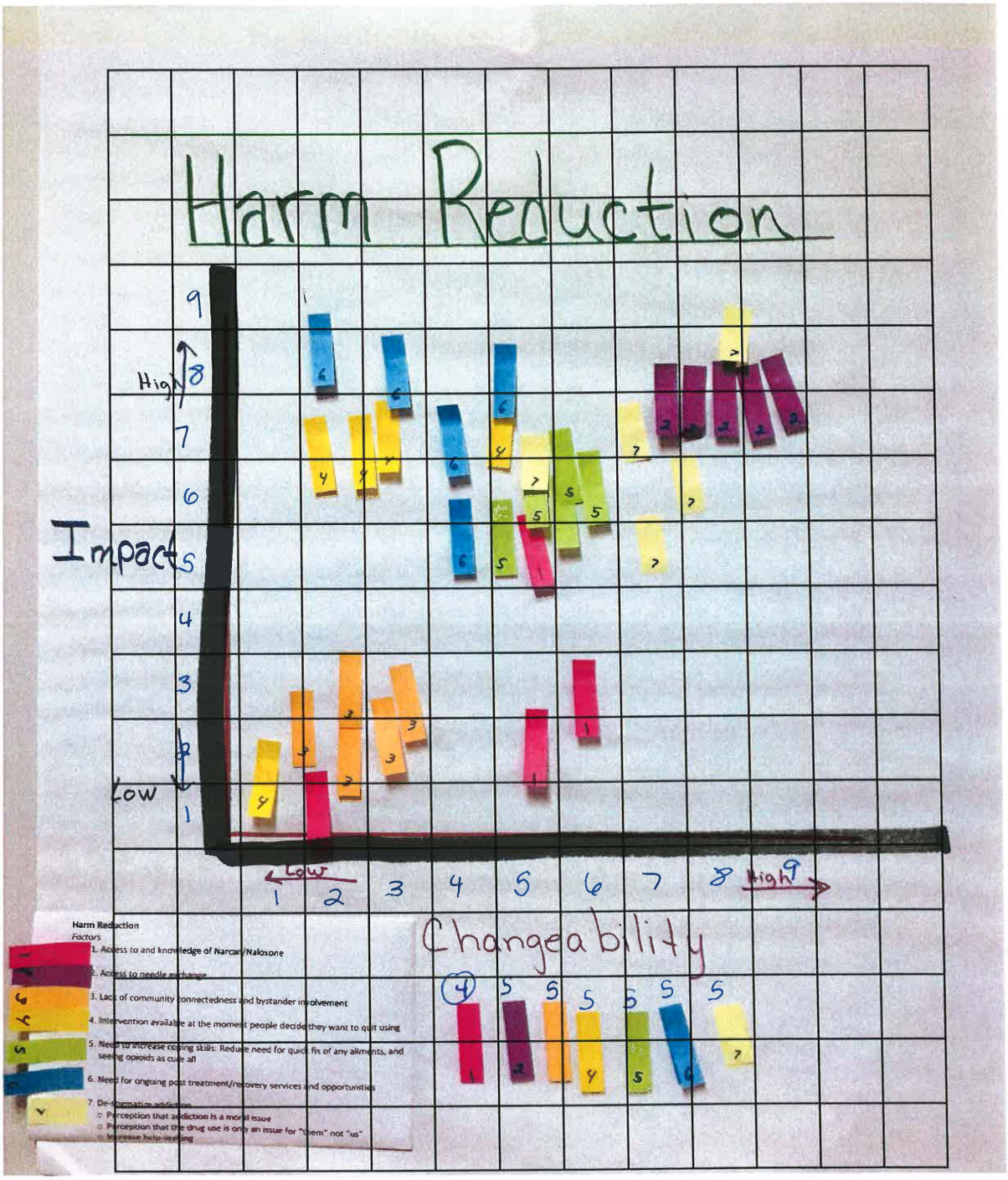
Harm Reduction
Impact
High
Low
Changeability
Low
High
Harm Reduction
Factors
1. Access to and knowledge of Narcan/Naloxone
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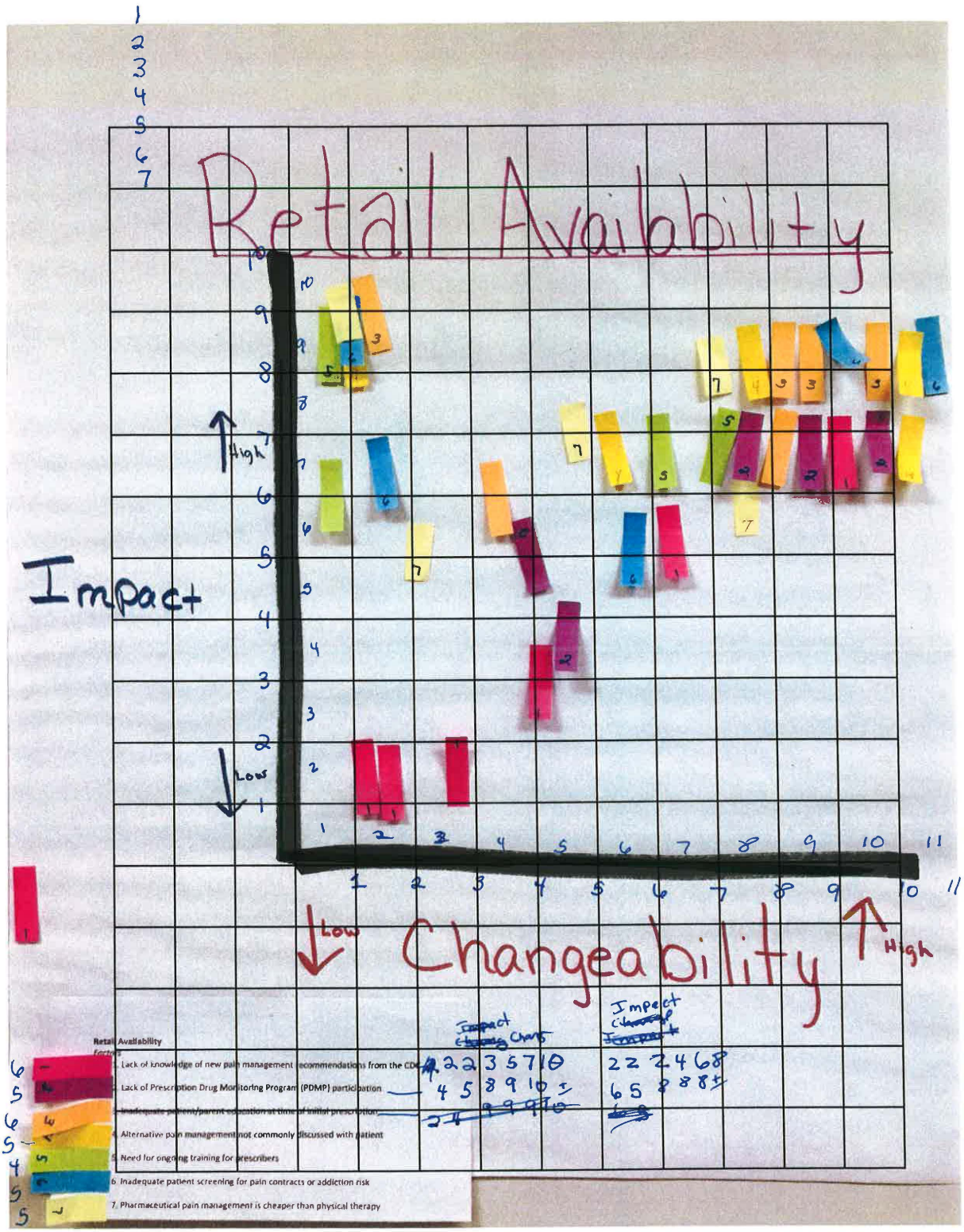
4. Intervention available at the moment people decide they want to quit using
5. Need to increase coping skills: Reduce need for quick fix of any ailments, and seeing opioids as cure all
6. Need for ongoing post treatment/recovery services and opportunities
7. De-[illegible] addiction
Perception that addiction is a moral issue
Perception that the drug use is only an issue for "them" not "us"
Increase hate-stopping


Retail Availability
Impact
High
Low
Low
Changeability
High
Retail Availability
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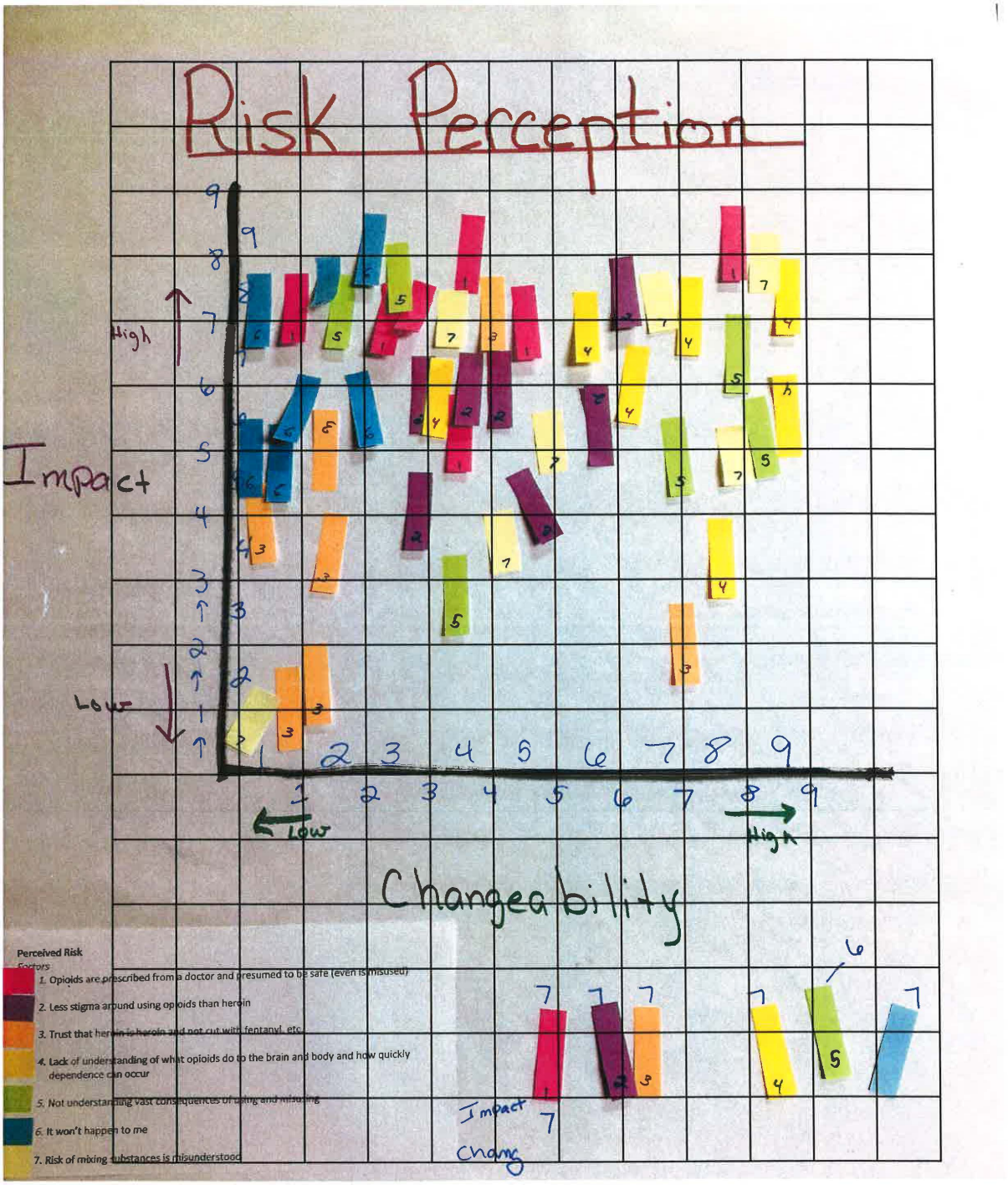
5. Need for ongoing training for prescribers
6. Inadequate patient screening for pain contracts or addiction risk
7. Pharmaceutical pain management is cheaper than physical therapy


Risk Perception
Impact
High
Low
Low
High
Changeability
Perceived Risk
Factors:
1. Opioids are prescribed from a doctor and presumed to be safe (even is misused)
2. Less stigma around using opioids than heroin
3. Trust that heroin is heroin and not cut with fentanyl, etc.
4. Lack of understanding of what opioids do to the brain and body and how quickly dependence can occur
5. Not understanding vast consequences of using and misusing
6. It won't happen to me
7. Risk of mixing substances is misunderstood
Impact
Chang

Final priority community factors

The HVHC coalition held a series of two community prioritization meetings. Below are the final determinations of the priority community factors.

Intermediate Variable	Priority Community Factors
Retail Availability	
	Alternative pain management not commonly discussed with patient
	Inadequate patient/parent education at time of initial prescription
	Lack of Prescription Drug Monitoring (PDMP) participation
Social Availability	
	Secure storage and safe disposal
	Social circle
Perception of Risk	
	Lack of understanding of what opioids do to the brain and body and how quickly dependence can occur
	Opioids are prescribed from a doctor and presumed to be safe. There is less stigma surrounding opioid use than other drugs such as heroin
	Not understanding the vast consequences of using and misusing
Harm Reduction	
	Access to needle exchange
	De-stigmatize addiction
	Lack of coping skills

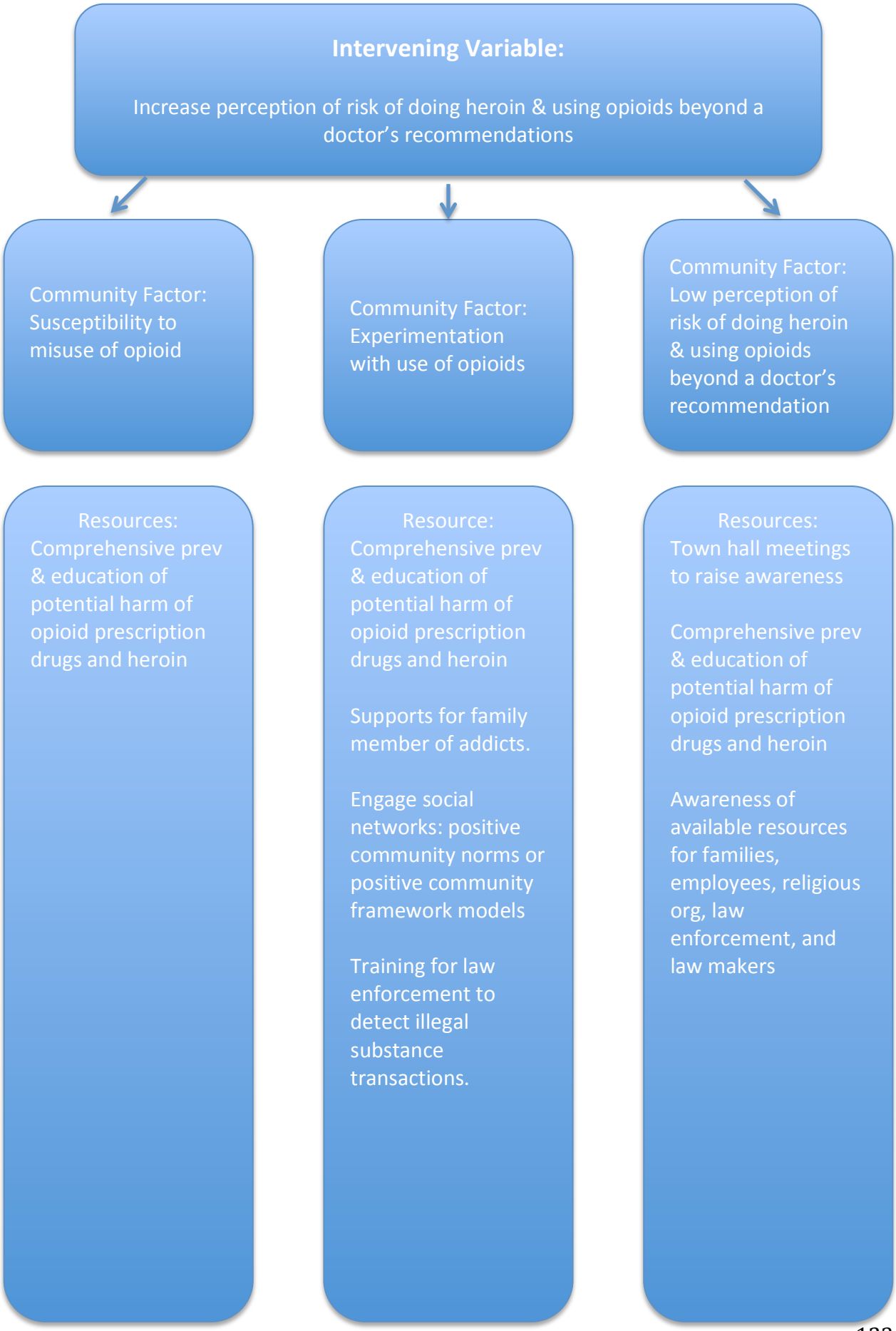
APPENDIX D – Community Resource Assessment

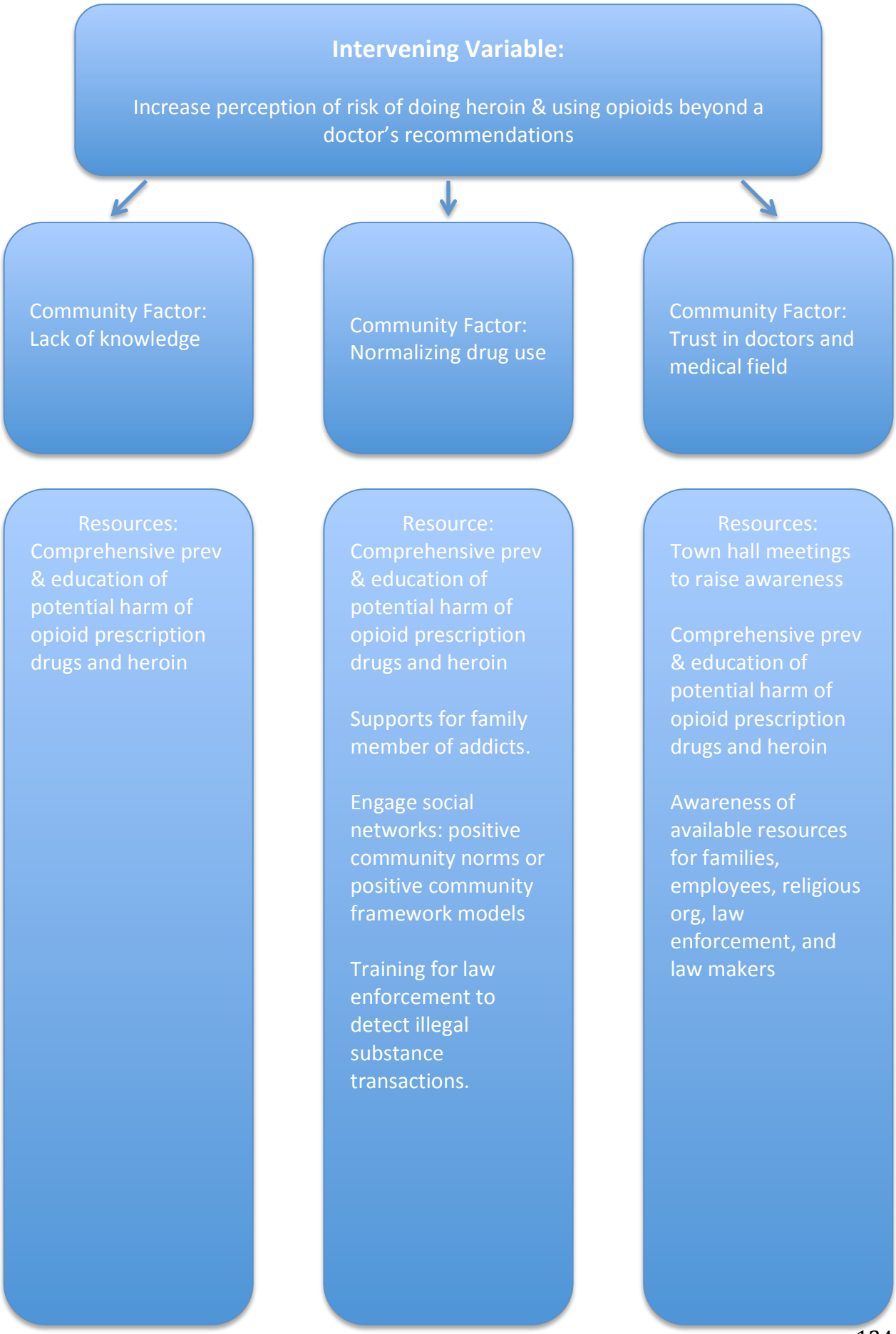
Intervening Variable:

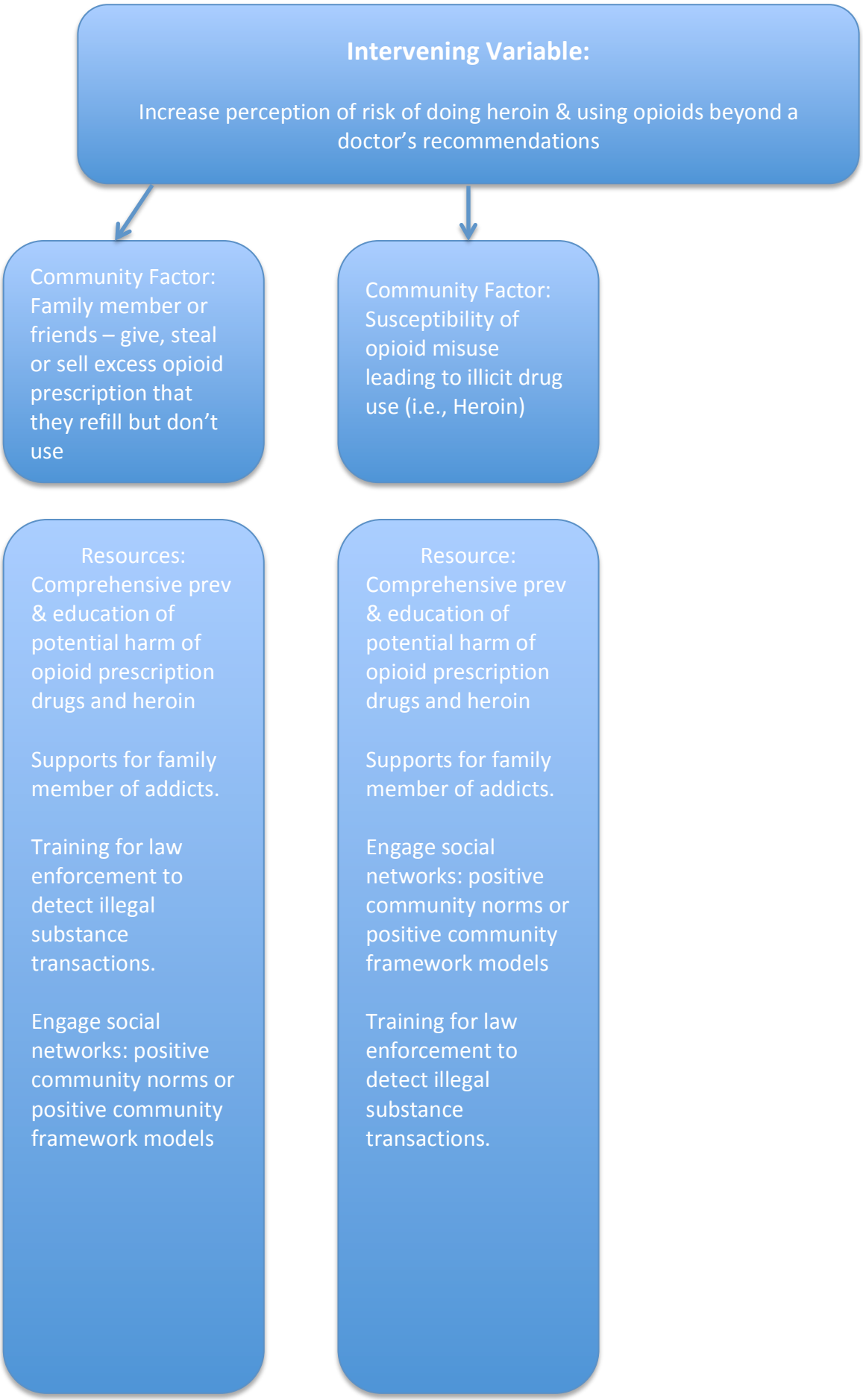
Decrease social and retail availability of prescription opioids

Community Factor: Lack of Active Prescription Drug Monitoring Program	Community Factor: Medication Disposal Program Location	Community Factor: Over-prescription of opioids from local providers
Resources: Adults and Prescribing Doctors trained to identify & refer individuals at risk. Funding dedicated to support opioid prevention efforts. People who work or volunteer in opioid prevention Prevention training & education offered Specialized programs to discourage use by pregnant women. Town hall meetings to raise awareness.	Resources: Medication Disposal Program M-F 8:30 – 6 p.m. Sat 9 am – 5 p.m. 3300 Providence Dr., Suite 101 (B Tower – Entrance #4) National Prescription Drug Take-Back Day, April 29, 2017 – 10 am – 2 pm Find location at https://www.deadiversion.usdoj.gov/drug_disposal/takeback/	Resources: Routine screening at primary care visits to identify at-risk children & adults. Specialized programs to discourage use by pregnant women. Care coordination & patient navigation services for people who receive painkillers. Town hall meetings to raise awareness. Database of prescriptions for medical providers & pharmacists (Southcentral Foundation & Geneva Woods Clinic) Methadone Clinic


Intervening Variable:
Decrease social availability of heroin
Community Factor: Lack of community understanding of the scope of heroin abuse problem
Community Factor: Experimentation with heroin use
Community Factor: Continuous care for recovery
Resources: Town hall meetings to raise awareness
Comprehensive prev & education of potential harm of opioid prescription drugs
Awareness of available resources for families, employees, religious org, law enforcement, and law makers
Resources: Prevention programs regarding substance abuse.
Low levels of parental approval of heroin use.
Education or proper information - effects of drug use.
Awareness of available resources for families, employees, religious org, law enforcement, and law makers
Programs & policies implemented, within community, to address opioid prevention.
Resources: Social and life skills treatment
Medically assisted treatment
Detox
Treatment for co-occurring disorders, i.e. mental health and addiction
Drug Court(s)
AA, NA, and Alanon
Faith based (non-AA/NA) treatment programs


Intervening Variable:
Increase perception of risk of doing heroin & using opioids beyond a doctor's recommendations
Community Factor: Susceptibility to misuse of opioid
Community Factor: Experimentation with use of opioids
Community Factor: Low perception of risk of doing heroin & using opioids beyond a doctor's recommendation
Resources: Comprehensive prev & education of potential harm of opioid prescription drugs and heroin
Resource: Comprehensive prev & education of potential harm of opioid prescription drugs and heroin
Supports for family member of addicts.
Engage social networks: positive community norms or positive community framework models
Training for law enforcement to detect illegal substance transactions.
Resources: Town hall meetings to raise awareness
Comprehensive prev & education of potential harm of opioid prescription drugs and heroin
Awareness of available resources for families, employees, religious org, law enforcement, and law makers


Intervening Variable:
Increase perception of risk of doing heroin & using opioids beyond a doctor's recommendations
Community Factor: Lack of knowledge
Community Factor: Normalizing drug use
Community Factor: Trust in doctors and medical field
Resources: Comprehensive prev & education of potential harm of opioid prescription drugs and heroin
Resource: Comprehensive prev & education of potential harm of opioid prescription drugs and heroin
Supports for family member of addicts.
Engage social networks: positive community norms or positive community framework models
Training for law enforcement to detect illegal substance transactions.
Resources: Town hall meetings to raise awareness
Comprehensive prev & education of potential harm of opioid prescription drugs and heroin
Awareness of available resources for families, employees, religious org, law enforcement, and law makers


Intervening Variable:
Increase perception of risk of doing heroin & using opioids beyond a doctor's recommendations
Community Factor: Family member or friends – give, steal or sell excess opioid prescription that they refill but don't use
Community Factor: Susceptibility of opioid misuse leading to illicit drug use (i.e., Heroin)
Resources: Comprehensive prev & education of potential harm of opioid prescription drugs and heroin
Supports for family member of addicts.
Training for law enforcement to detect illegal substance transactions.
Engage social networks: positive community norms or positive community framework models
Resource: Comprehensive prev & education of potential harm of opioid prescription drugs and heroin
Supports for family member of addicts.
Engage social networks: positive community norms or positive community framework models
Training for law enforcement to detect illegal substance transactions.

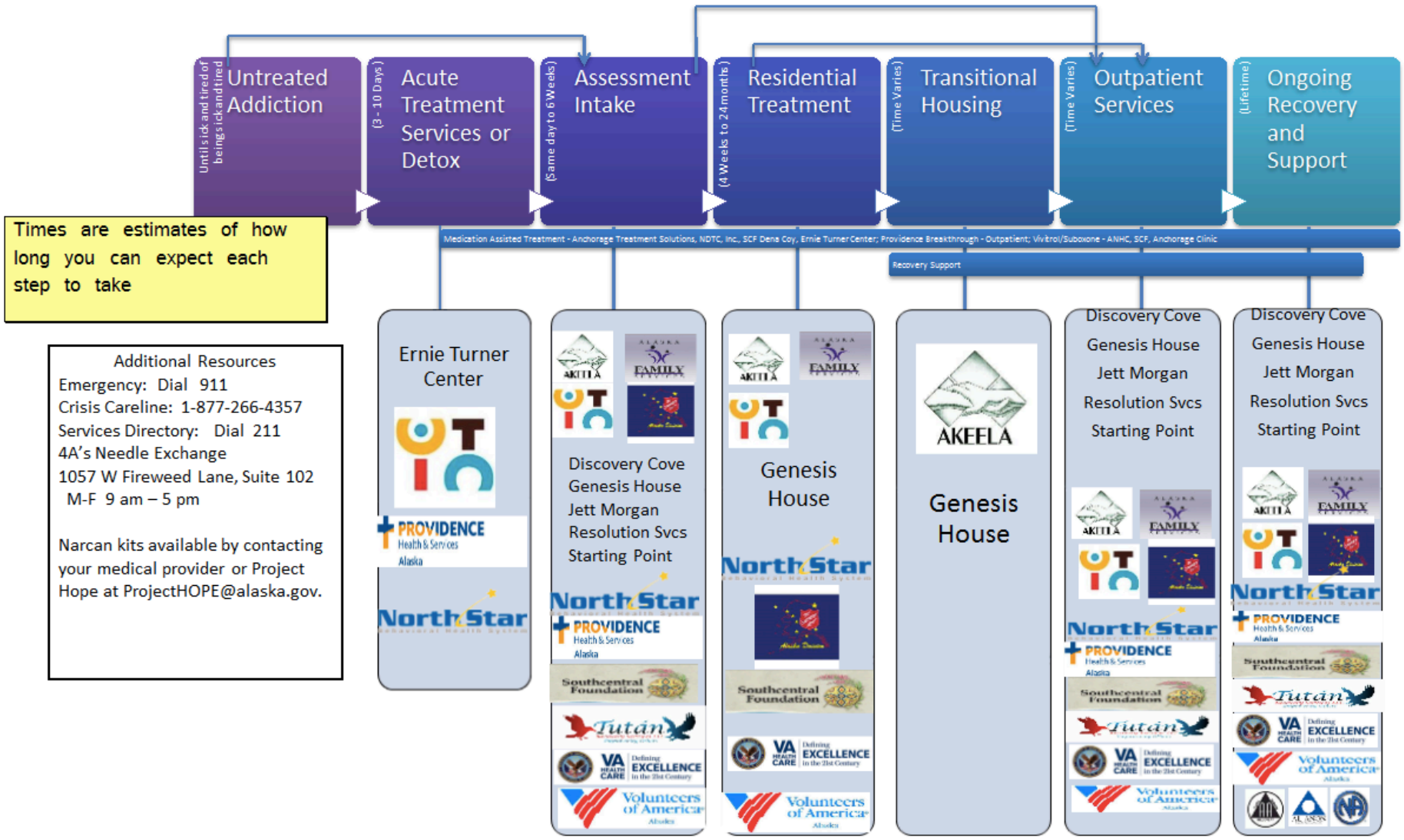
APPENDIX E – Community Resources Assessment List

1. AA of Alaska	272-2312	615 E 82nd ave, B-8
2. AEON	562-4606	4325 Laurel St, Suite 297A
3. Akeela	565-1200	360 W Benson Blvd
4. Alaska Native Tribal Health Consortium	729-354	4000 Ambassador Dr
5. Alaska Wisdom Recovery AKA Wisdom Traditions	562-4540	401 W International Road, Suite 127
6. Anchorage Methadone Clinic	866-369-5535	
7. Blais, Peggy	317-6704	pblais123@gmail.com
8. Charles, Tyrone	562-4606	talcharles@aol.com
9. Cook Inlet Council on Alcohol and Drug Abuse	771-9950	401 E Northern Lght
10. Cook Inlet Tribal Council	793-3200	3600 San Jeronimo Dr
11. Denali Cove Counseling Center	222-2436	1565 Bragaw St. Suite 201
12. Discovery Cove Recovery & Wellness Center	694-5550	16600 Centerfield Dr, #203
13. Durtschi, Shirley Dr.	317-6306	ltolli2112@aol.com
14. Genesis Recovery Svcs	243-5130	2825 W 42nd Ave
15. Igwacho, Peter Dr.	727-1324	igwachopeter@yahoo.com
16. Insight Therapy	677-8942	600 Cordova St, Suite 6
17. Jett Morgan Treatment Svcs	677-7709	
18. Narcotic Drug Treatment Center	276-6430	520 E 4th Ave, Suite 102
19. Nauska Counseling	277-1166	2509 Eide St, Suite 5
20. Nelson, Don LPC	229-5155	
21. North Star Behavioral Health	258-7575	2530 DeBarr Rd
22. Providence Breakthrough	212-6970	3760 Piper St, Suite 1108
23. RADACT	563-9202	3901 Old Seward Hwy, Suite 8
24. Rational Recovery	351-8249	308 G St, Suite 212

25. Recovery Alaska	333-6535	6401 E Northern Lights, Boulevard Room 207
26. Renew Your Mind	222-5464	123 E Fireweed Ln, Suit 212
27. Resolution Svcs	770-7769	401 E Northern Lights
28. Salvation Army	770-8821	1015 E 6th Ave & 8000 West End Road
29. Southcentral Foundation	729-5190	
30. Stephens, Kimberly	982-4040	georgiachief77@yahoo.com
31. The Delta Integrative Therapy	928-373-8488	239 W 4th Avenue
32. Tutan Recovery Services	563-0555	3001 Porcupine Drive
33. Vet Center	563-6966	
34. Veterans Admin.	257-4729	3001 C St
35. Volunteers of America, Alaska	279-9646	509 W 3rd Ave
36. Wright, Kelly	980-6648	www.kellywrightlcsw.com
37.		

APPENDIX F – Anchorage Recovery Agencies

Akeela, Inc.	•Akeela House Recovery Center is a long-term, co-ed, adult residential program. Outpatient, Assessment Center, Transitional Housing and Medication assisted treatment
Alaska Family Services	•Assessment and Outpatient
Alaska Wisdom Traditions Counseling Svcs., LLC	•Outpatient, Intensive Outpatient Program, Continuing Care, and a Continuum of Care
Anchorage Treatment Solutions	•Medication assisted treatment; Methadone, Suboxone, and Buprenorphine (Subutex)
Cook Inlet Tribal Council	•Chanlyut - 2 year residential work-training and education for men facing addiction, homelessness, and/or reentering society after incarceration. Outpatient; Intensive Outpatient; Medical and Social Detox; Residential and Medication assisted treatment
Denali Cove Counseling Center	•Clinical counseling: assessment, outpatient treatment, substance abuse, and co-ocurring disorders
Discovery Cove	•Outpatient treatment, substance abuse assessment and Medication assisted treatment
Genesis Recovery Svcs	•Residential, Intensive Outpatient, Outpatient, Aftercare and Transitional Housing
Jett Morgan Treatment Svcs	•Assessment and Outpatient
North Star Behavioral Health	•Assessment and Residential
Providence Health & Svcs	•Assessment, Outpatient, Intensive Outpatient, Adolescent Residential and Medication assisted treatment
Resolution Svcs	•Assessment, Outpatient, Intensive Outpatient, and Medication assisted treatment
Salvation Army, Alaska	•Assessment, Residential, Outpatient, Intensive Outpatient, Aftercare, and Medication assisted treatment
Southcentral Foundation	•Assessment, Residential, Outpatient, Intensive Outpatient, Aftercare, and Medication asssited treatment
Starting Point, Inc.	•Assessment and Outpatient
Tutan Recovery Svcs	•Assessment, Outpatient, and Intensive Outpatient
U.S. Dept of Veterans Affairs	•Assessment, Residential, Outpatient, and Medication assisted treatment
Volunteers of America Alaska	•Adolescent Residential, Assessment, Outpatient and Intensive Outpatient


Until sick and tired of being sick and tired
Untreated Addiction
(3 - 10 Days)
Acute Treatment Services or Detox
(Same day to 6 Weeks)
Assessment Intake
(4 Weeks to 24 months)
Residential Treatment
(Time Varies)
Transitional Housing
(Time Varies)
Outpatient Services
(Lifetime)
Ongoing Recovery and Support
Medication Assisted Treatment - Anchorage Treatment Solutions, NDTC, Inc., SCF Dena Coy, Ernie Turner Center; Providence Breakthrough - Outpatient; Vivitrol/Suboxone - ANHC, SCF, Anchorage Clinic
Recovery Support
Times are estimates of how long you can expect each step to take
Additional Resources
Emergency: Dial 911
Crisis Careline: 1-877-266-4357
Services Directory: Dial 211
4A's Needle Exchange
1057 W Fireweed Lane, Suite 102
M-F 9 am – 5 pm
Narcan kits available by contacting your medical provider or Project Hope at ProjectHOPE@alaska.gov.
Ernie Turner Center
Discovery Cove
Genesis House
Jett Morgan
Resolution Svcs
Starting Point
Genesis House
AKEELA
Genesis House
Discovery Cove
Genesis House
Jett Morgan
Resolution Svcs
Starting Point
Discovery Cove
Genesis House
Jett Morgan
Resolution Svcs
Starting Point

APPENDIX G – Anchorage Media Coverage

Date	Source	Search Term	Title	Author	Link
16-Dec-16	Alaska Dispatch News		It can happen to anyone': Director of Bean's Cafe confronts son's suspected overdose death	Devin Kelly	https://www.adn.com/alaska-news/anchorage/2016/12/16/it-can-happen-to-anyone-director-of-beans-cafe-confronts-sons-suspected-overdose-death/
13-Nov-16	Alaska Dispatch News		Overdose deaths suggest emergence of deadly synthetic opioid 'pink' in Alaska	Michelle Theriault Boots	https://www.adn.com/alaska-news/2016/11/13/overdose-deaths-suggest-emergence-of-new-deadly-synthetic-opioid-pink-in-alaska/
26-Oct-16	Alaska Dispatch News		Drug that can halt heroin overdoses will soon be available in Alaska stores	Michelle Theriault Boots	https://www.adn.com/alaska-news/health/2016/10/25/why-you-cant-buy-the-anti-overdose-drug-narcan-without-a-prescription-yet-despite-alaskas-change-in-law/
24-Sep-16	Alaska Dispatch News		Is methadone an answer to Alaska's heroin crisis?	Michelle Theriault Boots	http://www.adn.com/alaska-news/health/2016/09/24/wednesday-morning-at-the-methadone-clinic/
7-Sep-16	KTUU	Heroin	Anchorage man wanted for robbery, probation violations arrested near Dillingham	KTUU Staff	http://www.ktuu.com/content/news/Anchorage-man-wanted-for-robbery-probation-violation-arrested-near-Dillingham-392640011.html
6-Sep-16	KTUU	Heroin	Days-long manhunt continues for suspected heroin dealer in Dillingham	Cameron Mackintosh	http://www.ktuu.com/content/news/Days-long-manhunt-continues-for-suspected-heroin-dealer-in-Dillingham-392452411.html

4-Sep-16	Alaska Dispatch News	Opioid	Could a soon-to-be-closed Alaska prison become a much-needed detox center?	Zaz Hollander	http://www.adn.com/alaska-news/mat-su/2016/09/04/could-a-soon-to-be-closed-alaska-prison-become-a-much-needed-detox-center/
1-Sep-16	KTUU	Heroin	Nearly $3 million in federal funds headed to Alaska to combat opioid crisis	Paula Dobbyn	http://www.ktuu.com/content/news/Nearly-3-million-in-federal-funds-headed-to-Alaska-to-combat-opioid-crisis-392048921.html
1-Sep-16	Alaska Dispatch News		Rates of hepatitis C among young people increase across Alaska	Tegan Hanlon	https://www.adn.com/alaska-news/health/2016/09/01/rates-of-hepatitis-c-among-young-people-increase-across-alaska/
5-Aug-16	Alaska Public Media	Heroin	Surgeon General visits Palmer to discuss opioid epidemic	Ellen Lockyer	http://www.alaskapublic.org/2016/08/05/surgeon-general-visits-palmer-to-discuss-opioid-epidemic/
5-Aug-16	Alaska Public Media	Heroin	Health officials address opioid abuse at Wellness Summit	Ellen Lockyer	http://www.alaskapublic.org/2016/08/05/health-officials-address-opioid-abust-at-wellness-summit/
4-Aug-16	Alaska Dispatch News	Heroin	Alaskans battling opioid epidemic get audience with U.S. surgeon general	Zaz Hollander	http://www.adn.com/alaska-news/2016/08/04/summit-gives-surgeon-general-alaskan-perspective-on-heroin-addiction/
4-Aug-16	Alaska Dispatch News	Opioid	Medical board rejects offer from pill doctor, reaffirms suspension	Alex DeMarban	http://www.adn.com/alaska-news/health/2016/08/04/medical-board-rejects-offer-from-pill-doctor-continues-license-suspension/
2-Aug-16	Alaska Dispatch News	Opioid	High-powered Mat-Su summit takes on Alaska's opioid epidemic	Zaz Hollander	http://www.adn.com/alaska-news/health/2016/08/02/high-powered-mat-su-summit-takes-on-alaskas-opioid-epidemic/
30-Jul-16	Alaska Dispatch News	Opioid	Summit gathers forces to fight addiction in Alaska	Sen. Dan Sullivan	http://www.adn.com/opinions/2016/07/30/summit-gathers-forces-to-fight-addiction-in-alaska/

29-Jul-16	Alaska Public Media	Heroin	Opioids in Alaska	Lori Townsend	http://www.alaskapublic.org/2016/07/29/opioids-in-alaska/
3-Jul-16	Alaska Dispatch News	Opioid	Witness an overdose? Call 911. It may save a life.	Jill Burke	http://www.adn.com/alaska-news/health/2016/07/03/witness-an-overdose-call-911-it-may-save-a-life/
27-Jun-16	Alaska Dispatch News	Heroin	APD: Woman found dead in Hillside may have been moved after heroin overdose	Chris Klint	http://www.adn.com/alaska-news/2016/06/27/apd-woman-found-dead-on-hillside-may-have-been-moved-after-heroin-overdose/
7-Jun-16	Alaska Dispatch News	Overdose	Inmate at Anchorage jail died of drug overdose, DOC says	Michelle Theriault Boots	http://www.adn.com/alaska-news/2016/06/07/inmate-at-anchorage-jail-died-of-drug-overdose-doc-says/
28-May-16	Alaska Dispatch News	Opioid	Massive failure at many levels caused Alaska opioid detox shutdowns	John C. Laux	http://www.adn.com/voices/commentary/2016/05/28/massive-failure-at-many-levels-caused-alaska-opioid-detox-shutdowns/
26-May-16	Alaska Dispatch News	Opioid	Angry parents protest anesthesiologist accused of over-prescribing opiates	Alax DeMarban	http://www.adn.com/alaska-news/health/2016/05/26/angry-parents-protest-anesthesiologist-accused-of-over-prescribing-opiates/
23-May-16	Alaska Dispatch News	Opioid	Medical board suspends license of doctor accused of running painkiller 'pill mill' clinic in Anchorage	Michelle Theriault Boots	http://www.adn.com/alaska-news/2016/05/23/medical-board-suspends-license-of-doctor-accused-of-running-painkiller-pill-mill-clinic-in-anchorage/
17-May-16	Alaska Dispatch News	Heroin	She died in the Anchorage jail detoxing from heroin. Her family wants answers	Zaz Hollander	http://www.adn.com/alaska-news/article/father-sues-doc-over-wasilla-womans-death-anchorage-jail-while-detoxing-1/2016/04/09/
17-May-16	Alaska Dispatch News	Heroin	Anchorage man gets 7 years for his role in cocaine, heroin trafficking	Chris Klint	http://www.adn.com/crime-justice/article/anchorage-heroin-cocaine-dealer-gets-7-years-federal-plea-deal/2016/04/18/

17-May-16	Alaska Dispatch News	Heroin	Troopers: Man arrested in airport drug bust brought $1M in heroin into Alaska	Chris Klint	http://www.adn.com/crime-justice/article/man-airport-drug-bust-allegedly-brought-1m-heroin-alaska/2016/04/19/
17-May-16	Alaska Dispatch News	Heroin	A wave of federal funding for addiction treatment is heading to Alaska	Erica Martinson	http://www.adn.com/health/article/new-help-arrives-alaskan-addiction-problems/2016/04/03/
17-May-16	Alaska Dispatch News	Opioid	New statewide task force will take on Alaska's opioid epidemic	Michelle Theriault Boots	http://www.adn.com/alaska-news/article/new-statewide-task-force-will-take-alaskas-opioid-epidemic/2016/04/26/
17-May-16	Alaska Dispatch News	Opioid	Are post-accident painkillers causing a star employee to make errors?	Lynne Curry	http://www.adn.com/business/article/are-post-accident-painkillers-causing-star-employee-make-errors/2016/04/05/
1-May-16	Alaska Dispatch News	Opioid	Alaska's two inpatient opiate detox centers suspend new admissions	Michelle Theriault Boots	http://www.adn.com/alaska-news/article/states-two-inpatient-detox-centers-suspend-new-admissions/2016/05/02/
25-Mar-16	Alaska Dispatch News	Heroin	Alaska's heroin death rate spikes, but prescription opioids take more lives	Zaz Hollander	http://www.adn.com/health/article/alaskas-heroin-associated-death-rate-spikes-still-dwarfed-fatal-pain-med-ods/2016/03/25/
9-Mar-16	Alaska Dispatch News	Opioid	Legislature passes bill expanding access to overdose antidote	Rashah McChesney	http://www.adn.com/health/article/legislature-passes-bill-expanding-access-overdose-drug/2016/03/09/
7-Mar-16	Alaska Dispatch News	Heroin	House passes bill easing access to heroin overdose meds	Nathaniel Herz	http://www.adn.com/politics/article/house-passes-bill-easing-access-heroin-overdose-meds/2016/03/07/
20-Jan-16	Alaska Dispatch News	Heroin	Texas man gets 7 years for bringing meth, heroin to Alaska	Alaska News	http://www.adn.com/crime-justice/article/texas-man-sentenced-7-years-drug-conspiracy-brougt-pounds-meth-heroin-

					alaska/2016/01/21/
5-Jan-16	Alaska Dispatch News	Overdose	Alaska Fred Meyer stores could start selling anti-overdose drug if Legislature acts	The Associated Press	http://www.adn.com/health/article/alaska-fred-meyer-stores-could-start-selling-anti-overdose-drug-if-legislature-acts/2016/01/05/
23-Dec-15	Alaska Dispatch News	Heroin	Package of heroin, pills found inside Anchorage jail inmate	Alaska News	http://www.adn.com/crime-justice/article/package-heroin-pills-found-inside-anchorage-jail-inmate/2015/12/23/
20-Nov-15	Alaska Public Media	Heroin	Combating heroin in Alaska	Zachariah Hughes	http://www.alaskapublic.org/2015/11/20/combating-heroin-in-alaska/
18-Nov-15	Alaska Dispatch News	Heroin	Fixing Alaska's heroin problem could start by giving arrested addicts better chance at recovery	Mike Dingman	http://www.adn.com/commentary/article/alaska-should-give-drug-addicts-better-chance-recovery-not-just-jail/2015/11/19/
17-Nov-15	Alaska Dispatch News	Heroin	Alaska needs Narcan to fight back the rise of heroin addiction	Elise Patkotak	http://www.adn.com/commentary/article/narcan-necessary-tool-alaska-fight-back-rise-heroin-addiction/2015/11/18/
14-Nov-15	Alaska Dispatch News	Heroin	With heroin overdoses rising, a call for wider access to the drug that can halt them	Michelle Theriault Boots	http://www.adn.com/health/article/heroin-overdoses-rise-alaska-call-broader-access-drug-can-halt-them/2015/11/15/
10-Nov-15	Alaska Dispatch News	Heroin	Heroin story underscores need for Alaska to treat addicts, not imprison them	Mike Dingman	http://www.adn.com/commentary/article/heroin-story-underscores-need-alaska-treat-addicts-not-imprison-them/2015/11/11/
17-Oct-15	Alaska Dispatch News	Heroin	Efforts to stamp out heroin and other drugs dominate AFN resolutions	Alex DeMarban	http://www.adn.com/afn-coverage/article/efforts-stamp-out-heroine-and-other-drugs-dominate-afn-resolutions/2015/10/18/
14-Oct-15	Alaska Public Media	Heroin	New drug reduces heroin cravings, may reduce	Anne Hillman	http://www.alaskapublic.org/2015/10/14/new-drug-reduces-heroin-cravings-may-reduce-recidivism/

			recidivism		
11-Oct-15	Alaska Dispatch News	Opioid	After years in a prescription painkiller fog, Alaska patient fights for new laws	Michelle Theriault Boots	http://www.adn.com/alaska-news/article/after-years-prescription-painkiller-fog-one-patient-fights-new-laws-regulating/2015/10/12/
9-Oct-15	Alaska Public Media	Heroin	Heroin addiction in Alaska	Evan Erickson	http://www.alaskapublic.org/2015/10/09/heroin-addiction-in-alaska/
26-Jul-15	Alaska Dispatch News	Heroin	Simple change can save Alaskan lives, reduce alarming toll of heroin	Sen. Ellis	http://www.adn.com/commentary/article/bill-would-save-alaskan-lives-cut-opiate-overdose-deaths/2015/07/27/
20-Jul-15	Alaska Dispatch News	Heroin	Anchorage couple sentenced for crimes tied to local meth and heroin sales	Jerzy Shedlock	http://www.adn.com/crime-justice/article/anchorage-couple-sentences-gun-drug-charges-tied-local-meth-and-heroin-sales/2015/07/21/
14-Jul-15	Alaska Dispatch News	Heroin	Public health officials find steep rise in Alaska heroin deaths, overdoses	Michelle Theriault Boots	http://www.adn.com/health/article/public-health-officials-find-steep-rise-alaska-heroin-deaths-hospitalizations/2015/07/15/
14-Jul-15	Alaska Public Media	Heroin	Report: Alaska Heroin Use is Skyrocketing	Annie Feidt	http://www.alaskapublic.org/2015/07/14/report-heroin-use-is-skyrocketing-in-alaska/
9-May-15	Alaska Dispatch News	Opioid	Recovering addict finds a friend in pharmacist who busted her	Marc Lester	http://www.adn.com/health/article/deb-and-cat/2015/05/10/
1-May-15	Alaska Public Media	Heroin	Heroin in Alaska	Lori Townsend	http://www.alaskapublic.org/2015/05/01/heroin-in-alaska/
14-Mar-15	Alaska Dispatch News	Heroin	Video: a beautiful mind lost to heroin addiction	None given	http://www.adn.com/multimedia/video/video-beautiful-mind-lost-heroin-addiction/2015/03/15/
12-Jan-15	Alaska Dispatch News	Heroin	Anchorage man gets 21 years for drug charges tied to heroin overdose	Jerzy Shedlock	http://www.adn.com/crime-justice/article/anchorage-man-gets-21-years-drug-charges-tied-heroin-overdose/2015/01/12/

17-Nov-14	Alaska Public Media	Heroin	East Anchorage Drug Bust Part of State-Wide Rise in Heroin, Cocaine, Meth	Zachariah Hughes	http://www.alaskapublic.org/2014/11/17/east-anchorage-drug-bust-part-of-state-wide-rise-in-heroin-cocaine-meth/
3-Nov-14	Alaska Dispatch News	Heroin	Anchorage man, 7 others charged with conspiring to distribute cocaine, meth and heroin	Jerzy Shedlock	http://www.adn.com/crime-justice/article/anchorage-man-7-others-charged-conspiring-distribute-nearly-100-pounds-cocaine-meth/2014/11/03/
30-Jul-14	Alaska Dispatch News	Opioid	State: Anchorage physician billed more than $1.1 million in fraudulent Medicaid payments	Laurel Andrews	http://www.adn.com/crime-justice/article/state-anchorage-physician-billed-more-11-million-fraudulent-medicaid-payments/2014/07/31/
21-Mar-14	Alaska Dispatch News	Heroin	Anchorage drug bust nets 30k in meth, heroin	Casey Grove	http://www.adn.com/crime-justice/article/anchorage-drug-bust-nets-30k-meth-heroin/2014/03/21/
23-Oct-13	Alaska Dispatch News	Heroin	Heroin sales lead to lengthy prison sentences for Alaskans	Jerzy Shedlock	http://www.adn.com/crime-justice/article/young-anchorage-men-receive-multi-year-sentences-heroin-sting/2013/10/24/
5-Aug-13	Alaska Dispatch News	Heroin	Anchorage heroin dealers convicted on federal drug, weapons charges		http://www.adn.com/crime-justice/article/anchorage-heroin-dealers-convicted-federal-drug-weapons-charges/2013/08/06/
15-Feb-13	Alaska Public Media	Heroin	Addiction: From Heroin to Workaholism	Kristin Spack	http://www.alaskapublic.org/2013/02/15/addiction-from-heroin-to-workaholism/
9-Jan-13	Alaska Dispatch News	Heroin	Four men charged in 'family-run' heroin, marijuana operation	Casey Grove	http://www.adn.com/crime-justice/article/four-men-charged-family-run-heroin-marijuana-operation/2013/01/09/
19-Oct-12	Alaska Public Media	Heroin	Mayor Sullivan Releases Revised Budget Proposal; Heroin on the Rise	Michael Carey	http://www.alaskapublic.org/2012/10/19/mayor-sullivan-releases-revised-budget-proposal-heroin-use-on-the-rise/
29-Dec-11	Alaska	Heroin	14-year-old	Casey Grove	http://www.adn.com/alaska-

	Dispatch News		injected with heroin dies		news/article/14-year-old-injected-heroin-dies/2011/12/29/
29-Dec-11	Alaska Public Media	Heroin	Girl Injected With Heroin Dies	Josh Edge	http://www.alaskapublic.org/2011/12/29/girl-injected-with-heroin-dies/
27-Dec-11	Alaska Dispatch News	Heroin	Alaska teen in 'dire' condition after heroin overdose	Rachel D'Oro	http://www.adn.com/alaska-news/article/alaska-teen-dire-condition-after-heroin-overdose/2011/12/28/
27-Dec-11	Alaska Public Media	Heroin	Man Faces Four Charges For Injecting Teen With Heroin	Len Anderson	http://www.alaskapublic.org/2011/12/27/man-faces-four-charges-for-injecting-teen-with-heroin/
25-Dec-11	Alaska Dispatch News	Heroin	Man accused of injecting heroin into girl who overdosed	Rosemary Shinohara	http://www.adn.com/alaska-news/article/man-accused-injecting-heroin-girl-who-overdosed/2011/12/25/
24-Aug-11	Alaska Dispatch News	Heroin	Anchorage heroin dealer slapped with lengthy prison sentence	Craig Medred	http://www.adn.com/anchorage/article/anchorage-heroin-dealer-slapped-lengthy-prison-sentence/2011/08/25/
20-May-11	Alaska Public Media	Heroin	Customs Officials Seize $1.2 Million Worth of Heroin	Josh Edge	http://www.alaskapublic.org/2011/05/20/customs-officials-seize-1-2-million-worth-of-heroin/
19-Jun-10	Alaska Dispatch News	Heroin	Hooked (Seven Part Series)	Julia O'Malley	http://www.adn.com/anchorage/article/heroins-grip/2010/06/19/
2-Nov-09	Alaska Public Media	Heroin	Heroin Use on the Increase in Anchorage	Patrick Yack	http://www.alaskapublic.org/2009/11/02/herion-use-on-the-increase-in-anchorage/
22-Feb-09	Alaska Dispatch News	Opioid	Efforts made to start statewide prescription-drug database	Zaz Hollander	http://www.adn.com/science/article/efforts-made-start-statewide-prescription-drug-database/2009/02/23/

APPENDIX H – PRIME For Life Survey

Class Site _____ Class dates _____ to _____

Volunteers of America, Alaska

PRIME FOR LIFE – Participant Evaluation

Note: This survey is anonymous (no one will be able to connect your answers with you). All comments help us understand our students and improve as instructors, so please give honest feedback. Thank you!

Instructor #1: Name _____Instructor #2: Name_____

1. Please rate the Instructor on the following items, using a scale of **1** (Not at all) through **10** (exceptionally so):

A) The instructor was knowledgeable and well prepared: Instructor #1) 1 2 3 4 5 6 7 8 9 10
Comments: Instructor #2) 1 2 3 4 5 6 7 8 9 10

B) The instructor taught the information and led the discussions without judging anyone. Instructor #1) 1 2 3 4 5 6 7 8 9 10
Instructor #2) 1 2 3 4 5 6 7 8 9 10
Comments:

C) The instructor responded well to questions: Instructor #1) 1 2 3 4 5 6 7 8 9 10
Comments: Instructor #2) 1 2 3 4 5 6 7 8 9 10

2. Please rate Prime for Life on the following questions (Check all that apply).

A) Which part of the course was most useful to you?

☐ Instructor ☐ Alcohol Information ☐ Tobacco Information
☐ Video's Information ☐ Marijuana Information ☐ Other Drug
☐ Book & Packet ☐ Rx Information ☐
Other_____

B) What, if anything, do you think you will do differently after taking this class?

☐ No change ☐ Wait till legal ☐ Stop using Marijuana
☐ Use less ☐ Stop using drugs ☐
Other_____
☐ Share information ☐ Stop using Alcohol ☐
Other_____

3. Starting age of use (if ever used):

Alcohol: Age of first use _____ **Marijuana:** Age of first use _____

Cigarettes: Age of first use _____ **Illegal Rx drugs:** Age of first use _____

4. Drug and alcohol sources:
Where do you usually get the ***alcohol*** you drink? (please check one)
€ **1:** I have not had any alcohol to drink

€ **2:** I bought it in a store, restaurant, bar, club, or at a public event such as a concert or sporting event

€ **3:** I gave someone else money to buy it for me

€ **4:** I took it from a family member

€ **5:** Someone under 21 gave it to me

€ **6:** A family member, over 21, gave it to me

€ **7:** Someone else, over 21, gave it to me

€ **8:** I got it some other way:_____

Where do you usually get the ***marijuana*** you have used? (please check one if you have used pot or weed)

€ **1:** Someone smoked it with or gave it to me

€ **2:** I bought it in a public building, such as a store, restaurant, bar, club, or sports arena

€ **3:** I bought it inside a school building

€ **4:** I bought it outside on school property

€ **5:** I bought it inside a home or apartment

€ **6:** I bought it outside in a public area, such as a parking lot, street or park

€ **7:** I got it some other way: _____

Where do you usually get the ***cigarettes*** you have smoked or ***tobacco*** you used (if you have used tobacco)?

1: I bought them/it in a store

2: I gave someone money to buy them/it for me

3: I took them/it from a family member

4: I got them/it some other way: _____

5: A family member, over 19, gave them/it to me

6: Some else, over 19, gave them/it to me

Where do you usually get ***Illegal (Rx) prescription drugs*** you have used (if you have used pills or pharmed)?

1: I gave someone money to buy them for me

2: I took them from a family member

3: I got them some other way: (Not from a doctor)_____

_____

4: A family member, over 19, gave them to me

5: Some else, over 19, gave them to me

APPENDIX I – Four A's Survey

Partnerships for Success

Survey Introduction

This survey was designed by folks at the Alaska Injury Prevention Center. We are working with the Healthy Voices, Healthy Choices coalition to learn about heroin use and opioid use beyond medical recommendations. Many of us have family members and friends who use opioids and heroin and we would like to figure out ways to eliminate overdose deaths. We will use the information you and others provide to begin to come up with solutions to these substance use issues in Anchorage. It is going to take input from you and other community members to begin to figure out how we can all work together towards solutions.

- We will be using what we learn from this survey to work towards figuring out how to reduce the opioid use beyond medical recommendations and heroin use in Anchorage.
- Everyone has different and valuable experiences and perspectives regarding prescription opioid and heroin use. This makes your insights and ideas very important.

Confidentiality and Privacy

- As you answer the questions, feel free to tell your own personal stories: or if you'd rather, you can refer to experiences of a friend or acquaintance.
- Your name will not be included in any reports associated with the information you provide.
- You may be assured of complete privacy.
- Some of the questions may be uncomfortable and trigger painful emotions. Please feel free to stop answering the questions at any time. Your participation is completely voluntary, and we will give you the incentive no matter how much information you fill out.
- If you have any questions you can ask 4A's staff for more information?
- Thanks for participating.

The first 15 questions are about using opioids beyond the recommendations of a physician. If you haven't done this, please skip to the second section that asks about heroin use.

1. What drugs do you think of when you hear about prescription opioids?

2. At what point do you think using prescription opioids, beyond medical recommendations, becomes dangerous?

3. How did you start taking opioids?
    - Prescription for a sports injury ____
    - Prescription from a dentist ____
    - Prescription after surgery ____
    - Prescription from the ER ____
    - Recreational use ____
    - Other
      _____
      _____

4. If you started with a prescription:
    - Why did you start using beyond the prescription recommendations?

    - Did the doctor:
        - warn you about the dangers of not following the prescription? ___ yes ___ no
        - suggest ideas other than opioids for pain relief? ___yes ___no
        - talk to you about tapering off your use? ___yes ___no
        - prescribe more pills than you really needed to deal with the pain?___yes ___no

5. How do you, or people you know obtain prescription opioids?

    ___ dealer
    ___ street
    ___ doctor
    ___ friends
    ___ steal from family
    ___ steal from strangers
    ___ Other _____

6. What consequences have you seen from using opioids beyond medical recommendations?

___loss of family
___loss of friends
___loss of job
___homelessness
___poor health
___loss of idea of normal life
___jail
___Other_____

7. Which of these consequences did you know about before you started using?

___loss of family
___loss of friends
___loss of job
___homelessness
___poor health
___loss of idea of normal life
___jail
___Other
_____

8. How likely do you think it is that people who use opioids beyond recommendation will face these consequences?
    - Which ones might have persuaded you to not start using?
9. What other things could have prevented your use?
10. What are safe ways to store opioids so that only the person with the prescription can access them?
11. What would you do if opioids weren't readily available?
12. What resources are there for people who want help with opioid addiction?
13. What resources do you wish were available?
14. Have you heard of Naloxone (sometimes known as Narcan)? ___ yes ___ no
    - If you have heard of it, how long do you think it lasts?
    - If someone gets Naloxone after OD'ing, do they still need to get medical help? ___ yes ___ no
    - How do you think it could be distributed to make it more readily available?
15. What advice do you have for someone who is thinking about taking prescription opioids beyond a prescription for the first time?

Heroin use Questions

1. How do you, or people you know obtain heroin in Anchorage?

___ dealer
___ street
___ doctor
___ friends
___ steal from family
___ steal from strangers
___ Other _____

2. What consequences have you seen from heroin use?

___loss of family
___loss of friends
___loss of job
___homelessness
___poor health
___loss of idea of normal life
___jail
___Other _____

3. Which of these consequences did you know about before you started using?

___loss of family
___loss of friends
___loss of job
___homelessness
___poor health
___loss of idea of normal life
___jail
___Other _____

4. How likely do you think it is that people who use heroin will face these consequences?

5. Which consequences might have persuaded you to not start using?

6. What other things that could have prevented your heroin use?

7. What would you do if heroin weren't readily available?

8. What resources are there for people who want help with heroin use?

9. What resources do you wish were available?

10. Have you heard of Naloxone (sometimes known as Narcan)? ___ yes ___ no
    - If you have heard of it, how long do you think it lasts? _____
    - If someone gets Naloxone after OD'ing, do they still need to get medical help? ___ yes ___ no
    - How do you think it could be distributed to make it more readily available?

11. Do you know of programs in Anchorage that offer detox or treatment programs?

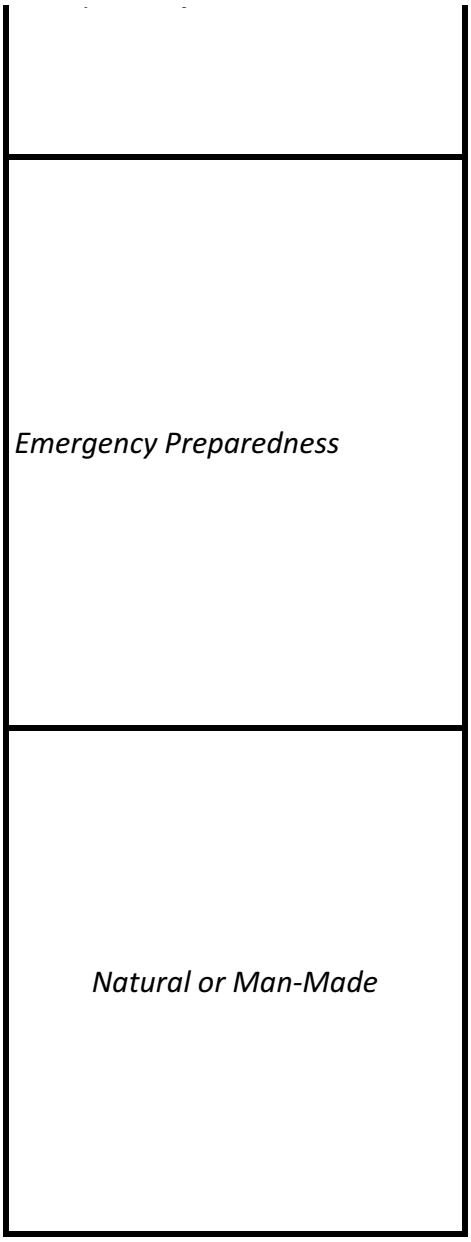
12. Where do you get information about heroin use or recovery?

13. What advice would you like to give to someone who is thinking about using heroin for the first time?

Thank you again for taking the time to answer these questions. Your thoughts and advice will help make a difference.

Type of Injury
Motor Vehicle Crashes
Older Adult Falls

Poisoning by Prescription Drug Overdoses
Violence and Suicide
Workplace Injuries


Emergency Preparedness
Natural or Man-Made

Trend

- In 2014, there were a total of 68 fatal crashes and 73 motor vehicle fatalities in the State of Alaska.
- Three-year average data from 2012-2014 for the State of Alaska shows an average of 61 fatalities per year and an average of 57 fatal crashes per year.
- In 2014, there were a total of 25 fatal crashes in the Municipality of Anchorage.
- There was an average of 14.3 fatal crashes between 2012 and 2014 in the Municipality of Anchorage.
- In 2014, there were 9 pedestrian fatalities, 7 alcohol impaired driving fatalities, 3 motorcycle crash fatalities, and 3 speeding related fatalities.

- There were 174 fall deaths in Alaska from 2009-2013, with 74% of fatalities accounted for by individuals 65 years or older.
- A total of 68 fall related deaths recorded in the Municipality of Anchorage between 2009 and 2013.
- From 2010-2015 in Anchorage,
    - there were 3577 fall related hospitalizations,
    - with an average age of 57.8 and
    - 54% over the age of 65.
    - Hospitalized falls for patients over 64 years old in Anchorage increased just over 7%. In 2010, there were 262 falls and in 2015 there were 282 falls. However, the population of Anchorage residents ages 65 and older increased 34% during the same time frame.

- Data collected from the Alaska Bureau of Vital Statistics mortality database, shows that from 2009-2015, there were 774 drug overdose deaths. Four hundred of these deaths were from opioid pain relievers and 128 were heroin related.
- The number of accidental poisoning deaths doubled from 66 in 2005 to 133 in 2012 (Strayer, Craig, Asay, Haakenson, & Provost, 2014).

- Poisoning deaths include, but are not limited to, unintentional overdoses from drugs. The number of heroin overdose deaths in Alaska increased by a factor of four from 2008-2013 (Hull-Jilly, Frasene, Gebru, & Boegli, 2015).

- Seventy-five percent of all heroin-associated death in Alaska from 2008-2013 occurred in Anchorage and the Matanuska Susitna regions (Hull-Jilly, Frasene, Gebru, & Boegli, 2015).

- From 2007-2011, Anchorage had 257 unintentionally drug induced deaths, which was 49% of all such deaths in the State. This is a rate of 17.1 per 100,000 and was 25 percent higher than the national average of 12.9 per 100,000 (Hull-Jilly, Frasene, Gebru, & Boegli, 2015).

- Poisoning was the leading cause of unintentional injury deaths for Alaska Natives/American Indians in the Anchorage Mat-Su area from 1992 2011 at 21%. (ATR poisoning data after 2011 does not include adults.)

- Alaska has one of the highest rates of suicide per capita in the country. In 2014, the rate of suicide in the state of Alaska was 22.3 suicides per 100,000 people. There were 1,525 suicides between 2005 and 2014.

- In Anchorage, from 2010-2015 there were 1010 hospitalized injuries coded as intentional. Six hundred thirty-one of them were coded as assaults.

- The numbers of suicide attempts, 379, grossly undercounts actual hospitalized suicide attempts. During those years, intentional poisonings were only recorded in 2010 for all ages. In 2010, there were 63 hospitalized suicide attempts in Anchorage. After 2010, poisoning suicide attempts were only counted for youth.

- From 2010-2015, 4% of hospitalized injuries, tracked in the Alaska Trauma Registry, occurring in Anchorage were work related.

- The number of work related injuries is trending downward. The industries with the highest rates of injuries are construction and the military.

- The Municipality of Anchorage Emergency Management Department lists earthquakes, wildfire, and extreme winter weather as the top three most likely disasters to occur in Anchorage.

- The municipality maintains a helpful website promoting preparedness as well as hosting multiple events around town and practice response events.
https://www.muni.org/Departments/OEM/Prepared/Pages/default.aspx

In 1964, a 9.2 magnitude earthquake occurred in Southcentral Alaska and caused extensive damage and destruction to the city of Anchorage. More recently, a 7.1 earthquake occurred in Anchorage in January 2016. The earthquake caused building damage, power outages, gas leaks, and water line breaks for some in Anchorage. There are over 20,000 earthquakes in Alaska in a year. Anchorage has suffered very few deaths from natural or manmade disasters since 1964. The deaths and injuries that have occurred tend to be through motor vehicle collisions after snow storms.

Injury Area: Motor Vehicle Crashes						
Project Name	Project Goal	Project Description	Promising/Evidence-Based?	Target Group	Length of Project	Partners
Child Passenger Safety Program	Decrease injuries and deaths suffered by children, and increase correct use for youth up to age 7.	AIPC operates a child passenger safety fitting station out of its office. With three CPS Instructors and Technicians on staff, AIPC serves as a community resource for up to date CPS information	The NHTSA's Countermeasures That Work indicates that the effectiveness of fitting stations is still undetermined. However, when combined with social marketing, legislation and an awareness campaign, we have seen increases in use, including 0 deaths for children under 4.	Parents and caregivers of car seat and booster seat aged children. Agencies working with and transporting children or in contact with car seat and booster seat aged parents	19 years	Alaska Highway Safety Office; Alaska Child Passenger Safety Coalition and members; Alaska Native Tribal Health Consortium, Anchorage Fire Department.
Bikeology	Increase safe cycling practices, increase pre-driver knowledge of cycling safety	Purchased trailer full of bicycles, donated bikes to Anchorage School District, trained teachers in the "Bikeology" Curriculum. Teachers implement program in gym classes for upper elementary through middle school students.	SHAPE AMERICA and National Highway Transportation Safety Administration collaboratively designed and evaluated curriculum.	Upper elementary and middle school students in the Anchorage School District.	July 2015-September 2016 with ongoing implementation at the Anchorage School District.	Alaska's Safe Routes to School Program; Anchorage School District; Bike Anchorage
Injury Area: Poisoning by Prescription Drug Overdoses						
Project Name	Project Goal	Project Description	Promising/Evidence-Based?	Target Group	Length of Project	Partners
Strategic Prevention Framework Partnership for Success	Decrease opioid overdoses in Anchorage	Multi-dimensional, including promoting safe storage and knowledge of Narcan.	Johns Hopkins Bloomberg School of Public health: The Prescription Opioid Epidemic: An Evidence-Based Approach.	Heroin users and parents of youth 12 and older.	Grant awarded July 7, 2016. Project is funded through June 2020.	Healthy Voices Healthy Choices with Volunteers of America and their coalition members.
Injury Area: Violence and Suicide						
Project Name	Project Goal	Project Description	Promising/Evidence-Based?	Target Group	Length of Project	Partners
Anchorage Collaborative Coalitions (ACC) Green Dot for 18-24 year olds	Decrease conditions that lead to suicide and suicide attempts and increase those that lead to mentally healthy 12-24 year olds.	Through an assessment of behavioral health in Anchorage, the ACC has found bullying to be connected to mental health and wellness for youth ages 12-24 years old in Anchorage.	Green Dot: https://www.cdc.gov/violenceprevention/sexualviolence/prevention.html Green dot is a promising practice to reduce violence.	Anchorage youth and young adults aged 12-24 years old.	June 2014-Present. Project is eligible to receive funding through June 2018.	Healthy Voices Healthy Choices with Volunteers of America; Spirit of Youth; Anchorage Youth Development Coalition; State of Alaska Division of Behavioral Health

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I. Evaluation Methods

Activities	Outcomes	Length	Indicator(s)	Method	Result
What did you (or will you) do?	What does success look like?	Short term intermediate term or long-term outcomes?	What did you (or will you) measure?	How did you (or will you) measure it?	What did you find? (if applicable)
Programs and Projects					
<u>Bikeology</u> Purchase trailer full of bicycles. Provide bikes to middle school and elementary school gym teachers along with the Bikeology curriculum and training on teaching the curriculum for implementation.	**Teens are safer cyclists and eventually safer drivers**	**Intermediate term outcomes. (Curriculum and trailer full of bicycles were donated from AIPC to the Anchorage School District. They now implement, evaluate and will sustain the project.)**	**1. How to properly wear a bike helmet. 2. How to properly signal a right turn. 3. Knowledge that bikes should be considered vehicles on the road.**	**Pre and post knowledge surveys. Post surveys were conducted immediately after implementation with follow-up a month later.**	**1. Increase from 30% to 60% 2. Increase from 15% to 62% 3. Increase from 55% to 91%**
Teen Driving	**Increase percent of teens who wear seatbelts.**	**Intermediate: counts of schools and youth who are exposed to Buckle Up messaging. Long term: Increase seatbelt use.**	**Observed seatbelt use.**	**Pre and Post Observations of seatbelt use as students drive to school in the morning.**	**Use increased from 88% to 91.4%, which is above the Statewide use rate of 89.3%.**
Safe Medication Storage Social Marketing Campaign	**Increase percent of parents who say they lock up their prescription medication.**	**Intermediate outcome**	**Percent of adults who lock up their prescription opioids.**	**Replicate citywide Adult Perception of Anchorage Youth survey annually for the next 3 years.**	**Increase percent of adults who lock up their prescription opioids from 37% to 50% in 3 years.**
Narcan Knowledge	**Increase awareness of Narcan by active users, its uses and limitations.**	**Intermediate outcome**	**Increase percent of users who are knowledgeable about Narcan from 50% to 75%.**	**Surveys with users at the needle exchange.**	**Increase percent of users who are knowledgeable about Narcan from 50% to 75% in 3 years.**

Child passenger safety	**Increase percent of youth who are appropriately restrained from 0-age 7.**	**Intermediate Outcome**	**Youth aged 4-7 who are appropriately using booster seats.**	**City-wide booster seat observation**	**In June 2009 52% of 4-7 year olds in Anchorage were observed appropriately restrained. That rose to 79% in 2013. We will conduct another observation in 2018 and hope the rate climbs to 85%.**

Community Inventory	
Motor Vehicle	**Target Group**
Buckle Up Campaigns	Teens ages 13-19
Raise Your Voice	Teens ages 13-19
Interactive Multimedia Event	Teens ages 13-19
Child Passenger Safety program	Parents of Car Seat and Booster Seat aged children
Child Passenger Safety Coalition	CPS Technicians and Instructors
Vision Zero	Anchorage Residents, Bike and Pedestrian Safety Advocates
Pedestrian Zone	High Risk Pedestrians and High Risk Locations
CarFit	Drivers over 50
Older Adult Falls	**Target Group**
State of Alaska STEADI online training and Senior Falls Community Coalition	Anchorage residents over 55.
Workplace Safety	**Target Group**
Boating Safety	Commercial Fisherman(highest risk worker in Alaska)
Violence and Suicide Prevention	**Target Group**
Anchorage Suicide Prevention Council	
Mental Health First Aid	Anchorage Residents
Green Dot	Anchorage Residents, especially 18-25 yr. olds
Emergency Preparedness	**Target Group**
AARP's Emergency Preparedness Fair	Anchorage Residents, especially over 50.
Anchorage Municipality Emergency Management ; Anchorage Residents	
Poisoning by Opioids, Prescription, Heroin and Analogues	**Target Group**
Anchorage Opioid Task Force	Treatment Providers and Family Members of Users
Safe Drug Alliance: Drug Take Back	Anchorage Residents
Opioid Harm Reduction	Active Heroin Users and Supporters
PDMP Promotion	Prescribers and Pharmacists
Safe Storage and Disposal Social Marketing Campaign	Youth and parents of 12-25 year olds

Strategic Plan and Logic Models

Youth and Young Adult Bullying in Anchorage, Alaska

Prepared By
Anchorage Collaborative Coalitions

For Review By
State Of Alaska
Department of Health and Social Services
Division of Behavioral Health

August 2016

ANCHORAGE
COLLABORATIVE
COALITIONS

Table of Contents

I. Vision

Together creating communities where youth and young adults thrive and are resilient.

II. Acknowledgements

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III. Introduction

In 2014, the State of Alaska's Department of Health and Social Services, Division of Behavioral Health (DBH) issued Comprehensive Behavioral Health Prevention and Early Intervention Services grants to coalitions across the State of Alaska. Within Anchorage, three coalitions were awarded funding: Anchorage Youth Development Coalition (AYDC) with The Alaska Injury Prevention Center (AIPC), Healthy Voices, Healthy Choices with Volunteers of America, and Spirit of Youth. In order to better serve the Anchorage community, the State asked AYDC, Healthy Voices Healthy Choices, and Spirit of Youth to combine resources and work together through the grant processes. Together these groups are working as the Anchorage Collaborative Coalitions (ACC).

Division of Behavioral Health Grant

The DBH presented grantees with three behavioral health conditions of interest: mental health, substance use, and suicide. Coalitions were to select one of these three behavioral health conditions as their priority area. After conducting a community assessment, coalitions were to identify a priority area, determine consequences relevant to the priority area, and define intermediate variables and contributing factors associated with the consequences based on assessment data. Community assessments such as this are the first step in utilizing the Substance Abuse and Mental Health Services Administration's Strategic Prevention Framework (SPF). Learning more about Anchorage, as well as understanding the prevalence and consequences of mental health, suicide, and substance abuse in Anchorage, allowed the ACC to strategically target and address relevant local conditions to be changed and improved. Once intermediate variables were prioritized, the coalition developed a logic model and plans for addressing the identified condition.

Strategic Prevention Framework

The SPF is a prevention model used by community coalitions to improve the behavioral health of their communities. The SPF takes a comprehensive approach to behavioral health and prevention and is rooted in principles of public health and community organizing. Strategies based on the SPF should address multiple levels including the individual, relationships, community and the environment. The SPF outlines a five step process: 1) Assessment, 2) Capacity Building, 3) Planning, 4) Implementation, and 5) Evaluation. The SPF places Cultural Competency and Sustainability at the core of this process, meaning that at each step of the SPF, coalitions should work to ensure their actions demonstrate cultural competence and that the work being done is sustainable.

Strategic Prevention Model

Note. Image retrieved from (Substance Abuse and Mental Health Services Administration)

Anchorage Collaborative Coalitions

Each of the three ACC coalitions (AYDC, Healthy Voices, Healthy Choices, and Spirit of Youth) has a youth focus and, as such, the work of the ACC is focused on youth in Anchorage. The ACC defines youth to include youth and young adults ages 12-24.

In November 2014, the ACC issued a request for proposals for a contractor to conduct an assessment to evaluate behavioral health indicators and related demographic, social, economic, and environmental factors pertaining to youth and young adults aged 9-24 in Anchorage, Alaska. After a thoughtful review process, the ACC selected the UAA Center for Human Development (CHD) and a team of UAA researchers to work collaboratively with the ACC on a community assessment. Members of the UAA Assessment Team included researchers at CHD as well as additional university researchers from the Center for Behavioral Health Research and Services, the Department of Health Sciences, and the Justice Center.

The UAA Assessment Team began their work in January 2015. At the conclusion of the first phase, the ACC selected its priority issue, identified relevant consequences, potential intermediate variables and contributing factors, and identified additional data needs. During the second phase of the assessment, the CHD Team collected primary data to address knowledge gaps left by the existing data analysis. The new data enabled the ACC to prioritize the intermediate variable(s) with the strongest relationship to the selected priority issue, and most likely to affect the consequences amongst Anchorage youth.

IV. Community Assessment Results

As part of the assessment, the ACC examined existing data, collected and analyzed new data, conducted youth focus groups, systematically reviewed existing prevention resources, interviewed members of the community, and involving members of the coalitions and the greater Anchorage community in the process.

Findings

Priority Issue

The ACC found the status of mental health of Anchorage youth and young adults to be of particular concern and selected mental health as the priority issue of focus. Of particular concern were high rates and upward trends in youth reporting feelings of sadness, alone in life and hopelessness, which were operationalized as indicators of mental health. The data show that consequences of poor mental health result in suicidal behavior and ideation and substance abuse. The ACC defined its long term goal: to decrease conditions that lead to suicide and suicide attempts and increase those that lead to mentally healthy 12-24 year olds. The prioritized intermediate variable chosen was bullying, with special emphases on bullying in 9th grade and affecting 18-24 year olds. The community engaged processes and data supporting the prioritization are summarized below.

Intermediate Variable

According to the UAA Assessment Team's review of the focus groups, there is a direct link between poor mental health conditions (including feelings of alone in life, sadness, and hopelessness) and bullying. As they observed in their review, "This is an important finding as it suggests the two main variables the team examined are inextricably linked" (Heath, et al., 2015; Anchorage Collaborative Coalitions, 2016). This finding underscores the importance of the selection of this intermediate variable and these focus groups, and the data from other sources underscore the importance of selecting ninth grade youth and 18-24 year olds as the target populations for interventions.

Across several datasets and sources, bullying was significantly tied to poor mental health outcomes among youth in Anchorage. Analysis of YRBS data shows that ASD high school students who were bullied, either in school or electronically, were more likely to report that they seriously considered suicide, planned a suicide attempt, felt sad or hopeless, currently drink, and binge drink. Analysis of data from the YAS, a survey administered to 18-24 year olds living in Anchorage, shows that bullying, second only to stress, is a significant predictor of mental health status for young adults in Anchorage. Qualitative data from focus groups with youth aged 12-24 reflect the extent to which bullying influences the mental health of youth in those age groups. Together, these findings further reinforced the ACC intermediate variable choices of bullying in ninth grade and among 18-24 year olds. Furthermore, in the assessment of all the data

available, clear connections were made between bullying and suicide, substance use, and mental health issues.

Bullying Definition

In order to assess prevalence, incidence and consequences of bullying, it was necessary to have an operative definition of the word. Bullying is unwanted, aggressive behavior that involves a real or perceived power imbalance. The behavior is repeated, or has the potential to be repeated, over time. Bullying includes actions such as making threats, spreading rumors, attacking someone physically or verbally, and excluding someone from a group on purpose.

Community Readiness

The ACC Executive Committee coordinated an evaluation of the Anchorage community's ability to address the selected intermediate variables and priority issue to assess community readiness. Overall, the level of readiness in the Anchorage community was moderate for both the ninth grade population as well as 18-24 year olds. There were some slight differences in readiness between dimensions. With prevention programming coming in at the highest level of readiness: 6=initiation (ninth grade)/5=preparation (18-24 year olds), and community climate and knowledge about the problem falling to the bottom with a score of 4=preplanning (ninth grade)/3=vague awareness (18-24 year olds). In addition to variances within dimensions, there were also notable differences among sectors. Healthcare had the highest readiness rating of 6=initiation, with the other sectors scoring between stages 4=preplanning and 5=preparation.

As prescribed by the community readiness manual, with the majority of scores within the stages of preplanning and preparation the ACC will focus on raising awareness of concrete ideas about bullying and gathering existing information with which to plan more specific strategies in the planning stage of our efforts.

Intervening/Contributing Factors:

The data point to several notable factors that are associated with protecting against bullying, sadness/hopelessness, and suicide. As evidenced by both focus groups and the Young Adult Survey, individual factors such as optimism, self-esteem, and self-awareness are protective for bullying and sadness/hopelessness. That is, youth perceived individuals with higher self-esteem and self-awareness to be less impacted by bullying and also less likely to be bullied.

The Young Adult Survey showed that higher levels of optimism were associated with better mental health. Optimism is equally predictive of good mental health as being bullied or harassed is a risk factor for poor mental health. The protective factors included youth feeling like they matter to their community and youth having trusted relationships, both peer and adult.

Primary data for the 12-17 year-old age group primarily focused on the Youth Risk Behavior Survey (YRBS) School Climate and Connectedness survey (SCCS), According to YRBS strength of association findings, youth feeling like they matter to their community is the second ranked protective factor against bullying, feeling sad/hopeless, suicide ideation, and a planned attempt at suicide.

This was also evidenced in the focus group discussion, where youth elaborated on what it meant to matter in their community and the importance of feeling engaged in one's community. Regarding trusted relationships, YRBS data indicated the highest ranked protective factor against being bullied was having a teacher who cares. Having a teacher who cares also meant youth were less likely to feel sad or hopeless and less likely to consider or plan a suicide attempt.

Trusted adults were mentioned in focus groups as a resource and support, second only to peer relationships. Peers were highly regarded across focus groups as the first line of defense for bullying and mental health concerns. Individuals often said they would talk to and rely on their peers first before seeking adult or professional help. It is important to note that while youth in focus groups refer to peer relationships, there is no measure of peer relationships in YRBS.

In summary, it is demonstrated through a variety of means (i.e., secondary data, primary data, quantitative and qualitative data) that bullying, mental health, and suicide are not independent constructs. As a result, there are a number of risk and protective factors that are associated with at least two if not all three of these variables. Therefore, it would be highly beneficial and efficient to focus interventions and next steps on intermediate variables that cross the main variables of focus, thereby increasing the potential impact of the intervention. For example, having trusted relationships is a protective factor for bullying, sadness/hopelessness, and suicide, and therefore an intervention focused on establishing trusted relationships would potentially reduce bullying behaviors, feelings of depression, and suicide ideation/attempts.

Future

The ACC used the results of its assessment to guide the strategic planning process. Identifying interventions that are appropriate to our level of readiness, built on strong data, and developed in conjunction with our community is essential. Toward that end, the ACC began developing a planning process in late February that drew on coalition members, people from the community, and youth from the identified age groups. The planning process yielded this strategic plan, which identifies implementing interventions and includes a final logic model reflecting the planning process. A cohesive evaluation strategy is in development that will ensure that the work we do effectively addresses the intermediate variables.

V. Strategic Planning Methodology

Introduction

DBH approved the ACC assessment document on February 17, 2016. (Anchorage Collaborative Coalitions, 2016) This review set in motion the strategic planning process. The ACC Executive Committee determined that the planning process would include an initial series of community meetings that would review and explain the assessment's findings and seek feedback on how those findings and recommendations might be more focused on specific interventions. Based on that determination, ACC would then identify key research areas reflecting community input, community readiness, and the assessment findings. These research areas, refined even further by the ACC Executive Committee, would then inform a research phase where professional researchers would be retained by ACC to identify evidence-based and other practices that might address each identified strategic intervention area.

Research findings would then be presented to community participants in an additional public meeting and further narrowed to those interventions that 1) were supported by research; 2) could be realistically addressed by the community; and 3) had a likelihood of being sustainable. These interventions were to then be presented to a stakeholder group that would include the ACC Executive Team, key members of each coalition, stakeholders, and members of the Evaluation team to identify up to six strategies using the SPF framework. Further meetings to refine those strategies would be conducted in individual strategic area work group meetings following the planning session. This process was effectively completed and those results follow.

Strategic Planning Steps

The strategic planning process included a number of major steps. These are summarized below:

1. Develop vision statement (completed during the assessment process, this helped refine our focus and direction)
2. Community engagement and input to identify potential areas of intervention and research. The community was engaged to examine the assessment findings, proposed area of focus, and community readiness and resources, to determine the most potentially effective interventions.
3. Research of community and assessment-identified areas of focus.
4. Community and ACC review of research to identify community relevance, feasibility, cultural relevance and appropriateness, and sustainability of areas researched. This then led to the identification of specific strategy areas.
5. Strategic planning session, based on the SPF SIG and Strategic Plan Guidance Document (Feathers) models, to develop goal and objective statements; short, mid, and long term

outcomes; strategy components, outputs, and community resources for each strategy area.

6. Develop SMART (Smart, Measurable, Achievable, Relevant, and Time-bound) objectives for each goal -- What will change, for who, by how much, and when?
7. Provide templates for planning workgroups (developed around each strategy) describing the fit of each strategy to the community, including community readiness; target population; cost and feasibility; culture; and other elements.
8. Identify community resources needed for each strategy (human, technical, fiscal, and structural/linkages)
9. Develop strategy level logic models that include resources, outputs, strategy components, short-term outcomes (changes in knowledge, skills, attitudes, beliefs), medium-term outcomes (changes in behavior), and long-term outcomes (changes in bullying rates)
10. For each strategy discuss target groups including number of people served, plans for recruiting participants, and plans for retaining participants.
11. For each strategy discuss collaborative partners and community members needed to succeed, including the role for each partner.
12. For each strategy identify potential barriers and possible solutions to these barriers.
13. Develop action plans for each strategy, including strategy components, key activities, target completion dates, person responsible for overseeing activities, resources and materials needed, and location for activities.

Strategic Planning Actions

The ACC Executive Team, working with numerous community partners and participants, coalition members, researchers, and professionals from the Center for Human Development (CHD), used the assessment document, community input, community readiness assessment, and research to identify six key strategies for addressing bullying within the 9th grade and the 18 – 24 year old populations. This process used modified forms of the SPF SIG model, the Strategic Plan Guidance model, and other strategic planning and community facilitation methods to develop SMART objectives, community and strategy level logic models, timelines, and other elements necessary to address the strategy areas.

The following chart summarizes the major actions of the planning process.

Date	**Major Actions**
February 17, 2016	Approval received of Community Assessment; vision statement was incorporated in this from earlier work. Planning began for community forums
March 8, 2016	First community forum held Issues further refined; key topical areas for research begin to be derived

March 14, 2016	AYDC forum held (“Why?” and “Why here?”)
March 16, 2016	ACC Executive Team narrowed its focus based on community input Initial research questions developed
March 30, 2016	Research questions finalized Researchers contracted
Month of May	Youth training in logic models and strategic planning conducted to prepare youth for planning process
May 10, 2016	Research completed and reviewed by ACC Executive Team
May 13, 2016	Community-level Logic Model drafted
May 16, 2016	Research presented to the public in a community forum Community appropriateness, capacity, and sustainability evaluated for ideas generated from research Initial strategy areas identified for further review and planning
Week of May 16	Further refining of strategies by ACC Executive Team and backbone contractors
May 23, 2016	Strategic planning session with ACC Executive Team, Coalition members, youth, some evaluation team members, and others Identified goals and objectives; long, mid, and short term outcomes; contributing elements; outputs; and, in some cases, timelines and resources.
May 24 – June 13, 2016	Further development of goals and objectives; long, mid, and short term outcomes; contributing elements; outputs; and timelines and resources Preliminary identification of evaluation goals
August 17, 2016	Completion of strategy level logic models
August 17, 2016	Identification of Evaluation methodology and some proposed measures for strategies Completion of submission to state in draft

VI. Strategies

Synopsis of Chosen Strategies

The Anchorage Collaborative Coalitions chose six strategies to address the intervening variables and contributing factors identified by the Anchorage Youth & Young Adults Community Behavioral Health Assessment.

Strategy 1: Infrastructure Development and Capacity Building

ACC will continue to support coalition growth, development, and sustainability through directed infrastructure development and capacity building activities. This strategy aims to increase capacity within the ACC and the Anchorage community to address bullying, its contributing factor, and its consequences. Specifically through increased infrastructure and capacity, this aims to grow the amount of youth that feel they matter in the community, add local businesses and postsecondary institutions that adopt recommended policies, and increase the number of youth serving organizations using best practices to promote health and wellness and protective factors.

Strategy 2: Awareness and Social Norms Campaign for Middle and High Schools

A citywide awareness campaign will be used to increase the community readiness scores of 4 in the dimensions of climate and knowledge about the problem. The campaign will aim to increase knowledge of bullying, awareness of its prevalence among middle- to high-school youth, and the negative consequences of bullying, reducing the stigma of reporting bullying and increasing awareness of associated proactive practices.

Strategy 3: Policy Education and Advocacy for Middle and High Schools

During the Community Needs Assessment Phase, focus groups with youth and the community readiness interviews uncovered a need for clearer, more consistently followed policies for dealing with bullying behaviors in our schools and other institutions serving Anchorage middle school and high-school youth. This strategy will recommend evidence based bullying policies to Anchorage schools and other institutions serving Anchorage middle school and high-school youth.

Strategy 4: Expansion of Existing Programs For Youth Aged 12-18 Years Old

This strategy is designed to expand existing youth, adult, and community programs to include life skills, bullying prevention, and consequence reduction (e.g. depression, substance use, suicide, etc.) Through this effort, youth, adults and community will have skills, strengths and resources needed to eliminate bulling and consequences of bullying. Specifically, this strategy will be accomplished by increasing protective factors with a focus on caring adults and increased parental engagement through expansion of the Start the Conversation program.

Strategy 5: Bystander Intervention

Currently used around the United States, and with an existing presence in Alaska, the Green Dot bystander intervention program work prepares individual community

members to actively participate in the reduction of interpersonal violence. Specifically created to address domestic violence, Green Dot curriculum has broadened to help sexual violence, alcohol and drug-abuse, child abuse and bullying. This strategy will focus on the main goal of improvements in the behavioral health status of the target population of 18-24 year olds. Green Dot programming will be implemented within Anchorage's restaurant industry or other environments with concentrations of the target population, with the goal to reduce workplace bullying.

Strategy 6: Community Awareness and Outreach Campaign for Young Adults

ACC will launch a targeted awareness campaign used to increase the community's knowledge of adult bullying and the consequences related to the issue of adult bullying. This strategy aims to increase the community readiness score of 3 (vague awareness) in the dimension of community awareness of the problem. Specifically, this strategy will address community awareness and understanding of adult bullying, its consequences, and resources available in the community.

Following is detailed information about each of the six strategies the Anchorage Collaborative Coalitions selected to implement to address bullying and the negative consequences of bullying among youth and young adults in Anchorage. Each strategy description includes the following: a description of the intermediate variables the strategy will address, the objectives ACC hopes to meet as a result of implementing the strategy, a narrative description of the activities that will be implemented as part of the strategy, the resources, both human and financial that will be used, and an implementation timeline.

Strategy 1: Infrastructure Development and Capacity Building

Description

Anchorage Collaborative Coalitions (ACC) will use infrastructure development and capacity building to support coalition growth, development and sustainability. This strategy aims to increase capacity within the ACC, our coalitions, and the Anchorage community to address bullying, its contributing factors, and its consequences.

This strategy is integral to building community support and helps us to accomplish the remaining five strategies to reduce and prevent bullying behavior and its consequences. Infrastructure development and capacity building includes these primary activities: 1) creating and implementing a plan to increase youth who feel like they matter in the community through coalition partners; 2) creating an advocacy plan to address policies, procedures, and practices addressing young adult bullying at work places and postsecondary institutions; and 3) building capacity of youth-serving organizations through targeted training and recommending best practices.

Building coalition capacity will support our coalition members to build resiliency, increase life skills and assets to reduce bullying and the consequences of bullying as they contribute to poor mental health of Anchorage area youth. At the Community Planning

sessions participants were clear that support should be given to programs/project that currently exist vs. developing new programs/projects and trying to fit them into the school/community. The ACC will first support programs/projects currently being conducted by coalitions that make up the ACC (Alaska Injury Prevention Center/Anchorage Youth Development Coalition, Healthy Voices, Healthy Choices and Spirit of Youth) that will contribute to the goal.

The objectives selected are supported by data and information contained in Growing Up Anchorage report and the ACC Community Assessment Anchorage Youth & Young Adults (Anchorage Collaborative Coalitions, 2016). Strength of Association Between Bullying and Behavioral Health Indicators shows youth who are bullied in school are 119% more likely to drink alcohol, 87% more likely to currently use marijuana, and 201% more likely to have feelings of sad and hopelessness and 189% more likely to seriously considered suicide (Heath, et al., 2015).

National data show that bullying is higher among 9th graders than in any other high school group. Twenty five percent (25%) of 9th grade students reported being bullied on school property and 16% reported being bullies electronically (cyber bullying). The most important program elements that were associated with a decrease in bullying were parent training/meetings, improved playground supervision, disciplinary methods, classroom management, teacher training, classroom rules, a whole school anti-bullying policy, school conferences, information for parents, and cooperative group work. In addition, the total number of elements and the duration and intensity of the program for teachers and children were significantly associated with a decrease in bullying (Saylor, 2016).

They recommend that anti-bullying programs should be designed to go beyond the scope of the school, and target wider systemic factors such as the family. Bullied children often do not communicate their problems to anyone while parents and teachers often do not talk to bullies about their conduct. This suggests that parent training and meetings are significantly related to a decrease in both bullying and victimization (Saylor, 2016).

Life Skills Training

One specific requirement of this review was to address life skills training. While there may be some differences in training curricula, there are some basic similarities (Kastner & Wyatt, 2009). The list of skills below were intended to address the needs of high-risk youth, most of the skills learned in a life skills training program appear to address bullying risk and protective factors (Anand & Ritu, 2015; Campbell-Heider, Tuttle, & Knapp, 2009; Tuttle, Campbell-Heider, & David, 2006).

Motivation for personal goals	Executive functioning skills
Independent living skills and self-reliance	Emotional awareness, reflection and regulation

Physical fitness and healthful habits	Academic skills
Social skills	Relationship skills and values
Moral behavior, integrity and character	Spirituality and a purposeful life

Through research of local and national policies dealing with bullying, the ACC will be able to recommend model policies for local institutions of higher education, employers of young adults and other organizations. The need for policy research for the 18-24-year-old age group was directly informed by the assessment findings, both locally and nationally. During our focus groups and community readiness survey, there were few resources available describing best practices and a low level of general awareness of this issue. Additionally, during our initial search both locally and nationally for any evidence-based programs, we found few examples. The policy research will allow our workgroup to build the best possible models for local organizations to address bullying outcomes.

Objectives

Increase the capacity of Anchorage Collaborative Coalition (ACC) and the Anchorage community to address bullying, its contributing factors, and its consequences.

Resources

The ACC will prioritize and look at potential resources in the community, such as human resources. Human resources include coalition staff, coalition members, coalition members' organizational resources such as staff and volunteers, interns and/or VISTA members, and others with the expertise and interest in capacity building.

Local agencies will be awarded a grant around the goals of increasing the number of youth that feel they matter to the community and increasing youth serving organizations using best practices. Advisory and training resources will be determined based upon need of knowledge and understanding of bullying and the consequences on individual's mental wellness. The ACC Executive Team and data and evaluation team will provide oversight to these programs, collecting status reports and evaluation data.

Healthy Voices, Healthy Choices will lead on developing an advocacy plan to address policies, practices, and processes (3P) for young adults, supported by other community members with 3P expertise and interest. Some key partners may include University of Alaska, Alaska Pacific University, local business leaders, and other places of higher learning (Job Corps, trade schools).

Anchorage Youth Development Coalition will lead in developing best practices for youth serving organizations to address bullying with the support from its coalition members.

Activities

Infrastructure development and capacity building have several activities that will help support this strategy. See below.

A. Research, develop, and implement a plan to increase the amount of youth who feel like they matter in the community. The ACC will convene a work group to research best and promising practices, collect youth and community input and data, and implement new efforts. Change will be measured through existing surveys and/or the questions from, YRBS, SCCS, as well as focus groups. Evaluation strategies will be determined based on existing methods in the appropriate best and promising practices

B. Create an advocacy plan to address policies, procedures, and practices framework. The ACC will convene a work group to identify model policies that address young adult bullying for both workplaces and places of higher learning based on research findings. To build partnerships and champions in the community, we will conduct trainings and provide policy templates for adoption for workplaces and places of higher learning.

C. Build capacity of youth-serving organizations through targeted training and supportive best practices. The ACC will work to increase programming that promotes skills, strengths and resources needed to promote health and wellness and protective factors. A workgroup engaging in participatory evaluation methods will develop shared measures so each selected agency will collectively contribute to the same goals and use the same evaluation methods, as well as work with and review the selected agencies.

Timeline

Component	***Key Activities***	***Who is Responsible***	***End Date***
Increase youth that feel they matter in community	Conduct research	AIPC / Becky Judd	September 15, 2016
	Develop plan and process to support and fund coalition agencies	AIPC / AYDC	Ongoing
	Evaluate agency programs	ACC Evaluation Team	Ongoing
Increase youth serving organizations using best practices relevant to preventing bullying and its consequences	Form committee to identify best and promising practices	AYDC	October 1, 2016
	Choose partnering organizations	AYDC	December 1, 2016
	Implement plan	Community agencies	January 1, 2017
	Create evaluation metrics to assess success of programs	ACC Evaluation Team	January 1, 2018
Policies, practices and processes	Research and create 3P advocacy plan	HVHC	November 1, 2016
	Vet business partners and institutions of high learning	HVHC and ACC Executive Committee	January 1, 2016
	Develop and conduct trainings with	HVHC	May 1, 2017

	partners		
	Create evaluation metrics of programs in businesses and places of learning	ACC Evaluation Team	2017

Strategy 2: Awareness and Social Norms Campaign for Middle and High Schools

Description

Bullying prevention research consistently recommends developing a shared understanding of what bullying is and its impact (Stuart-Cassell, Bell, & Springer, 2011; Rivara & Le Menestrel, 2016; Gladden, Vivolo-Kantor, Hamburger & Lumpkin, 2014). The CDC defines bullying as "any unwanted aggressive behavior(s) involving an observed or perceived power imbalance and is repeated multiple times or is highly likely to be repeated" (Gladden, Vivolo-Kantor, Hamburger, & Lumpkin, 2014).

The CDC's Stopbullying.gov Community Action Toolkit warns coalitions and planning groups that perceptions about bullying can have powerful influences on youth and adults and suggests groups will likely need to address some myths before implementing prevention strategies (U.S. Department of Health & Human Services, *n.d.*)

Research by Rivara & Le Menestral (2016) supports the need for clear and consistent messaging on bullying:

> Bullying, long tolerated by many as a rite of passage into adulthood, is now recognized as a major and preventable public health problem, one that can have long-lasting consequences. Those consequences—for those who are bullied, for the perpetrators of bullying, and for witnesses who are present during a bullying event—include poor school performance, anxiety, depression, and future delinquent and aggressive behavior. Federal, state, and local governments have responded by adopting laws and implementing programs to prevent bullying and deal with its consequences. However, many of these responses have been undertaken with little attention to what is known about bullying and its effects. Even the definition of bullying varies among both researchers and lawmakers… (Rivara & Le Menestrel, 2016)

Anchorage Collaborative Coalitions will launch a citywide awareness campaign to increase knowledge of factual issues of bullying and its negative consequences and promote clear and consistent messaging around bullying within middle and high school populations. We will be following the model prescribed by the Stopbullying.gov Community Action Toolkit.

Due to Anchorage 9th grade students reporting the highest level of bullying incidents the ACC will be using bullying among 9th graders as a target and proxy to measure the success of this campaign.

This strategy addresses the Intervening Variable: community perceptions, norms and knowledge about bullying. This awareness campaign aims to increase knowledge of what bullying is (by definition) and awareness of bullying's negative consequences. Ultimately the campaign will decrease the stigma surrounding reporting incidents of bullying.

According to the community readiness assessment conducted by the ACC in January of 2016 the overall level of readiness in the Anchorage community regarding bullying in the ninth grade population is currently moderate. There are some slight differences in readiness between dimensions with prevention programming coming in at the highest level of readiness: 6=initiation and community climate and knowledge about the problem falling to the bottom with a score of 4=preplanning.

This awareness campaign strategy is intended to increase the community readiness score for the dimension of the community climate score of 4 (preplanning) as well as the dimension of knowledge about the problem 4 (preplanning).

Objectives

Objective 1: There will be an increase from baseline in the number of "reporters and supporters" (youth, parents, teachers, school administrators, after-school providers, clergy) who understand what bullying is after completion of the awareness campaign.

Objective 2: There will be a decrease from baseline in the number of middle and high school students who self-report that there is stigma around reporting bullying after completion of awareness campaign.

Activities

A. Research baseline – Utilizing the APAY survey currently being conducted ACC will become better aware of the baseline among Anchorage adults of their attitudes, beliefs and knowledge regarding bullying among middle and high school students are. This information will allow us to evaluate the success of our campaign. The ACC will also partner with ASD classrooms to conduct participatory evaluation within the high school population regarding attitudes, beliefs and knowledge regarding bullying.

B. Message development by students at local high schools specific to their schools and diverse perspectives – Coalition partners will work with Anchorage high schools to allow students to develop messages in their own words regarding the definition of bullying

and the seriousness of its consequences. These messages will assist our effort to be culturally competent in our language and depictions, as the diverse student base of the district will develop them. An added benefit will be discussion among students, and thereby raising awareness regarding about bullying.

C. Determine methods - Methods to be considered include social media platforms, radio, YouTube, Pandora, promotional materials, and a presence at various community events throughout the city. Media methods will be selected based on the target audience for each message.

D. Meetings with local leaders- ACC Coalition members and leadership will meet with local leaders such as Assembly members, staff in the Mayor's office, Principals, student council members, Church leaders, and Community Council members to discuss bullying and its serious consequences.

Resources

Human Resources. To carry out this strategy, the coalition will form an Awareness Campaign Workgroup chaired by an ACC member, facilitated by staff, and that will include media/communications specialists, youth (aged 15-18), and volunteers.

Financial Resources. Grant funds from FY16 through FY18 will be utilized. Estimates have been accomplished to ensure feasibility. Cash matches may be contributed to the campaign in FY17 and FY18.

Timeline

Key Activities	***Who is responsible***	***End Date***
The 9th grade awareness campaign workgroup will develop a detailed plan for this strategy. This plan will include the details of who, what, where, and how the campaign will be conducted.	9th grade awareness campaign Workgroup	October 1, 2016
Message developed and methods determined	Workgroup	January 1, 2016
Meet with local leaders	ACC Executive Committee	February 1, 2016, Ongoing
Launch awareness campaign	ACC and partners	March 1, 2016, Ongoing

Strategy 3: Policy Education and Advocacy for Middle and High Schools

Description

Focus groups with youth as well as the community readiness interviews conducted during the community needs assessment phase, uncovered a need in Anchorage for clearer, more consistently followed policies for dealing with bullying behaviors in our schools and other institutions serving Anchorage middle-school and high-school youth (Anchorage Collaborative Coalitions, 2016; Heath, et al., 2015).

In addition, the ACC found that most state laws, including Alaska's, do not follow research-based definitions of bullying (Sacco, Silbaugh, Corredor, Casey, & Doherty, 2012). Without a proper definition of bullying it is virtually impossible for a school or school district to properly address the issue.

According to the National Academies of Science, "law and policy can play a significant role in strengthening state and local efforts to prevent, identify, and respond to bullying" (Rivara & Le Menestrel, 2016).

The US Department of Education (DOE) recommends school districts adopt policies with broadly defined, explicit definitions of prohibited behavior that contain mechanisms to ensure accountability. In addition, the Department indicates that states with best practice model policies provide: (a) enumeration of protected groups; (b) investigations and use of written records; (c) mental health referrals; and (d) transparency and monitoring. These elements will be explored as possible policy recommendations (Stuart-Cassell, Bell, & Springer, 2011).

Research conducted for the Journal of American Medical Association Pediatrics showed that "students in states with at least 1 DOE legislative component in the antibullying law had a 24% (95% CI, 15%-32%) reduced odds of reporting bullying and 20% (95% CI, 9%-29%) reduced odds of reporting cyberbullying compared with students in states whose laws had no DOE legislative components (Hatzenbuehler, Schwab-Reese, Ranapurwala, Hertz, & Ramirez, 2015).

National data show that bullying is higher among 9th graders than in any other high school group. Twenty five percent (25%) of 9th grade students reported being bullied on school property and 16% reported being bullies electronically (cyber bullying). The most important program elements that were associated with a decrease in bullying were parent training/meetings, improved playground supervision, disciplinary methods, classroom management, teacher training, classroom rules, a whole school anti-bullying policy, school conferences, information for parents, and cooperative group work. In addition, the total number of elements and the duration and intensity of the program for teachers and children were significantly associated with a decrease in bullying (Saylor, 2016).

This strategy will recommend evidence based bullying policies to Anchorage schools and other institutions serving Anchorage middle-school and high-school youth. ACC will promote evidence based model policies for local institutions interacting with 9th grade communities.

This group will follow the policy development model developed by Scotland's Anti-Bullying Service which recommends an inclusive approach to policy making. Policies developed using this approach are more likely to be successful, as those implementing and receiving the policies have greater ownership due to being consulted in the development of the policies (RespectMe Scotland's Anti-Bullying Service, *n.d.*). This approach will ensure that the recommendations we are making are the most effective to this end.

Objectives

(1) Develop evidence-based, clear and consistent, culturally appropriate policy recommendations for dealing with bullying behaviors including cyber-bullying, in our schools and other institutions serving Anchorage middle school and high-school youth.

(2) Evidence-based, clear, consistent, policies for dealing with bullying behaviors, including cyber-bullying, will be recommended to Anchorage schools and other institutions serving Anchorage middle-school and high-school youth.

Activities

The Policy Education and Advocacy strategy is focused around building knowledge within ACC to vet create and recommend model policies to local groups serving 9th grade youth. The majority of the tasks will be overseen by the workgroup created to carry out the primary activities for the strategy. Each member of the workgroup will be selected to maximize the effect of the model policies through the Anchorage community. Members will include ACC staff, school and non-profit organizations.

Primary strategy activities include:

A. Recruit and convene strategy workgroup with key Anchorage community members.
B. Launch process evaluation
C. Review existing local policies as well as National evidence based bullying policy recommendations.
D. Assess for diversity and fit
E. Consult and vet with partners.
F. Work with local youth groups to help inform and lead the strategy.
G. Provide model evidence-based policies for dealing with bullying and cyber bullying behavior to Anchorage schools and other institutions serving Anchorage middle school and high-school youth with model evidence-based policies for dealing with bullying and cyber bullying behavior
H. Ongoing assessment of policy adoption and consistency of implementation

Resources

Several partners will serve as resources to ensure this strategy's success by contributing to the workgroup. Key stakeholders from youth serving organizations and Anchorage schools will develop model policies based on research. These partnerships will increase the likelihood of achieving this strategy's objectives. A few example partnerships are:

- Youth serving organizations and their youth to help develop realistic and inclusive policies to accompany best practices research.
- You are Not Alone
- Members of the planning process
- Anchorage Youth Court
- AYDC members
- Spirit of Youth's Teen Advisory Council
- Healthy Voices, Healthy Choices

We will rely on ACC's evaluator to conduct a thorough process evaluation of this strategy area in order to assess quality of the group's planning and outreach and to assess barriers to policy adoption.

Timeline

Key Activities	***Who is Responsible***	***End Dates***
Invite participants into Workgroup	SOY / Deb Casello	September 1, 2016
Launch process evaluation	Evaluator	October 1, 2016
Review existing policies and best practices	Workgroup	November 1, 2016
Assess for diversity and fit and consult partners	Workgroup	December 15, 2016
Identify key schools and youth-serving organizations	Workgroup	January 1, 2017
Present recommendations	ACC Executive Committee	2017, Ongoing
Evaluation of programs	ACC Evaluation Team	2018

Strategy 4: Expansion of Existing Programs For Youth Aged 12-18 Years Old

Description

Strategy 4 is designed to expand existing youth, adult, and community programs to include life skills, bullying prevention, and consequence reduction (e.g. depression,

substance use, suicide, etc.) Through this effort, youth, adults and community will have skills, strengths and resources needed to eliminate bulling and consequences of bullying.

The ACC strategy is to build resiliency, increase life skills and assets to reduce bullying and the consequences of bullying as they contribute to poor mental health of Anchorage area youth. Specific assets to be improved include Family Support and Positive Family Communication, Increased Time at Home, and Increased Resistance Skills. This strategy will be accomplished by increasing protective factors through focusing on caring adults, increased parental engagement, and providing parents with tools and resources for appropriately responding to bullying issues..

At the Community Planning sessions participants were clear that support should be given to programs and projects that currently exist rather than developing new programs/projects and trying to fit them into the school and community. The ACC will focus on expanding the "Start the Conversation" project, which the AYDC and HVHC coalitions have collaborated on in the past.

Data Support

The objectives selected are supported by data and information contained in Growing Up Anchorage report and the ACC Community Assessment Anchorage Youth & Young Adults (Anchorage Collaborative Coalitions, 2016, p. 57).

Parents are often unaware of the severity of bullying in their child's school, and do not know how to help (Harcourt, Jasperse, and Green, 2014). Parent involvement and support is a protective factor for bullying. Poor parent child communication is related to victimization. Victimization is related to negative parenting, which includes less communication, warmth and affection (Lereya, Samara and Wolke, 2013). Youth are often skeptical of seeking help from their parents regarding bullying (Perren et al., 2012).

National data show that bullying is higher among 9th graders than in any other high school group. Twenty five percent (25%) of 9th grade students reported being bullied on school property and 16% reported being bullies electronically (cyber bullying). The most important program elements that were associated with a decrease in bullying were providing information to and training for parents.

Recommendations for anti-bullying programs should be designed to go beyond the scope of the school, and target wider systemic factors such as the family. Bullied children often do not communicate their problems to anyone while parents and teachers often do not talk to bullies about their conduct. This suggests that parent training and meetings are significantly related to a decrease in both bullying and victimization (Farrington and Ttofi, 2009).

Start the Conversation at Family Meals

A body of empirical evidence suggests significant associations between the frequent family meals (i.e., 5 or more per week) and a number of improved youth health and behavioral health outcomes. These include positive family relationships (Franko et al. 2008) and enhancing parent-child communication (Fulkerson et al., 2010), as well as positive identity development (Fulkerson et al. 2006). Frequent family meals also are found to reduce youth risk behaviors including reduced depression, self-harm (Eisenberg et al., 2004; Fiese, Foley, & Spagnola, 2006; Fulkerson et al., 2009), and aggression (Griffin et al., 2000).

Goldfarb and colleagues (2015), explain that, "the routine aspects of the meal environment, such as the positive exchange of ideas, ***discussion of sensitive issues*** (emphasis added), problem-solving, and family closeness, serve to mediate the relationship between frequent family meals and healthier adolescent adjustment" (p. 134). In other words, the literature suggests that what happens at family mealtimes, beyond the act of eating, may offer protective effects in the prevention of a variety of health and behavioral health youth risk factors (Skeer & Ballard, 2013).

In one UK study, Levin, Kirby, and Currie (2012) utilized data from the 2006 Health Behaviour in School-Aged Children Survey (similar to the U.S. Youth Risk Behavior Survey) that included 18,834 middle and high school students. Frequent family meals were inversely associated with a number of youth risk factors, including being bullied. Results of another recent study conducted by Elgar and fellow researchers (2014) found that family dinners have a positive effect on adolescent mental health and are likely to be protective of the harmful consequences of adolescent cyberbullying. This study may provide guidance for evaluation methods to measure STC success.
In an attempt to harness the positive impact of the family meal, in 2012 the AYDC and HVHC coalitions developed *Start the Conversation @ Family Meals* (STC) project to encourage family dinnertime conversations as a means of reducing youth substance use and increase academic success. The group has now distributed over 5,000 kits to families of middle school students across Anchorage.

The impact of this effort was evaluated by Cho and Garcia (2014) using a pre- posttest survey of parents who reported statistically significant increases in the number of weekly meals they had with their children; however, mealtime conversation quality, which did increase very slightly, did not show a statistically significant difference.

The ACC now hopes to use STC as an intervention for reducing youth bullying. This is also based on several existing bullying educator and parent toolkits that provide specific information about defining, identifying, intervening, and reporting of bullying.

Family meals in and of themselves should not be considered causal to improved youth outcomes, but a tool that caregivers can better understand the importance of connecting, openly communicating with, and supporting youth's well-being. Going forward, the ACC will review existing bullying education and parent-targeted kits to better adapt the STC kits with specific education and conversations starters relevant to bullying.

Objectives

1. Increase the quantity of quality time spent between parents/caregivers and youth.
2. Increase youth willingness to talk to parents about bullying.
3. Increase parent feeling of self-efficacy in their ability to respond to bullying.

Activities

Increase parent/caregiver knowledge about and quantity of quality time spent with youth as it impacts mental wellness over baseline. Evaluation will be conducted through the existing and improved Start the Conversation methodology.

A. Develop appropriate bullying information for the STC toolkit and evaluation methods.

C. Promote the Start the Conversation toolkit and train implementers on the project. Frequent communication with implementers before, during, and after distribution is critical in ensuring they

D. Involve coalition members on outreach and implementation of STC toolkits to reinforce the purpose and best uses of the toolkit.

E. Expand implementation and evaluation of STC toolkits to appropriate programs, projects and events. This includes in considering expanded populations within the community to reach key demographics as well as foster care families, faith communities, and more.

Sustainability: provide toolkit for a nominal fee that will sustain the program.
Pursue designation of Start the Conversation as a Best Practice.

Resources

Human Resources

The Anchorage School District has agreed to distribute the STC packet and conversation cards to Middle School Students throughout Anchorage. The ACC workgroup/executive team/data & evaluation team will provide oversight to this program, collecting status reports and evaluation data.

Financial resources

Estimates for both FY17 and FY18 expenditures have been made to ensure feasibility. A 10% cash match from the local agencies selected to implement and manage this strategy is required.

Timeline

Key Activities	***Who is Responsible***	***End Date***
Evaluate past STC programs, including for cultural relevancy	ACC Evaluation Team	February 1, 2017
Develop bullying information for toolkits	AYDC/HVHC	April 1, 2017
Promote and train on use of Start the Conversation kits	AYDC/HVHC	August 1, 2017
Distribute Start The Conversation kits	AYDC/HVHC	June 30, 2018
Distribute Start the Conversation to Middle School and Community wide with information that addresses quality time spent by parents/caregivers to their children/youth and provides bullying prevention resources		

Strategy 5: Bystander Intervention

Description

Currently used around the United States, and with an existing presence in Alaska, the Green Dot bystander intervention program work prepares individual community members to actively participate in the reduction of interpersonal violence (Burke, 2016). Specifically created to address domestic violence, Green Dot curriculum has broadened to help sexual violence, alcohol and drug-abuse, child abuse and bullying.

Green Dot works on the premise that each individual holds the power to impact their community through small acts of intervention, social justice and awareness. Through Green Dot's training, participants learn easy methods that address the current barriers that stop a bystander from intervening during a violent act (Green Dot, 2010).

Bystander intervention has been recommended by two leading scientific organizations. The World Health Organization has included bystander intervention in its suite of programs for reducing violence against children (WHO, 2016). Recently the National Academy of Sciences (2016) endorsed bystander intervention programs such as Green Dot to reduce bullying rates throughout the United States. Green Dot Anchorage agrees that bystander intervention is an effective strategy for addressing bullying behaviors (J. Dale, personal communication, August 3, 2016).

Focusing on the main goal of improvements in the behavioral health status of the target population of 18-24 year olds, Green Dot programming would be implemented within

Anchorage's restaurant industry or other environments with concentrations of the target population, with the goal to reduce workplace bullying.

Green Dot curriculum centers on engaging community leadership to achieve the most social influence. By teaching bystanders how to overcome the main barriers that prevent them from intervening in a potential violent or negative situation, Green Dot allows situations to disperse in a positive, safe manner.

Literature Support

Green Dot uses social diffusion theory to start a social movement, empowering individuals within communities to actively take a role in helping fellow neighbors (Green Dot, 2010). Green Dot acknowledges found barriers to bystander intervention, including diffusion of responsibility, the evaluation apprehension, pluralist ignorance (Latane & Darley, 1970), and confidence in skills and modeling (Bryan & Test, 1967). By teaching methods to easily overcome these barriers, Green Dot empowers individuals to intervene in possibly violent or negative situations. The National Academy of Sciences (2016) states, "some research points to an opportunity to better engage bystanders, who have the best opportunity to intervene and minimize the effects of bullying" (National Academy of Sciences, 2016, p. 5-6).

The Green Dot program works to engage bystanders, which has been applied to bullying particularly in youth. The curriculum in Green Dot offers strategies that are easy to apply to any situation in which the bystander can actively diffuse or prevent a violent interaction. In many situations, bystander intervention, particularly by peers, is shown to reduce the occurrence of bullying or interpersonal violence. Denny et al (2014) found that in New Zealand high schools, peer intervention (in comparison to teachers or other administrators) most drastically impacted bullying rates.

Some research has directly tested the applicability and performance of Green Dot within the target population of 18-24 years old. Coker et al (2011, 2015) trained a portion of college students aged 18-26 in Green Dot practices and found compared to a control group with no bystander intervention training, Green Dot trainees engaged in "significantly more bystanders behaviors and observing more self-reported active bystander behavior scores of students".

Although Green Dot is still expanding without much formal evaluation, its application to prevent interpersonal violence of all forms is gradually becoming widely accepted. In Alaska, Green Dot has been used in Nome and other rural communities to combat interpersonal violence caused by alcohol abuses. In Anchorage, Mayor Berkowitz trained municipal employees in Green Dot practices to help lower crime rates (Slater, 2015). Outside of city employees, Green Dot training has never been applied to a formal industry.

Based on its potential to reduce bullying, Strategy 5 will initially be applying Green Dot practices within the restaurant sector, with the final goal of possible application within the tourism industry as a whole. A study by Mathisen, Einarsen and Mykletun (2008) of the Scandinavian restaurant industry examined the prevalence of bullying and its impacts. They found "bullying prevails in the restaurant industry" with negative association to "job satisfaction, commitment, employees' perceptions of creative behavior, and external evaluations of restaurant creativity level, and positively related to burnout and intention to leave the job" (Mathisen, Einarsen and Mykletun, 2008, p. 59). As Anchorage and Alaska's restaurant industries employ many employees in the 18-24 year old age range, Strategy 5 plans to use a series of Anchorage based restaurants to target this population and reduce bullying. In turn this reduction or awareness of methods to target interpersonal violence will result in improvements in the behavioral health status of the target population.

Objectives

The main objective of the Green Dot program is to decrease the number of young adults (18-24 years old) who report experiencing at least one kind of bullying or harassment.

Activities

A. Convene Alaska Green Dot staff and leading stakeholders to modify Green Dot to address bullying prevention and racial equity in 18 to 24 year old food service workers.

B. To secure the agreement of the restaurant industry or a similar sector and Anchorage residents interested in racial justice in which 18-24 year olds are concentrated.

C. Provide Green Dot bystander intervention training to selected target groups.

D. Evaluate the effectiveness of the training in changing knowledge. Attitudes and beliefs about the value and effectiveness of bystander intervention in preventing incidents of bullying and racism.

E. Identify areas of additional support and expansion of the initiative, possibly to additional groups.

Resources

Currently, the Anchorage Collaborative Coalitions are working to use financial resources from the State of Alaska focused on improvements in the behavioral health status of 18-24 year olds and reduce the impact of racial inequity. With the support of the Anchorage Injury Prevention Coalition and the First Alaskans Institute, evaluators hope to find Green Dot programming acts as an already developed tool to enhance our community's workplace environments. As well, because of the interface between restaurant employees and the community at large, any reduction in bullying or harassment within that industry should spread. Other resources include partnerships

with the Anchorage Collaborative Coalitions, Snow City Café and participating restaurants, Alaska Pacific University students and faculty and Green Dot of Alaska.

- Green Dot Anchorage
- First Alaskans Institute
- Restaurant industry leaders
- Restaurant industry employees
- Evaluators (including APU students and faculty)
- Business Associations

Timeline

Key Activities	***Who is Responsible***	***End Date***
Convene Alaska Green Dot staff and leading stakeholders, and focus group. Summarize findings in report.	AIPC / Brian Saylor	August 25, 2016
Adapt Green Dot training curriculum for bullying and racial equity.	AIPC / Brian Saylor	September 1, 2016
Train restaurant and food service employees	AIPC / Brian Saylor	October 1, 2016
Complete preliminary evaluation of short-term outcomes associated with the training program	AIPC / Brian Saylor	November 1, 2016
Expand training opportunities to additional groups.	ACC Executive Committee	December 1, 2016
Offer trainings to additional groups.	AIPC / Brian Saylor	Ongoing 2017

Resources

Currently, the Anchorage Collaborative Coalitions are working to use financial resources from the State of Alaska focused on improvements in the behavioral health status of 18-24 year olds and reduce the impact of racial inequity. With the support of the Anchorage Injury Prevention Coalition and the First Alaskans Institute, evaluators hope to find Green Dot programming acts as an already developed tool to enhance our community's workplace environments. As well, because of the interface between restaurant employees and the community at large, any reduction in bullying or harassment within that industry should spread. Other resources include partnerships with the Anchorage Collaborative Coalitions, Snow City Café and participating restaurants, Alaska Pacific University students and faculty and Green Dot of Alaska.

- Green Dot Anchorage
- First Alaskans Institute
- Restaurant industry leaders
- Restaurant industry employees
- Evaluators (including APU students and faculty)
- Business Associations

Strategy 6: Community Awareness and Outreach Campaign for Young Adults

Description

ACC will launch a community wide awareness campaign used to increase the community's knowledge of adult bullying and the consequences related to the issue of adult bullying.

Bullying is a serious issue for 18-24 year olds and emerged as the intermediate variable that had a very strong correlation with mental health; a stronger correlation, in total, than any other that was examined. According to the ACC's new data, bullying emerged as a crucial issue to mental health in this age group. The following findings clearly demonstrated the prevalence of bullying among young adults 18-24 years old in Anchorage and its connection to mental health (Heath, et al., 2015, p. 78).

- In the YAS, which gathered data from young adults aged 18-24, 29.4% of respondents reported they had been verbally bullied in the past year, and 17.1% reported they had been cyber bullied in the past year (Heath et al., 2015). Overall, more than a third (36.2%) reported experiencing at least one kind of bullying or harassment (verbal, physical, or cyber) during the past year. Notably, many respondents volunteered additional information and described bullying experiences "in elementary school" or "10 years ago" (Heath, et al., 2015; Brank, Hoetger, & Hazen, 2012).
- Results from the YAS indicate that being bullied or harassed is associated with reduced mental health. When placed in a model with other factors, bullying was found to have a greater relationship to mental health than social support, feeling like one matters to the community, race, sexual orientation, and other factors (Heath et al., 2015). Its negative effect is equal to the positive effect of optimism.
- Bullying can have several long-term health consequences for victims, perpetrators, and bystanders (Brank, Hoetger, & Hazen, 2012; Haynie, et al., 2001; Hinduja & Patchin, 2010). Documented effects on perpetrators of bullying include alcohol and drug abuse as adults, getting into fights, vandalism, dropping out of school, early sexual activity, criminal convictions, traffic citations, and abusive behavior toward partners as adults (Vanderbilt & Augustyn, 2010). In one large-scale study, data from the 2007 National Survey of Children's Health were reviewed and children aged 6-17 with a diagnosis of depression, anxiety, or ADHD were found to be more than three times as likely to engage in bullying behavior (Benedict, Vivier, & Gjelsvik, 2015). The study examined a total of 63,997 children who had data for both parental reported mental health and bullying status nationwide and found that the diagnosis of a mental health disorder is strongly associated with being identified as a bully (Heath, et al., 2015).

Additionally, this strategy correlates with the following indicators in the State of Alaska Healthy Alaska 2020 Priorities: #7 Reduce Alaskan deaths from suicide and #15 Reduce the number of Alaskans experiencing alcohol dependence and abuse (Read & Dickey, 2015).

According to the community readiness assessment conducted by the ACC in January of 2016 the overall level of readiness in the Anchorage community regarding bullying for adults ages 18-24 year old population is currently moderate. There are some slight differences in readiness between dimensions with prevention programming coming in at the highest level of readiness: 6=initiation and community climate and knowledge about the problem falling to the bottom with a score of 4=preplanning.

This awareness campaign strategy is intended to increase the community readiness score for the dimension of the community climate score of 4 (preplanning) as well as the dimension of knowledge about the problem 4 (preplanning).

Objectives

There will be an increase from baseline in the percent of community members who understand the dynamics of adult bullying after completion of awareness campaign. (Community Readiness scores)

Resources

Human Resources

The ACC will form an Awareness Campaign workgroup chaired by an ACC member, facilitated by staff and that will include media/communications specialist (some contracted), local representatives from media sector of the AIPC/AYDC, SOY and HVHC coalitions, young adults (18-24) and other community members. Bullying experts from outside organizations will be asked to assist in the development of the campaign message and plan.

Financial Resources

Grant funds from FY16 – FY18 will be utilized along with in-kind/cash match value from coalition members associated with Media Sector.

Activities

A. Develop Message – Based on what is learned during meetings the campaign group will develop and messages and methods of delivery. Messages developed will be based on the data from the needs assessment as well as additional formative information gathered.
B. Determine Methods – Methods to be considered include social media platforms, promotional materials, a series of newspaper articles and presences at various community events throughout the Anchorage bowl. Methods will be determined by each messages' focused population and marketing research.
C. Develop Detailed Plan – Based on the messages and delivery method selected, the workgroup will write a plan to be approved by the ACC executive committee. This plan will include details of who, what where and how the campaign will be conducted along with the overall cost associated with the plan.
D. Implement Plan – The approved plan will be carried out by the workgroup, contractors, and coalition members that make up the ACC (HVHC, SOY, AIPC/AYDC).

The plan will be reviewed and modified annually to ensure goals associated with this strategy are being met.

Timeline

Key Activities	***Who is Responsible***	***End Date***
Recruit workgroup members	HVHC	September 1, 2016
Develop specific messages and campaign strategy	Workgroup	October 15, 2016
Determine methods of dissemination (newspaper, PSA, social media, outreach events, etc.)	Workgroup/contractor(s)	December 1, 2016
Develop detailed plan to be approved by the ACC (include details of who, what, where, and how the campaign will be conducted)	Workgroup/contractor(s)	February 1, 2017
Launch awareness campaign	Workgroup	March 1, 2017

VII. Infrastructure Needs

ACC recognizes that implementing the six identified strategies requires maintaining current infrastructure components, augmenting some of these components, and identifying new elements necessary for fulfilling the goals and objectives identified through the community strategic planning process. While many of these needs are repeated in the short strategy summaries above, below is a brief iteration of these needs.

Building internal coalition evaluation capacity. Coalition members played a crucial role in the assessment process. Many received IRB certification and evaluation training, which prepared them to assist with focus groups and other original data gathering efforts. This will continue to be an essential part of our ongoing participatory evaluation efforts and will contribute to long-term sustainability of efforts.

Ensuring continuation of current data collection efforts. Currently the Anchorage School District (ASD) collects YRBS data and coalition partners collect other information research such as the Adult Perceptions of Anchorage Youth (APAY) survey. These need to be maintained and, when evaluation requires it, similar survey processes need to be developed for years where these measures are not available.

Developing new data sources where data is missing. Not all areas covered in our strategies have consistent data sources. Where identified in our planning process, new data sources need to be developed and collection needs to be institutionalized.

Developing sustainable, evidence-based approaches for awareness and policy efforts. ACC recognizes that long-term, effective efforts at developing and sustaining community awareness of bullying and consistent and effective policies to address bullying behaviors are essential to our long-term effort of reducing bullying and improving mental health in our community. Consequently, sustainable, evidence-based approaches to awareness and school and work place policies are essential to our efforts.

Developing and updating model policies and guides for best practices for addressing bullying behaviors. Not only is it important to develop the approaches, we need to develop guides that can be used by others and that have a protocol for updating that keeps them relevant. This could become a vibrant community resource in the long-term.

Developing an anti-bullying champion award program for those who have created a model bully-free workplace or school environment. This program effort is loosely an infrastructure need, as it will require a long-term commitment to sustain it when these funding efforts end. However, this should be an output of this process.

Continued support and buy-in from youth serving organizations and other community partners. While all three coalitions that comprise ACC have a broad reach into the youth-serving community, inclusion of new and existing organizations must continue on a sustainable level. Partnerships are essential to many of these strategies and so efforts to institutionalize partnership relationships should be developed and maintained.

Continued support for youth-reaching efforts that help build resiliency, life skills and assets. Efforts like HVHC's Emerging Youth Leadership Academy, AYDC's Start The Conversation, and Spirit of Youth's Que Pasa page are essential components of our information delivery system for youth. These need to be sustained and expanded with informed, evidence based approaches that help build youth resiliency, and create the conditions in which youth and young adults are comfortable reporting bullying behaviors.

Continued development of youth-serving organizations' employers and institutions of higher learning capacities to provide skills to address, and knowledge of bullying. It has been and will continue to be a priority to develop the skills and knowledge of coalition member organizations and other youth serving entities to know and be prepared to address bullying behaviors as well as growing protective factors within the adults as well as youth. Several strategies address the need to continuously develop this capacity. This is a critical component to sustainability for efforts as well.

VIII. Cultural Responsiveness

The Anchorage Collaborative Coalitions (ACC) contracted the Young Women's Christian Association (YWCA) to provide consultative services, reviewing the cultural responsiveness of our processes of data collection and community planning for the Anchorage community. The YWCA has extensive expertise and knowledge regarding the diversity of cultures within our community and the considerations such diversity requires. The YWCA participated throughout the assessment and planning phases to ensure the ACC's assessment and planning processes were carried out according to the State of Alaska SPF fidelity checklist.

Examples of the services the YWCA provided:

- Attended Anchorage Collaborative Coalitions (ACC) Planning Meetings, Implementation Meetings, and Evaluation Meetings, including the Planning, Implementation, and Evaluation workgroup meetings, and other meetings as requested.
- Provided an updated intercultural sensitivity checklist for use by the teams during planning and implementation.
- Participated in the review of proposed planning and implementation work to identify potential cultural competency gaps.
- Provided written feedback and recommendations on cultural responsiveness of ACC strategies, materials, and actions.
- Participated and continues to participate in an ongoing dialogue regarding YWCA Alaska recommendations for cultural responsiveness of ACC strategies, actions, and materials.
- Incorporated YWCA Alaska cultural responsiveness recommendations into ACC strategies, actions, and materials as appropriate.

As a result of the work conducted by the YWCA, the ACC has been able to include input from a variety of community groups and individuals. In our surveys, focus groups and planning meetings the executive team of the ACC made sure that we meaningfully included various ethnicities, genders, age groups as well as those individuals who are at greater risk of being bullied i.e. LGBTQ, religious groups, and individuals with disabilities in our processes. By including members from the various populations we have been able to ensure support and involvement from our community members and as the ACC moves forward in implementing strategies and activities that will increase mental wellness among youth and young adults in our community we are ensuring buy in and ownership from these various stakeholders and partners in our community.

IX. Evaluation

Evaluation is necessary to determine if the strategies employed by ACC are effective at accomplishing their stated objectives and goals. ACC identified the importance of effective evaluation early in its planning process and understood that an evaluation team should be established to observe the actual strategic planning process and to inform the ACC Executive Team on possible directions in strategy level evaluation. An initial core team was identified from members of the Assessment Committee (which oversaw the initial assessment phase of the plan). This team was augmented with members drawn from each coalition and members of target age groups. All participants in the Evaluation Team either participated in, or observed, the strategic planning process. This team includes Marcia Howell (AIPC/AYDC), Karen Zeman (SOY), Lindsey Hajduk (AYDC), Marney Rivera (UAA), Logan Daniels (HVHC), Joy Clark (VOA), Sylvia Craig (AYDC/AIPC), Will Hurr (BGC), and Val Clark (YWCA). The group was staffed by backbone managers, Tom Begich and Sarah Sledge.

Following completion of strategy level logic models, the Evaluation Team met to set parameters for how each strategy group would develop its evaluation measures. Overall the Evaluation Team first identified a need for a professional evaluator to guide the participatory evaluation process. It was determined that this evaluator would have the following overall responsibilities:

- Meet with each strategy core group (which includes coalition and affected group members) on a regular basis to ensure that they are conducting their appropriate measures and are engaged in defining measurement processes
- Work with each strategy core group to identify both individual strategies and some collective measures for short, mid and long term outcomes
- Identify components for an MIS system to report on measures at both the strategy and community level
- Understanding that strategy core groups would establish certain measures that they would be responsible for collecting information on, the evaluator will be responsible for ensuring that information is being collected and presented in a timely and accurate manner.
- Identify broader community tools that could be used to measure effectiveness of the overall strategies.

No timeline was established for hiring this position, though this will likely occur in September/October, 2016.

The ACC planning process identified six strategies to address the intervening variables and contributing factors identified by the Anchorage Youth & Young Adults Community Behavioral Health Assessment. These strategies include infrastructure development and capacity building, awareness campaigns, policy changes, expanding existing programs to

include bullying prevention resources, and bystander intervention. Awareness campaigns were further divided into the two target age groups – 9th grade and 18 – 24 year old persons. It is anticipated that the core planning teams for each strategic area – those persons that developed the plans – would become the leads for broader teams for each strategy area. These teams would be comprised of persons who are diverse, represent the constituent coalitions, and include target populations. Each team would have responsibility for developing tools for measuring change and effectiveness beyond those already available at the community level. Some ideas to help guide each strategy area are presented below.

Infrastructure Development and Capacity Building

This strategy focuses on a need to strengthen the infrastructure and capacity of both the Anchorage Collaborative Coalitions and businesses and youth-serving organizations in the community at large to address bullying, its contributing factors, and its consequences. In some measure this is tied in to the activities of each strategy, but this strategy specifically addresses three areas: 1) Increasing the number of youth who think they matter in their community; 2) ensuring local businesses and postsecondary educational institutions adopt policies on bullying recommended by ACC; and 3) increasing the number of youth-serving organizations using best practices that promote skills, strengths, and resources needed to promote health and wellness and protective factors.

While measuring an increase in the percentage of youth who feel they matter can be done through the YRBS and School Climate and Connectedness Survey, additional tracking methods will have to be developed to measure the other factors. These could answer questions such as:

- Do local businesses employ policies that address bullying?
- Do local businesses and youth-serving organizations understand youth and adult bullying and recommended policies?
- Do youth serving organizations provide skills training that promote health and wellness?

The strategy level teams will all be asked to be aware of the infrastructure and capacity strategy progress as this either directly or indirectly will have an impact on each strategy area and certainly on broader measures of community readiness. This strategy will also involve the development and evaluation of appropriate training for businesses and youth serving organizations.

Awareness and Social Norms Campaigns

Middle and High School Campaign

There are broader questions to be addressed through community level measures that might be found in documents such as the YRBS (or YRBS questions asked through a non-YRBS process), Adult Perceptions of Anchorage Youth survey of adults and young adults in the community (APAY), and the School Climate and Connectedness survey, as well as use of social media such as SOY's Que Pasa page. These questions might include:

- Does the community know what bullying is?
- Does the community know the consequences of bullying?
- Does the community believe it can make change in bullying behavior?

Such measures would be able to start from baseline data through these same surveys conducted over these past two years.

Middle and High School and Young Adult Campaign
Other questions might be established by the strategy area teams for both awareness campaigns such as:

- Are community members advocating for bullying prevention?
- How have we, or how might we, reduce the stigma of reporting bullying?
- How do we measure the perception of the importance of reporting bullying?
- Do observers or direct victims recognize the benefits of reporting?

Additional measures could also be part of phone or other surveys to target populations that test levels of knowledge regarding bullying.

The strategy level teams will be asked to identify other elements related to the focus of an awareness campaign that they may want to measure and which they can participate in measuring. These two teams will likely work closely together to ensure that, where possible, measurements are similar and consistent, and collection of data is non duplicative.

Policy Education and Advocacy

18-24 Year Old Policy Education and Advocacy

The evaluation process for this strategy area will be mainly focused on outputs as this is essentially a research and training strategy.

Some potential measures to consider here are:

- Number of evidence based or working policies identified.
- Effectiveness of existing policies (what exists, are they working?)
- Strategy area teams reviewing all policies – recently identified and new proposals – to determine whether or not policies are relevant to target group (remember, target group are part of the team as are those effected such as businesses, legal community, etc…).
- Strategy area teams designing criteria for a policy recommendation process (should there be multiple identified policies)

Other questions to consider for measuring outputs would include:

- Were trainings developed?
- How many trainings did we hold?
- How many persons/businesses/post-secondary institutions/organizations participated?
- Did people learn from policies?
- Was there a voiced intention to adopt new policies by participants?
- Did they have an understanding of adult bullying behavior after training?

These questions could be developed and collected by the strategy level team and added into the MIS.

Middle School and High School Policy Recommendations and Advocacy

The school age policy strategy area (9th grade) is likely to be similar to the 18-24 year old process, but significantly shorter in its conduct as more information is readily available in this area. Similar questions would be addressed.

In addition to these questions, throughout the process broader questions on effective collaboration would also be measured within each strategic area. These would include questions such as:

- Who is working together?
- How effective is their collaboration?
- Do organizations understand what best practices are?

Expand Existing Programs

This strategy area represents efforts to improve communication between youth and parents/caregivers initially within the context of Start the Conversation, an AIPC/AYDC effort. It also involves an expansion of the Start the Conversation program both in reach and content (adding significant elements of bullying discussion to the content). Internally ACC will examine the reach and impact of Start the Conversation and its content.

Some actions and questions that will need to be addressed by this strategic area team include:

- A review of existing evaluation methodology for Start the Conversation and a determination to redesign evaluation measures to reflect content change
- Identification of bullying elements to be added to Start the Conversation
- Developing a process for how to expand the Start the Conversation
- Identifying elements of long term sustainability for Start the Conversation

Bystander Intervention

For this strategy area, the ACC will assess if implementing Green Dot results in fewer young adults reporting experiencing bullying or harassment. Indicators for evaluating outcomes will include an increase in the number of 18-24 year old restaurant workers who believe in the value and effectiveness of bystander intervention in preventing bullying, and a decrease in the number of young adults who report experiencing at least one kind of bullying or harassment. These outcomes will be measured using target group survey developed by the strategic area team as well as through re-administration of the Young Adult Survey used by the ACC in Fall 2015.

Community Level Change

Finally, throughout the process, ACC and its strategy level teams will work with the evaluator to develop more thorough community readiness processes that look at the populations of focus (18 – 24 year olds and school-age youth) in more depth, and seek a

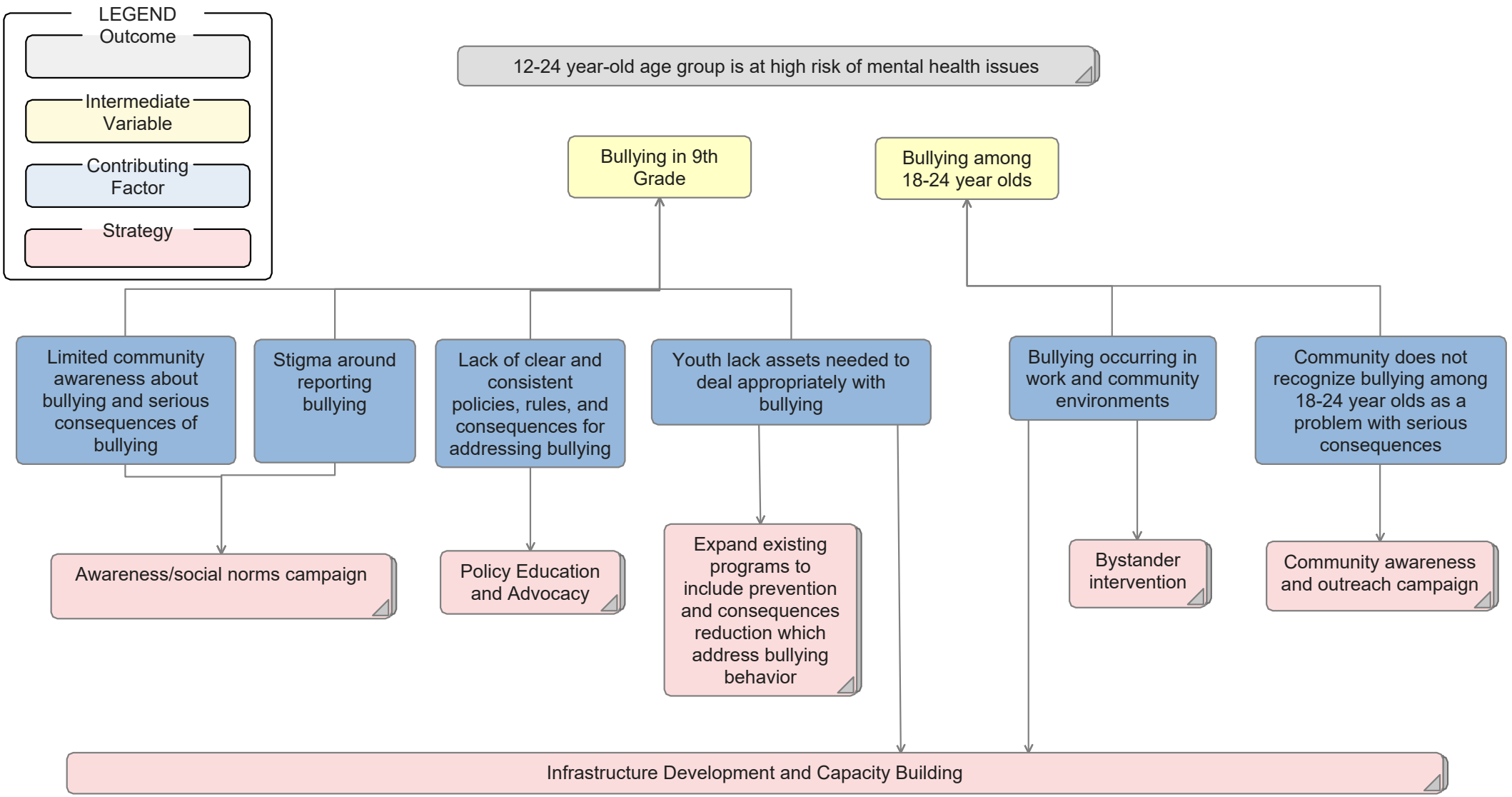
greater diversity of voices. This will not only include the continued application of community readiness surveys, but also likely will include focus groups, and area wide evaluation measures with existing survey tools (described above). Working with all five teams, the ACC Executive team, and the evaluator, ACC will also explore other measures that might be developed at a communitywide level to ensure that these identified

X. Management Information System

To ensure this plan is fully implemented, appropriately monitored by the coalition, and ultimately successful, the coalition will develop an Excel workbook to serve as our Management Information System (MIS). This workbook will contain a tab for each strategy activity, providing the appropriate action list of the what, who, when, and how details that will be continuously updated throughout the implementation of the plan. This workbook will be used to develop monthly progress charts to keep coalition members informed, and also for quarterly reports to the state.

Both the MIS and the progress charts will be maintained in and shared through Dropbox, which is already in use by the coalition. Project folders will be set up in Dropbox for each strategy and/or strategy activity and will contain final (for record-keeping) and working documents. All members of the workgroup or agency managing the strategy or strategy activity will have access to the applicable folders and be able to update working documents. Members will have the ability to electronically collaborate and each workgroup will also meet on a recurring basis in person. The details of how often each will meet will vary between workgroups depending on availability and workload. Attendance will be kept for all workgroup meetings and actions updated in the MIS either in real time or shortly after meeting.

XI. Logic Models



12-24 year-old age group is at high risk of mental health issues

ACC 2016 Community Assessment Indicators

- 26.5% youth reported feeling sad or helpless for two wks or more (2013 YRBS)

- 23.4% youth feeling alone in life (2013 YRBS)

- 18.8% of 18-24 year olds reporting depressive disorder (BRFSS 2013)

- 24% of young adults 18-25 in Anchorage who report having any mental illness in past year (2010-2012 NSDUH)

- 27% of ASD ninth grade students reported being bullied in school. (YRBS 2013)

- ASD students in grades 9-12 who are bullied at school are 201% more likely to feel so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities (YRBS 2003-2013)

- ASD students in grades 9-12 who are electronically bullied are 210% more likely to feel sad or hopeless (YRBS 2003-2013)

- ACC community readiness scores in community climate and knowledge about the problem of 4=preplanning (ninth grade)

- Seventy-five percent of adults surveyed reported they were not knowledgeable (36%) or only somewhat knowledgeable (39%) about bullying among Anchorage youth (APAY Survey 2015)

- Focus groups with middle and high school students identified lack of clarity and understanding of bullying, including its prevalence and meaning

- Community readiness interviews indicated that youth believe reporting bullying would cause them to be further bullied

- Focus groups and community readiness interviews identified need in Anchorage for clearer, more consistently followed policies for dealing with bullying behaviors in our schools and other institutions serving Anchorage middle-school and high-school youth

- ASD students in grades 9-12 who report their school has clear rules and consequences for their behavior are 29.1% less likely to have been bullied in school (YRBS 2003-2013)

- ASD students in grades 9-12 who report talking to their parents about school every day are 26.2% less likely to feel sad or hopeless (YRBS 2003-2013)

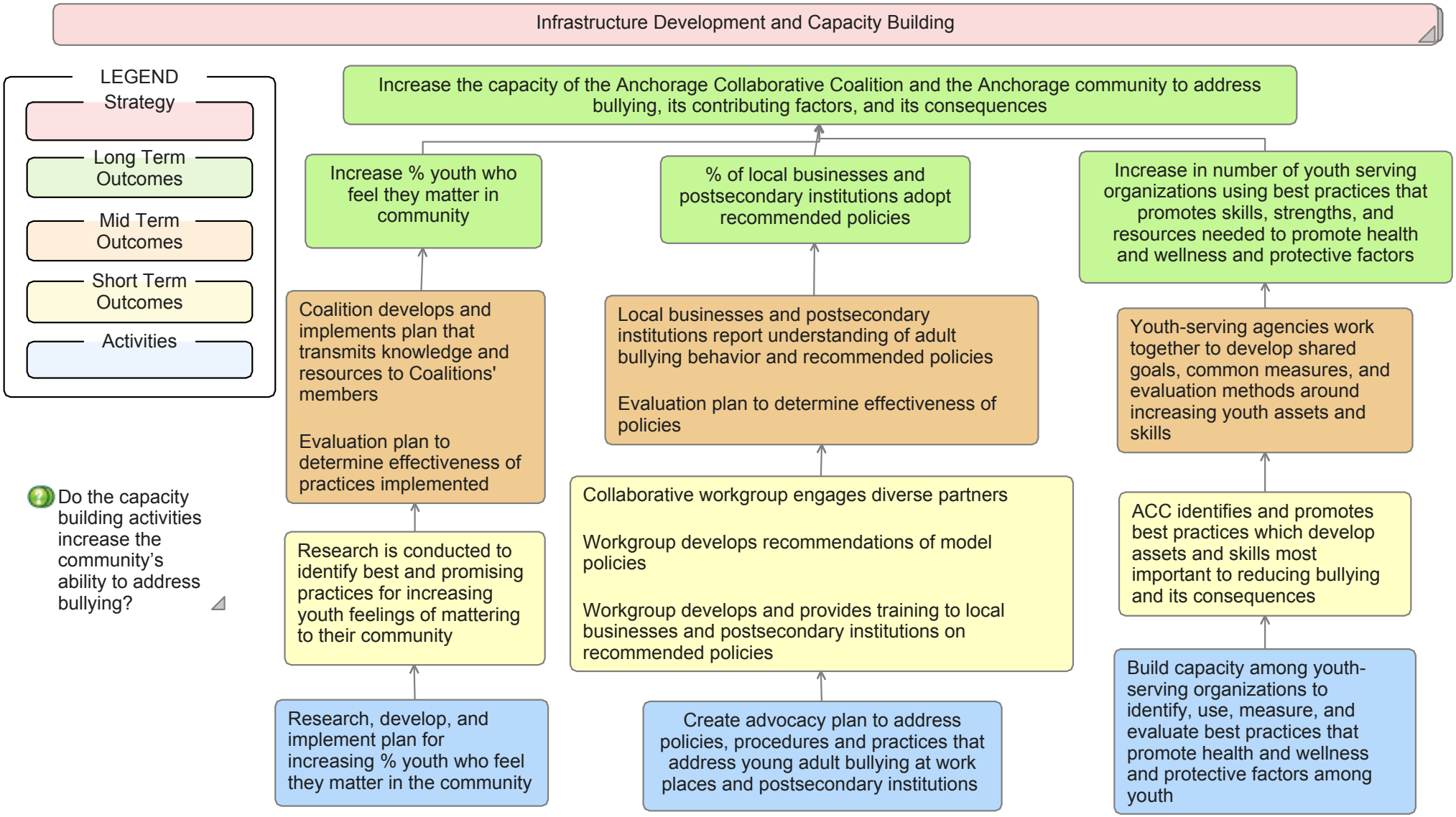
- ASD students in grades 9-12 who report having 1 or more adults they are comfortable seeking help from are 28.3% less likely to have been bullied in school and 37.9% less likely to have been electronically bullied (YRBS 2003-2013)

- ASD students in grades 9-12 who strongly agree/agree that they feel they matter to people in their community are 32.6% less likely to have been bullied in school (YRBS 2003-2013)

- 36.2% of young adults 18-24 surveyed reported experiencing at least one kind of bullying or harassment (verbal, physical, or cyber) during the past year (YAS 2015)

- Bullying was found to have a greater relationship to mental health among 18-24 year olds than social support, feeling like one matters to the community, race, sexual orientation, and other factors (YAS 2015)

- ACC community readiness scores in community climate and knowledge about the problem of 3=vague awareness (18-24 year olds)



doview.com model

ACC Community Level Logic Model/Infrastructure Development and Capacity Building [1.1]

Do the capacity building activities increase the community's ability to address bullying?

Indicators of progress toward outcomes

- Best and promising practices for increasing youth feelings of mattering to their community are identified through research
- Coalition develops a plan informed by research
- Coalition implements plan
- Number of work group meetings
- Number and quality of work group participants (diversity, across sectors)
- Documented recommendations for local policies
- Training to local businesses and postsecondary institutions on recommended policies is delivered

Tools for monitoring progress toward outcomes

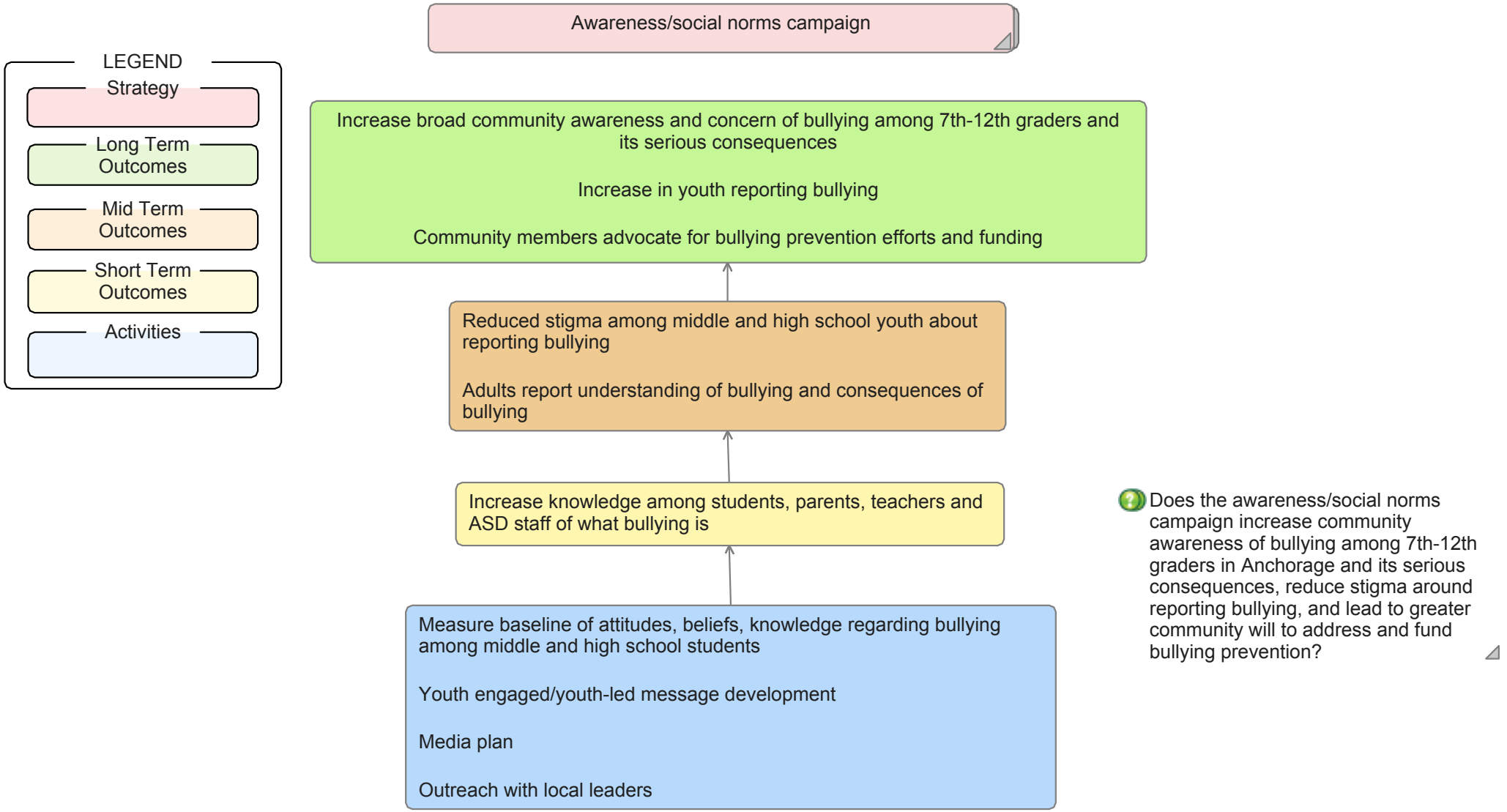
- Documentation of research; identification of best/promising practices
- Collection of data; track participation
- Completed plan
- Evaluation plan in place; indicators and evaluation methods are identified

Indicators for evaluating outcomes

- Local businesses and colleges report understanding of adult bullying behavior and recommended policies
- Number and percent of local businesses and postsecondary institutions that adopt recommended policies
- Youth-serving agencies developed shared goals, measures, and evaluation methods around increasing youth assets and skills
- Increase number of youth-serving organizations using programming that promotes skills, strengths, and resources needed to promote health and wellness and protective factors
- Increase % of youth who feel they matter in community

Tools for evaluating outcomes

- Post-training evaluation
- Collection of data; track participation
- Documentation of developed goals, measures, and evaluation methods
- Implement and track evaluation methods
- 2017 YRBS


LEGEND
Strategy
Long Term Outcomes
Mid Term Outcomes
Short Term Outcomes
Activities
Awareness/social norms campaign
Increase broad community awareness and concern of bullying among 7th-12th graders and its serious consequences
Increase in youth reporting bullying
Community members advocate for bullying prevention efforts and funding
Reduced stigma among middle and high school youth about reporting bullying
Adults report understanding of bullying and consequences of bullying
Increase knowledge among students, parents, teachers and ASD staff of what bullying is
Measure baseline of attitudes, beliefs, knowledge regarding bullying among middle and high school students
Youth engaged/youth-led message development
Media plan
Outreach with local leaders
Does the awareness/social norms campaign increase community awareness of bullying among 7th-12th graders in Anchorage and its serious consequences, reduce stigma around reporting bullying, and lead to greater community will to address and fund bullying prevention?
doview.com model

Does the awareness/social norms campaign increase community awareness of bullying among 7th-12th graders in Anchorage and its serious consequences, reduce stigma around reporting bullying, and lead to greater community will to address and fund bullying prevention?

Indicators of progress toward outcomes

- Number of awareness campaigns conducted
- Number of youth involved in development of campaigns
- Number of individuals who report seeing/hearing campaign messages
- Number of meetings with community leaders
- Number of events/town halls
- Results from assessments of events/town halls
- Increase in community resources to address bullying behavior

Tools for monitoring progress toward outcomes

- Collection of data
- Community perception survey
- Resource assessment
  Note: Building upon assessment conducted for needs assessment

Indicators for evaluating outcomes

- Number/percent of Anchorage residents who are able to correctly define bullying behavior
- Number/percent of Anchorage residents who are knowledgeable about community efforts for bullying prevention
- The "Community Climate" Community Readiness score increases from baseline of 4
- Number/percent of Anchorage residents who are knowledgeable about the issue of bullying
- Decrease from baseline in the number of middle and high school students who self-report that there is stigma around reporting bullying after completion of awareness campaign
- Increase number of youth reporting bullying

Tools for evaluating outcomes

- Focus groups
- Community Readiness Assessment
- Community perception survey
- ASD Disciplinary Reports
- AIPC Phone Survey

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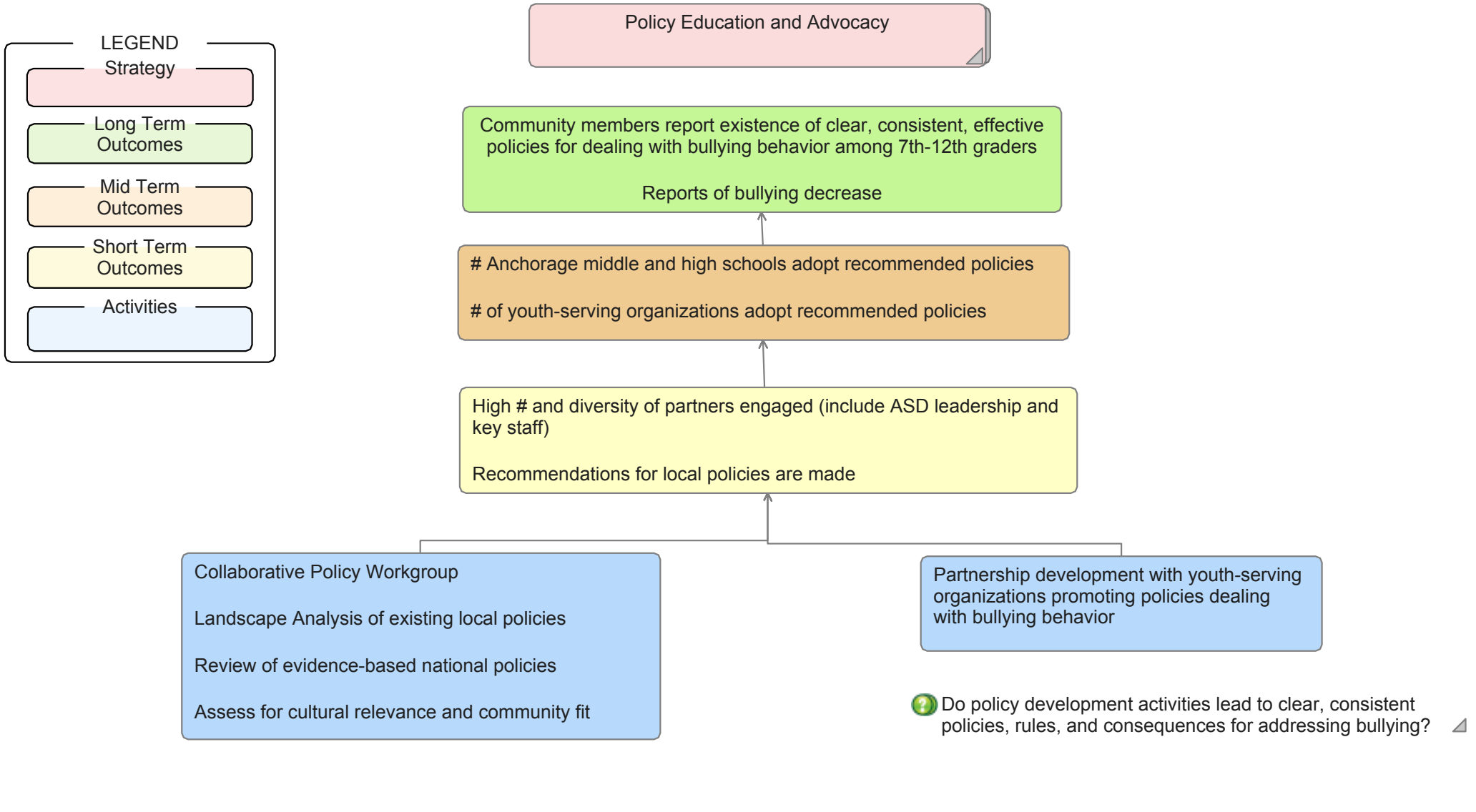
ACC Community Level Logic Model/Awareness/social norms campaign/Does the awareness/social norms campaign increase community awareness of bullying among 7th-12th graders in Anchorage and its serious consequences, reduce stigma around reporting bullying, and lead to greater community will to address and fund bullying prevention? [1.2.1]


LEGEND
Strategy
Long Term Outcomes
Mid Term Outcomes
Short Term Outcomes
Activities
Policy Education and Advocacy
Community members report existence of clear, consistent, effective policies for dealing with bullying behavior among 7th-12th graders
Reports of bullying decrease
Anchorage middle and high schools adopt recommended policies
of youth-serving organizations adopt recommended policies
High # and diversity of partners engaged (include ASD leadership and key staff)
Recommendations for local policies are made
Collaborative Policy Workgroup
Landscape Analysis of existing local policies
Review of evidence-based national policies
Assess for cultural relevance and community fit
Partnership development with youth-serving organizations promoting policies dealing with bullying behavior
Do policy development activities lead to clear, consistent policies, rules, and consequences for addressing bullying?
doview.com model

Do policy development activities lead to clear, consistent policies, rules, and consequences for addressing bullying?

Indicators of progress toward outcomes

- Number of work group meetings
- Number and quality of work group participants (diversity, across sectors, includes ASD leadership and staff)
- Documented recommendations for local policies
- Number of meetings/presentations with organizations and leaders

Tools for monitoring progress toward outcomes

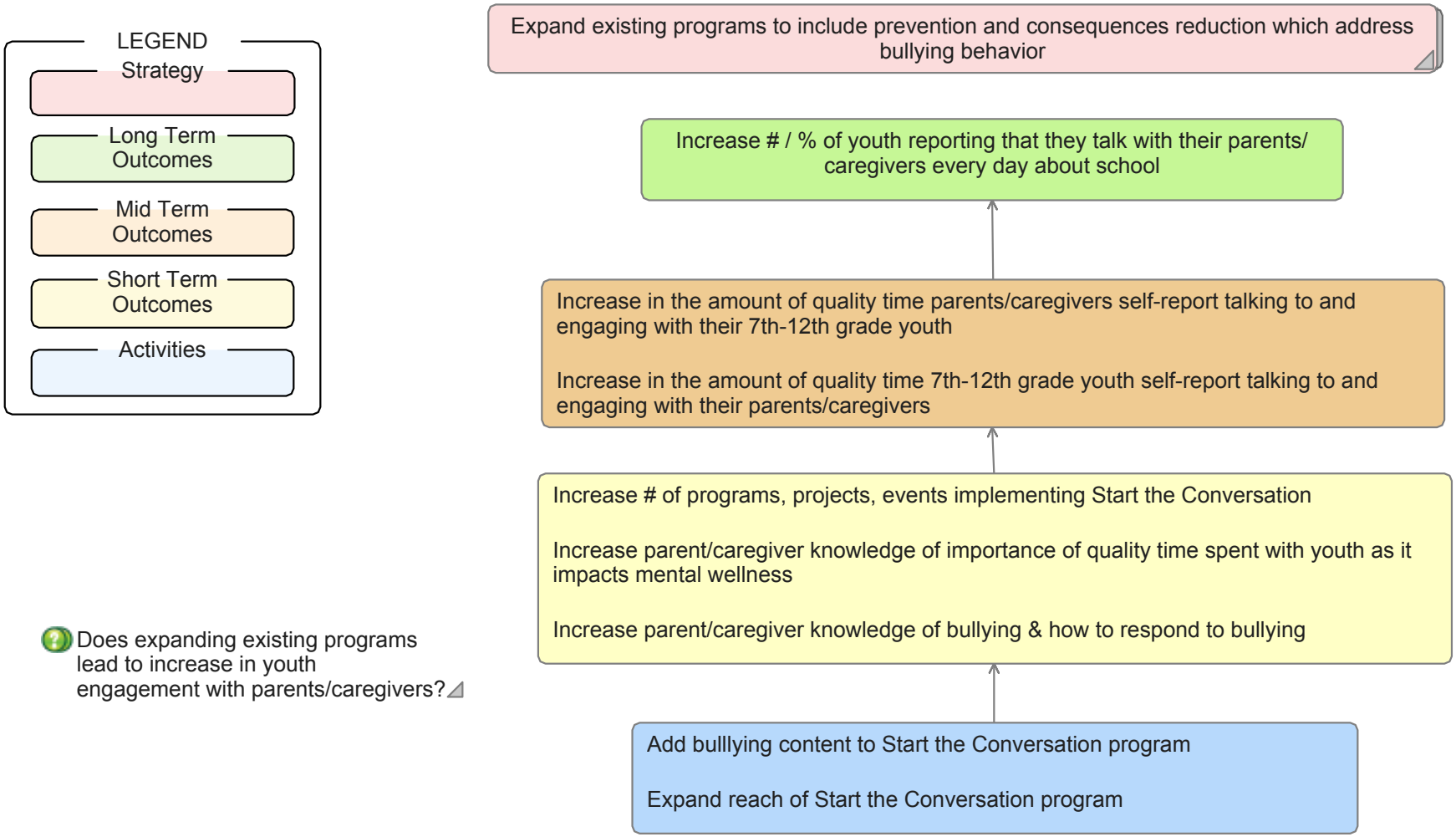
- Collection of data; track participation

Indicators for evaluating outcomes

- Number of schools adopting recommended policies
- Number of youth-serving organizations adopting recommended policies
- Community members report existence of clear, effective policies for dealing with bullying behavior among 7th-12th graders that are consistently enforced.
- Youth development agency staff and ASD employees report existence of clear, effective policies for dealing with bullying behavior among 7th-12th graders that are consistently enforced.
- Increase number of youth reporting bullying

Tools for evaluating outcomes

- Collection of data; track policy adoption
- Community Readiness Assessment
- Interviews, surveys or focus groups with youth development agency staff and ASD personnel.
- 2017 YRBS: ASD students in grades 9-12 who report their school has clear rules and consequences for their behavior;
- ASD Disciplinary Reports



Does expanding existing programs lead to increase in youth engagement with parents/ caregivers?

Indicators of progress toward outcomes

- Appropriate bulllying content is developed and added to toolkit
- Outreach and promotion occurs
- Implementers have knowledge necessary to successfully deliver Start the Conversation program
- Number of coalition members engaged in outreach and promotion
- Increase in number of existing programs, projects, events implementing Start the Conversation

Tools for monitoring progress toward outcomes

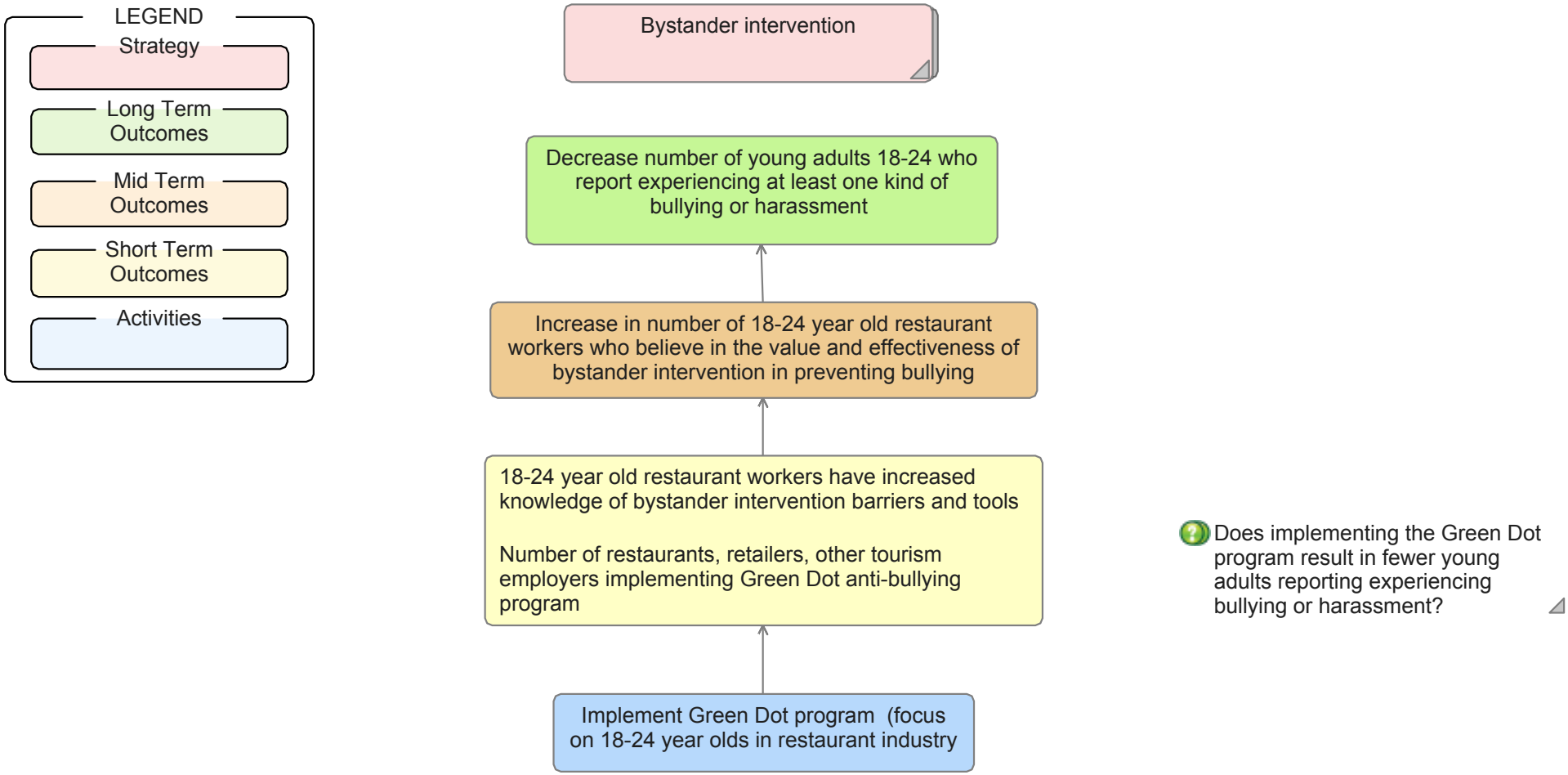
- Toolkit reflects new content
- Collection of data
- Training delivered; post-training evaluation

Indicators for evaluating outcomes

- Increase parent/caregiver knowledge of importance of quality time spent with youth as it impacts mental wellness
- Increase parent/caregiver knowledge of bulling and consequences of bullying
- Increase in the amount of quality time parents/caregivers self-report talking to and engaging with their 7th-12th grade youth
- Increase in the amount of quality time 7th-12th grade youth self-report talking to and engaging with their parents/caregivers
- Increase # / % of youth reporting that they talk with their parents/caregivers every day about school

Tools for evaluating outcomes

- Pre/post survey of parents/caregivers
- Pre/post survey of 7th-12th grade youth
- 2017 YRBS



Does implementing the Green Dot program result in fewer young adults reporting experiencing bullying or harassment?

Indicators of progress toward outcomes

- Baseline on nature and extent of bullying and racism among target group
- Implementation issues identified
- Green Dot program and training adapted for bullying and racial equity
- Number of trainings delivered; number of participants
- Trainees have increased knowledge about bystander intervention barriers and tools
- Number of meetings/presentations with restaurant, retailer, tourism industry employers/associations
- Number of restaurants, retailers, other tourism employers implementing Green Dot anti-bullying program

Tools for monitoring progress toward outcomes

- Stakeholder meeting; report
- Focus group of restaurant and food service workers
- Program and training materials updated
- Collect data and track participation
- Pre/post training assessments

Indicators for evaluating outcomes

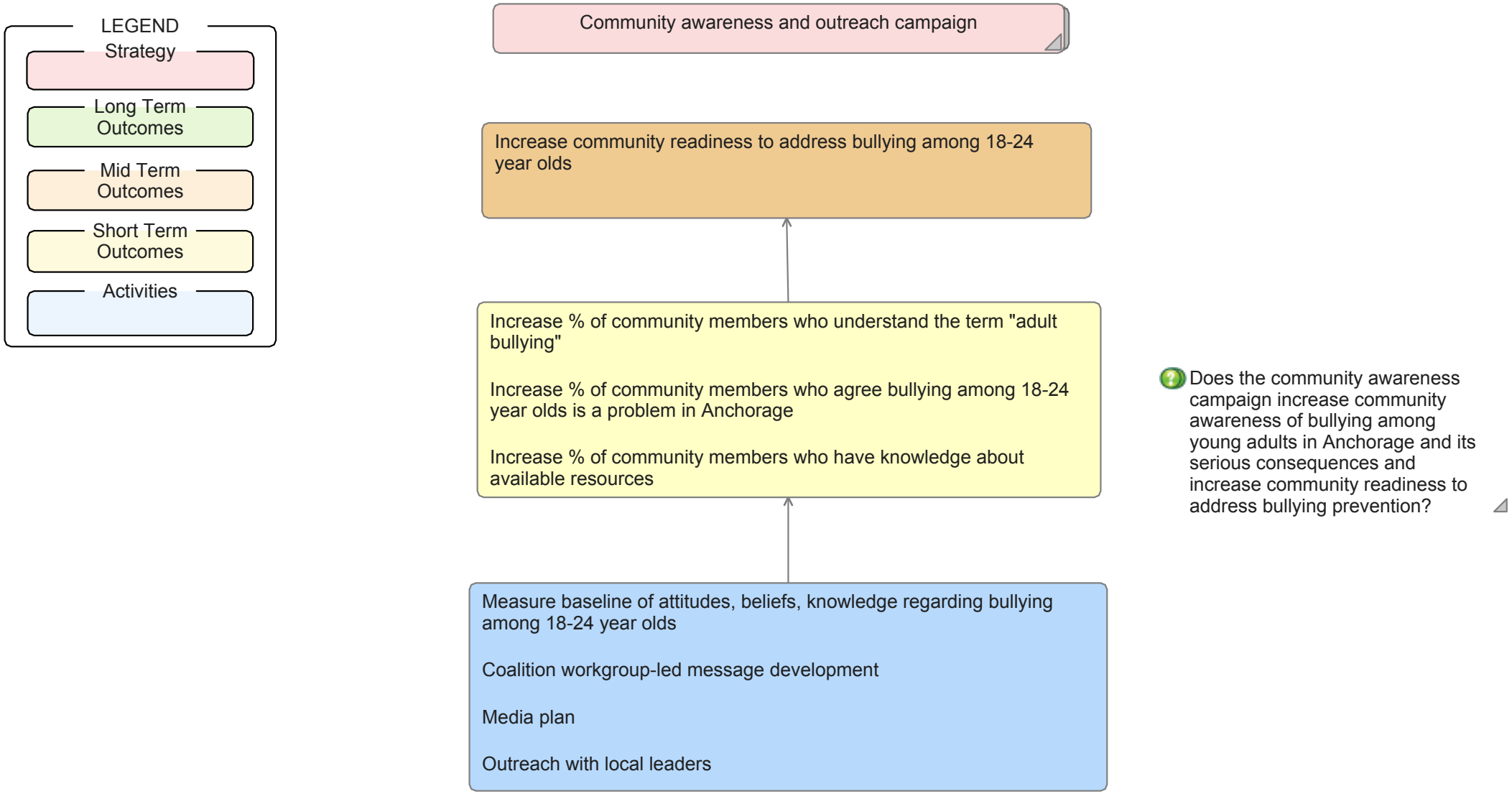
- Increase in number of 18-24 year old restaurant workers who believe in the value and effectiveness of bystander intervention in preventing bullying
- Decrease number of young adults 18-24 who report experiencing at least one kind of bullying or harassment

Tools for evaluating outcomes

- Target group survey
- Young Adult Survey

doview.com model

ACC Community Level Logic Model/Bystander intervention/Does implementing the Green Dot program result in fewer young adults reporting experiencing bullying or harassment? [1.7.1]



ACC Community Level Logic Model/Community awareness and outreach campaign [1.5]

Does the community awareness campaign increase community awareness of bullying among young adults in Anchorage and its serious consequences and increase community readiness to address bullying prevention?

Indicators of progress toward outcomes

- Baseline of attitudes, beliefs, knowledge regarding bullying among 18-24 year olds
- Number of awareness campaigns conducted
- Number of coalition members involved in development of campaigns
- Number of individuals who report seeing/hearing campaign messages
- Number of meetings with community leaders

Tools for monitoring progress toward outcomes

- Community Readiness Interviews
- Young Adult Survey (YAS) 2015
- Focus Groups
- Collection of data

Indicators for evaluating outcomes

- Increase % of community members who understand the term "adult bullying"
- Increase % of community members who agree bullying among 18-24 year olds is a problem in Anchorage
- Increase % of community members who have knowledge about available resources
- The "Community Climate" Community Readiness score increases from baseline of 3
- The "Knowledge about the Problem" Community Readiness score increases from baseline of 3

Tools for evaluating outcomes

- Community Readiness Assessment
- Community perception survey
- Resource assessment
  Note: Building upon assessment conducted for needs assessment

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Anchorage Prescription Opioid Misuse and Heroin Use Prevention Strategic Plan

Healthy Voices Healthy Choices & Alaska Injury Prevention Center

June 30, 2017

Healthy Voices Healthy Choices

Anchorage Prescription Opioid Misuse and Heroin Use Prevention Strategic Plan

Partnerships for Success Grant

June 30, 2017

Prepared for

Healthy Voices Healthy Choices Coalition

Volunteers of America
Charlie Daniels
Phone: 907-265-1912
Email: cdaniels@voaak.org
Website: www.voaak.org/healthy-voices-healthy-choices

Prepared by

Alaska Injury Prevention Center
Marcia Howell, Lindsey Hajduk and Sylvia Craig
Phone: 907-929-3939
Email: Marcia.Howell@alaska-ipc.org
Website: www.alaskainjurypreventioncenter.org

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Statement of Intent

The Healthy Voices Healthy Choices (HVHC) coalition within Volunteers of America Alaska brings together various stakeholders to promote healthy choices through public education, outreach, advocacy, and youth-led activities. The vision of HVHC is to educate and promote healthy lifestyle choices related to our community's youth and young adult's mental, physical, and emotional wellness.

In 2016, HVHC received the State of Alaska's Department of Health and Social Services, Division of Behavioral Health (DBH) Strategic Prevention Framework Partnerships for Success Grant (SPF PFS). This grant supports coalitions across the state of Alaska to prevent the non-medical use of prescription opioids (NMUPO) among 12-25 year olds and heroin use among 18-25 year olds. HVHC is focused on working within Anchorage. Grantees were asked to assess community factors related to social and retail availability, and perceived risk for harm of NMUPO and heroin use. Through the assessment process, the coalition identified an additional intervening variable of harm reduction. PFS grantees were also asked to assess the community's capacity and readiness to address NMUPO and heroin use.

The community needs assessment was approved May 8, 2017. Based on this community assessment, the HVHC coalition worked to identify evidence-based strategies to implement within Anchorage that would address community factors that will prevent the misuse of opioids and heroin use for the specific age group. These strategies, logic models, action steps, and evaluation plans are detailed within this document.

HVHC contracted with Alaska Injury Prevention Center (AIPC) to conduct the community needs assessment and this strategic plan.

Overview/Abstract

The Municipality of Anchorage, Alaska includes the communities of Anchorage, Chugiak, Eagle River, Joint Base-Elmendorf Richardson, Girdwood and communities along Turnagain Arm. The U.S. Census Bureau estimates the July 2016 population of Anchorage to be 299,816. Anchorage is the largest community in the state, with just over 40% of Alaska's population. Anchorage is home to more Alaska Native people than any other city in the United States (Hunsinger & Sandberg, 2013). In 2010, 26% of the state's Alaska Native population lived in Anchorage (Williams, 2010). Today, parts of Anchorage are more than 50% people of color. As reported in the Alaska Dispatch News, Anchorage's Mountain View census area was recently identified as the most racially diverse census tract in the entire United States (McCoy, 2013).

Rates of opioid overdose deaths have been in the rise in Alaska (State of Alaska Epidemiology, 2017). Within the state of Alaska, Anchorage experiences one of the highest rates of overdose mortality by region. To combat the issue, State of Alaska's Department of Health and Social Services, Division of Behavioral Health (DBH) issued several Strategic Prevention Framework Partnerships for Success Grants (SPF PFS) to communities in Alaska.

As part of the State of Alaska's DBH SPF PFS grant, HVHC assessed community factors related to social and retail availability of opioids, and perceived risk for harm of NMUPO and heroin use. Through the assessment process, the coalition identified an additional intervening variable of harm reduction. The coalition then explored community factors that contribute to social and retail availability, perceived risk for harm from NMUPO and heroin use, and harm reduction. As seen below, several of the factors address multiple intervening variables. HVHC selected the following community factors as elements of the opioid/heroin issue to address:

- Lack of Prescription Drug Monitoring (PDMP) participation
- Lack of understanding of alternatives to prescription painkillers for pain management
- Inadequate understanding of risks of prescription painkiller misuse
- Medications not stored properly
- Inadequate safe disposal of prescription painkillers
- Prescription opioids and heroin users in social circle
- Lack of coping skills
- Access to needle exchange resources

The coalition will implement four strategies to prevent NMUPO among 12-25 year olds and heroin use among 18-25 year olds that addresses the intervening variables. Each strategy addresses community factors that will impact the intervening variables. The four strategies selected are: Patient Education, Social Marketing Campaign, Healthy Relationships and Asset Development, Education for Users and Supporters.

Step 1: Community Needs Assessment

HVHC and AIPC worked in collaboration to complete the assessment in accordance with the guidance document provided by DBH. This assessment covered four areas of NMUPO and heroin use in compliance with DBH's recommendations. First, HVHC and AIPC assessed consumption and related consequences. Second, the coalition assessed intervening variables and community factors related to NMUPO and heroin use. These key intervening variables are: social availability of prescription opioids and heroin, retail availability of prescription opioids through providers, and perceptions of risk for harm. Third, the assessment looked at community resources and community readiness. Fourth and last, the coalition prioritized community factors related to NMUPO and heroin use.

1.1 Assessment Data on Priority Areas

A combination of primary and secondary data sources and tools were used to capture and analyze both quantitative and qualitative datasets. Because of the complexity of opioid misuse and heroin use, HVHC and AIPC jointly decided to gather primary data, both qualitative and quantitative.

Primary Data Collection

Because of the complexity of opioid misuse and heroin use, HVHC and AIPC jointly decided to gather primary data, both qualitative and quantitative. Qualitative data collection methods allow participants to provide in-depth explanations and rich narrative on a topic. Since NMUPO and heroin prevention are an emerging issue in the Anchorage community, HVHC and AIPC wanted to collect as much information as possible. Primary data collection included written closed and open-ended survey questions for current opioid and heroin users, interviews with key informants, PRIME for Life youth surveys, a telephone survey, community readiness interviews, and the Adult Perception of Anchorage Youth survey (APAY).

Giving community members the chance to speak freely on the issue provided HVHC and AIPC with a more comprehensive understanding of the issue. HVHC and AIPC conducted interviews and open-ended surveys with community members and current NMUPO and heroin users to gather more information about the consequences of NMUPO and heroin use in the community. A telephone survey, conducted by Hays Research Group, collected data from Anchorage residents around knowledge of the problem of NMUPO and heroin use, concern about the issues and levels of knowledge of efforts to address the problems. For more information about primary data source collection see Appendix A.

Secondary Data

To measure NMUPO and heroin consumption and its consequences, the assessment relied on data from existing sources. This included data from the Youth Risk Behavior Survey (YRBS), National Survey on Drug Use and Health (NSDUH), Alaska Trauma Registry (ATR), Volunteers of America Alaska, and the State of Alaska Department of Health and Social Services (DHSS) epidemiology bulletins. HVHC and AIPC also used data from the Alaska Young Adults Substance Use Survey (YASUS).

These data sources provided estimates of NMUPO use and heroin use in Anchorage, as well as information about overdose and fatality. For more information about secondary data source collection see Appendix A.

Data Highlights Regarding the Extent of Use in Anchorage

Prescription opioid misuse and heroin use are prevalent throughout the community. For more information about key findings from the community needs assessment regarding the extent of use of prescription opioid and heroin use, see Appendix B. Based on our key informant interviews with people

in recovery and our open-ended surveys from current users, roughly half of people reported being initially introduced to opioids recreationally and half for medical purposes. People also shared that if they were using prescription opioids they would often both use and sell them to others.

There were varying opinions of what constituted "misusing prescription opioids." Some thought it was when a person first begins to use them beyond medical recommendations, others believed it was when the opioids were not treating pain, and others believed it was as soon as a dependency is established.

Use Among Youth 12-17 Years Old

- Prescription opioid use among 12-17 year olds in Anchorage is higher than the statewide and national averages. According to the National Survey on Drug Use and Health (NSDUH), Anchorage rates were 7.2%, 6.41% statewide, and 5.85% nationally in 2010/2012.
- Information gathered from PRIME for Life participant surveys, it is important to note that prescription drugs are the third most-used substance after marijuana and alcohol.
    - Many of the youth participating in PRIME for Life self-reported that they began using prescription drugs at the average age of 14.
- Use of prescription drugs within lifetime:
    - Data from the 2015 YRBS indicate that 15.0% of Anchorage School District students had taken a prescription drug without a prescription from a doctor during their life. According to 2015 YRBS data, the rates for lifetime use by females (15.6%) was not substantially different compared to males (14.3%).
    - There was little difference in prevalence for lifetime use when comparing racial/ethnic groups. Alaska Native and students of "Other Races" each had approximately 16% lifetime use of prescription drugs without a prescription, and 13.7% of white students reported lifetime use.
    - Approximately 21.5% of students with primarily grades of C, D, or F reported lifetime use of a non-prescribed prescription drug compared to 12.4% of students with grades of primarily A or B. This data shows that there is little difference in lifetime use between males and females, or students of different racial/ethnic groups. There are, however, differences in lifetime use by grade year as well as by academic performance.
- Use of heroin over lifetime:
    - An estimated 1.6% of students reported ever having used heroin.
    - From the 2015 YRBS, heroin use among males was 2.6% and 0.6% among females.
    - Approximately 2.6% of students of "Other Races" reported use, compared to 1.1% among white students, and 0.8% Alaska Native students.
    - Highest use is among 11th grade at 3.1%, compared to 9th grade (0.8%), 10th grade (1.7%), and 12th grade (1.1%).
    - Approximately 2.9% of students with primarily grades of C, D, or F reported use, and 1.0% of students with primarily grades of A or B reported use.

Use Among Adults 18-25 Years Old:

- Young adults misuse of prescription opioids and heroin are trending upwards in Anchorage, where rates are already greater than Alaska's statewide and national averages. According to the National Survey on Drug Use and Health (NSDUH), there has been an increase in the nonmedical use of pain relievers among 18-25 year olds in Anchorage, from 11.79% to 12.35% from 2006/2008 to 2012/2012 (Heath, et al., 2015). Reported rates of use are greater in Anchorage than Alaska's statewide rate (11.78 in the 2010/2012 survey) and greater than the U.S. rate (10.29 in the 2010/2012 survey).

- The 2015 UAA Drug and Alcohol survey also shows prescription drug use on the rise on campus. Of the 4,000 students who responded to the survey, 6.6% reported using sedatives once a week and 4.2% reported using sedatives three or more times a week (Heath, et al., 2015). Law enforcement data show illegal use of pharmaceuticals is a growing concern, hydrocodone and OxyContin/oxycodone abuse, in particular.

Consequences of Opioid Misuse

Prescription opioid misuse and heroin use are prevalent throughout the community. Based on a combination of data and community interviews, consequences to individuals, families, and our community are far reaching and fall along similar lines for both prescription and heroin misuse. Consequences were varied, often serious, and included: addiction, overdose, poor health, losing family and friends, losing jobs, homelessness, loss of normal life, jail, and death. One challenge key informants shared were that a person might not know the full extent of the consequences until it is too close or happening.

Seventy-five percent of all heroin-associated death in Alaska from 2008-2013 occurred in Anchorage and the Matanuska Susitna regions. From 2007-2011, Anchorage had 257 unintentionally drug induced deaths, which was 49% of all such deaths in the State. This is a rate of 17.1 per 100,000 and was 25 percent higher than the national average of 12.9 per 100,000 (Hull-Jilly, Frasene, Gebru, & Boegli, 2015).

Poisoning was the leading cause of unintentional injury deaths for Alaska Natives/American Indians in the Anchorage Mat-Su area from 1992-2011 at 21, surpassing motor vehicle crash deaths, meaning that there were 20% more poisoning deaths than motor vehicle deaths during this time period (Strayer, Craig, Asay, Haakenson, & Provost, 2014).

Health Disparities

Analysis of the data found varying disparities based on data set and variables assessed. Youth Risk Behavior Survey data finds that rates of prescription drug use without a prescription are slightly less amongst white students than students of all other races. Rates of 30-day misuse, lifetime prescription drug misuse, and heroin use, were all higher amongst students with mostly C's, D's, and F's compared to students with mostly A's and B's.

A greater percentage of women (66%) were discharged from the emergency room in Anchorage for prescription opioid poisoning than men (34%) in 2015. Conversely, men comprised 80% of heroin emergency room poisoning discharges during the same period. Statewide data shows that overdose death rates are higher for males at than females at 20.9 and 12.3 per 100,000 respectively.

Data Gaps

Retail access to prescription opioids will soon be tracked more closely through the state's Prescription Drug Monitoring Program (PDMP). The Coalition will work to learn about the new system to better understand the data monitoring and tracking of prescription opioids, which may also include if or where higher numbers of prescriptions may enter the public. This system will be rich in data to inform prevention efforts once it is fully implemented and mandated for all prescribers.

Through the Anchorage community needs assessment process, HVHC has established baseline measurements for key indicators. Self-reported non-medical use of prescription opioids is collected bi-annually for youth 12-17 years old and young adults 18-25 years old. We will monitor these baselines for trends, including working with coalition partners to collect data necessary to fill data gaps.

Cultural Competence and Sustainability

Cultural competence is a foundation for the HVHC coalition's work and will be integrated into the strategies and implementation. HVHC has worked with representatives from different communities throughout the assessment and strategic planning processes, including the Alaska Native and Hispanic communities, faith community, and more. Stigma surrounds addiction in all communities and was a key component in crafting strategies. Stigma often inhibits people to ask questions or offer information around opioid use, to seek needed treatment, or to find help for family members or loved ones.

HVHC and Volunteers of America have a long history of addressing substance use, abuse prevention and treatment issues in Anchorage. The opportunity to work towards prevention of NMUPO and heroin use in Anchorage builds on and strengthens its existing capacity. Through its work on this project, HVHC will continue to expand its capacity by developing new relationships and partnerships with members of the medical profession, law enforcement and other stakeholders. Through expansion of the coalition's membership and reach, it will be in a strong position to seek new funding, and continuously work towards sustaining these initiatives.

1.2 Vision Statement Related to Priority Areas

Healthy Voices, Healthy Choices Vision Statement: A strengthened behavioral health prevention and treatment effort that leads to improved health and safety for our community.

HVHC is a community-based coalition geared to all segments of the Anchorage population, with special focus on middle and high school youth and their families and young adults. The Coalition brings together various stakeholders to promote healthy choices through public education, outreach, advocacy, and youth-led activities. The Coalition believes that we can maximize resources from a unified voice around public policy and action, which covers a broad array of behaviorally health prevention and treatment efforts that are focused and guided in an identified direction. Together, the Coalition is committed to assisting youth and young adults with the development or strengthening of positive life style choices, so they may reach their full potential.

In relation to this grant, the Coalition is working to prevent the misuse of prescription opioids among youth and young adults 12-25 years old. Our community needs assessment found that half of young adult heroin users first misused prescription opioids. By focusing on reducing the misuse of prescription opioids, we will also reduce heroin use among 18-25 year olds. Misuse is also known as non-medical use, which is using prescription opioids without a personal prescription or outside of the personally recommended instructions.

1.3 Assessing Intervening Variables and Community Factors Linked to Priority Areas

HVHC and AIPC partnered to collect data on intervening variables and community factors as they related to the priority area. All data sources and collection methods are discussed previously in this document.

The HVHC considered required variables impacting NMUPO and heroin use, including retail availability, social availability, and perception of risk. Through the community process another variable relating to harm reduction was also identified and considered in our prioritization process. AIPC and HVHC coordinated two prioritization meetings with members of the HVHC leadership team, as well as members of the HVHC coalition as a whole and general community members.

Based on the data and the Coalition's input, the following community factors were prioritized for each intervening variable.

Retail Availability

In Anchorage, there appears to be easy access to retail opioids. There is a relationship between those that misuse prescription opioids with those that begin using heroin. In Anchorage, half of people using heroin were introduced to opioids through legitimate prescriptions to treat pain and the other half started recreationally. There is currently no standard education or protocols, such as pain management plans, between patients and prescribers resulting in a lack of education to patients receiving opioid prescriptions regarding addiction risk, alternative pain management options, or tapering use.

The HVHC coalition has identified the following community factors as the main contributors of retail availability of prescription opioids misuse and heroin use:

- Alternative pain management not commonly discussed with patient
- Inadequate patient/parent education at time of initial prescription
- Lack of Prescription Drug Monitoring (PDMP) participation

Few Anchorage residents who were recently prescribed opioids were informed of alternatives to opioids. There are many alternatives to prescribing opioid medication, including massage therapy, physical therapy or eastern medicines, such as acupuncture. Non-steroidal anti-inflammatory drugs (NSAIDs) may also be used rather than prescription opioids. These NSAIDs are a class of drugs that provides analgesic and antipyretic effects, and in higher doses also provide anti-inflammatory effects. These may include Ibuprofen, aspirin, and more. Many community members agree they would like to see prescribers look at other alternatives before prescribing drugs at high-risk for addiction.

There is also no standard education or warning to give to patients regarding the risks of addiction. Instead, families often seek information or programs only after they are severely impacted by addiction and its consequences. Finally, very few prescribers or pharmacies have pain agreements with patients explicitly stating proper medication use.

Prescribers in Anchorage have begun to use the Alaska Prescription Drug Monitoring Program (AKPDMP), which will soon become mandatory. A mandatory system will allow all prescribers to monitor and ensure that over-prescribing will not occur and allow them to apply best practices as defined by the Center for Disease Control in prescribing and dispensing prescription opioids.

Social Availability

Prescription opioids and heroin are readily available through social means. Among those misusing prescription opioids and using heroin, many were able to obtain opioids through friends, family, or on the street. Safe storage, disposal, and promoting healthy social circles is necessary to reduce social access to opioids.

The HVHC coalition has identified the following community factors as the main contributors of social availability of prescription opioids misuse and heroin use:

- Secure storage
- Safe disposal
- Changes in social circle

In Anchorage, most people do not throw away unused prescription medication. Stockpiling of unused drugs “for another day” is a common practice. From a citywide survey, nearly half of all community members reported that they still have their unused prescription opioids. A quarter of respondents

reported that they did not have any medication remaining so did not have to dispose of them. That leaves over a quarter of respondents that disposed of them either by throwing them in the trash, flushing them down a toilet, bringing them to a "take back" (only 2%), and the remainder gave them away (8%). Parents of 12-24 year olds also were significantly less likely than other adults to take steps to reduce youth access to prescription drugs at home, like hiding pills, locking them up, or keeping pills with them.

Another frequently mentioned means for obtaining prescription opioids was through the street. Obtaining prescription drugs from the street was often mentioned as networking, or through word-of-mouth. A few respondents indicated faking scripts, but dealers, friends, and stealing from family and strangers were also common responses. For youth, common responses of obtaining prescription opioids were taking them from a family member or giving someone money for them.

Perception of Risk for Harm

In Anchorage, there is a high understanding that using heroin is a high-risk activity, but many people believe prescription opioids are less risky. Youth tend to believe prescription opioids have an even lesser risk than young adults, possibly because they trust doctors and do not see them as "illegal" drugs. Youth and young adults alike do not understand how susceptible they are to becoming dependent or addicted from prescription opioids. Active users largely did not know or fully understand the depth and impact of the consequences of opioid use.

The HVHC coalition has identified the following community factors as the main contributors impacting the perception of risk for harm of prescription opioids misuse and heroin use:

- Lack of understanding of what opioids do to the brain and body and how quickly dependence can occur
- Opioids are prescribed from a doctor and presumed to be safe. There is less stigma surrounding opioid use than other drugs such as heroin.
- Not understanding the vast consequences of using and misusing

Harm Reduction

The HVHC coalition identified harm reduction as an important intervening variable to address in Anchorage. Misperceptions and stigma around addiction result in misuse, leading to dependence and addiction. Social stigma causes individuals to not to seek help for themselves, and for others to not recognize the need for help in friends and family members. Stigma is an issue that impacts many community factors resulting in prescription opioid misuse and heroin use and will need to be addressed throughout all of the community strategies. The coalition identified a lack of coping skills among Anchorage residents as a barrier that allows people to become susceptible to opioid misuse.

The HVHC coalition has identified the following community factors as necessary to reduce the consequences of prescription opioids misuse and heroin use:

- Access to needle exchange
- De-stigmatize addiction
- Lack of coping skills

Once a person develops an opioid dependence, there are methods to reduce risks that will reduce the consequences of use. Community members identified needs to increase availability of Naloxone (known as Narcan), access to syringe exchanges, more medical detox beds, and medically assisted treatment. Public education and readiness around these areas varies, but are worthwhile for future pursuit.

1.4 Technical Assistance Needs Related to Assessment

Alaska's Prescription Drug Monitoring Program (PDMP) is a new system currently being rolled out across the state. New legislation, regulations, funding, and implementation are all impacting the system, making it challenging for the Coalition to closely and effectively monitor the program. Support from the state to monitor use and access to data collected by the PDMP program is requested.

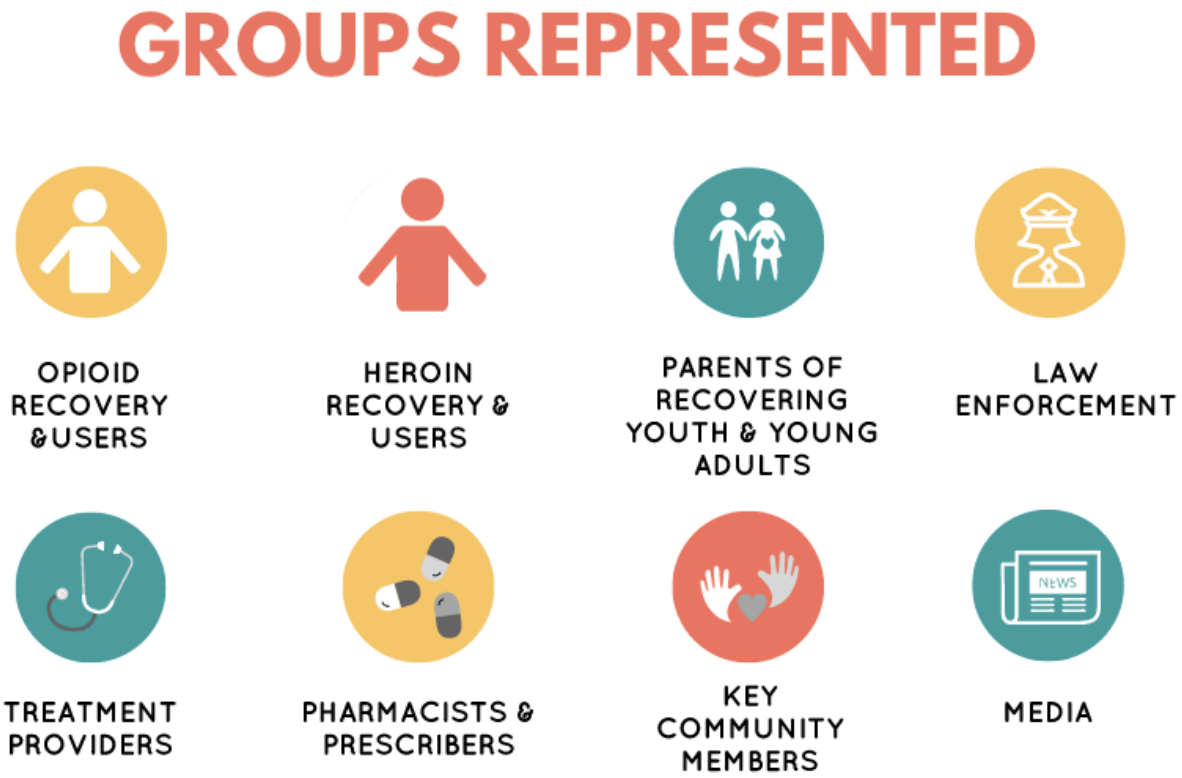
Throughout the community needs assessment and strategic planning process, the Coalition has been interested in better understanding opioid misuse and its link to crime in Anchorage. Safety is a high concern for community members in conversations around opioid misuse but we do not have strong data to understand its relationship to crime. This information can be used to mobilize efforts to address opioid misuse. Also, additional data around hospital discharge data and insurance coverage may also allow the Coalition to better assess the economic levels of people impacted in Anchorage. Technical support on these issues would be appreciated.

Step 2: Capacity Building

2.1 Community and Key Stakeholder Involvement

Partners in Anchorage have a long history of working together on substance abuse issues. This includes treatment providers, members of multiple coalitions, youth serving organizations, and the Anchorage School District. Some relationships that are in the development phase include medical professionals not involved in treatment services and law enforcement. Most collaborative substance abuse efforts have been geared towards underage drinking. In underage drinking prevention efforts, law enforcement was a key partner. The new direction of prescription opioid misuse and heroin use prevention can work to re-invigorate relationships from prior collaborative efforts. As with all collaborative work, relationships are the key starting point. Anchorage is a relatively small community, and many of the necessary relationships are well formed.

Through the assessment HVHC and AIPC engaged individuals from key sectors. Groups represented are outlined in the figure below.



HVHC will continue to engage with its partners and with the general community through presenting the data found as part of the needs assessment. This will help both educate the community about the issue and help with engaging individuals from sectors not yet represented.

2.2 Structure and Functioning

Organizational Structure

In organizing the Coalition, HVHC took note that other anti-drug and youth coalitions in Anchorage, e.g. AYDC and Anchorage United for Youth, have struggled with getting diverse sector members in the same room at the same time to conduct Coalition business. Rather than "fight nature," HVHC has adopted an organizational structure that takes advantage of the strengths of its diverse membership. HVHC holds leadership team meetings with human services, local government, law enforcement, tribal and other professionals in the community during the regular business week and general Coalition meetings and activities are held on weekends, evenings to accommodate the schedules of youth, parents, other caregivers, and community volunteers. By taking this approach, HVHC has been able to include all 12 sectors effectively.

The leadership team and the Coalition share information via program reports, meeting minutes, and email correspondence. HVHC decision-making is based on advice and support from the leadership team (key stake holders in our community along with individuals from skilled disciplines, i.e., medical providers, mental health clinicians, and professional marketing individuals) and approval from the full Coalition. The decision-making process for the Coalition is based on the Youth Leadership Institute model where youth have a voice in all decision-making processes. HVHC believes that if youth are engaged on the basis of their strengths, interests, and needs to address the problem of ATOD, the

inevitable result will be a healthier society and the change will be a long-term solution rather than a short-term fix.

Agendas are developed based on input from all Coalition members, and standing business items include information from our Strategic Action Plan. Standing agenda items include: community event reports, work group updates, community announcements, resources needed/resources to share, and action plan updates. Community event reports are detailed reports that include event goals and objectives, outputs, expenditures, in-kind donations, partnerships in support of the event, and volunteer hours, as well as successes and challenges experienced in all phases of planning and implementing an event.

The coalition currently has four key work groups/task forces that are facilitated by a member of the leadership team and include both members of the leadership team and HVHC Coalition:

- The *Laws/Policies Work Group* includes members of the Alaska Wellness Coalition (AWC). This is a group of coalitions from across the State who track, monitor and act as advocates to issues that impact our youth and young adults. HVHC uses this forum to help plan and guide our decision-making process so we have greater strength when being advocate change agents.
- The *Near Peer Work Group* is made up of 21-28 year olds who are both leadership team and Coalition members. Members of the Near Peer Work Group are a diverse partnership that includes young adults who grew up in the foster care system, experienced family issues related to use/abuse of alcohol and other drugs, involvement with the juvenile justice system, University of Alaska Health and Human Services programs (Social Work, Public Health, Justice, Social Sciences) along with the Wellness Coordinator from the Dean of Students office, along with professionals in the prevention/intervention community.
- The *Parental Monitoring Task Force* includes the Director of Prevention/Early Intervention Services, a therapist who actively works with families in a local pediatrics clinic, a case manager at one of Anchorage's community mental health clinics, a teacher from the Anchorage School District, *Prime for Life* instructors, members from the faith based community, parenting experts and parents of middle and high school students.
- The *Media/Youth Group* is made up of coalition members between the ages of 9-20. Members of this group provide assistance to other partner agencies as the communities' youth voice. This groups current projects include: developing and conducting youth focus groups for awareness campaigns to other agencies, training other community youth groups in media literacy skills, life skills training, event coordination of drug and alcohol free community events, training parents and other adult community members about marijuana, edibles, opioids, Narcan and offering volunteers services for Drug Take Back Events. They provide input into activities to assist with the recruitment of new members, provide volunteer support to prevention camps, e.g. FAScinating Families Camp and Camp Hope (a summer camp for children who have a parent or family member who is active in their addiction or in recovery from an addiction) and are the key link to the local middle and high schools.

Each workgroup does research in specific areas for the Coalition as a whole, though they are linked to the group they are working with.

Through active and systematic recruitment of Coalition and leadership team members in the last 7 years, HVHC has grown to include 26 leadership team members who represent the 12 sectors, 82 youth and adult Coalition members, and 97 community volunteers (which include non-coalition members). In 2016, HVHC Coalition members, leadership team members, and community volunteers performed 1,867 hours of community service with HVHC to reduce substance use/abuse in Anchorage.

VOA is the fiscal agent for HVHC and is the legal applicant for funding. In 2009, VOA was asked by the Initiative to serve as the fiscal agent for the coalition. As a result of a mutual cooperative agreement, VOA continues to provide oversight of financial responsibilities, provides coalition member representation via their clinical staff and assists with leadership training as well as office space. VOA has experience and success in providing prevention/early intervention and treatment services to youth with substance use/abuse issues in Alaska for over 35 years. VOA's responsibilities as fiscal agent include recordkeeping, accounting, internal control, source documentation, cash management, financial audits, and financial reporting to agencies and entities granting funds to HVHC. The Coalition is responsible for management and oversight of HVHC funds. Financial decisions are made through an annual budgeting process that accounts for anticipated receipts and expenditures, including grant funding secured and anticipated, cash and in-kind donations, fundraising, and Coalition partnerships. Monthly financial reports and forecasts are prepared by the Coalition Program Director to keep leadership team and Coalition members informed of HVHC's financial status. The Program Director and VOA's Chief Financial Officer ensure all spending follows VOA Policies and Procedures, Generally Accepted Accounting Principles (GAAP) and federal grant financial regulations and guidelines, as appropriate.

HVHC/VOA are devoted to fiscal integrity by ensuring that every dollar is directed towards prevention efforts, leveraging other funding, leveraging in-kind resources, and energizing local businesses, non-profits, government and tribal entities, and community members to find a way to contribute to the cause in their own unique ways.

Team Challenges

The only challenge so far is coordinating everyone's time to attend meetings as a whole. As a coalition, we function pretty well together and so far, have not major challenges at this time. Only this is can think of is the amount of education that is needed for our members to understand how opioids work and what the effects of long term us to the brain and on the developing brain is. We are working on this via presentations and sending folks to trainings locally and at National Conferences.

2.3 Core Planning Committee

Membership is made up of various sectors in our community. The community members who have been most involved in our efforts so far have been:

- Cooper Baldwin – Clinical Director of Substance Use/Abuse Youth Serving Organization
- Morgenn Jensen – Repertory Therapist Medical Center
- Marcia Howell – Alaska Injury Prevention Center – Youth Serving Organization
- Matt Keith – Director of Pharmacy Geneva Woods – Northwest Pharmacy Company
- Lakota Holman – Program Manager of Substance Prevention Alaska Native Tribal
- Tim Miller – Criminal Unit Deceptive Anchorage Police Department
- Logan Daniels-Engevold Peer 2 Peer Mentor Youth Serving Organization
- Sylvia Craig Alaska Injury Prevention Center – Youth Serving Organization
- Matt Allen and Heather Davis – Alaskan AIDS Assistance Association (4 A's)
- Gwen Alexander – Community Member
- Pastor Jerry Webb – Faith Based community member and clinician
- Kim Whittaker – HELP Director grassroots treatment and recovery organization
- Lindsey Daily – Media representative Alpha Media
- Joyce Dean – National Guard Counter Drug (or a member of their team)
- Mariaha Campbell – Title 1 School Coordinator – Anchorage School District

Core Planning Committee Challenges

We have not encountered any challenges at this time but we are only in our beginning stages of the development of our strategy planning. It's hard for individuals in treatment and recovery to look at the prevention strategies as these are sometimes very different than what is needed for treatment and recovery i.e. funds for safe housing while awaiting openings for treatment beds, or funding for flying to treatment services, housing after treatment has occurred.

Sector members

Members of the 12 sectors were intentionally selected based on their commitment to the issues HVHC is addressing. HVHC looked for community leaders who have the ability to engage others, have past experience with community action, have experience in the substance abuse field, the ability to bring cultural competency to the Coalition, are visionary and have the ability to link strategies with other groups in the community. Based on these qualities these members were recruited to assist us in increasing community collaboration and reducing youth substance use.

Coalition members are recruited from all areas of the community. Our "Meet and Greet" events occur quarterly. These meetings have a theme that relates in some way to Coalition activities in our community. For example, the April 2017 "Meet and Greet" theme will be "Monitor Your Medication". Coalition recruitment is conducted in this manner to foster interactive, fun, and interesting information about who we are and what we do. During the Meet and Greets information is provided on the Coalition's mission, vision, and annual action plans.

Our current youth members help to bring in new youth members by recruitment via the ASD's local youth clubs and organizations. ASD hosts a medical academy at three different local traditional high schools. We have developed a relationship with this sector and teachers support our efforts by offering to allow us classroom time for recruitment or offering extra credit to students who participate in Coalition events. Once they come and volunteer many of them are "hooked" and decide to join the coalition to gain life skills, professional skills or enhance their college portfolios. HVHC ensures that we match the prospective member's interest with work on the Coalition. Our youth members tend to be long-term members. Last year we had seven youth graduate from high school that have been with the coalition since they were in the 5th grade. In the past seven years, we have added 24 new active youth members.

Members are provided a variety of activities that occur at various times and require different skills. Everyone is encouraged to join the Coalition even if they can only give a few hours of service during the year. Community involvement in prevention of substance use/abuse can happen at any given time and needs to be demonstrated at schools, church, stores, and all other areas of community life in Anchorage. Because we offer drug and alcohol free events all over Anchorage and provide education and skill development in conjunction with other community groups, both traditional and non-traditional schools and at the University, we have been able to ensure that our Coalition is representative of the population in our community.

To keep our members interested and ensure their growth, we offer monthly trainings at our meetings, e.g., the April training will be on youth brain development, marijuana and edibles, and vapor pens. In June HVHC will partner with the Alaska National Guard's Civil Operations Team to provide a high ropes course leadership training to 30 adult and youth members. The training will include subtopics on: overcoming challenges, setting and achieving goals, team building, problem solving, abstract thinking, trust building, and cultural differences to problem solving.

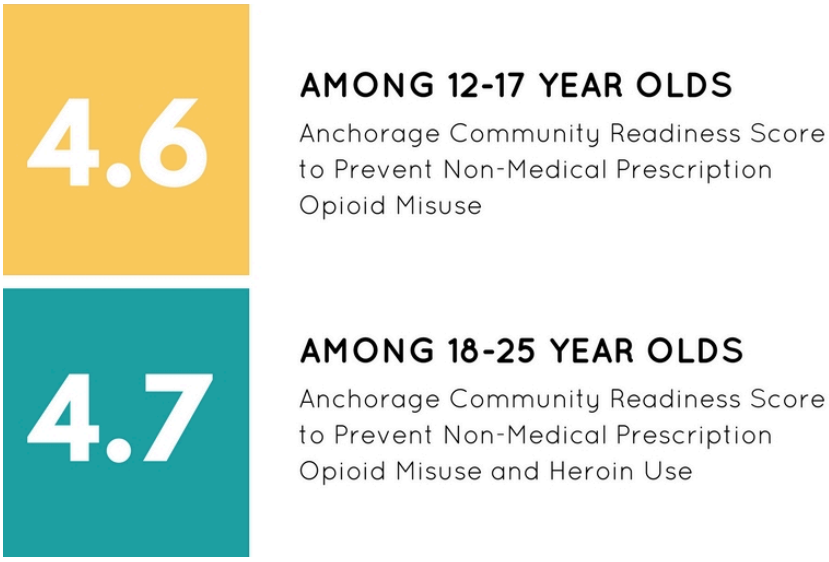
2.4 Capacity-Building Needs Related to Priority Areas

As the misuse of opioids grow within Anchorage, more and more community members are impacted by the consequences either directly or indirectly. Because of the issue's vast reach in people's lives the community overall is prime for action to address challenges with opioid misuse for ages 12-25.

In 2017, the HVHC coalition conduced a Tri-Ethnic Center for Prevention Research's model of Community Readiness for Community Change (Colorado State University, 2014) to assess the community's readiness around five dimensions: 1) Community knowledge of the issues (how much does the community know about the issues?); 2) Community knowledge of efforts (How much does the community know about current prevention programs and activities?); 3) Community climate (What is the community's attitude toward addressing the issues?); 4) Leadership (What is he leadership's attitude toward addressing the issue?); and 5) Resources (What are the resources being used or that could be used to address the issue?).

Based on the Tri-Ethnic Community Readiness Assessment model, the overall community readiness score for prescription opioid misuse prevention for ages 12-17 was 4.6 (on a scale of 1 to 9). The overall community readiness score for prescription opioid misuse and heroin use prevention for ages 18-25 was 4.7. Both these scores indicate a level of community readiness that is above "Stage 4: Preplanning," meaning there is some concern and acknowledgement of concern of the problem and stigma around the issue, but little known of the issue or of local efforts, and that there are limited resources to further the efforts.

Honing in on the scores for both age ranges and for all five dimensions tells a story of where strengths and areas for growth exist within Anchorage.



Strengths within Community

From our community needs assessment, generally people within Anchorage have high levels of concern and believe there is risk in someone trying prescription opioids even once or twice beyond recommended amounts. People generally have a higher perception of risk for heroin use. Because of these high levels of concern and the far-reaching consequences of opioid misuse throughout Anchorage, community members are ready to act.

When considering policy-related issues to address opioid misuse among 17-25 year olds there is a higher readiness within Anchorage. When considering harm reduction strategies, the community's desire is extremely high to reduce the stigma of opioid misuse, promote alternative pain management options, and provide syringe exchanges.

Areas for Growth

Through our community needs assessment, we found an interesting theme that though there are high levels of concern about opioid misuse and some knowledge around community efforts, there is a general lack of knowledge about the issues themselves. This creates an opportunity for education and awareness efforts around opioid misuse, addiction risk, and likely consequences of misuse.

Themes also arose around leadership and community members, understanding and working to take action on opioid and heroin use. However, a lack of resources and enough funding to expand existing resources was raised as a common barrier.

We also found there are challenges around cultural responsiveness. Generally, among the Alaska Native and other ethnic groups, there are challenges centered on social stigma and language barriers around education efforts. There are opportunities to address this through capacity building efforts for the broader community.

Capacity Building Plan

By assessing the community readiness around opioid misuse prevention, the HVHC coalition was able to identify areas to build capacity within Anchorage. Recognizing that half of active heroin users surveyed began through opioid medications to address pain, a focus can be placed on raising knowledge and practices around prescription opioid use.

The following table addresses actions that can be taken to build community capacity, which in turn will raise community readiness scores, in the areas of community knowledge about prevention efforts and community knowledge of resources.

Area of Growth/ Capacity Need	How it will be Addressed	Who is Responsible	Timeline	Measure of Success
Recruit key medical community stakeholders	Outreach and meet with medical professional associations, pharmacists, and prescribers	HVHC Coalition members	- July 2017 - Ongoing	5 new coalition partners
Build Coalition knowledge of PDMP program	Create PDMP Action Committee	HVHC Coalition members	- July 2017 - Ongoing	Host bi-monthly committee meetings
Evaluation support for strategy implementation and action steps	Hire consultant(s)	HVHC Research and Evaluation Committee	- July 2017 - Ongoing	Contractors support HVHC committee
Community education on disposal sites and	Build partnerships with hospitals and medical centers	HVHC Media Group and Coalition members	- July 2017 - Ongoing	Media spots placed to reach key audiences

disposal bags				
Support Anchorage Area Opioid Task Force	Build partnerships with local stakeholders	HVHC staff and coalition members	- July 2017 - Ongoing	Participate in task force meetings
Create HVHC Harm Reduction Committee	Build partnerships with Four A's, REAL About Addiction, and other stakeholders	HVHC Coalition members	- July 2017 - Ongoing	Create Committee. Review and create harm reduction educational materials
Media and communications training	Attend training	HVHC Media Group	- August 2017	Three coalition members trained
Build partnership with the Anchorage School District and Alternative Schools	Meetings with school board members and ASD staff	HVHC Coalition members	- September 2017	Partner program with schools
Train youth on peer-to-peer programs and messaging	Train committee on best practices	HVHC Youth Group	- October 2017	All committee members trained before program implementation
Cultural Awareness training	Host community training	HVHC Youth Group and Coalition members	- January 2018	50 youth and adults trained

Integrating Cultural Competency and Sustainability

Reaching community members most likely to misuse opioids is an important area to address with cultural competency. We have identified language barriers for community members to receive the needed education when receiving prescription opioids, including the Hispanic community. Increasing education and awareness campaigns also requires adapting messages and dispersal methods to be relevant to the correct community targets.

Among the Alaska Native and other ethnic groups, there are challenges centered on social stigma. Integrating cultural competency during strategy development and implementation will be necessary to address this community barrier.

The HVHC coalition will also host a cultural awareness training for community members to gain skills to incorporate into the coalition efforts.

Our coalition will also consider implementing projects that can be continued throughout the community. In building partnerships, we can ensure projects can be carried out beyond the life of this grant. For example, partnering with the Drug Enforcement Administration on prescription drug take-back events to promoted awareness around the need to safe disposal and how to access the take-backs can ensure they will be carried out into the future.

2.5 Technical Assistance Needs Related to Capacity

DETAL webinars have been helpful throughout the assessment and planning processes. The Coalition requests that these continue to provide information and also to connect the coalitions across the state.

Alaska's Prescription Drug Monitoring Program (PDMP) is a new system currently being rolled out across the state. New legislation, regulations, funding, and implementation are all impacting the system, making it challenging for the Coalition to closely and effectively monitor the program. Support from the state to monitor use and access to data collected by the PDMP program is requested.

Additionally, HVHC is working to develop stronger ties to the medical and prescribing community. HVHC would appreciate any guidance the DETAL team could provide in developing those relationships.

Step 3: Strategic Planning

3.1 Planning Process

HVHC contracted with AIPC to coordinate the planning process. After the final set of community factors were prioritized, AIPC reviewed best practices for opioid prevention to determine potential strategies. AIPC considered strategies based on their conceptual and practical fit. Conceptual fit of potential strategies included whether it had been tested with the 12-25 year old population and if implementation of the strategy would help achieve the desired outcomes for this grant. To assess practical fit, AIPC and HVHC considered several factors. The first factor was whether the coalition had the resources to implement the strategy. Coalition resources included human power, financial ability, and access to the right people. The second factor AIPC and HVHC considered was coalition climate, or whether the strategy would fit in with existing work, if there would be buy in from leadership, and if the coalition would be willing to implement the strategy. The third factor considered was community climate and the fourth was sustainability of the strategy in the long term.

After selecting potential strategies based on their conceptual and practical fit, AIPC worked with HVHC to hold two strategic planning meetings so the coalition could provide feedback and begin to develop action plans around each strategy.

The first strategic planning meeting was held on June 1, 2017 and was open to all members of the HVHC coalition. To start the meeting, AIPC presented the final set of community factors as prioritized by the coalition. AIPC then introduced four proposed strategies and the rationale for each. Coalition members were asked to break out into groups based on which strategy they were most interested in. Staff from HVHC and AIPC led groups through an exercise to brainstorm action plans for three of the four strategies. AIPC and HVHC did not have group members participate in the action plan brainstorming exercise for strategy related to the Prescription Drug Monitoring Program as there is new legislation regarding the PDMP and the implementation details of those policies is not yet widely known. AIPC used the notes from the action planning brainstorm activity to guide the development of the action plans included in this document.

The second strategic planning meeting was held for the HVHC Leadership Team to provide feedback on the logic model and generate action plan steps. This meeting was held on June 14, 2017. HVHC and AIPC were able to gain rich perspective from the Leadership Team members present. Action steps related to PDMP participation were discussed at this meeting. There was general agreement that PDMP participation, and the need for patients to be better educated on risks of NMUPO were linked.

AIPC developed the final action plans for each strategy using input from HVHC coalition members, HVHC's Leadership Team, and HVHC staff. The strategies and their action plans are included in Section 4.1 of this document.

3.2 Planning to Address Priority Areas

Final Set of Community Factors

Once the final set of community factors was prioritized, two things became clear. First, many of the factors are relevant to more than one intervening variables. To try to separate them into siloes would result in a piece-meal effort, and lack the potential synergy of a cohesive approach. Second, stigma associated with substance abuse cuts across all intervening variables. Reducing stigma will be incorporated into all of the work HVHC does on this project.

Retail Availability

To reduce retail availability, it is important to increase PDMP participation, increase patient understanding of alternatives to prescription opioids for pain relief, and increase knowledge of the risks associated with NMUPO to reduce demand.

- Lack of Prescription Drug Monitoring (PDMP) participation
- Lack of understanding of alternatives to prescription painkillers for pain management
- Inadequate understanding of risks of prescription painkiller misuse

Perceived Risk

Perception of risk is inextricably linked to multiple community factors and other intervening variables. Increasing knowledge of the risks associated with NMUPO will lead to proper storage and disposal and ultimately reduced retail and social availability.

- Inadequate understanding of risks of prescription painkiller misuse, including how quickly misuse can lead to dependence
- Medications not stored properly
- Inadequate safe disposal of prescription painkillers

Social Availability

Proper storage and disposal of prescription opioids are part of the solution to reducing social availability. In order to motivate these behavior changes, patients with prescriptions for opioids need to realize the potential risks associated with improper storage and failing to dispose of the medications. Additionally, community members strongly believed that lack of coping skills is an important factor that leads to NMUPO. And once misuse is initiated, social circles change, leading to unhealthy relationships and negative peer pressure. These factors result in increases in social availability.

- Medications not stored properly
- Inadequate safe disposal of prescription painkillers
- Prescription opioids and heroin users in social circle
- Lack of coping skills

Harm Reduction

The key community factor regarding harm reduction, for everyone misusing opioids and using heroin was access to information regarding Narcan. One of the best local resources recognized by community members for disseminating that information is the Four A's syringe exchange.

- Access to needle exchange resources

Sub Groups Targeted

HVHC will target youth and young adults per the parameters of the grant. The Coalition will also work to reach parents of youth, especially for strategies around safe storage and disposal. HVHC will also target current users utilizing services for 4 A's needle exchange, re-entry programs, prescribers and pharmacists, and other agencies or organizations which provide information and education opportunities.

List of Strategies to Implement

To improve conditions of the prioritized community factors, the HVHC members agreed upon the following strategies: Patient Education, a multi-pronged Social Marketing Campaign, Developing Healthy Relationships and Encouraging Asset Development, and Implementing an Education Initiative for Users and Supporters. The Coalition recognized that multiple intervening variables will be impacted when addressing some community factors. For example, the inadequate understanding of risks of prescription painkiller misuse addresses both the retail availability and perceived risk of harm. This is illustrated in the logic model where two arrows connect the community factor to the different intervening variables.

To address prescription opioids not being stored properly there must be increased perception of risk of harm to incentivize safe storage, which will reduce social availability. Similarly, to address the inadequate safe disposal of prescription opioids, there must first be increased perception of risk of harm to then incentivize safe storage, which will reduce social availability. Again, this is illustrated on the logic model by multiple arrows. By recognizing the interconnectivity of the strategies, the community factors and intervening variables, action steps will make impacts on multiple levels, rather than separately. Engaging in strategic efforts will result in greater effects. This interconnectivity is also recognized in the overlapping indicators in the evaluation plans described later.

Rationales

<u>Patient Education</u>

Patient Education is a multi-layered strategy. Throughout the assessment, it became clear that many active heroin users, who's opioid use started with prescription pain killers had received inadequate information at the time of their first prescription. They did not understand the risks associated with misuse, the need to taper off at the end of use, the risk that abuse could lead to heroin use nor that in many instances there are alternatives to using prescription opioids to reduce pain. Fifty percent of surveyed heroin users in Anchorage started opioid use with a legitimate prescription to reduce pain. Meanwhile, the Centers for Disease Control has released new recommendations for pain treatment options of which many patients are not aware. Patient education is best coming from the initial prescribers. Key informants told us that doctors are trusted sources of information. It is critical that the information physicians are providing is truly best practice.

HVHC will track the new PDMP requirements, and determine the best ways for the coalition to assist with implementation in Anchorage. It will also work with the Alaska Wellness Coalition and other PFS grantees to leverage community level and statewide support for improved doctor education to improve information doctors are providing to patients.

Throughout patient education initiatives, reducing stigma around opioid use will be addressed. This includes the stigma that prescriptions painkillers are safer than heroin, that heroin users choose to be addicts and that it only happens to "bad" people.

Social Marketing Campaign

After reviewing best practices for promoting behavior change, and theories behind changing behaviors, social marketing rose to the top as the method for getting people to safely store and dispose of their prescription medications (Substance Abuse and Mental Health Services Administration, 2017). Education dissemination efforts can be effective when there are few barriers to adopting a new behavior. Few education dissemination efforts have been formally evaluated for effectiveness on this issue. Instead, multiple studies have found social marketing campaigns effective at prompting audiences to safely store prescriptions, increasing perception of risk and properly dispose of prescriptions drugs. The community let us know that there are significant barriers to safely storing and disposing of prescription opioids. It will be important to carefully craft campaign initiatives to reach specific populations in ways that will be persuasive for them. The social marketing campaign will raise the perception of risk of improperly storing and disposing of prescription opioids, decrease social availability of prescription opioids, and work towards reducing stigmas about prescription painkillers and heroin.

Healthy Relationships and Developmental Assets

The HVHC coalition has a high level of youth engagement in its committee structure where youth coalition members provide a savvy, in-depth approach to advancing efforts to prevent substance abuse. Throughout the community needs assessment and strategic planning process, community members, coalition members, and active users all raised issues to address providing the right supports in relationships, environments, and experiences for youth.

Discussions centered on addressing youth's need for healthy social circles through building youth developmental assets as well as increasing coping skills. These areas were found as central to prevent opioid misuse and heroin use among youth and young adults. Community members identified social circles as a contributing factor to social access of opioids, which may lead some youth to begin misusing prescription opioids. Increased coping skills were also identified to build resilience in youth who may be undergoing trauma as well as to provide youth and young adults with other means to address mental and physical pain, including mindfulness practices, yoga, etc.

The Developmental Assets Model was created by Search Institute to identify the building blocks that contribute to three healthy types of outcomes:

- Preventing high-risk behaviors, including substance abuse and use of drugs;
- Building resilience, or the capacity to function adequately in the face of adversity; and
- Enhancing thriving behaviors.

A core concept in building developmental assets in youth is that the approach also builds "connectedness," which is the quality and stability of the emotional bonds of support and caring that exists between youth and caregivers, youth and peers, and among adults in young people's worlds. By taking a strength-based approach to build developmental assets, the HVHC coalition will be providing the community with the tools they need to build health social circles and increase coping skills, while preventing opioid misuse.

There is a growing body of evidence that the cumulative benefits of developmental assets for youth can help to increase an understanding of what constitutes risk, explain the prevention of high-risk behaviors, explain the protection from high-risk behaviors, and explain the expression of thriving behaviors (Fisher, Imm, Chinman, & Wandersman, 2009). Programmatic, community-based, and statewide applications of the asset model also are shown to decrease alcohol, tobacco, and other drug use by youth, as well as

building a stronger sense of belonging, self-efficacy, and self-confidence, and strengthened relationships with significant adults in their lives (Fisher, Imm, Chinman, & Wandersman, 2009).

Education for Users and Supporters

In the assessment, we learned that most heroin users were unfamiliar with important aspects of the use of Narcan, including the length of time it works, and even that it exists. In the assessment, we learned that heroin users who participate in the needle exchange try to be safe users and realize the risks confronting their use. For these users, disseminating information about Narcan through the needle exchange in Anchorage is likely to be effective at reducing harm, including overdose associated deaths. One thing it should also do, which will skew the initial evaluation on the State level, is increase emergency room visits, for overdoses reversed by Narcan.

Cultural Competence

Cultural competence is a foundation for the HVHC coalition's work and will be integrated into the strategies and implementation. HVHC has worked with representatives from different communities throughout the assessment and strategic planning processes, including the Alaska Native and Hispanic communities, faith community, and more. Stigma surrounds addiction in all communities and has become central to addressing in crafting strategies. Stigma often inhibits people to ask questions or offer information around opioid use, to seek needed treatment, or to find help for family members or loved ones.

Sustainability

HVHC and Volunteers of America have a long history of addressing substance use, abuse prevention and treatment issues in Anchorage. The opportunity to work towards prevention of NMUPO and heroin use in Anchorage builds on and strengthens their existing capacity. Through its work on this project, HVHC will continue to expand its capacity by developing new relationships and partnerships with members of the medical profession, law enforcement and other stakeholders. Through expansion of the coalition's membership and reach, it will be in a strong position to seek new funding, and continuously work towards sustainability.

The HVHC coalition is also working closely with other coalitions across the state that are also implementing efforts to prevent the misuse of prescription opioids and heroin use. HVHC serves in a leadership role on the statewide Alaska Wellness Coalition's capacity building committee. The Coalition is bolstering the efficacy of these efforts and ensuring programs are built with sustainability in mind by working more collaboratively across communities in the state to address capacity needs, share best practices, and address challenges in this prevention work. Additionally, as healthy relationship, coping skills and developmental assets improve among youth, prevention efforts will be stronger.

3.3 Logic Model

The logic model below, graphically shows the interconnection between strategies, community factors and intervening variables.

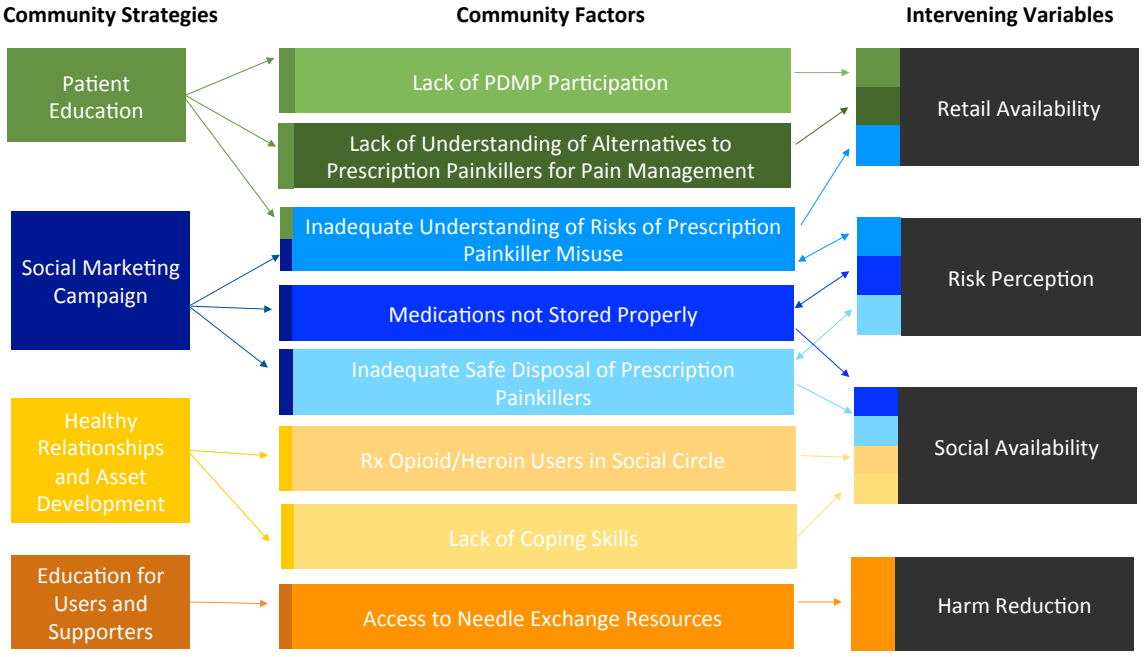
Patient education will address three community factors. Lack of PDMP participation will be addressed. As more prescribers and pharmacists utilize the PDMP, and receive newly required painkiller prescriber education, patients will be better educated and retail availability will decrease. Two primary areas of patient education determined to be important in the assessment were improving understanding of

alternatives to painkillers for managing pain, and increasing knowledge around the multiple risks associated with painkiller misuse.

The Social Marketing Campaign will seek to change behaviors of prescription opioid storage and disposal, thereby reducing social availability. One of the ways it will do this is through increasing knowledge around the multiple risks associated with painkiller misuse. As seen in the two sided arrows, as risk perception increases through other efforts, there will be an effect on storage and disposal.

The Healthy Relationship and Asset Development strategy will reduce social availability by helping youth develop and maintain positive peer social circles, and developing coping skills that reduce the desire to mask emotional pain with opioids. Although the arrows don't show it, this strategy is also a way of increasing understanding of alternatives to pain management because improved coping skills, whether gained through mindfulness, yoga or life skills training, are alternatives to some degrees of physical pain.

Finally, although Education for Users and Supporters only has two arrows, one to the community factor of access to needle exchange resources and then to harm reduction, knowledge about Narcan it is a critical step to reducing opioid related mortality.



3.4 Technical Assistance Needs Related to Strategic Planning and Logic Models

The HVHC coalition requests timely feedback from the state regarding the strategic plan and logic models before the coalition moves into implementation.

Step 4: Implementation

4.1 Implementation of Strategies

Patient Education Action Plan

Strategy: Patient Education			
Action Steps	Who is Responsible	Timeline to begin	Measure Success
Goal: Increase PDMP Participation			
Form PDMP Action Committee	HVHC Leadership Team	September, 2017	Committee kickoff meeting
Recruit key medical community stakeholders	PDMP Action Committee	September, 2017	New stakeholders join effort
Develop Relationships with Pharmacists and Prescribers and relevant organizations	PDMP Action Committee	September, 2017	Increase in number of pharmacists, prescribers and relevant organizations involved in HVHC efforts
Assess advocacy needs including: status of PDMP legislation and data collected by DETAL regarding PDMP participation	PDMP Action Committee along with external community stakeholders	October, 2017	Assessment complete
Collaborate with other grantees to determine actions needed based on status of legislation and PDMP data	PDMP Action Committee	All Grantee Meeting	Discussions begin around development of shared statewide action plan
Goal: Increase understanding of alternatives to prescription painkillers for pain management			
Work with key medical stakeholders to develop guidance for alternatives to using prescription opioids for pain relief.	PDMP Action Committee and key medical stakeholders	November, 2017	Guidance information developed.
Develop strategy to disseminate guidance to medical community based	PDMP Action Committee and key	March, 2018	Dissemination strategy designed.

on stakeholder insights into best ways to do this.	medical stakeholders		
Assess existence of already developed guidance material for fit in community as well as availability of community resources to address the alternatives.	PDMP Action Committee and key medical stakeholders	April, 2018	Existing guidance materials regarding alternatives to prescription opioids for addressing pain compiled
Develop more material if necessary designed to meet needs of Anchorage community	PDMP Action Committee and key medical stakeholders	June, 2018	Anchorage specific guidance material developed if needed.
Disseminate guidance based on action plan.	PDMP Action Committee and key medical stakeholders	August, 2018	Begin dissemination of guidance material.
Goal: Improve Understanding of Risks of Prescription Opioid Misuse (Some of the action steps towards this goal will be done through the social marketing campaign designed to increase safe storage and disposal.)			
Work with key medical stakeholders to review up to date prescribing protocols, including tapering recommendations, number of days for a prescription, etc.	PDMP Action Committee and key medical stakeholders	November, 2017	Guidance information developed.
Assess education opportunities for prescribers, this might include PDMP mandatory trainings.	PDMP Action Committee and key medical stakeholders	March, 2018	List of educational opportunities for prescribers in Anchorage compiled.
Promote educational opportunities to prescribers.	PDMP Action Committee and key medical stakeholders	April, 2018	Count of prescribers participating in trainings.

Social Marketing Campaign Action Plan

Strategy: Social Marketing Campaign			
Action Steps	Who is Responsible	Timeline to begin	Measure Success
Goal: Increase Proper Storage of Prescription Opioids			
Determine segments of the population to reach by reviewing data from assessment (parents of young children, parents of teens, chronic pain patients, assisted living facility, etc)	HVHC Media Committee	July, 2018	Demographics of segment populations defined.
Conduct audience research to learn about motivators and barriers to proper storage, perceptions of risk of consequences of improper storage and belief that they can engage in safe storage (focus groups, key informant interviews).	HVHC Media Committee	August, 2018	Motivators, barriers, and risk perceptions and self-efficacy defined.
Design key messages for each audience, and review existing resources from with and outside of Alaska	HVHC Media Committee	September, 2018	Message design completed for various audiences as well as communication channels.
Determine best communication "channels" for each audience (church bulletins, social media, radio, word of mouth, berry baskets, etc)	HVHC Media Committee	September, 20187	Strategic communications plan completed
Test messages and chosen "channels"	HVHC Media Committee	November, 2018	Final messages and channels determined.

Monitor reach and frequency of messages	HVHC Media Committee	December, 2018	Message exposure measured (A plan for measuring reach and frequency cannot be developed until communication channels are determined.
Monitor impact of messages	HVHC Media Committee	December, 2018	Strength of messages measured and changes made if necessary.
Make adjustments as necessary	HVHC Media Committee	December, 2018	Revisions to the strategic communication plan.
Goal: Increase Safe Disposal of Prescription Opioids			
Determine segments of the population to reach by reviewing data from assessment (parents of young children, parents of teens, chronic pain patients, assisted living facility, etc)	HVHC Media Committee	July, 2018	Demographics of segment populations defined.
Conduct audience research to learn about motivators and barriers to proper storage, perceptions of risk of consequences of improper storage and belief that they can engage in safe storage (focus groups, key informant interviews).	HVHC Media Committee	August, 2018	Motivators, barriers, and risk perceptions and self-efficacy defined.
Design key messages for each audience, and review existing resources from with and outside of Alaska	HVHC Media Committee	September, 2018	Message design completed for various audiences as well as communication channels.
Determine best communication “channels”	HVHC Media	September, 20187	Strategic communications plan

for each audience (church bulletins, social media, radio, word of mouth, berry baskets, etc)	Committee		completed
Test messages and chosen "channels"	HVHC Media Committee	November, 2018	Final messages and channels determined.
Monitor reach and frequency of messages	HVHC Media Committee	December, 2018	Message exposure measured
Monitor impact of messages	HVHC Media Committee	December, 2018	Strength of messages measured and changes made if necessary.
Make adjustments as necessary	HVHC Media Committee	December, 2018	Revisions to the strategic communication plan.

Healthy Relationships and Asset Development Action Plan

Strategy: Healthy Relationships and Developmental Assets			
Action Steps	Who is Responsible	Timeline to begin	Measure Success
Goal: Build healthy relationships and developmental assets to protect against NMUPO.			
Identify and create plan to promote protective factors that build healthy, supportive relationships for youth and young adults to build healthy social circles.	HVHC Youth Committee	July, 2017	Key protective factors are identified. Detailed action plan is created.
Partner with youth-serving organizations through funding to promote programs to build life skills, leadership, social and emotional skills, drug refusal, and decision-making skills.	HVHC Youth Committee and partners	September, 2017	Produce RFP for organizations to achieve action plan goals.
Partner with the school district and alternative schools to support	HVHC Youth Committee and partners	September, 2017	New stakeholders join effort.

youth groups for peer-to-peer programs.			
Partner with community groups to reach families to promote quality time and build positive values for youth.	HVHC Youth Committee and partners	October, 2017	New stakeholders join effort.
Create an online resources and platform for youth-created resources and activities for dissemination.	HVHC Youth Committee	October, 2017	Message design completed for youth audiences.
Test youth-created materials and resources for appropriateness with Anchorage youth audience.	HVHC Youth Committee and Evaluation Committee	November, 2017	Pilot materials tested for youth audience.
Revise materials and/or create new material to make it relevant to Anchorage youth.	HVHC Youth Committee	December, 2018	Revisions made, and final materials created, produced, and distributed through partners.
Evaluate supported partner programs, including youth-serving organizations, schools, and community groups.	HVHC Youth Committee and Evaluation Committee	Ongoing	Partner-supported programs evaluated and revised.
Goal: Increase coping skills among youth and young adults to protect against NMUPO.			
Identify pain and trauma coping skills for youth and young adults.	HVHC Youth Committee	July, 2017	Detailed action plan is created.
Partner with youth-serving organizations through funding to promote programs to integrate active programming, mindfulness, and social and emotional skills.	HVHC Youth Committee and partners	September, 2017	Produce RFP for organizations to achieve action plan goals.
Partner with the school or afterschool sport programs and clubs to	HVHC Youth Committee and partners	September, 2017	New stakeholders join effort.

integrate pain management education, and mindfulness and yoga practices.			
Host community events to promote coping skills to families (such as block parties, intergenerational programs, and fairs).	HVHC Youth Committee	October, 2017	New stakeholders join effort.
Evaluate supported partner programs, including youth-serving organizations, sports clubs, and community groups.	HVHC Youth Committee and Evaluation Committee	Ongoing	Partner-supported programs evaluated and revised.

Education for Users and Supporters Action Plan

Strategy: Educate Users on Harm Reduction			
Action Steps	Who is Responsible	Timeline to begin	Measure Success
Goal: Increase knowledge regarding use and limitations of Naloxone			
Build partnerships to stakeholders, such as Alaska AIDS Assistance Association (Four A's), REAL About Addiction, and more.	HVHC coalition members	July, 2017	Create HVHC Harm Reduction Committee
Review available educational material regarding naloxone.	Four A's and HVHC Harm Reduction Committee	July, 2017	Naloxone educational material compiled.
Determine whether other harm reduction information should be included, such as how to protect from using heroin cut with fentanyl, etc.	Four A's and HVHC harm reduction committee	August, 2017	Harm reduction education material compiled
Test materials for appropriateness with Anchorage audience (heroin users)	Four A's and HVHC harm reduction committee	September, 2017	Determination made regarding which existing resources will work in Anchorage.

Revise material and/or create new material to make it relevant to the Anchorage audience of users.	Four A's and HVHC harm reduction committee	October, 2017	If needed, new and/or revised material are developed.
Explore methods of distributing information in addition to needle exchange clients as well as other ways to reach users.	Four A's and HVHC harm reduction committee	October, 2017	Strategic distribution plan completed.
Disseminate material to users.	Four A's and HVHC harm reduction committee	November, 2017	Track reach of materials, based on dissemination channels, such as number of cards picked up, distribution of naloxone, etc.
Assess reach of material through channels chosen and adjust as needed.	Four A's and HVHC harm reduction committee	May, 2018	Interviews and surveys of segmented audience every 6 months.
Assess effectiveness of material and adjust as needed.	Four A's and HVHC harm reduction committee	May, 2018	Interviews and surveys of segmented audience every six months.

4.2 Technical Assistance Needs Related to Implementation

The HVHC coalition values the ongoing technical assistance the state and DETAL provide to facilitate collaboration across grantees. The collaboration and sharing of ideas across the state will be a key to success for the HVHC coalition to learn not only from implementation and adjustments in Anchorage, but also across different communities.

Step 5: Evaluation

5.1 Evaluation of Strategies

Strategy process evaluation methods are described above in the final column of the action steps. Outcome evaluation methodologies are described in the tables below.

- **Strategy Name: Patient Education**
- **Goal: Reduce retail availability and demand for prescription opioids**

Community Factors:	**Intervening Variable:**	**CSAP Category:**	**Strategy Target Populations:**
• Lack of PDMP Participation • Lack of understanding of alternatives to prescription painkillers for pain management • Inadequate understanding of risks prescription painkiller misuse	• Retail Availability and • Risk Perception	Information Dissemination/ Policy Advocacy	• Prescribers and Pharmacists • Parents of 12-17 year olds • 18-25 year olds

Key Strategy Outcomes	**Indicators**	**Method / Measure**
• Increase number of pharmacists and prescribers who participate in the PDMP • Increase knowledge of alternatives to prescription painkillers for pain management • Increase perception that misusing painkillers is risky. • Increase perception that the risk is for everyone.	• # of Anchorage area pharmacists and prescribers using PDMP • Increase in Opioid Overdose Attitude and Knowledge • % of patients who were provided accurate and comprehensive information about taking prescription opioids by their physician or pharmacist.	• Data from PDMP once it becomes available, checked annually. (This measure needs technical assistance from DETAL.) • Administer Opioid Overdose Attitude and Knowledge Scale to sample of population (Williams, 2013) • YASUS questions 3, 24, 25 • APAY Survey Questions 7(f-g) and 9(j-k) Administered every 2 years

<table>
<tr><td colspan="4">Strategy Name: Social Marketing Campaign promoting Safe Storage and Disposal of Prescription Painkillers

Goal: Reduce Social Availability of Prescription Opioids</td></tr>
<tr><td>Community Factors:
Prescription Painkillers are not stored properly
Inadequate safe disposal of prescription painkillers</td><td>Intervening Variables:
Social Availability
Risk Perception</td><td>CSAP Category:
Information dissemination</td><td>Strategy Target Population:

Households with a prescription for opioids, especially:
Parents of young children
Parents of teens
Households with prescription pain medications
Assisted Living Facilities</td></tr>
<tr><td>Key Strategy Outcomes</td><td>Indicators</td><td colspan="2">Method / Measure</td></tr>
<tr><td>Increase knowledge about risks associated with easy access to Rx opioids
Increase knowledge about ways to reduce social access to Rx opioids
Increase willingness to safely dispose of Rx opioids</td><td>% of adults who accurately recognize how youth in Anchorage access prescription drugs.
% of adults in Anchorage who understand the risks associated with misusing prescription drugs.
% of parents who</td><td colspan="2">APAY Survey questions 7(f-g) and 9 (j-k) 15 and 16 administered every 2 years
Phone survey questions 10-12 administered annually
YASUS questions 3, 4, 24, 25
YRBS question 64</td></tr>
</table>

	recognize the importance of taking steps to reduce access to prescription drugs in their homes. • % of Anchorage adults who say they take steps to reduce access to prescription drugs in their homes. • % of adults in Anchorage who are concerned about prescription drug misuse by 12-18 and 19-25 year olds. • Increase in percent who recognize risk of misuse.	

Strategy Name: Healthy Relationships and Asset Development **Goal: Reduce Prescription Opioid Misuse**			
Community Factors: • Lack of Coping Skills • Protecting Healthy Social Circle in Healthy Relationships	**Intervening Variable:** • Social Availability • Harm Reduction	**CSAP Category:** Environmental	**Strategy Target Population:** Youth and Young Adults in Anchorage ages 12-25
Key Strategy Outcomes	**Indicators**	**Method / Measure**	
• Increase Coping Skills • Youth Serving Organizations implement Healthy Social Circles in Healthy Relationships initiatives • Decrease Social Availability for 12-18 yr. olds	• Increase in COPE Inventory scores • Count of participating youth serving organizations • Self-reported access to prescription drugs	• Administer COPE Inventory (Carver 2013) with sample of participating youth. • Question 4-D in Prime for Life survey, administered weekly, analyzed quarterly	

Strategy Name: Education for Users **Goal: Reduce Harm from Prescription Opioid Misuse and Heroin Use**			
Community Factor: Access to Harm Reduction Information through the Four A's Needle Exchange	**Intervening Variable:** Harm Reduction	**CSAP Category:** Information Dissemination	**Strategy Target Population:** Heroin users

Key Strategy Outcomes	Indicators	Method / Measure
• Increased knowledge regarding Narcan	• % of Users who report accurate knowledge about Narcan. • % of Users who can accurately explain how long Narcan lasts. • Increase in requests for Narcan from the needle exchange	• Survey of needle exchange clients, questions 14 for prescription opioid users and question 10 for IV heroin users – every 6 months • Administer Brief Opioid Overdose Knowledge (BOOK) Questionnaire with sample of targeted population. (Dunn, 2016).

5.2 Technical Assistance Needs Related to Strategic Planning and Logic Models

HVHC requests the state provide timely feedback on the strategic plan, logic model, action plans, and the evaluation plans before moving into implementation.

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Appendix

Appendix A: Community Needs Assessment Data Sources

Primary Data Collection

Because of the complexity of opioid misuse and heroin use, HVHC and AIPC jointly decided to gather primary data, both qualitative and quantitative. Qualitative data collection methods allow participants to provide in-depth explanations and rich narrative on a topic. Since NMUPO and heroin prevention are an emerging issue in the Anchorage community, HVHC and AIPC wanted to collect as much information as possible. Giving community members the chance to speak freely on the issue provided HVHC and AIPC with a more comprehensive understanding of the issue. HVHC and AIPC conducted interviews and open-ended surveys with community members and current NMUPO and heroin users to gather more information about the consequences of NMUPO and heroin use in the community. A telephone survey, conducted by Hays Research Group, collected data from Anchorage residents around knowledge of the problem of NMUPO and heroin use, concern about the issues and levels of knowledge of efforts to address the problems.

Key Informant Interviews

The assessment team first considered conducting focus groups. However, due to the sensitive nature of the topic, the assessment team ultimately decided to conduct one-on-one interviews. The assessment team chose to conduct one-on-one interviews to ensure that all participants were given room to speak freely on the topic and to avoid any discomfort an individual might feel sharing in a group.

The key informant interviews were qualitative, in-depth interviews with people who know what is going on in the community regarding non-medical prescription opioid use and heroin use within our target population. The key informants provided nature on the insight of the nature of the challenges around the issues as well as provided recommendations for solutions within Anchorage.

HVHC and AIPC worked together to identify individuals to interview. Interviewees included a mix of existing and new contacts. AIPC and HVHC chose to interview parents, individuals in recovery for opioid use, individuals in recovery for heroin use, active users, treatment providers, prescribers, military personnel, corrections/law, and community members representing health care, education, business, and local media. Interviewees were asked to identify others they think might have valuable input or be interested in participating in coalition activities.

Open and Closed-Ended Written Surveys

To collect data from current users, AIPC distributed open-ended written surveys to Alaskan AIDS Assistance Association (Four A's). Four A's coordinates and houses the city's only syringe exchange program. AIPC initially provided Four A's with 25 surveys. After receiving the completed 25 surveys back from Four A's staff, AIPC provided 25 more surveys with a few modifications based on responses from the initial survey distribution. Both surveys are included in the Appendix I of this document.

In total, Four A's staff distributed and collected 50 surveys from current users of either heroin, opioids, or both. In exchange for completing the survey, respondents received a $25 WalMart gift card. Four A's began distributing surveys on February 8, 2017 and had 50 surveys completed by February 13, 2017.

Volunteers of America Alaska PRIME for Life Data

Volunteers of America Alaska, in collaboration with the Anchorage School District, the Boys and Girls Club of Southcentral Alaska, and the First Christian Methodist Episcopal Church offers PRIME for Life to middle and high school students in the greater Anchorage area (Volunteers of America Alaska, 2017).

PRIME for Life is a three-day, alternative to suspension course for first-time drug and alcohol offenses. It can also serve as a preventive course for students wishing to avoid suspension. The PRIME for Life program engages students in self-evaluation of their decision to use drugs and alcohol, helps students see the life-long consequences of drug and alcohol use, and equips students with the skills needed to prevent future substance use.

Volunteers of America Alaska coordinates the PRIME for Life program and conducts surveys with participants. The surveys contain questions pertaining to drug and alcohol use, including social availability. AIPC and HVHC analyzed the data from these surveys for this assessment.

Telephone Survey

The Alaska Injury Prevention Center contracted with Hays Research Group LLC to conduct a telephone survey regarding attitudes, opinions, and behaviors related to several behavioral health issues in Anchorage, Alaska. Questions about opioid and heroin use were included. Marcia Howell of AIPC and Adam Hays of Hays Research Group developed the survey instrument. The telephone survey was conducted from August 4, 2016 to August 9, 2016. Each survey averaged approximately eight minutes in length.

A total of 382 residents from Anchorage, Alaska were interviewed. The sample was kept in proportion to state population figures with the margin of error for age groups and gender.

Hays Research Group team used IBM SPSS software to analyze the data. They provided frequency and cross tabulation data. Those results are presented in the Key Findings section of this report.

Secondary Data

To measure NMUPO and heroin consumption and its consequences, the assessment relied on data from existing sources. This included data from the Youth Risk Behavior Survey (YRBS), National Survey on Drug Use and Health (NSDUH), Alaska Trauma Registry (ATR), Volunteers of America Alaska, and the State of Alaska Department of Health and Social Services (DHSS). These data sources provided estimates of NMUPO use and heroin use in Anchorage, as well as information about overdose and fatality. HVHC and AIPC also used data from the Alaska Young Adults Substance Use Survey (YASUS).

Youth Risk Behavior Survey

The YRBS is an anonymous school-based survey of high school students that covers six categories of adolescent health and social behaviors (Alaska Division of Behavioral Health, 2012). The survey is administered every other year and the most recent survey was conducted in 2015. In spring 2015, 1,418 students from across the state of Alaska were surveyed. The YRBS contains questions pertaining to current and lifetime prescription drug use (not specific to opioid use/misuse) and heroin use. Data is available at the district level for the Anchorage School District.

Alaska Trauma Registry

The Alaska Trauma Registry (ATR) collects data from 24 of Alaska's acute care hospitals for patients with serious injuries. Alaska Injury Prevention Center analyzed data from the Division of Public Health pertaining to opioid and heroin overdose for the appropriate age groups.

State of Alaska Department of Health and Social Services

The DHSS has issued several epidemiology bulletins covering the NMUPO and heroin use issue. In March of 2016, the DHSS issued a bulletin with information about drug overdose deaths in Alaska from 2009-2015. This bulletin relied on mortality data collected by the Alaska Bureau of Vital Statistics.

Alaska Young Adult Substance Use Survey

The Center for Behavioral Health Research and Services at University of Alaska Anchorage conducted a telephone survey to assess young adult substance use in Alaska (J.D. Barnett, personal communication, December 23, 2016). Specifically, the YASUS aimed to establish state-level estimates of opioid and heroin consumption and consequences among 18-27 year olds. The YASUS also contained questions pertaining to social availability, retail availability, and perceived risk of harm. There were a total of 39 questions within the survey.

A total of 7,130 individuals were invited to participate and a total of 1,031 respondents completed the survey. While the research team intended to only invite participants in the 18-27 age range, some participants were older than 25. Of the 1,031 respondents to complete the survey, 779 (75.6%) were within the target age range of 18-27. Of the 7,130 participants invited to participate, 2,100 were residents of Anchorage. Anchorage participants in the 18-27 year range completed a total of 212 surveys.

The UAA research team obtained Institutional Review Board (IRB) approval from the University of Alaska Anchorage and the Alaska Area Institutional Review Board to conduct the YASUS. Per IRB protocol the research team could not provide raw data for further analysis, but did provide data analysis for statewide and Anchorage data as a whole, and by race and gender.

Appendix B: Extent of Use in Anchorage

Prescription opioid misuse and heroin use are prevalent throughout the community. A summary of the key findings identified in the Anchorage community needs assessment are detailed below.

Use Among Youth 12-17 Years Old

- Prescription opioid use among 12-17 year olds is higher than the statewide and national averages. According to the National Survey on Drug Use and Health (NSDUH), Anchorage rates were 7.2%, 6.41% statewide, and 5.85% nationally in 2010/2012.
- Information gathered from PRIME for Life participant surveys, it is important to note that prescription drugs are the third most-used substance after marijuana and alcohol.
    - Many of the youth participating in PRIME for Life self-reported that they began using prescription drugs at the average age of 14.
- Use of prescription drugs in the last 30 days:
    - Based on gender, there is a near-even percentage of males and females that 30-day use of prescription drugs at 7.5% for both genders.
    - Based on grade level, use of prescription drugs increases over grade levels and age of youth. An estimated 7.5% of Anchorage high school students had taken a prescription drug without a prescription from a doctor one or more times during the past 30 days. Rates of use in the past 30 days range from 4.2% in 9th grade to more than double that in 12th grade (11.0%).
    - Use of prescription drugs without a prescription by students in alternative high schools in Alaska was over 40%, in 2011, compared to 16.9% for all Alaskan high school youth.
    - Compared to white and Alaska Native students, the Other Races group saw the highest rate (9.7%) of prescription drug use without a prescription.
    - There were also differing rates of past 30-day use by academic performance. Approximately 12% of students with primarily grades of C, D, or F reported past 30-day use; this compares to 5.5% of students with grades of primarily A or B. This data shows that there is a greater rate of non-prescription drug use among students not identifying as white or Alaska Native, students primarily receiving grades of C, D, and F, and upperclassmen.
- Use of prescription drugs within lifetime:
    - Data from the 2015 YRBS indicate that 15.0% of Anchorage School District students had taken a prescription drug without a prescription from a doctor during their life. According to 2015 YRBS data, the rates for lifetime use by females (15.6%) was not substantially different compared to males (14.3%).
    - There was little difference in prevalence for lifetime use when comparing racial/ethnic groups. Alaska Native and students of "Other Races" each had approximately 16% lifetime use of prescription drugs without a prescription, and 13.7% of white students reported lifetime use.
    - There was a greater rate of lifetime use for upperclassmen compared to underclassmen. Just over 10% of high school freshman and 12% of high school sophomores reported lifetime use. High school juniors had the highest lifetime use rate in 2015 at 19.6% and 18.9% of high school seniors reported lifetime use.
    - Approximately 21.5% of students with primarily grades of C, D, or F reported lifetime use of a non-prescribed prescription drug compared to 12.4% of students with grades of primarily A or B. This data shows that there is little difference in lifetime use between

males and females, or students of different racial/ethnic groups. There are, however, differences in lifetime use by grade year as well as by academic performance.

- Use of heroin over lifetime:
    - An estimated 1.6% of students reported ever having used heroin.
    - From the 2015 YRBS, heroin use among males was 2.6% and 0.6% among females.
    - Approximately 2.6% of students of "Other Races" reported use, compared to 1.1% among white students, and 0.8% Alaska Native students.
    - Highest use is among 11th grade at 3.1%, compared to 9th grade (0.8%), 10th grade (1.7%), and 12th grade (1.1%).
    - Approximately 2.9% of students with primarily grades of C, D, or F reported use, and 1.0% of students with primarily grades of A or B reported use.

Use Among Adults 18-25 Years Old:

- Young adults misuse of prescription opioids and heroin are trending upwards in Anchorage, where rates are already greater than Alaska's statewide and national averages. According to the National Survey on Drug Use and Health (NSDUH), there has been an increase in the nonmedical use of pain relievers among 18-25 year olds in Anchorage, from 11.79% to 12.35% from 2006/2008 to 2012/2012 (Heath, et al., 2015). Reported rates of use are greater in Anchorage than Alaska's statewide rate (11.78 in the 2010/2012 survey) and greater than the U.S. rate (10.29 in the 2010/2012 survey).
- The 2015 UAA Drug and Alcohol survey also shows prescription drug use on the rise on campus. Of the 4,000 students who responded to the survey, 6.6% reported using sedatives once a week and 4.2% reported using sedatives three or more times a week (Heath, et al., 2015). Law enforcement data show illegal use of pharmaceuticals is a growing concern, hydrocodone and OxyContin/oxycodone abuse, in particular.

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4/15/2015

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