ASSEMBLY HUMAN RESOURCES COMMITTEE AGENDA

April 17, 2023 at 6:00 PM

Assembly Chambers/Zoom Webinar

https://juneau.zoom.us/j/95241164899 or 1-253-215-8782 Webinar ID: 952 4116 4899

A. CALL TO ORDER

B. LAND ACKNOWLEDGEMENT

We would like to acknowledge that the City and Borough of Juneau is on Tlingit land, and wish to honor the indigenous people of this land. For more than ten thousand years, Alaska Native people have been and continue to be integral to the well-being of our community. We are grateful to be in this place, a part of this community, and to honor the culture, traditions, and resilience of the Tlingit people. Gunalchéesh!

C. ROLL CALL

D. APPROVAL OF AGENDA

E. APPROVAL OF MINUTES

1. February 27, 2023 Assembly Human Resources Committee Meeting Minutes - Draft
2. March 20, 2023 Assembly Human Resources Committee Meeting Minutes - Draft

F. AGENDA TOPICS

3. **HRC Finalization of Questions for Parks & Recreation Advisory Committee (PRAC) Applicants**
4. **Alaskan AIDS Assistance Association & State of AK/Public Health Nursing Presentation**

   Harm reduction, prevention strategies and education efforts in substance use presented by the Four A's and SOA/Div. Public Health

G. STAFF REPORTS

As of April 14 the Clerk's Office has received **20** applications for the Parks & Recreation Advisory Committee (PRAC). Finalized questions will be sent out to applicants Tuesday, April 18 with a requested return deadline of Monday, May 1. Following Empowered Board interview process, applications and returned responses will be in the HRC committee member packet and only redacted applications will be in the standard HRC public packet for the Monday, May 8 meeting beginnig at 5:30 p.m.

H. STANDING COMMITTEE TOPICS

5. **Assembly Goal - Specific to Human Resources Committee**

   Goal 4: Community, Wellness and Public Safety - Juneau is safe and welcoming for all citizens

   A. Acknowledge and honor Juneau's indigenous culture, place names, naming policy and recognize Elizabeth Peratrovich Day.

6. **Discussions Regarding CBJ Boards & Committees - *as meeting time allows***

   Committee Recruitment, Member Development, Application & Interview Process, Other Related Topics

   Additional Document Tools for HRC

   2023 CBJ Boards-Committees Description List (link to 3/20/2023 HRC agenda item)

   HRC Pending List - April 2023 (included in packet as informational, guaranteed to change)

I. COMMITTEE MEMBER COMMENTS AND QUESTIONS

J. NEXT MEETING DATE

Monday, May 8, 2023 at **5:30 p.m**. for PRAC application review & recommendations of appointments

K. SUPPLEMENTAL MATERIAL

7. **State of Alaska/Division of Public Health - Handouts Related to Substance Abuse Presentation**

L. ADJOURNMENT

ADA accommodations available upon request: Please contact the Clerk's office 36 hours prior to any meeting so arrangements can be made for closed captioning or sign language interpreter services depending on the meeting format. The Clerk's office telephone number is 586-5278, TDD 586-5351, e-mail: city.clerk@juneau.gov.

ASSEMBLY HUMAN RESOURCES COMMITTEE MINUTES

February 27, 2023 at 6:00 PM

Assembly Chambers/Zoom Webinar

https://juneau.zoom.us/j/95241164899 or 1-253-215-8782 Webinar ID: 952 4116 4899

A. CALL TO ORDER

HRC Chair Smith called the Assembly Human Resources Committee meeting to order at 6:03 p.m.

B. LAND ACKNOWLEDGEMENT

We would like to acknowledge that the City and Borough of Juneau is on Tlingit land, and wish to honor the indigenous people of this land. For more than ten thousand years, Alaska Native people have been and continue to be integral to the well-being of our community. We are grateful to be in this place, a part of this community, and to honor the culture, traditions, and resilience of the Tlingit people. Gunalchéesh!

C. ROLL CALL

Members Present: Chair Greg Smith, Maria Gladziszewski, Alicia Hughes-Skandijs and Christine Woll
Members Absent: None
Others Present: Deputy Clerk Di Cathcart, City Clerk, Beth McEwen, Deputy City Manager Robert Barr

D. APPROVAL OF AGENDA

Agenda approved as presented

E. APPROVAL OF MINUTES

Minutes approved as amended and presented.

1. **September 12, 2022 HRC Minutes – Draft –** *approved as presented.*
2. **November 21, 2022 HRC Minutes – Draft -** *approved as presented.*
3. **January 9, 2023 HRC Minutes – Draft –** *approved with Woll edit to JCOA aging question.*
4. **January 30, 2023 HRC Minutes – Draft -** *approved as presented.*
5. **January 31, 2023 Full Assembly as the HRC Minutes – Draft -** *approved as presented.*

F. AGENDA TOPICS

6. **Local Emergency Planning Committee (LEPC) Appointment**

   The LEPC serves as a community coalition advising staff on emergency management issues, reviews the emergency response plan for CBJ and functions, when necessary, as the Local Emergency Planning Committee under SARA Title III. The Assembly nominates applicants and final appointments are done by the State Emergency Response Commission. A ***memo from Deputy Clerk Cathcart in the HRC packet outlines which LEPC seat is requiring action as well as a recommended motion.***

MOTION: by Ms. Gladziszewski to forward to the full Assembly for approval, the recommendation to forward to the State of Alaska Emergency Response Commission the appointment of Louisa Phillips to the Local Emergency Planning Committee General Public Seat 4a – alternate seat for a term beginning immediately and ending December 31, 2023 and ask for unanimous consent. ***Hearing no objections, motion passed.***

7. Juneau Economic Development Council (JEDC) Board Appointment

(JEDC) Board Members serve staggered three-year terms and may serve two consecutive terms. Article Four, Section 2, Paragraph E, of JEDC Bylaws, states:

"The JEDC shall publish notice of vacancies on the JEDC Board of Directors. The JEDC Board or a recruitment committee will review and may interview candidates for the JEDC Board of Directors. The JEDC Board will forward the names of recommended candidates to the CBJ Assembly. The CBJ Assembly will appoint JEDC board members."

The two JEDC applicants are included in the Human Resources Committee packet along with a memo from JEDC Executive Director Brian Holst outlining the the process and recommendation.

MOTION: by Ms. Hughes-Skandijs to forward to the full Assembly for approval, appointment to the Juneau Economic Development Council Board as outlined in the memo presented by the Juneau Economic Development Council: Trenton English to the Organized Labor Seat for a term beginning immediately and ending October 31, 2025 and ask for unanimous consent. ***Hearing no objections, motion passed.***

8. CBJ Board & Committee Outreach & Diversity

The committee discussed having this topic as a standing agenda item so members can discuss as time allows. Questions that arose during the boards and committees outreach and diversity discussion were as follows: Ms. Hughes-Skandijs asked if boards are doing what the Assembly want them to do and is board membership reflective of the make-up of our town. Chair Smith asked which boards are required and how often do the various boards meet. Ms. Gladziszewski asked which boards are we having trouble recruiting for, how did those boards get created and do the members serving the board think it's important. Ms. Woll stated one of the problems is not getting diverse voices interested in applying and appointed. Ms. Hughes-Skandijs asked how many boards have staff liaisons. Chair Smith asked if we have the right amount of boards for a community our size and are people interested in serving or, once serving on a board, do they feel supported. Ms. Gladziszewski agreed that diversity is important and broad; she suggested creating short videos posted to the CBJ YouTube channel on what a particular board does e.g.: "What the Planning Commission Does". Ms. Hughes-Skandijs asked who the stakeholder groups are and how can we educate the community.

G. STANDING COMMITTEE TOPICS

The committee did not take up 2023 Assembly Goal 4 as an agenda topic for discussion at this meeting.

2023 Assembly Goal 4: Community, Wellness and Public Safety - Juneau is safe and welcoming for all citizens

A. Acknowledge and honor Juneau's indigenous culture, place names, naming policy and recognize Elizabeth Peratrovich Day.

H. STAFF REPORTS

Clerk staff will compile a board overview spreadsheet answering some of the questions posed by members regarding CBJ boards and board make-up.

I. COMMITTEE COMMENTS AND QUESTIONS - None

J. NEXT MEETING DATE - Regular HRC Meeting - March 20, 2023 @ 6:00pm Assembly Chambers/Zoom

K. ADJOURNMENT

There being no further business to come before the committee, meeting adjourned at 6:52 p.m.

ASSEMBLY HUMAN RESOURCES COMMITTEE MINUTES

March 20, 2023 at 6:00 PM

Assembly Chambers/Zoom Webinar

https://juneau.zoom.us/j/95241164899 or 1-253-215-8782 Webinar ID: 952 4116 4899

A. CALL TO ORDER

HRC Chair Smith called the Assembly Human Resources Committee meeting to order at 6:02 p.m.

B. LAND ACKNOWLEDGEMENT

C. ROLL CALL

Members Present: Chair Greg Smith, Maria Gladziszewski, Alicia Hughes-Skandijs and Christine Woll(via Zoom)
Members Absent: None
Others Present: Deputy Clerk Di Cathcart, City Clerk, Beth McEwen, CBJ Attorney Sherri Layne and P&R Director George Schaaf

D. APPROVAL OF AGENDA

Agenda approved as presented.

E. AGENDA TOPICS

1. Local Emergency Planning Committee (LEPC) Appointments

The LEPC serves as a community coalition advising staff on emergency management issues, reviews the emergency response plan for CBJ and functions, when necessary, as the Local Emergency Planning Committee under SARA Title III. The Assembly nominates applicants and final appointments are done by the State Emergency Response Commission. *A memo from Deputy Clerk Cathcart in the HRC packet outlines which LEPC seats are requiring action as well as a recommended motion.*

MOTION: by Ms. Hughes-Skandijs to forward to the full Assembly for approval, the recommendation to forward to the State of Alaska Emergency Response Commission the appointments of Travis Wolfe to the Firefighter/EMS Seat 3a, Kenneth Murphy to the Haz/Mat Transporter Seat 10a and Jamie Bursell to the Healthcare Systems Seat 13a on the Local Emergency Planning Committee and ask for unanimous consent. ***Hearing no objections, motion passed***.

2. Personnel Board Appointments

Per 44.05.060; the Personnel Board is composed of five members appointed by the Assembly. All appointments shall be for staggered three-year terms. Two seats shall be designated for members with a background in labor, two designated for members with a background in management, and one for a member of the general public. No member of the Personnel Board who has served for three consecutive terms or nine years shall again be eligible for appointment until one full year has intervened, provided, however, this restriction shall not apply if there are no other qualified applicants at the time reappointment is considered by the Assembly Human Resources Committee.

Both Labor Representative Seats are for terms beginning immediately (February 1, 2023) and ending January 31, 2026.

MOTION: by Ms. Gladziszewski to forward to the full Assembly for approval, the recommendation to appoint Nadine Lefebvre and to reappoint Cindy Spanyers to the two Labor Representative Seats on the Personnel Board, both for terms beginning immediately and ending January 31, 2026. ***Hearing no objections, motion passed.***

F. STANDING COMMITTEE TOPICS

3. Assembly Goal - Specific to Human Resources Committee

Goal 4: Community, Wellness and Public Safety - Juneau is safe and welcoming for all citizens

A. Acknowledge and honor Juneau's indigenous culture, place names, naming policy and recognize Elizabeth Peratrovich Day.

Chair Smith will ask Mr. Barr to provide additional material at a future HRC meeting for Goal 4 topics and will reach out to HRRM Director Dallas Hargrave regarding Elizabeth Peratrovich Day.

Committee members asked if CBJ has a current naming policy, it doesn't, so step 1 is to come up with a naming policy and look at a naming convention consistent with names currently on the books or in use. It was requested to look at what the Empowered Boards, Streets or Parks and Recreation do in regards to naming. Lastly, to be proactive vs. reactive when creating a naming policy that is actively reflecting on the indigenous cultures landscape of place names.

4. CBJ Board & Committee Outreach & Diversity

Ms. Cathcart gave an overview of the material included in the packet relating to boards and committee. Ms. Hughes-Skandijs noted that it was helpful to see how many of the boards were listed "as needed". Ms. Woll appreciated seeing the staff support listed and noticed that city clerk was on many of the items and wondered how much is because of tech or minutes needs and asked if going on-line created more work. Ms. Gladziszewski stated that if have engaged boards doing work the City Manager should assign some type of staff support but not necessarily default to clerks. Ms. Hughes-Skandijs discussed reviewing each boards governing legislation as well as wondering if perhaps CBJ can be too formal which could be a deterrent for some people applying. Ms. Woll agreed with Ms. Hughes-Skandijs that CBJ's systems can be intimidating and would appreciate having a future discussion around how to improve our board application questions and interview process and questions. Chair Smith agreed it would be a good idea to take up application questions at a future meeting as well as to start to capture the ideas discussed during the last couple meetings around board outreach and diversity.

G. STAFF REPORTS

The "new" Parks & Recreation Advisory Committee - Clerk's Office and Parks & Recreation are advertising and reaching out to members of the various consolidated Parks & Recreation boards and encouraging interested people in submitting an application via: https://juneau.org/clerk/boards-committees

The HRC should discuss how they would like to proceed with reviewing applications and if the HRC wishes to hold interviews or not; if they do, they will need to come up with advanced interview questions as well as a schedule. If the HRC does not plan on holding interviews then Clerk staff recommends reviewing applications and forwarding recommendations to the full Assembly during the regularly scheduled Assembly Human Resources Comittee Meeting on April 17, 2023 with a start time of 5:30pm. PRAC appointments would most likely be the only thing on the agenda.

Ms. Cathcart outlined potential processes for reviewing of applications and requested the HRC decide how they would like to move forward, either with standard review of applications received or to create additional interview questions and holding interviews on a designated night. Ms. Gladziszewski stated she would like to see a hybrid of that, sending out some additional questions that would be included with the application and not hold interviews. Ms. Hughes-Skandijs said she didn't think we needed to do interviews since we have this

committee to review applications. She noted that the application does hit some of the questions we are looking for as Ms. Gladziszewski had mentioned about 'why are you interested in serving'. Ms. Woll agreed that not holding interviews was fine and agreed with Ms. Gladziszewski about including a few additional questions. In the future Ms. Woll would like to look at updating the application questions to make them more specific to the board being applied for. Ms. Cathcart did note that our current board management program only allows for a generic set of questions vs. board specific and will be looking at the new board management program CBJ is transitioning into to see if it's possible to make specific applications for boards. Chair Smith agreed with coming up with and sending out some additional questions.

Ms. Cathcart will send out an email reminder to committee members to send in any questions they would like to see as part of the PRAC application and review process and will include copies of the current Empowered Board questions and the CBJ board application as examples. Committee members will send any questions in by Wednesday prior to the April 17 HRC meeting. The committee will finalize questions which will be sent to applicants and the HRC will review applications at its May 8, 2023 meeting.

H. COMMITTEE MEMBER COMMENTS AND QUESTIONS

None

I. NEXT MEETING DATE

Monday, April 17, 2023

J. ADJOURNMENT

There being no further business to come before the committee, meeting adjourned at 6:45 p.m.

POTENTIAL PRAC APPLICANT QUESTIONS FOR HRC FINALIZATION

1. Please describe your vision for Juneau's parks and recreational resources.
2. How does your current work, community service and other activities and interests prepare you for the duties of the Parks & Recreation Advisory Committee?
3. Describe your experience and approach to balancing different community interests and needs.
4. What things do you hope to accomplish as a member of PRAC? Are there improvements to the management of Juneau's parks and recreational resources that you'd like to see?
5. Describe your experience and approach to working with a group with diverse and/or conflicting perspectives.
6. Have you previously served on the Parks & Recreation Advisory Committee, the Aquatics Board, the Treadwell Arena Advisory Board or the Jensen-Olson Arboretum Advisory Board?
7. Do you or any of your family members have an affiliation with or use any of the following Parks & Recreation managed facilities: Treadwell Arena, Augustus Brown Pool, Dimond Park Aquatic Center, Dimond Park Field House, or Jensen-Olson Arboretum?
8. Do you or any of your family members have an affiliation with or regularly use other Parks & Recreation facilities or infrastructure such as: parks, trails, sports fields, shelters, Eagle Valley Center, Zach Gordon Youth Center, Amalga Cabin or Mt. Jumbo Gym?

	A	B
1		**2023 HRC MEETINGS - PENDING LIST**
2		*This is a guideline to the entity that is Boards/Commissions and subject to change*
3	**2023 HRC dates**	
4	**January**	JCOA Appointments
5	**9th**	Ordinance 2022-64 - P&R Board Consolidation for HRC review
6		
7	**30th**	BCAC Appointments
8		JCOS Appointment - vacant seat
9		Resolution 3020 Personnel Rules for HRC review
10		
11	**31st**	Full Assembly as HRC for BRH & PC Interviews
12		
13	**February**	LEPC Appointment
14	**27th**	JEDC Appointment - vacant Labor seat
15		Board recruitment & diversity discussion
16		
17	**March**	Outling process for PRAC Appointments at the 4/17 HRC
18	**20th**	LEPC Appointment
19		Personnel Board Appointments
20		
21	**April**	Per Chair Smith - Rank Choice Voting Presentation
22	**17th**	Per Chair Smith - Substance Abuse Presentation
23		BOE Appointments (if we have applicants)
24		
25		
26	**May**	PRAC Appointments
27	**8th**	Setting Dates for Empowered Board Interviews: Eaglecrest/Airport/Docks & Harbors
28		BOE Appointments (if we have applicants)
29		
30	**June**	Juneau Commission on Sustainability Annual Report & Appointments - or July
31	**12th**	Historic Resources Advisory Committee Annual Report & Appointments
32		SRRC Appointments - or w/ other Empowered Boards w/ Full Assembly as HRC
33		JHRC Annual Report & Appointments - or August (JHRC takes summers off)
34		Bidding Review Board Appointments
35		Utility Advisory Board Annual Report & Appointments - or July
36		
37		
38	**TENTATIVE**	Airport Board Interviews/Appointments (Full Assembly as HRC)
39	**Week of June**	Eaglecrest Board Interviews/Appointments (Full Assembly as HRC)
40	**12th or 26th**	Docks & Harbors Board Interviews/Appointments (Full Assembly as HRC)
41		
42		
43	**July**	
44	**10th or 31st**	Youth Activities Board Annual Report & Appointments
45		
46		
47	**August**	
48	**21st**	Community Development Block Grant Proposal Review w/ CDD Staff Recommendation if applying this year
49		
50		
51	**September**	Douglas Advisory Board Annual Report & Appointments
52	**11th**	
53		
54	***October***	***NO HRC MEETING DUE TO ASSEMBLY REORGANIZATION***

	A	B
55		
56	**November**	Review of 2024 Assembly Meeting Calendar
57	**13th**	Juneau Economic Development Council Appointments
58		Setting Dates for Empowered Board Interviews: Hospital Board & Planning Commission
59		
60		
61	**December**	LEPC Annual Report & Appointments (or Jan 2024)
62	**11th**	Juneau Commission on Aging Annual Report & Appointments (or Jan 2024)
63		Sister Cities Committee Annual Report & Appointments
64		Board of Equalization Appointments (or Jan 2024)
65		Sales Tax Board of Appeals Appointments
66		Building Code Advisory Committee Annual Report & Appointments
67		
68	**TENTATIVE**	Hospital Board Interviews/Appointments (Full Assembly as HRC)
69	**Week of Dec**	Planning Commission Interviews/Appointments (Full Assembly as HRC)
70	**11th**	
71		

Alaska Department of Health
Division of Public Health
Health Analytics and Vital Records Section
HealthAnalytics@Alaska.Gov
Office of Substance Misuse and Addiction Prevention
OSMAP@Alaska.Gov

Alaska Facts and Figures

2021 Drug Overdose Mortality Update (July 25th, 2022)

Background

Drug overdoses are a significant contributor to mortality in Alaska and represent an ongoing public health concern. Deaths by overdose have been increasing annually since 2018. This report is designed to provide an update on the current state of Alaska drug overdose mortality through 2021. Data from 2021 may be incomplete and should be considered provisional and subject to change.

Methods

The Alaska Health Analytics and Vital Records Section's Electronic Vital Records System was queried for Alaska resident or non-resident certificates of death occurring in-state between 2012 and 2021. Overdoses are identified using the International Classification of Disease, 10th Revision (ICD-10) codes for unintentional (X40-X44), suicide (X60-X64), homicide (X85), or undetermined intent (Y10-Y14) drug poisoning. Overdose deaths are tabulated based on the decedent's underlying cause of death (defined as the condition or injury that initiated the train of morbid events leading directly to death). Deaths due to alcohol-poisoning or drug-related traumatic injuries such as motor vehicle accidents are not included.

Overdose deaths are further categorized by the multiple contributing causes of death (defined as all other causes in the train of morbid events) in order to identify select types of illicit drugs. This includes selected ICD-10 codes for narcotic and psychodysleptic (hallucinogen) drugs ("narcotics": T400-T409), antiepileptic, sedative-hypnotic and antiparkinsonism drugs ("sedatives": T420-T428) and psychotropic drugs, not elsewhere classified ("psychotropics": T430-T439). The literal text of the cause of death descriptions are also analyzed to identify additional drugs not directly captured using ICD-10 codes. This includes fentanyl and its analogues and methamphetamine, which are classified as sub-categories of other synthetic narcotic (T404) and psychostimulant (T436) drugs, respectively. Tabulations of overdose deaths by drug type are not mutually exclusive and a single overdose involving multiple drugs can be counted in multiple drug categories. Multidrug overdoses and the top fatal drug combinations are also examined.

Data are stratified by the demographic and regional characteristics of the decedent, including sex, bridged race, ethnicity, age, and Public Health Region where the death occurred. Death rates per 100,000 are calculated using population estimates from the Alaska Department of Labor and Workforce Development. If any population estimates were not available at the time of analysis, values were substituted using the previous year's estimate. Rates are age-adjusted by U.S. Standard Year 2000 Population levels, when possible, to correct for natural differences in the age distribution of the population. Results have not been tested for statistical significance and are subject to change.

Results

Overdose Summary

- 1,382 drug overdose deaths have occurred in Alaska between 2012 and 2021 (an average of about 138 deaths per year).
  - In 2021, there were 253 overdose deaths, up from 146 in 2020.
  - In 2021, the overdose death rate was 35.2 deaths per 100,000, up from 20.2 in 2020.
- By sex, men typically experience higher overdose death rates than women.
  - In 2021, the overdose death rate for men was 42.9 deaths per 100,000, compared to 26.9 for women.
- By race, American Indian/Alaska Native (AI/AN) people typically experience higher overdose death rates than other races.
  - In 2021, the overdose death rate for AI/AN people was 77.7 deaths per 100,000, compared to 40.1 in 2020.
  - In 2021, the overdose death rate for White people was 28.8 deaths per 100,000, compared to 15.6 in 2020.
  - In 2021, Asian/PI, Black, and Hispanic (of any race) people experienced fewer than 20 overdose deaths, making rate estimates statistically unreliable.
- By age, young adults and middle-aged people between 25 to 54 years old typically experience higher overdose death rates than other ages.
  - In 2021, the overdose death rate was highest among people aged 25 to 34 years old, at 64.6 deaths per 100,000. This was followed closely by people aged 45 to 54 years old and aged 35 to 44 years old, at 63.4 and 57.2 deaths per 100,000, respectively.
- By geography, the Anchorage Public Health Region had the state's highest overdose death rate in 2021, at 49.3 deaths per 100,000, up from 31.4 in 2020.

Figure 1. Overdose Deaths by Year (2012-2021)

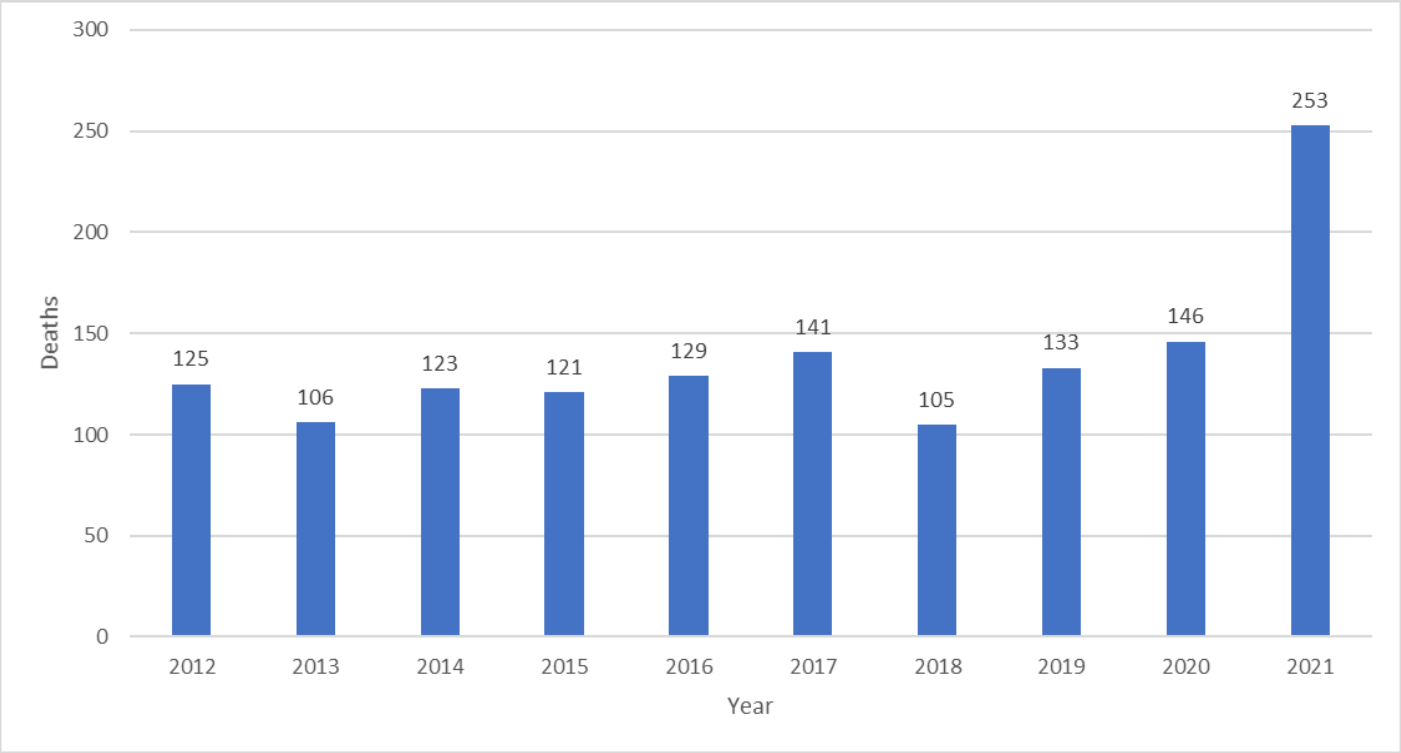

Table 1. Overdose Deaths by Year (2012-2021)

Underlying Cause	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	Total
Drug Overdose	125	106	123	121	129	141	105	133	146	253	1,382

Note: Drug poisoning (overdose) underlying cause of death ICD-10 codes: X40-X44, X60-X64, X85, Y10-Y14.

Table 2. Overdose Deaths (Rates) by Sex (2017-2021)[1]

Sex	2017	2018	2019	2020	2021
Male	82 (22.3)	60 (15.1)	93 (24.4)	94 (25.3)	159 (42.9)
Female	59 (16.1)	45 (12.7)	40 (11.3)	52 (14.8)	94 (26.9)

Table 3. Overdose Deaths (Rates) by Race/Ethnicity (2017-2021)[1]

Race/Ethnicity	2017	2018	2019	2020	2021
White	94 (18.3)	73 (13.5)	80 (15.3)	80 (15.6)	146 (28.8)
AI/AN	36 (30.7)	22 (20.7)	40 (34.8)	45 (40.1)	90 (77.7)
Asian/PI	2 (**)	1 (**)	5 (**)	4 (**)	2 (**)
Black	7 (24.2*)	8 (21.8*)	8 (27.0*)	12 (34.7*)	13 (39.4*)
Hispanic (Any Race)	8 (16.2*)	3 (**)	1 (**)	4 (**)	6 (11.3*)

Table 4. Overdose Deaths (Rates) by Age (2017-2021)[1]

Age	2017	2018	2019	2020	2021
<5 Years	0 (NA)	0 (NA)	1 (**)	0 (NA)	0 (NA)
5-14 Years	0 (NA)	0 (NA)	0 (NA)	0 (NA)	0 (NA)
15-24 Years	11 (11.4*)	10 (10.5*)	7 (7.5*)	18 (19.5*)	27 (29.2)
25-34 Years	35 (30.4)	22 (19.5)	46 (41.0)	33 (30.0)	71 (64.6)
35-44 Years	32 (34.1)	23 (24.1)	34 (35.0)	36 (36.1)	57 (57.2)
45-54 Years	36 (39.2)	23 (26.0)	19 (22.2*)	29 (34.7)	53 (63.4)
55-64 Years	21 (21.1)	24 (24.3)	17 (17.4*)	24 (25.3)	32 (33.7)
65-74 Years	4 (**)	3 (**)	7 (11.3*)	5 (**)	10 (15.5*)
75-84 Years	2 (**)	0 (NA)	2 (**)	1 (**)	3 (**)
85+ Years	0 (NA)	0 (NA)	0 (NA)	0 (NA)	0 (NA)

Table 5. Overdose Deaths (Rates) by Region (2017-2021)[1]

Region	2017	2018	2019	2020	2021
Anchorage	81 (27.3)	51 (16.5)	57 (19.3)	90 (31.4)	142 (49.3)
Gulf Coast	10 (13.1*)	15 (17.7*)	16 (18.8*)	12 (12.8*)	30 (40.3)
Interior	17 (14.8*)	12 (10.3*)	22 (19.3)	10 (8.2*)	19 (15.9*)
Mat-Su	13 (12.4*)	15 (14.1*)	15 (15.0*)	20 (19.0)	27 (24.5)
Northern	0 (NA)	1 (**)	5 (**)	3 (**)	3 (**)
Southeast	15 (20.5*)	7 (9.0*)	11 (15.3*)	7 (10.8*)	24 (35.0)
Southwest	5 (**)	4 (**)	7 (16.9*)	4 (**)	8 (21.1*)
Statewide	**141 (19.3)**	**105 (14.0)**	**133 (18.1)**	**146 (20.2)**	**253 (35.2)**

Note: Drug poisoning (overdose) underlying cause of death ICD-10 codes: X40-X44, X60-X64, X85, Y10-Y14.

1. Death rate per 100,000 population. Age-adjusted by U.S. Year 2000 Standard Populations for Sex, Race/Ethnicity, and Region.

* Rates based on fewer than 20 events are statistically unreliable and should be used with caution.

* Rates based on fewer than 6 events are not reported.

Overdoses by Drug

- 778 total drug overdose deaths occurred in Alaska between 2017 and 2021.
- 546 opioid overdose deaths occurred in Alaska between 2017 and 2021 (an average of about 109 deaths per year).
  - In 2021, there were 196 opioid overdose deaths, up from 102 in 2020.
  - In 2021, the opioid overdose death rate was 27.3 deaths per 100,000, up from 14.0 in 2020.
  - Other synthetic narcotics, a category that includes synthetic opioids such as fentanyl, were involved in 150 deaths.
- 403 psychostimulant overdose deaths occurred in Alaska between 2017 and 2021 (an average of about 81 deaths per year).
  - In 2021, there were 159 psychostimulant overdose deaths, up from 67 in 2020.
  - In 2021, the psychostimulant overdose death rate was 22.2 deaths per 100,000, up from 9.4 in 2020.

Table 6. Narcotics Overdose Deaths (Rates) by Drug (2017-2021)[1]

Drug (ICD-10 Code)	2017	2018	2019	2020	2021
Total Narcotics (T400-T409)	**107 (14.4)**	**72 (9.3)**	**88 (11.7)**	**107 (14.6)**	**199 (27.6)**
Opioids (T400-T404, T406)	100 (13.6)	65 (8.4)	83 (11.0)	102 (14.0)	196 (27.3)
Heroin (T401)	36 (4.9)	28 (3.7)	45 (6.0)	31 (4.3)	65 (9.0)
Analgesic Opioids (T402-T404)	75 (10.0)	46 (5.9)	60 (7.8)	88 (12.1)	177 (24.7)
Analgesics Excl. Other Synth. (T402-T403)	50 (6.6)	37 (4.8)	46 (6.0)	44 (5.7)	79 (10.9)
Other Opioids (T402)	46 (6.1)	33 (4.3)	41 (5.3)	37 (4.7)	72 (9.9)
Methadone (T403)	8 (1.0*)	9 (1.2*)	9 (1.2*)	8 (1.1*)	12 (1.6*)
Other Synthetic Narcotics (T404)	37 (4.8)	16 (2.0*)	23 (3.2)	61 (8.7)	150 (21.1)
Fentanyl (T404 + Fentanyl Or Analogue)	28 (3.6)	9 (1.1*)	15 (2.2*)	58 (8.2)	145 (20.4)
Other And Unspecified Narcotics (T406)	24 (3.4)	22 (2.9)	24 (3.0)	23 (3.0)	15 (2.0*)
Non-Opioids (T405, 407-409)	18 (2.3*)	11 (1.4*)	7 (0.9*)	21 (2.9)	13 (1.5*)
Cocaine (T405)	18 (2.3*)	10 (1.3*)	7 (0.9*)	21 (2.9)	11 (1.3*)
Cannabis (Derivatives) (T407)	0 (NA)	1 (**)	0 (NA)	0 (NA)	2 (**)

Table 7. Sedatives Overdose Deaths (Rates) by Drug (2017-2021)[1]

Drug (ICD-10 Code)	2017	2018	2019	2020	2021
Total Sedatives (T420-T428)	**39 (5.4)**	**26 (3.6)**	**26 (3.7)**	**26 (3.6)**	**20 (2.9)**
Benzodiazepines (T424)	32 (4.5)	24 (3.2)	18 (2.6*)	20 (2.8)	12 (1.7*)

Table 8. Psychotropics Overdose Deaths (Rates) by Drug (2017-2021)[1]

Drug (ICD-10 Code)	2017	2018	2019	2020	2021
Total Psychotropics (T430-T439)	**78 (10.8)**	**59 (8.2)**	**74 (9.9)**	**75 (10.4)**	**169 (23.6)**
Antidepressants (T430-T432)	13 (1.8*)	11 (1.7*)	11 (1.6*)	10 (1.3*)	13 (1.9*)
Antipsychotics (T433-T435)	7 (0.9*)	5 (**)	2 (**)	4 (**)	6 (0.9*)
Psychostimulants (T436)	64 (9.0)	49 (6.7)	64 (8.6)	67 (9.4)	159 (22.2)
Methamphetamine (T436 + Meth.)	60 (8.4)	44 (6.0)	59 (7.8)	62 (8.7)	154 (21.5)

Note: Drug categories are not mutually exclusive. A single overdose death involving multiple drugs can be counted in multiple categories.
1. Death rate per 100,000 population. Age-adjusted by U.S. Year 2000 Standard Population.
* Rates based on fewer than 20 events are statistically unreliable and should be used with caution.
* Rates based on fewer than 6 events are not reported.

Overdoses by Drug - Trends

- Total drug overdose death rates have increased annually since 2018.
  - In 2021, the overdose death rate was 35.2 deaths per 100,000, up from 17.0 in 2012.
  - Increases in overdose death rates since 2018 appear to be driven largely by increases in narcotic and psychotropic drugs, both of which have increased since 2012.
  - Sedative drug overdose rates have been relatively stable over time, decreasing slightly since 2012.

Figure 2. Overdose Death Rates by Drug (2012-2021)[1]

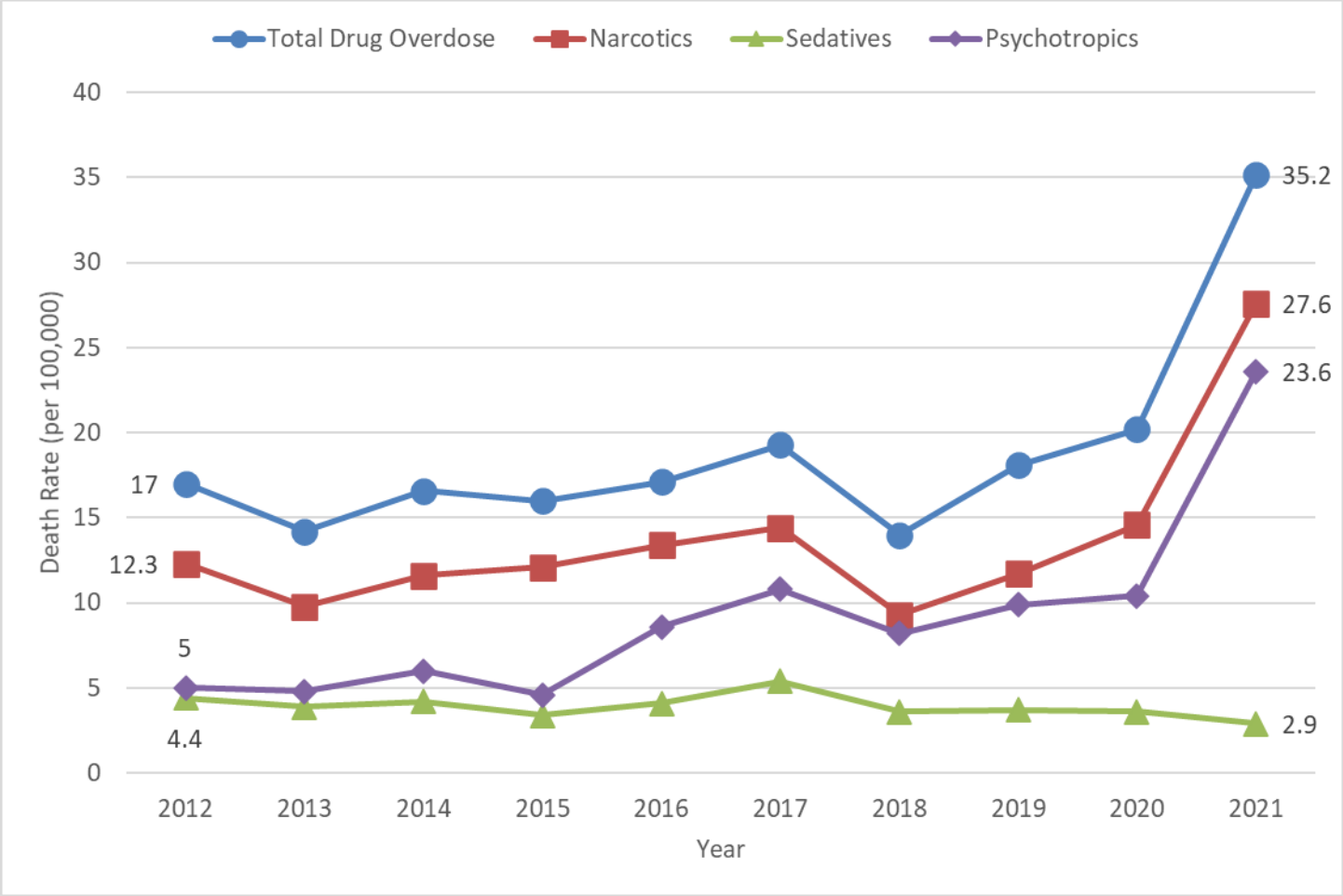

Table 9. Overdose Death Rates by Drug (2012-2021)[1]

Drug	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Total Drug Overdose	**17**	**14.2**	**16.6**	**16**	**17.1**	**19.3**	**14**	**18.1**	**20.2**	**35.2**
Narcotics	12.3	9.8	11.6	12.1	13.4	14.4	9.3	11.7	14.6	27.6
Sedatives	4.4	3.9	4.2	3.4	4.1	5.4	3.6	3.7	3.6	2.9
Psychotropics	5	4.8	6	4.6	8.6	10.8	8.2	9.9	10.4	23.6

Note: Drug categories are not mutually exclusive. A single overdose death involving multiple drugs can be counted in multiple categories.
1. Death rate per 100,000 population. Age-adjusted by U.S. Year 2000 Standard Population.

Multidrug Overdoses

- Between 2017 and 2021, 37% of drug overdose deaths involved a single type of narcotic, sedative, or psychotropic drug, 25% involved two drugs, and 34% involved three or more drugs.
- Between 2017 and 2021, heroin plus psychostimulants were the two most common lethal multidrug combinations, found in 18.6% of drug overdose deaths. This was followed closely by other synthetic narcotics plus psychostimulants, found in 18.4% of deaths.

Table 10. Drug Overdose Deaths (Percentage) by Number of Drugs (2017-2021)

Drugs	2017	2018	2019	2020	2021	Total
One Drug	48 (34%)	45 (43%)	48 (36%)	57 (39%)	88 (35%)	286 (37%)
Two Drugs	39 (28%)	19 (18%)	29 (22%)	36 (25%)	69 (27%)	192 (25%)
Three or More Drugs	49 (35%)	38 (36%)	42 (32%)	43 (29%)	90 (36%)	262 (34%)
Other or Unspecified Drugs	5 (4%)	3 (3%)	14 (11%)	10 (7%)	6 (2%)	38 (5%)
Total Drug Overdoses	**141 (100%)**	**105 (100%)**	**133 (100%)**	**146 (100%)**	**253 (100%)**	**778 (100%)**

Note: Multidrug overdose deaths with drug types in selected ICD-10 code ranges for narcotic, sedative, or psychotropic drugs: T400-T409, T420-T428, T430-T439. Deaths with codes outside the selected range or where no drug was identified are classified as other or unspecified.

Table 11. Top Ten Multidrug Overdose Combinations by Deaths (2017-2021)

Rank	Drug A (ICD-10 Code)	Drug B (ICD-10 Code)	Deaths	% Total ODs (N=778)
1	Heroin (T401)	Psychostimulants (T436)	145	18.6%
2	Other Synthetic Narcotics (T404)	Psychostimulants (T436)	143	18.4%
3	Other Opioids (T402)	Psychostimulants (T436)	107	13.8%
4	Other Opioids (T402)	Other Synthetic Narcotics (T404)	90	11.6%
5	Heroin (T401)	Other And Unspecified Narcotics (T406)	76	9.8%
6	Other And Unspecified Narcotics (T406)	Psychostimulants (T436)	72	9.3%
7	Heroin (T401)	Other Synthetic Narcotics (T404)	71	9.1%
8	Heroin (T401)	Other Opioids (T402)	70	9.0%
9	Benzodiazepines (T424)	Other Opioids (T402)	52	6.7%
10	Other And Unspecified Narcotics (T406)	Other Opioids (T402)	51	6.6%

Note: Multidrug overdoses with drug types in selected ICD-10 code ranges for narcotic, sedative, or psychotropic drugs: T400-T409, T420-T428, T430-T439. Drug A and B order is arbitrary and not indicative of each drug's level of contribution to the overdose death.

Discussion

In 2021, Alaska experienced the largest percent increase in overdose deaths of any state in the United States.[1] Between 2020–2021, drug overdose death rates increased for most drug categories examined in this report, resulting in a 74% increase in the overall drug overdose death rate. Of the drugs evaluated in the report, the largest increases were seen in overdose deaths involving fentanyl (a synthetic opioid) and methamphetamine (a psychostimulant), increasing 150% and 148%, respectively. The largest declines were seen in cocaine and benzodiazepine overdose deaths (48% and 40%, respectively). In 2021, individuals at comparatively higher risk of dying from drug overdose included men, American Indian/Alaska Native people, young adults, and those residing in the Anchorage Public Health Region. Multidrug use can be a significant driver of overdose mortality due to the physiological effects on the cardiovascular and respiratory systems when mixing categories of substances. Of the 778 total overdose deaths that occurred between 2017–2021, 58% involved drugs from more than one narcotic, sedative, or psychotropic category, including 34% that involved drugs from three or more categories.

[1] Ahmad FB, Rossen LM, Sutton P. Provisional drug overdose death counts. National Center for Health Statistics. 2021.

These data are consistent with recent national findings of most overdose deaths involving more than one sub[illegible] across 24 states and Washington DC revealed that fentanyl, heroin, cocaine, or methamphetamine (alone or in combination) were involved in nearly 85% of drug overdose deaths.[3] Overdose deaths involving synthetic opioids excluding methadone (primarily fentanyl) are projected to have increased for the ninth straight year in 2021,[4] as fentanyl continues to be mixed with heroin, stimulants, and counterfeit pills.[5] In Alaska, fentanyl was involved in nearly three out of four opioid overdose deaths, and many of these fentanyl-involved overdose deaths involved an additional substance, such as methamphetamine or heroin. The high potency of fentanyl combined with the tendency for mixing or co-use with other substances complicates intervention and treatment efforts.

In Alaska, the number of overdose deaths involving methamphetamines increased by 148% in 2021. The significant number of deaths involving psychostimulants warrants an increase in available and accessible stimulant use disorder treatment, and further analysis into risk and protective factors associated with stimulant misuse and addiction. Psychostimulants were involved in the top three overdose drug combinations (with heroin, other synthetic narcotics, and other opioids being the other substances) across 778 overdose deaths in the last five years. This suggests that harm reduction strategies should be integrated across multiple venues that include naloxone distribution to people who use stimulants, and multidrug use education on the lethality of combining substances.

More than a dozen State of Alaska (SOA) programs focus on prevention, treatment, and recovery strategies to counter overdose morbidity and mortality. Several initiatives specifically address fentanyl-involved overdose deaths. Since 2017, SOA Department of Health (DOH) Office of Substance Misuse and Addiction Prevention, through Project HOPE,[6] has distributed over 60,000 kits of naloxone to community members, a medication that has been demonstrated worldwide to reduce fatal overdose, with over 300 overdoses reversed in Alaska.[7, 8] Currently, Project HOPE incorporates fentanyl test strips and other resources into each naloxone kit. In 2022, a new initiative called Project Gabe,[9] supported by Project HOPE and the Section of Public Health Nursing, was launched to provide opioid misuse awareness, education, and prevention resources (including naloxone) to the fishing industry, as studies demonstrate employees in some occupational industries are at higher risk of being affected by the opioid epidemic. Finally, several public service announcements, posters, an Anchorage located bus advertisement, and website were developed and can be found at http://opioids.alaska.gov.

Engaging with people at high risk of overdose is key to preventing more deaths. Mobile crisis units connect people with the most appropriate resources from the onset of a behavioral health crisis through their recovery and follow up care. The Restore Hope in Linkage to Care Collaboration Program supports local behavioral health agencies, Anchorage Fire Department, and City of Fairbanks partners to connect people at point of emergency response to treatment and other social services. Since the inception of this program, 34 people engaged in treatment. The 1115 Medicaid Waiver Services is also integral to these efforts as it incorporated reimbursement rates for an increased breadth of behavioral health agencies as well as for mobile outreach and crisis response services.

SOA DOH has also been working with tribal and academic partners to incorporate a variety of provider education trainings, and tools including Project ECHO, a collaborative model of education that makes specialty knowledge more accessible to rural healthcare providers.[10] Improving awareness among providers of their existing prescribing practices is important to support the

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[2] Hedegaard, H., Bastian, B., Trinidad, J., Warner, M. (2018). "Drugs most frequently involved in drug overdose deaths: United State, 2011-2016." *National Vital Statistics Reports, 67*(9). Retrieved 22 Aug 2019 from: https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_09-508.pdf.

[3] O'Donnell, J., Gladden, RM., Mattson, C., et al. (2020). "Vital signs: characteristics of drug overdose deaths involving opioids and stimulants – 24 states and the District of Columbia, January-June 2019". *MMWR Morbidity and Mortality Weekly Report, 69*(35): 1189-1197.

[4] Ahmad FB, Rossen LM, Sutton P. Provisional drug overdose death counts. National Center for Health Statistics. 2021.

[5] Drug Enforcement Administration (DEA). "2020 National Drug Threat Assessment." Retrieved from: https://www.dea.gov/sites/default/files/2021-02/DIR-008-21%202020%20National%20Drug%20Threat%20Assessment_WEB.pdf.

[6] Project Hope: https://dhss.alaska.gov/health/osmap/Pages/hope.aspx.

[7] Chimbar, L., & Moleta, Y. (2018). "Naloxone effectiveness: a systematic review." *Journal of Addictions Nursing, 29*(3): 161-171.

[8] B. Hanson (personal communication, November 10, 2020).

[9] Project GABE: https://dhss.alaska.gov/health/News/Documents/press/2022/DHSS_PressRelease_DPH_ProjectGabe_20220607.pdf.

[10] Project ECHO: https://health.alaska.gov/dph/HealthPlanning/Pages/telehealth/ECHO.aspx.

increase in training opportunities. The Alaska Medicaid Drug Utilization Program continues to promote evider prescribing activities and has resulted in a decrease in overall opioid prescribing within the Alaska Medicaid population. The SOA Department of Commerce, Community, and Economic Development facilitates the Prescription Drug Monitoring Program,[11] a system that requires all providers to report prescriptions of opioids and benzodiazepines as well as other substances. The system has seen a 41% increase in the number of registered users since 2018 and a 30% decrease in the total number of opioid prescriptions between 2017 and 2021[12] The SOA DOH and Department of Corrections has scaled up screening, referral, linkage to care, and treatment funding and intervention through the implementation of the 1115 waiver,[13] Alaska Prenatal Screening Program,[14] and Medication Assisted Treatment training.[15] Studies indicate that mortality risk is lowered when people access methadone or buprenorphine treatment.[16]

Aside from these examples of the SOA's efforts, a variety of state, federal, and local organizations have conducted interventions across the spectrum of prevention, treatment, and recovery. To continue to see the impact in 2023, SOA and its partners have, and will continue to, work upstream addressing social determinants of health[17] and Adverse Childhood Experiences,[18] availability of medication assisted treatment, and the demographic disparities in overdose mortality.

Evidence-Based Strategies to Reduce Drug Overdose Deaths

1. Prevention:
    a. Educational campaigns.
    b. Interventions tailored to the community.
    c. Prescription drug monitoring programs.
    d. Opioid prescribing guidelines.
    e. Regulating promotion and marketing of opioids.
    f. Better mental health care.
    g. Opioid safe disposal locations.
2. Harm Reduction:
    a. Availability of fentanyl test strips.
    b. Naloxone access and training.
    c. Syringe services programs.
    d. Supervised injection sites.
3. Treatment:
    a. Increase access to treatment, including through telehealth.
    b. Medications for opioid use disorder.
    c. Expand and diversify treatment workforce.
    d. Improve health care workforce addiction training.
    e. Reduce stigma for seeking care.
    f. Access to culturally competent care.
    g. Treatment alternatives to incarceration.
4. Recovery:

[11] https://www.commerce.alaska.gov/web/cbpl/ProfessionalLicensing/PrescriptionDrugMonitoringProgram.aspx.

[12] Alaska Prescription Drug Monitoring Program. (2022). "Alaska Prescription Drug Monitoring Program report to the 32nd Alaska State Legislature (2022)." *Prepared for the 32nd Alaska Legislature on May 2, 2022.* Retrieved from: https://www.commerce.alaska.gov/web/portals/5/pub/PHA_PDMP_2022_LegislativeReport.pdf.

[13] https://health.alaska.gov/dbh/Pages/1115/default.aspx.

[14] Singleton, R., Slaunwhite, A., Herrick, M., Hirschfeld, M., Brunner, L., …Rider, E. (2019). "Research and policy priorities for addressing prenatal exposure to opioids in Alaska." *International Journal of Circumpolar Health, 78*(1).

[15] https://aws.state.ak.us/OnlinePublicNotices/Notices/View.aspx?id=192562.

[16] Sordo, L., Barrio, G., Bravo, M., Indave, B., Degehardt, L., …Pastor-Barriuso, R. (2017). "Mortality risk during and after opioid substation treatment: systematic review and meta-analysis of cohort studies." *The BMJ, 357*.

[17] Healthypeople.gov. (2019). "Substance Abuse." Retrieved 16 Sept 2019 from: https://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Substance-Abuse/determinants.

[18] Hughes, K., Bellis, M., Hardcastle, K., Sethi, D., Butchart, A., … Dunne, M. (2017). "The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis." *The Lancet, Public Health, 2*(8): ee356-e366.

   a. Employment opportunities for people in recovery.
   b. Expanded access to recovery housing.
   c. Peer counseling.
   d. Intensive support to sustain recovery.
5. Data Collection
   a. Promote timely collection of local data, including demographics.
   b. Make real-time, disaggregated data available for identifying at-risk groups.
   c. Use information gathered to inform effective, community tailored strategies.

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JUNEAU
YOUR VOICE, YOUR COMMUNITY: FEEDBACK ON LOCAL OPIOID AND POLYSUBSTANCE USE, OVERDOSE, AND SUBSTANCE USE DISORDERS

Brief Summary

On February 24th, over 100 people from the Juneau community met at Elizabeth Peratrovich Hall to give feedback in support of revisions to the Alaska Statewide Opioid Action Plan. This document contains the raw, unprocessed information they provided. This information will be used by the Office of Substance Misuse and Addiction Prevention to revise the Action Plan. Communities can also use this information in their local planning efforts.

State of Alaska, Department of Health - Office of Substance Misuse and Addiction Prevention

osmap@alaska.gov

Contents

Acknowledgments

We thank all of our speakers and performers for helping us open and close our event with care, wisdom, and healing:

- Tina Woods
- Christina Love
- Corey Cox
- Jeni Brown
- Justin McDonald
- Litseeni Sháa

Thank you to SEARHC and Sealaska for sponsoring lunch and snacks for the event.

We also thank the following people and organizations for helping us plan and implement the community cafe:

- Juneau Opioid and Polysubstance Use Work Group
- Juneau Suicide Prevention Coalition
- NAMI Juneau
- Advisory Board on Alcoholism and Drug Abuse
- Central Council Tlingit and Haida
- State of Alaska Section of Public Health Nursing
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- Theresa Welton
- Tim Easterly
- Terry Kadel

THANK YOU to everyone who helped make gathering this information possible.
Your Voice, Your Community

What to do with this information and Next Steps

What communities can do with this information:

While the feedback gathered in your community will be used by the Office of Substance Misuse and Addiction Prevention (OSMAP), at the State of Alaska's Department of Health, to revise the Statewide Opioid Action Plan, community members are encouraged to use this feedback to assist in local planning efforts. This information is intended to be useful for community planning activities. Local organizations and providers who attended the café can use the feedback to explore changes to their practices, based on what their community has said is needed. Local policy makers can explore solutions to support efforts that the community is stating may currently lack support. Community members can use this information to support one another, reduce stigma, and engage in local advocacy.

The Statewide Opioid Action Plan is intended to be a guiding document for prevention work across the state, however communities are also encouraged to take their own action and make their own plans. While the Action Plan is in the process of being revised, communities can use this feedback to create change today.

Next steps

OSMAP has visited multiple communities to gather feedback on opioid and polysubstance misuse in support of revising the Statewide Opioid Action Plan. When community visits have been completed, feedback from all communities will be summarized and used in the process of revising the Statewide Opioid Action Plan. Revising the Action Plan will also include a review of current drug misuse and overdose data, state and nationwide policy analysis, and a review of current opioid and polysubstance misuse literature.

When revisions to the Action Plan are complete, it will be widely distributed to State agencies, local organizations, and throughout our communities, so that everyone can take part in addressing these issues with the support of a plan that was developed with their feedback.

Polysubstance Misuse in your Community: Knowledge and Perceptions

Overview

An important part of developing strategies to address polysubstance and opioid misuse, overdose, and substance use disorders is understanding what is going on in Alaska's local communities. To help OSMAP develop strategies that are grounded in the realities of what is happening locally, the following questions were asked of those who attended the community café:

1. When people are involved in substance misuse, how often do you think they are mixing substances?

2. Why do you think people are mixing substances?

3. Do you think that substance misuse, including mixing substances, may be more common in certain groups within the community? Such as particular industries, occupations, social groups, etc.

Below are the feedback community members provided.

Captured Feedback

1. **When people are involved in substance misuse, how often do you think they are mixing substances?**

- Regularly - almost every story you hear.
- Sometimes intentional
- Always multiple drugs in my own experience I think it's intentional.
- 90-100T people mixing
- PH nursing - usually denies use. Marijuana sometimes reported
- Pretty regularly - 99% anytime not being mixed - due to no availability.
- All the time whether intentional or not.
- 80%
- Very often
- Don't "feel it" as much anymore
- Will do what is necessary.
- Based on availability
- Alcohol increases effects.
- Addiction becomes part of life and is subconscious as routine.
- Teen use starts more opportunist.
- Self-medication based on availability.
- A LOT.
- Often, always "100%"
    - Usually
- All the time, a lot, often, always
- Unintentionally mixing substances - some are aware that fentanyl might be in their drugs of choice.
- Many don't perceive alcohol or beer as a substance in this context.
- Depends on their state of addiction - at the beginning, they'll do one drug for a while; then try another before graduating to another substance while still trying to be functional.
- All the time
- Taking more when they need more.

- When not using substances, they think about where they'll get it next.
- Often, people need to be educated on what is a substance considered for misuse "beer."
- Always
- Unintentionally mixing.
- "high in the morning and low in the evening."
- 90% using meth, use opioids.
- "most using alcohol first are less likely to mix with other substances. Those that use opioids are more likely to mix with alcohol" - medical pro said this.
- Often more than not.
- Could be unknown polysubstance abuse - they take heroin, etc. and have a suspicion that fentanyl Is in their substance of use.
- Mixing because of withdrawals.
- Depends on your stage of addiction - at first probably trying one at a time, then graduating to another substance while still trying to be functional.
- 90% of the time
- Quite often depending on person and situation
- almost all the time
- More often than they know as a lot of substances are cut with others.
- Often
- 50% of the time
- unknown
- Most of the time.
- almost always
- I think it's increasing. I think when we respond to an OD, often the patient used multiple substances, or a drugs laced with another substance.

2. Why do you think people are mixing substances?

- Petersburg: almost guaranteed. Mostly out of conscience depending on supply. (1)
- During summer fishing, town is full of drugs. (1)
- Fentanyl is more popular than heroin which is really crazy for me to see.
- The halfway house (where I work) it's the biggest attractive drug because of how cheap and accessible.
- They couldn't' UA for it until recently.
- Wintertime - people start during prescription cough syrup, alcohol whatever available. (1)
- People may begin by dabbling, but eventually their body becomes addicted.
- People use because of pain.
- Alcohol always part of mix.
- Night scene - use on upper, tired of being up, use a downer.
- People on prescriptions such as Adderall during day need benzo to sleep. Legitimate uses, prescribed.
- Person just starting may use only one drug. But as they get more comfortable, they will use more.
- Common misperception meth can counter opioid overdose - I've seen it work before. Doctors say it won't.
- Drug of choice heroin. I would do meth to do more heroin. I'd be nodding out and I wanted more
- People want to forget their pain.
- People want the rush, beat the hype.
    - "I used fentanyl and I'm alive, so does that mean it's not real?"

- In youth shelters, sense of invincibility.
    - It won't happen to me.
    - Some education, but not enough that's relatable.
- Millennials helicopter parent.
- Safe risk taking, alternative risk taking.
- Social lubricant - when I went to college, I cut loose. Had a very tight, restrictive childhood.
- Economic reasons - fentanyl
- Once you get rid of one drug dealer, there are more deaths and overdoses. (Skagway)
- Legislative action
    - Decriminalization of drugs.
    - BC just decriminalized most drugs.
- Oregon - terrifying to have decriminalization.
- Need system change.
- Education is key.
- Mixing uppers and downers to get through day.
- Most people use.
- A lot of people I work with don't consider marijuana a drug. The want off the harder stuff they can die from.
- Youth
    - Methadone - preferred treatment of pregnant women
        i. It's an option.
    - Suboxone strips - dosage
    - Sublocade (sic)
- "Withdrawal from methadone worse than heroin"
- Generational use: Marijuana - 1st time I used was with my uncle. Then my dad and I smoked together. In the 80's cocaine was part of socially accepted amongst fishing. Now they are old and still using cocaine - look down on meth. Don't consider cocaine a problem. (Petersburg)
- I'm the first one in my family to get past addiction. My family won't see doctors - not just using drugs, neglecting rest of health.
- People struggle with mental health.
    - Drugs are tools, what they know.
- Sometimes it's a social thing just to find a group to fit in. It's a way.
- Often kids using just because they get offered.
- Reacting to situation
- Trauma - trigger
- Availability
- Reactionary services vs. prevention (law enforcement)
- Intergeneration - learned behavior.
- Trauma
- Self-medicating
    - What is their illness?
- Lack of connection
- Policy change from punishment.
- Harm reduction.
- Education programs and building community.
- Helps wake-up, get to sleep, gone to have fun and chasing the high and avoiding the low
    - Ceremonial
    - Tolerance >>> "chasing feeling to escape."
    - "high and lows"
    - Dependance
- Follows life events/stressors.
- "personal experience or history with"
    - Secrecy/shame.
    - Vulnerability.
    - Distraction/coping.
    - Self-medication.
    - Acceptance.
    - Something used for release.
    - Out of spite/rebellion.
    - Isolation.
    - Feeling less connected.

- Use mimics euphoria/joy.
    - Similar to those felt connection with others.
- "does not discriminate."
- Preference by substance and ease of access.
- Financial/economic.
- Visibility.
- Exposure to/presence of >>>stigma perception.
- Social acceptance/connection trending.
    - Popularize via celebrity.
    - Social media, rap music.
- Trade
- Addiction history
- Placebo >>>"spelling"
- For perceived benefit
- Role of prescription (opioids) meds
- (+) trauma/history ACES
- Coping mechanism/strategies
- Promote abstaining but 0 (zero) really.
- Advocating resources if using
- Role of educator vs. advocate in difference/dismissive
- Paradigms/pre-judge
    - "bad apple"
- The cost may drive mixing of substances.
- Accessibility of what is available is a major factor.
- Will try mixing with other substances to curb the side effects of withdrawals, to avoid feeling sick or numb.
- Occupational drug testing - knowing about an upcoming drug test may drive mixing substances.
- Social pressures and trying to fix in, especially to drink alcohol or try another substance while drinking.
- People that choose alcohol first are less likely to mix with opioids or other substances; however, those that are addicted to opioids or other substances are likely to drink.
- Cost.
- Accessibility - whatever is available.
- Often - open to any substance.
- Whatever the goal is - avoiding feeling sick or to feel numb.
- When not accessible, visit the garage or get what they can get; examples: Lysol on pilot bread, hand sanitizer gel, antifreeze, isopropyl alcohol.
- From AN/AI perspective: hard to trust medical authorities knowing that in the mid-century, native people were being sterilized. (1)
- Pharmaceutical companies provided the original problem then profited on suboxone.
- Some use another substance to relieve the side effects of withdrawals.
    - Using substances that each relieve certain side effects - example: voices in the head.
- Historical and personal life traumas
    - Use substances to numb traumas - PTSD.
- Self-medicating from surgery or perceived pain after building a tolerance.
- Quiet their mind and numb their pains from traumas.
- People take what they can get.
- "Can guess how much fentanyl is in town when you look at how many show up in a clinic."
- Using substances just to score more.
- Access to healthcare.
- Drug testing - is it a concern or not.
- Questions about cheapest drugs, where to find them, or how they get here.
- Fentanyl is the cheapest drug at $5/pill. Some patients use 50 pills or more a day.

- Precursors made in China, sent to Mexico, and processed an then sent here stealthily.
- Mixing to cope with different situations throughout the day.
- Severe alcoholics are usually repulsed when asked if they are street drugs.
- Availability of substances drive mixing, often to avoid withdrawals.
- To experience new things and mixing helps to try new heightened experiences.
- Social pressures who's doing what and how do you fit in.
- Transition to a prescribed rig (Xanax, gabapentin, etc.) and they feel it's "less bad" even though they are abusing it.
- No drug is okay if a person has a psychological vulnerability to being addicted, including marijuana.
- Some switch up prescriptions, mix and abuse them just to keep "others off their back" by still trying to alleviate their symptoms while using something "healthier".
- To numb pain and trauma and get a different out of body sensation and experience.
- Ease of access to the substance, wanting something specific but being unable to access it.
- lack of resources/will try available substances
- Sometimes unintentionally. Sometimes to intensify or extend the high.
- Enhanced reaction or un-aware of the mix
- more potency, economical
- better high, all they can get
- Equal opportunity addicts.
- because they use what they can get, and eventually that is multiple substances.
- I suspect that drugs come into Juneau in "batches." It seems we'll drug related medical calls in waves. I think users may unintentionally using a drug that is laced with another substance unbeknownst to them.

NOTES:
(1) convenient, accessible, depending on their mood, physical addiction

3. Do you think that substance misuse, including mixing substances, may be more common in certain groups within the community? Such as particular industries, occupations, social groups, etc.

- Seasonal workers - traditionally younger group. A lot of seafood fishermen work hard, play hard. And fish processing plants.
- Food industry.
- People who struggle with homelessness.
    - They may begin to use before or after.
- Blind spot of data with regard to SOA jobs. Not willing dry testing.
- Logging, construction - lots of seasonal jobs and spend all winter XXX.
- Winter worst time/peak of addiction for commercial.
- Service industry - kitchens
- Commercial fishing/seasonal jobs
- College students

- Bars - year round
- Construction
- Tourism
- Hotels
- Middle school/high school
- Foster youth
- I didn't know drugs were bad until a…
- Senior Pioneer Homes
- Huge ADHD medication shortage - people turning to meth.
- Fishing, logging - long hard hours
- Unhoused
- Cab/taxi industry
- High-stress level jobs - pilots
- White collar/blue collar difference?
    - No difference use, but maybe more stability, routine
- People with access to pharmacy insurance
- Nurses/doctors divert equally
- Limited population of kids using harder drugs
    - Alcohol and marijuana
    - Heavy marijuana use is a normal Thursday night
- Generational use
    - MH and addiction
- Yes
- Social groups influence behaviors.
- Genetics
- "you are what you eat."
- Lots of youth "you don't expect" use drugs.
- And adults
    - (fentanyl makes things more dangerous)
- Intergenerational trauma is underlying problem and other trauma (healing first).
- Pillars (in H.S._
- Surround with successful people and build each other up. Love and friendship!
- Substance misuse is common across all groups.
- Labor workers, i.e., construction, fishing industry, food services seemingly make it more acceptable to abuse and mix substances socially and out of necessity for pain management.
- Upper class, i.e., legislative workers have the means to prevent being caught (god lawyers, access to treatments, socio-economic neighborhoods, etc.), but it's also a social requirement to meet for drinks.
- Racial and socio-economic inequities, including the predisposition to intergenerational and personal traumas increase risk of abuse and mixing.
- Construction workers
- Fishing industries - alcohol and uppers"
- Food service industry
- "work hard, play hard."
- Physical labor jobs are more likely to be prescribed pain meds.
- State job workers may conceal their usage and still be functional. But labor workers don't care to be seen drinking heavily or using other substances.
- Drug testing seems to be a concern if you give your employer a reason to test you.
- In rural communities, some people think they're "breaking the cycle" of generational alcoholism by doing another substance.
- It's not always occupation specific; some groups (ex: legislative) are quiet about use and some labor workers don't care to be seen using.
- A question - what about the people who don't' have an occupation but still abuse substances?
- People around those who abuse substances don't take care of the

people using if they're functional on the job.

- A question - when a drug bust happens, is our community prepared to care for the aftermath of those addicted to those seized drugs?
- The smaller the community - the more noticeable that someone you know is using.
- Legislature, higher class - to fit in - alcohol, inhibitions are down; more likely to try and mix substances.
- People that experience homelessness.
- Some industries where it's acceptable:
    - Food industry - shift drink
    - Fishing industry - meth for an upper
    - Gov't jobs - going out for drinks to ft in
- Social Stigma for not doing what others are doing.
    - "use substances to fit in."
- Survivors, marginalized communities, people in poverty use substances, including veterans.
- Men above 40 less likely to reach out - MANI community needs assessment.
- "opposite of addiction is connection."
- Alcohol and substances have been weaponized since colonization.
- Provide more resources to community orgs that are most affected to support equity.
- Tlingit and Haida have been putting on events to make it more welcoming to support the community including bonfires.
- Same across all groups.
- Socio-economically, if you don't have a home, the people your surround yourself with can influence you.
- Cases are dismissed daily for white collar workers using substances because they have lawyers they can afford.
- On paper demographics and statistics drive where law enforcement patrol and may affect social groups getting caught with substances and not being able to get resources; however, the upper class has the financial economics to prevent getting caught and also get them access to resources.
- The narrative of how someone overdoses and dies from drugs is different across social groups, i.e., a marginalized community person will show up in the newspaper as dying with a "rig in their arm" vs. an upper class person "died suddenly" with little to no reference to substance use.
- groups of individuals that have experienced high rates of trauma and adversity
- social groups, some occupations
- Again, I often think this is happening without knowledge. I think the group at most risk is the uneducated. Those that don't have the knowledge of the risk. Also, those who struggle with funds.
- experienced drug users
- **Who is less likely to use and why?**
    - Access to resources, including financial support.
    - Do people see themselves represented in the resources that are effective and equitable for the affected community?
    - Simple application process for resources.
        - currently applications are tedious and lengthy and difficult to understand, which creates a barrier.

        - Have someone sit there and help someone to complete applications.
    - People are hesitant to get support from places where they may experience more trauma - representation matters.

Additional Notes Not Linked to Specific Question:

- A Tribe should always support each other. A worrier (warrior?) should never have to beg for help. All for one, one for all, everybody counts.

Polysubstance Misuse in your Community: Unique Community Factors

Overview

Alaska is a large state, and with its size comes communities that have unique characteristics which influence what opioid and polysubstance misuse, overdose, and substance use disorders look like locally. The way one community experiences these issues, will differ from another. To help OSMAP develop strategies that are geographically and culturally relevant, the following questions were asked of those who attended the community café:

1. What factors in your community are contributing to substance misuse, overdose, and substance use disorders?

2. What factors are unique to your community and make responding to substance misuse, overdose, and substance use disorders difficult?

3. What protects your community from engaging in substance misuse? This includes people, programs, location, etc.

Below are the feedback community members provided.

Captured Feedback

1. What factors in your community are contributing to substance misuse, overdose, and substance use disorders?

- Prescribers that are overprescribing and providers
- Factors like surgery or medical procedures and lack of education.
    - "I was sober and then got surgery and relapsed."
- TV/Movies glorifying drug use.
- Dental procedures. People receiving more than they need for drugs.
- Surgery: part of protocol for drugs for surgery receiving Rx for opioids
- Prescribing
    - PDMP can it tie in with other states?
    - Geographic
- Where do we go to report concerns or issues in JNU related people over prescribing?
- Weak point in system and ferry terminals and ferry traffic - lack of security on ALASKA MARINE HIGHWAY SYSTEM.
- Tourism: in Juneau transient population, seasonal workers can be big source of partying.
- Hotels of housing can be high risk areas
- Relationships -
    - things like human trafficking.
    - or abuse in horrid, relationships that can be harming.
    - things like peer-pressure.

    - lack of community (or you could think of it like people have a hard time)
- The Glory Hall, AWARE, Housing first that are the safety net can be really hard places to stay sober.
- Forming new community/resources if you are in toxic circle.
- Accountability
- Rely on each other (not always in a good way) like you "hang with the people you use with"
- Really high rates of domestic violence.
- Juneau - very high rates of trauma, ACES
- Adverse community experiences
    - Board schools
- Juneau holds each other up.
    - Investment of doing really hard work rooted in restorative practices.
- Hard when you have people coming in from outside agencies.
- Making promises that aren't fulfilled.
    - Stemming from boarding schools.
- Lack of peers in places that can make a difference.
- Alaska recruits a lot of workers form outside state that are here to gain experience or maybe to build work experience that maybe don't have qualifications to support patient with lot of history/trauma.
- Historical cultural trauma of kids being taken away/split up from families.
- Lack of sunlight
- Lots of clouds.
- Expensive housing.
- Racism - particularly colonization of Indigenous community.
- It is hard to live cheaply.
- Lots of work is seasonal. You can' be in a good place, but it is ephemeral.
- Small town. Lots of services, but one version of a service. If that service doesn't work, that service is no longer available.
- MH care is expensive.
- MH care is hard to access.
- Not enough peer support services.
- Lack of diversity in MH provider pool.
- Transient medical/mental health staff.
- Transient staff means lack of continuity of care.
- Jump through lots of hoops to access services.
- Bias against people who have history of past crimes.
- The weather - higher rates of depression/isolation contributing factor.
    - Can be expensive to engage in recreation.
- Historical trauma; generational substance use.
- Domestic violence. Sexual assault in Juneau.
- Easier to access substances than it is to seek recovery resources (like how many people are in this room. The resources might only be able to help 5 people)
- Programs that separate families - not okay.
- Sober culture can be a very small in Juneau.
- Childcare (lack of resources)
- Lack of resources that help people with mental health.
- Segregating program services (programs that have really specific criteria).
- Lack of intervention services.
    - Lack of family.
    - Total family resources that support the "whole family" vs. the individual.

- Lack of caregiver education.
    - Lack of wrap around social support programs that address social determinant of health.
- Allowance in places like the Glory Hall (homeless shelter) Housing First that allow people to use substances, drink, etc.
- Barriers are not having insurance (too much $ for Medicaid, too low for private insurance)
- Co-occurring psychosis
- Lack of enough resources, can't just drive to another city.
- Medication costs more in Juneau vs. lower-48
- ISOLATION, lack of things to do.
- Small town, people you know are present at the places you seek help.
- Lack of shared knowledge of services.
- High turnover at social services agencies.
- Lack of low barrier housing.
- Need to stay warm through the night.
- Glory Hall closes at 11 p.m., which limits access at night.
- Warming shelter downtown but GH is in the valley.
- Police interacts. JPD confiscating Narcan/MAT
- Lack of availability of resources
    - Waiting list
    - Hard to get providers here
- Medicaid/medicare reimbursement rates aren't matching cost of care
- Historical trauma rates
    - Trust issues related to that trauma
- Many people who move to Juneau are transient and don't have family support
- Small town, see lots of triggers and people around that were part of the addiction
- Fishing industry requires high performance for long periods of time (meth)
- Industry workers w/ SUD lose jobs due to SUD and then can't get home
- Unaddressed MH issues. Co-Occuring
- People fall through cracks when they have weird work schedules
- lack of employment related to reentry and legal limitation related to what types of jobs you can get
- growing up in Juneau you get put into a category by the community. Family reputation is hard to break out of
- Stigma
- Lack of resources, limited space
- Hard to get drugs here, so leads to polysubstance use to get the same high. Increased risk when mixing drugs leads to increased OD
- Incentive for people to sell drugs here because there is such a high profit margin
- Small 12-step communities that seem "cliquey"
- Where are the sweat lodges?
- Lack of access to recreation and other activities.
- Long, dark winter
- Seclusion in...
- Lack of treatment/medical care
- Ease of access in Juneau to illicit drugs
- Sales to minors
- Education system that lets kids slip through via lack of attention.
- Systems that fail families (OCS, justice, etc.)
- Mental health services that are hard to access.
- isolation
- Stressors
    - Housing
    - Financial

    - How do you “find new friends” in smaller communities
    - Access
    - Community size/”anonymity in larger size places”
- lack of access
- Cost barrier >>>to activities
- Following the crowd
- Barriers to participation in subs use activities.
- Lack of knowledge of resources
- Shame “blind eye to” tolerance
- Not wanting to deal with it
- Generational trauma >>>
    - “don’t talk about.”
    - Don’t want to get in trouble.
- Perceived outcomes
    - Will lose kids, jobs.
- Fear of harm.
- Peer pressure.
- Self-esteem/not seen.
- Post treatment change of environment.
    - Structure to non-structure environment.
    - “does this fit my new life or my old life?”
- Receptiveness/readiness to change.
- Societal influence/judgment by others.
- Lack of continued support at stages of recovery.
- Lack of employment/connection.
- Stigma - no end chance/no trust.
- Fear
- Subs/use and mental health >>> stigma
- Better to know and deal with known thing even if bad/negative than the unknown.
- Avoidance
- Triggers
- Clouds judgement/prohibits good decision making.
- low wages and not enough economic stability to support families which links with not being able to meet basic needs. When you can't meet basic needs, it's very stressful.
- Traumatic experiences when people do try and seek services (jaded ER providers and abusive medical personnel) that are not empathetic or trained in trauma-informed care with sensitivity to substance misuse and historical trauma, racism.
- Trauma, domestic violence, high rates of adverse childhood experiences, physical/sexual assault and pain both emotional and physical.
- availability, lack of substance abuse counselors available, mental illness, darkness and cold, feeling isolated
- Lack of affordable activities and groups for our children.
- Lack of mental health services for families.
- Generational trauma and substance use within the home.
- Lack of a positive purpose.
- Stopped seeking financial independence.
- Once you legalize one drug then people use harder drugs more frequently waiting for law to change and make it legal. Drugs that cause addiction and death should be illegal or very controlled. Including prescription drugs.
- Poverty, lack of health care, systems that weren't designed to support marginalized bodies (basically anyone who isn't a straight white male, but particularly AK Native and people of the global majority, queer folks, differently abled, neurodivergent, etc.)
- Poverty and abuse
- race
- I don’t know what factors are contributing to substance misuse that

are unique to Juneau. I would like more education.

2. What factors are unique to your community and make responding to substance misuse, overdose, and substance use disorders difficult?

- Medical clearance needed to get services if detoxing.
- Housing, behavioral health resources, lack of services
- Stigma in small communities
- Sometimes many people wearing multiple hats.
- Mistrust >>> makes a deterrent for asking for help.
- Sometimes people coming in from remote areas, $ to
    - cost to travel.
- After being incarcerated, can be really difficult to receive services, housing, treatment resources.
    - Lack of mental health.
- The "necessary" steps to get into recovery programs or treatment resources are so many steps.
- When you're in active addiction, jumping through hoops.
- Juneau as a hub community.
    - Smaller communities (like Hoonah) and others have to commute but people come here to access and can also be the point of entry.
- Positive community and collaboration, people know each other, and they know how to connect with each other.
- Tlingit & Haida have held up a tremendous amount of courage and support to keep stewarding culture.
- Juneau can e physically/emotionally isolated.
- People might be coming here to lemon creek to serve prison sentence and how DOC might be housed/released here and have no idea what is happening in Juneau.
- People using drugs in prison. "I used drugs for the first time in prison system" at Lemon Creek.
- Judgement/bias against people.
- Revolving door of continued cycle
    - Systems not collaborating or getting outside their "usual way of doing things."
- Sometimes people perceive you need a title or certificate to help or support.
- People have to "beg" for services or hit rock bottom before someone might consider change.
- More funding/availability resources to ALL people. Sometimes there's so much built up programming around felony people.
    - If you don't have felony, can be harder.
- Nepotism - pandora's box. Sometimes people (social/health agencies) don't want to help or support.
- The names of organizations can limit or be associated with stigma.
- Organizations that are set in their ways and not thinking creatively about how to switch things up or change.
- Getting OD prevention kits is challenging. Supply issues with Narcan.
- Youth are often too busy to come hang out at ZGYC and have to go south for treatment.
- Limited housing.

- Limited prevention efforts, esp. for youth.
- The nature of industries such as fishing/slope/mining schedules/isolation
- Juneau is isolated and a hub. Pulls people in but then they get stuck
- Short resources
- Recidivism. Lack of resources
    - The jobs people get when they get out of jail don't support a real life
    - Lack of holistic support
- High cost of living, lack of housing
- Lack of funding for resources
- Generational Trauma
    - Lack of adolescent and elderly support
- Juneau is an awkward size that sometimes doesn't fit into definition of "rural" or "city"
- Fear of reaching out for help because they might know someone at the TX facility
- Lateral violence
    - Because marginalized populations can't take out on oppressor. They take it out on each other
    - Training: lateral kindness
- Not knowing what other agencies are doing
- Stigma with getting help (and SUD/MH)
- Lack of qualified social services and clinicians.
    - Education that fails to fill this need.
- Lack of housing for both workers and other folks.
- Hub of SE - straining services
- Short term staff at services.
- Access (places/technology)
- Awareness
- Fear >>> if on probation may go back to jail.
- Crisis intervention
- Limited resource/access when ready to go to treatment or detox.
- Connection to support.
    - Program restrictions/rules
    - Meeting clients where they are.
    - Rigid/less flexible
    - Available hours to access.
- Criteria for access >>> can't have felon
- Long wait lists for mental health providers and professionals to connect with people seeking services.
- There are tremendous barriers to accessing care (like the stupid assessments needed for treatment plans and how you have to schedule these in advance and often wait a long time to schedule step 1 of a million more steps).
- For many communities in Alaska, intergenerational trauma and high rates of domestic violence and sexual assault in this state contribute highly to the amount of people using opioids in our community.
- professional counselors and other resources that are unavailable
- Stigma around substance use and mental health. There is a lot of animosity in Juneau towards folks who use due to all the crime. People blame substance users for everything, judge them and call them mean names. It makes it hard for someone who needs help, to feel comfortable getting it.
- There are plenty of factors available in our community to respond well to drug misuse.
- Limited in-patient care with wait lists, limited culturally/identity affirming care that is well known and easily accessible

- We need more reliable rehabs and housing.
- race
- Retention of employees at my place of work. We have a difficult keeping all of our ambulances staffed to respond to ODs. We're in a constant state of training, making for less time for community engagement.

3. What protects your community from engaging in substance misuse? This includes people, programs, location, etc.

- Halfway house or re-entry programs can have better access to services.
- Recreation, being out on the water, relaxing, enjoying hobbies.
- Arts/culture community >>> contributes more to wellness.
- Sober activities like sauna, pools, recreation, fitness
    - Can be $$
- NA, AA resources in-person
- Culture heals and culture focused programs on indigenous populations
- Care providers that are caring
- Resource RICH
- Doing more things in community and **TOGETHER** with each other
- Tons of active coalitions and work groups
    - Amazing grass roots efforts
- Behavioral health with SEARHC
- Peer-peer support
- Access to NATURE, great trails.
- No road (used to be protective factor)
    - Changes as people have grown more creative in bringing drugs in via ferry, planes.
- Community champions that can share their story of recovery. Peer support specialist.
- Peer support specialists: culture in Juneau thriving.
- NA/AA website repeatedly updated in Juneau
    - Great info continuously refreshed.
- AWARE - spectrum of peer support available through their program.
- Services- on profits per capita seems anecdotally very good.
- Groups and circles of people stick together.
    - "19/22 of the people I used with are all sober now. (2 died)"
- Work happening within school district.
    - Focused group every 2 weeks that focuses on "high risk" kids. "Many of the high risk kids have parents using drugs."
    - This group sounds like a case management model.
- Homeless youth shelter - really incredible for kids experiencing homelessness/issues related to social determinants of health.
- Mobility of services. Teal Street Center.
- Sense of community.
- It's a pain in the ass to live here, which creates a shared experience
- Culture of collaboration in human services.
- State capital leads to a lot of additional resources spent here.

- We are a regional hub so additional resources are spent here.
- Limited geographic footprint means it is impossible to live apart form the rest of the community.
- Small town makes it seem possible to make a difference.
- Being a beautiful place makes it enticing to be here.
- Less providers prescribing drugs.
- More wellness activities (some you have to meet criteria)
    - But more resources and activities are around.
- Peer-to-peer recovery services.
- Culture - talking circles, healing circles, craft circles.
- We have lots of $ in tribal. Lots of land (not always to access or navigate)
- Peer-peer recovery activities/can we have more recreation that doesn't cost so much.
- Morning activities.
- SEARHC and T&H holistic approach.
- Housing First.
- Collaboration.
- Trauma informed care is the norm.
- Community that believes in harm reduction.
- Tribal programs starting more re-entry/recovery programs.
- Prioritizing connection.
- Bringing back native culture into daily living and city norms
- Examples of healing out the "soul wounds"
- Lots of sports/NAO camps for kids
- ACT team
- Men's healing
- Women's healing
- Lateral kindness training
- HTL Haa Tooch Licheesh cultural ties and ceremony
    - Traditional dips and practices
- Last few years a lot better communication between organizations
- Tlinglit and Haida reentry/recidivism program
- T&H expanding services
- Advocates
- Good knowledge worker (social & otherwise)
- Interconnected agencies and programs
- BEAUTIFUL GREAT OUTDOORS
- Social events and community
- CARE van/sobering center.
- Rainforest.
- Inpatient: JAMHI, GHS
- Outpatient
- Front Street Clinic
- Education
- Narcan
- Engagement/connection
- Safe, sober activities
- Tailoring treatment plans
- Presence of authority/deter from places for people to feel safe.
- Education
- Awareness
- Events like this
- Efforts to restore the person/re-entry support.
- Strong sense of culture and expansive efforts that focus on healing through art and connection with culture. A very caring community, Juneau has a lot of local force and knowledge, we are a "smaller" city and can connect easier with people.
- CCTHITA, AWARE, ANDVSA, SEARHC, people in recovery and support.
- a few of the programs that we have in place help protect those that may be engaging in substance use and misuse
- Programs like your help to spread knowledge and reduce stigma by giving

a safe space for those who have recovered to share their stories.
- Tlingit & Haida has been working hard to address mental health through their healing center and Wellness Court.
- The DARE program. Police presence in schools and at events. Social services and social workers. Mental health works like JAMI and others.
- places and spaces to connect with like-minded folks, culturally affirming, intersectional, welcoming and identity affirming spaces
- Everyone is failing.
- The Great Spirit
- CCFR's Community Paramedic program, "Mobile Integrated Health" (MIH), and the CCFR CARES program. The project HOPE kits are on each rig. I think we are trying to aggressively combat homelessness as a community.
- **Ideas:**
    - expand employment programs like Polaris House, that does 50/50 salary matching
    - Hub resource center for all agencies to put their events/training resources
    - Community support spaces for people to go to just hang out

Polysubstance Misuse in your Community: Existing Efforts

Overview

An important part of developing strategic initiatives to address polysubstance misuse, overdose, and substance use disorders is understanding what is or is not already happening at the local level. To help OSMAP develop strategies that capitalize on existing local efforts and fill any gaps, the following questions were asked of those who attended the community café:

1. What efforts already exist to help your community respond to substance misuse, overdose, and substance use disorders?

2. What gaps are there in your community's efforts to respond to substance misuse, overdose, and substance use disorders?

Below are the feedback community members provided.

Collected Feedback

1. What efforts already exist to help your community respond to substance misuse, overdose, and substance use disorders?

- Project Hope is big here, but not well known.
  - Schools on track.
  - Schools know about P.H.
- H.S. overdose sparked interest - three weeks out.
  - Nalox used in school.
- Workgroup for Outreach Clinic (Front St) SEARHC
  - They had Narcan and were out being effective.
- Info for Narcan is out there and kids know at parties they can use and get narcanned.
- App for phone CBS, XXX, Tlingit/Haida tribe
  - Gives info about polysub.
  - Community cultural services
  - "culture heals" - just go to website.
  - Phone # 988? (similar)
  - Icon added.
- 12 step Native American "Well-briety"
- Crafting group "talk circle."
- T/H tribal D.V./child abuse support
- Broke but being re-funded.
  - Heaven House
  - Haven
- 4A Needle exchange.
- Hello Baby - SUD/case management.
- JMH organization; AA/NA; NAMI
  - Matrix of providers
  - Good handouts
- Rainforest Residential
  - Methadone clinic
  - G.H.S. Gastineau
  - Glacier Mountain House (halfway house)
- CARES vans - good!
- Medication assisted treatment.
  - Valley medical center
  - JAMHI Health & Wellness
  - Ideal options

    - Front Street - opioid treatment program
    - BOP
    - Southeast Psychiatry
- Supported Housing
    - Housing First
    - Gastineau human services
    - TAMHI Health & Wellness
- Outpatient
    - VA outreach clinic
    - Bartlett Rainforest Recovery Center
    - SEARHC Behavioral Health
    - UAS Counseling Services
    - Private practice therapists (listed on Juneaumentalhealth.org)
- Support
    - Four A's
    - AA/NA
    - JAMHI Adult drug and alcohol school
    - JAMHI Alcohol safety Acton program
- Judicial
    - T&H Tribal Court
    - Drug Court
- Rainforest Recovery
- Bartlett
- GRS Gastineau House 2.5 LOC
    - MH clinicians
    - Juneau House 2.0/2.5/3.5 LOC
- JYS - Spruce house, homeless children
    - Safe space for 10-17 year olds.
- CARES van
    - St. Vincent hot home at night.
- JAMI
- SEARHC - case management
- AA Holy Trinity/Public health
    - NA GHS JAMI conference room.
- Glory Hall - MCH "Piper?"
- SEARHC - new clinic
- Housing First program
    - Detox - transition
- Idea/Options - doctor based opioid replacement.
- Valley Medical Primary Providers
- Ideal Options
- GHS Behavioral Services
- Private addiction providers.
- Rainforest
- Sitka Raven's Way
- T/H Juneau House
- Capital City Five of their MCRT.
- Caring providers that are willing to connect and meet up to case conference and discuss gaps and barriers.
- Caring organizations that are committed to exploring areas of growth and change.
- Narcan kits and trainings. Community and partner conversations. Groups and trainings. Peer support efforts.
- Paramedics, narcan, hospitals rehabs and clinics
- Preventative programming like afterschool activities, social-emotional learning in schools, culturally affirming care, harm reduction like narcan and safe needle exchange/disposal
- None.
- free narcan
- Multiple housing options, Community Paramedicine, CARES Sobering Center.
- **Treatment:**
    - Emergency Services - passing out Naloxone kits to members of the community – emphasis on telling people they are commonly used to help reduce stigma
    - "Hello Baby" Bartlett Health Center program for expecting mothers to provide them needed care with questions regarding their circumstances, family issues, substance misuse etc

- Housing first: meet people where they live: provide housing for those dealing with substance to help get them off the street and reduce risk factors
- Medical detox: the hospital is the only facility that offers this in Juneau
- Rainforest: Residential facility for those in recovery (one of the only facilities in Juneau): only 28 days for patients and limited space
- Juneau has an Opioid Treatment Court
- AA/NA
- Warm up houses provide limited housing for those that aren't in halfway houses
- Juneau DOC – handing out Naloxone kits to individuals leaving the prison.
  - Juneau DOC- they now have a substance abuse counselor
  - Juneau DOC – coordination with JAMI and other reentry programs
  - Tlingit and Haida – reentry and housing services as well as counseling
  - JROC – Juneau reentry coalition to help those leaving prison to connect with resources
  - SEARCHES – Sitka reentry program
  - Glory Hall – Harm reduction
  - Fire and Police Departments (first responders to overdose)
  - Ideal options (MAT)
  - Juneau House (free sober living for a month)
  - Gastineau House (men's sober living housing) Patients must refrain from seeking employment for 6-8 weeks as part of the program)

- **Prevention:**
  - Public service adds for driving under the influence
  - Youth Navigators: teaches at risk populations life skills and builds community
  - Teaching at risk populations about life skills and healthier ways of having relationships with others through counseling (DOC, JAMI)
    - Talk they hear you: (SAMSHA campaign and Tlingit Haida) speaks to youth at schools about substance abuse
    - Juneau youth services (purchased by SEARHC) helps with those aging out of youth services
    - Cultural immersion programs
    - DARE – studies have shown it not to be effective
    - Zach Gordon Youth Center (drop in) – free place for youth to come and connect with other youth in a healthy environment and have access to services including those that are aging out
    - Big Brothers, Big Sisters (managed from outside of Juneau)
    - High Schools have teen mental health services for students
    - Juneau Suicide prevention Coalition – teaches youth healthy coping mechanisms
    - Clinicians from Rainforest go to schools to talk to students about the dangers of addiction
    - SERRC Southeast Regional Resource Center – education, GED, job training, help with resumes, etc.
    - Division of Vocational Rehab – vocational services
- Tribal programs preventative
  - Family events

    - Elder program >>> social activities
    - Support groups
    - BH
- Re-entry
- SEARCH >>> clinical services/mobile van
- Narcan kit availability/dispense instructions.
- Mental health first aid
    - Peer to peer support groups
- Building community relationships
- JPD
- Recognition and response
- Appropriate to the situation
- Community/neighborhood watch
- Trained responders match needs of mental health, subs abuse issues.
- Community effort
    - Collaborative work with agencies.

2. What gaps are there in your community's efforts to respond to substance misuse, overdose, and substance use disorders?

- Women/children sobering centers.
- Housing needed.
- Jobs
- Oversight agency - Detox Facility
- Rec center/sobering house (safe space, no sub)
    - Social center community center
    - "No membership needed kind of place."
- Treatment center/detox facility
- Criminals get services. Drug addicts that don't commit crimes don't get access to services.
- Nepotism, family too close to providers.
- Embarrassment
    - No specific in general
    - (asked for specific providers - non iterative - deferred to other traumas)
- Families rejected because of their family surname.
    - Not equal for the T/H tribal members. Bar to access "socially unacceptable member of the tribe."
- Childcare/Daycare
- Advocates for M.I.
- High weeds get transferred.
- Lack of high level service
- Chris Kyle Anchorage ? Veteran
- VA Clinic
- In patient program not enough
- Residential facility for trauma
- SE Alaska needs MCRT.
- Juneau/Ketchikan get more of the money.
    - Competing with Anchorage/Fairbanks
- Community Navigator
- Taxi/Bus vouchers
- Housing
- Safe spaces to land post hospital
- NO LTC
- Community sober center/rec therapy
- No transition from jail to community.
    - Choose to go back to drugs.
- Need a list of sober people who could peer assist.
- No resources app for Juneau.
- Agencies in town need to work together. "they bash each other."
- Qualifying for mental health services
- Education could grow.
- Lacks (sic) of understanding.
- "how do we make services providers better connect people to service?"

    - Lower barriers.
- Waitlists.
- Lack of love.
- Increase penalties.
- Triggers and/or habit.
- Enough resources >>> same day MAT but 0 (zero) to BH services.
- Behavioral heath intake packet is HUGE barrier.
- Self-efficiency skills
    - Volunteers
    - Navigators/case management
- Lack of space/opportunity to share personal stories.
    - (Barriers/success)
- Safety
- Empowerment
- Connection to culture
- Perspective/learned experience in people running program (relatability)
- Programs to help support families of those in recovery or attempting to maintain.
- There are several programs that assist with recovery but many of the programs are post-recovery resources and many of these resources might have emphasis on felony charges--- a lot of the resources are very specific or narrow to a particular population or charge which puts things in a range of categories which always leaves out people or needs.
- I feel like there is a HUGE gap of support for parents who engage in poly substance use or in recovery. Parents and families need support to address the patterns of use that exist, they need relationships to heal and support one another. Kids need to know that there are other families struggling with this.
- I think we really need to get into the schools. I'm talking about starting early elementary. We need to normalize talking circles where everyone has a safe space, uninterrupted, without judgement to share our feelings about ay and everything. If we can normalize that, it may help prevent some of the mental health issues many of us suffer from.
- We need to clean up our streets. Get the needles cleaned up, make sure drugs don't get into the community in the first place, make it known that we want a clean community. We don't want to tolerate the danger and death these drugs threaten our loved ones with. Zero tolerance.
- schools and youth programming, criminal justice and reentry programs, etc. anyone working with "vulnerable" populations should receive training in harm reduction and suicide prevention, safety planning, community resource access and navigation
- There is a gap in every direction.
- People who affirm that drug use is not to be glamourized.
- Enough mental health services (therapist, psychiatrist, counselors) for the general population. The fire department is understaffed, and unable to staff a third ambulance frequently.
- **Treatment:**
    - Limited residential care facilities for youth
    - Fear of involvement with OCS by parents dealing with addiction. They are worried about losing their children.
    - There is a wide range in quality of care based on the facilities/resources available (some are good, some are lacking)
    - A lot of treatment services a not provided in a timely manner
    - No cost treatment programs are limited

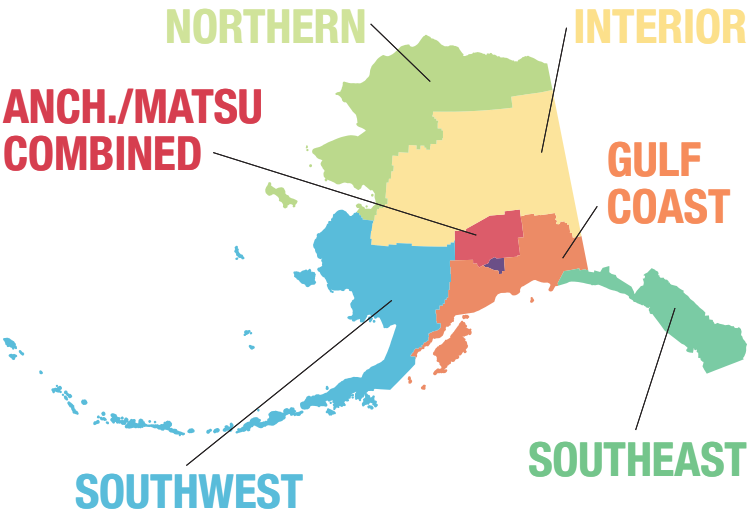
- Limited follow up with probation offices with employers of those in recovery
- Hours of treatment services are limited to working hours so many must choose between work or treatment
- Court system is understaffed and have limited time resources for everyone on probation
- JAMI – wants to extend hours for treatment but has limited staff
- Staffing in all facets of treatment/prevention services is often lacking
- In some organizations there is a "good ol boy" culture when it comes to hiring, or preferences for out-of-state applicants
- Residential facility for those in recovery that is longer than only 28 days (Rainforest)
- Too much administrative red tape to get someone into a recovery program
- Certain facilities require patients to have Covid 19 vaccinations
- A need for more sober living housing vs just recovery/detox center
- Transitional housing often has restrictions based on their criminal history (specific types of charges)

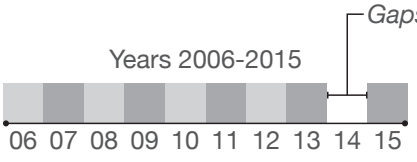
- **Prevention:**
  - Lack of free therapy to address trauma (root causes of substance misuse)
  - More emphasis on mental health in our schools to help create a foundation of knowledge for youth
  - Teaching youth coping mechanisms and using trauma informed care to deal with life difficulties
  - Courses to teach parenting skills
  - There needs to be more programs using mentors to teach youth the potential negative consequences of addiction and the positive impact of living clean
  - Mental health programs to address trauma (including historical trauma)
  - Expand the use of cultural immersion programs
  - SAMSHA regulations prevent giving Naloxone kits to those under 18 years of age
  - A lot of housing services turn people away for using substances while trying to seek entry
  - A lack of peer support programs to help provide a support for those who are struggling with being in recovery (oftentimes these are hard positions to fill due to barriers to state employment - criminal history)

RECOVER ALASKA

CONSUMPTION, HARMS, AND PERCEPTIONS

KEY





US Average

Alaska

0.0% Percentage of Last Year Recorded

Overall Trend Indicators

Increase

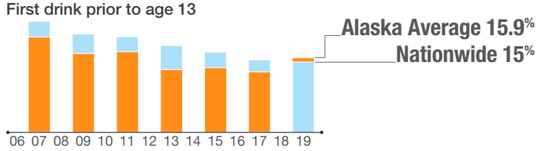
Flat

Decrease

CONSUMPTION

YOUTH

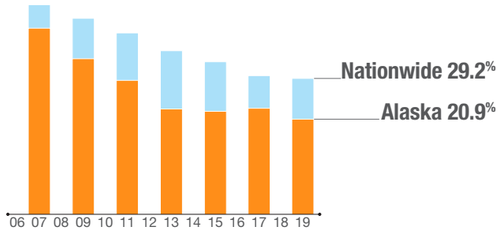
First drink prior to age 13



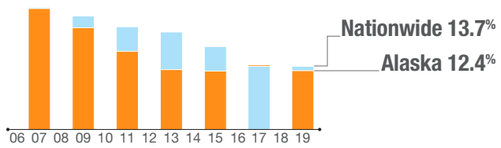
Source: Youth Risk Behaviors Survey

TEEN

Current use



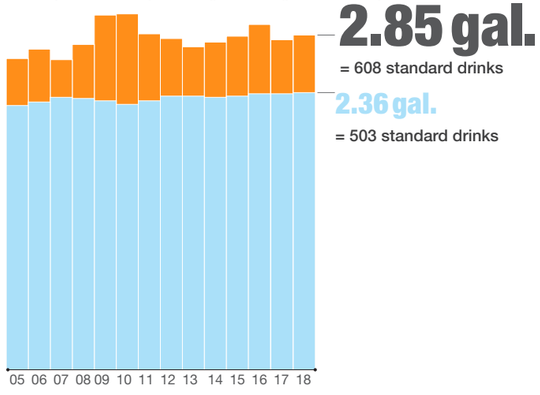
Binge Drinking



Source: Youth Risk Behaviors Survey

ETHANOL CONSUMPTION

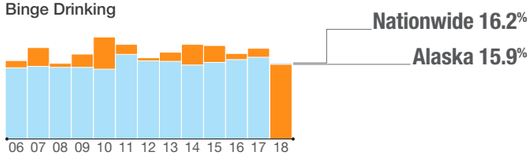
Per capita consumption in gallons, ages 14 and up.



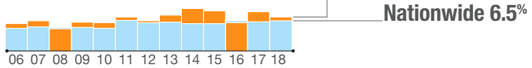
Source: National Institute on Alcohol Abuse and Alcoholism, National Institutes of Health

ADULT

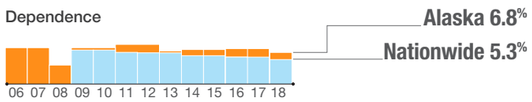
Binge Drinking



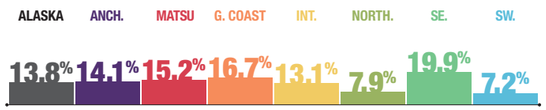
Heavy Use



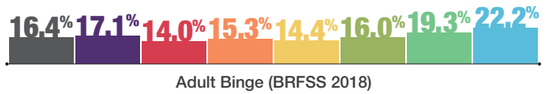
Dependence



Alaska Behavioral Risk Factor Surveillance System *National Survey on Drug Use and Health*



Teen Binge (YRBS 2017)



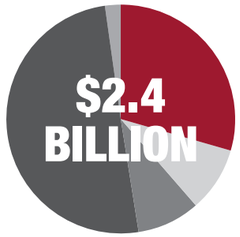
Adult Binge (BRFSS 2018)

Source: Youth Risk Behaviors Survey
Alaska Behavioral Risk Factor Surveillance System

HARMS

ECONOMIC COSTS OF ALCOHOL MISUSE, PRODUCTIVITY LOSSES

2018 Estimated Annual Alcohol-related Productivity Losses



30% Productivity Loss $709 million

$385 million	Premature death (primary diagnosis)	54%
$53 million	Incarceration	7%
$244 million	Diminished productivity	34%
$11 million	Substance misuse treatment	2%
$16 million	Medical conditions	2%

The Economic Costs of Alcohol Abuse in Alaska, 2019 Update, Prepared for: Alaska Mental Health Trust Authority January 2020, McDowell Group
Source: McDowell Group calculations. Does not include valuation of quality-adjusted life years due to alcohol-related traffic collisions ($996 million) or indirect costs related to victimization ($811 million).

ECONOMIC REVENUE AND COSTS OF ALCOHOL

2018 Impacts of Alcohol Sales

A comparison of the alcohol sales contributing to the Alaskan economy through jobs, earnings, and tax revenues to the costs ($1.84 billion) created by the use of alcohol.

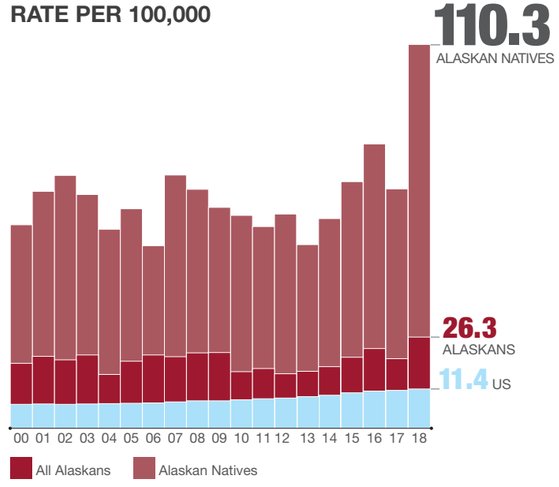
The Economic Costs of Alcohol Abuse in Alaska, 2019 Update, Prepared for: Alaska Mental Health Trust Authority January 2020, McDowell Group

ESTIMATED ECONOMIC COSTS OF ALCOHOL MISUSE, BY CATEGORY

2018 Estimated Alcohol-related Costs ($2.4 billion)

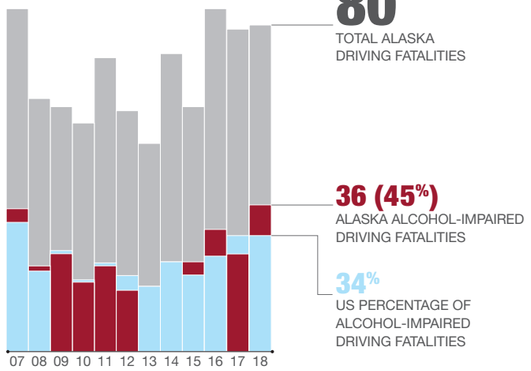
The Economic Costs of Alcohol Abuse in Alaska, 2019 Update, Prepared for: Alaska Mental Health Trust Authority January 2020, McDowell Group
Source: McDowell Group calculations. Does not include valuation of quality-adjusted life years due to alcohol-related traffic collisions ($996 million) or indirect costs related to victimization ($811 million).

ALCOHOL-INDUCED MORTALITY, RATE PER 100,000



Alaska Bureau of Vital Statistics, Division of Public Health, Department of Health and Social Services
National Vital Statistics System, National Center for Health Statistics, U.S. Centers for Disease Control and Prevention

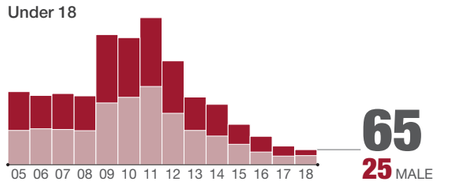
ALCOHOL IMPAIRED DRIVING FATALITIES



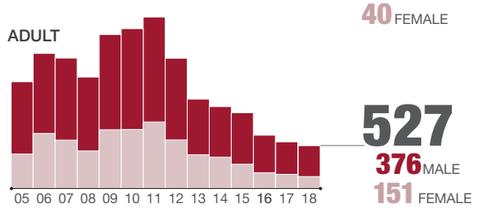
Alaska Bureau of Vital Statistics, Division of Public Health, Department of Health and Social Services
National Vital Statistics System, National Center for Health Statistics, U.S. Centers for Disease Control and Prevention

LIQUOR LAW VIOLATIONS

Under 18

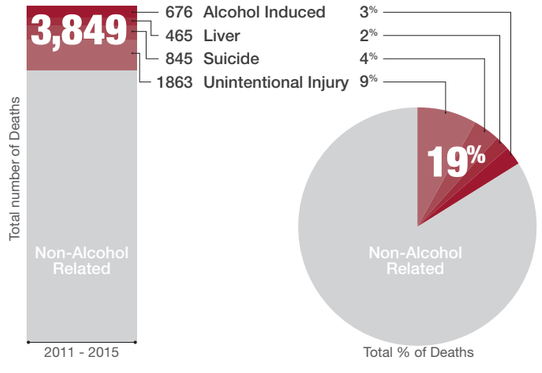


ADULT



Source: Uniform Crime Reports, Division of Statewide Services, Department of Public Safety

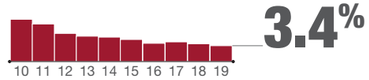
ALCOHOL-RELATED DEATHS OVER 5 YEARS



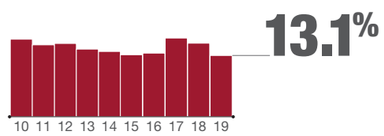
Source: Alaska Department of Health and Social Services, Bureau of Vital Statistics

DUI COURT FILINGS

% of DUI Felony Court Filings



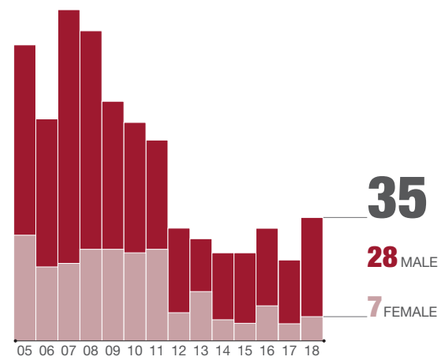
% of Misdemeanor Court Filings



Source: Alaska Court System: Annual Report (state fiscal years)

DUI CRIME DATA

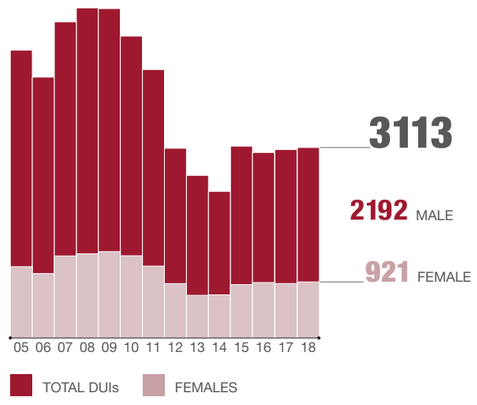
Under 18



Source: Uniform Crime Reports, Division of Statewide Services, Department of Public Safety

DUI CRIME DATA

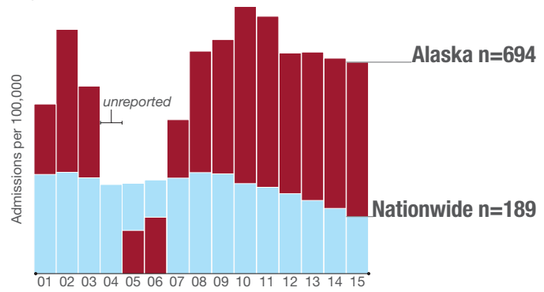
Adult



Source: Uniform Crime Reports, Division of Statewide Services, Department of Public Safety

TREATMENT ADMISSIONS (TEDs)

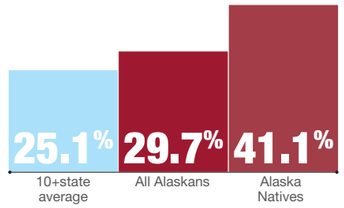
12 years and older



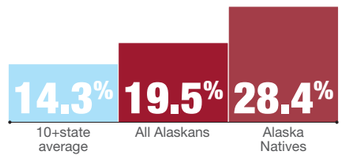
Treatment Episodes Dataset (under SAMHSA):
http://wwwdasis.samhsa.gov/webt/tedsweb/tab_year.choose_year_web_table?t_state=AK

ADVERSE CHILDHOOD EXPERIENCES (ACEs)

Household member with substance misuse, 2013-2015



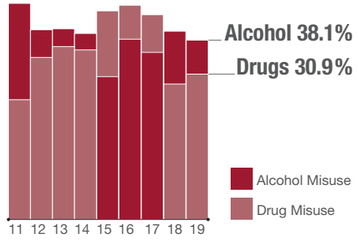
ACE score 4 or more, 2013-2015



Source: http://www.cdc.gov/violenceprevention/acestudy/ace_brfss.html / BRFSS ACE Module, CDC

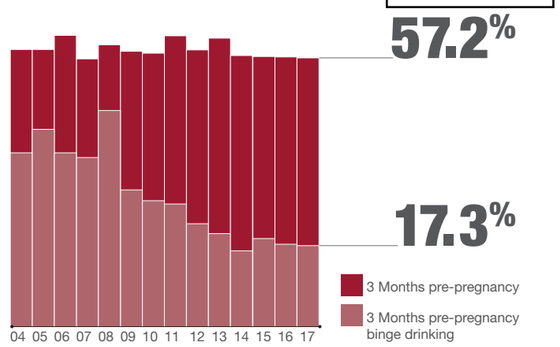
CHILD MALTREATMENT

% of families with child maltreatment with Parental Alcohol/Drug Misuse



Source: Alaska Department of Health and Social Services, Office of Children's Services

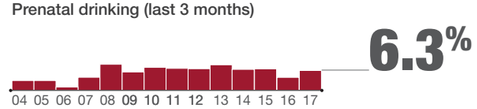
PRE-PREGNANCY ALCOHOL CONSUMPTION



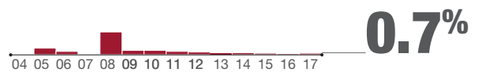
Source: Alaska Pregnancy Risk Assessment Measurement System (PRAMS)

POTENTIAL FOR FETAL ALCOHOL SPECTRUM DISORDERS

Prenatal drinking (last 3 months)



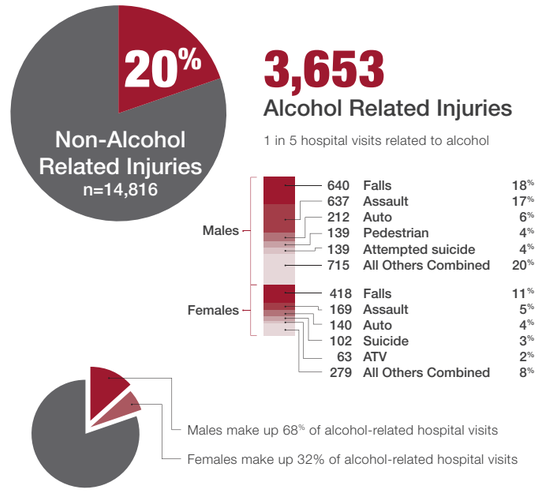
Prenatal binge drinking (last 3 months)



Source: Alaska Pregnancy Risk Assessment Measurement System (PRAMS)

INJURY CASES

Hospitalized injury associated with alcohol use by gender 2015 - 2019

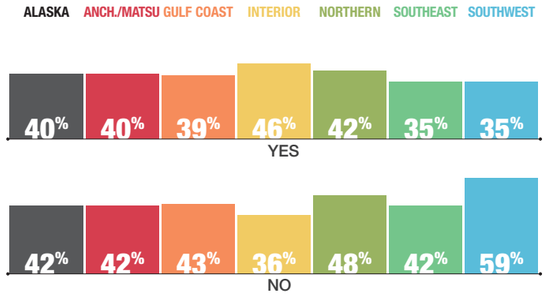


State of Alaska Epidemiologic Profile on Substance Use, Abuse, and Dependency / Alaska Trauma Registry.

PERCEPTIONS

PERCEPTION OF ACCESS

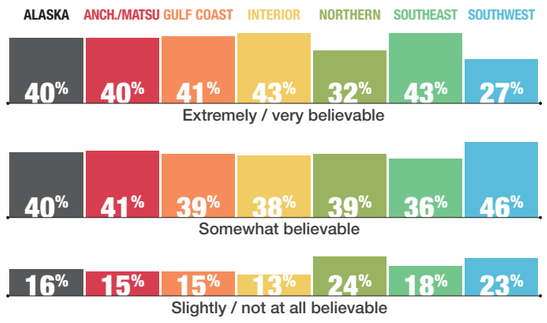
If a friend or family member who lives nearby needed treatment for an alcohol problem, do you think it would be easy for them to get into a treatment program or not?



SSRS 2018 Research Poll, June 18, 2018 - July 22, 2018

PERCEPTION OF "TREATMENT WORKS."

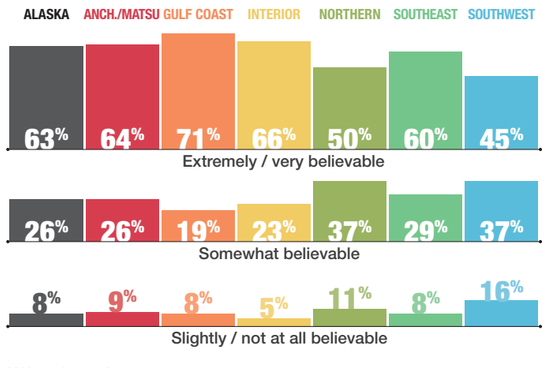
Statement: Do you think treatment works . . . ?



SSRS 2018 Research Poll, June 18, 2018 - July 22, 2018

PERCEPTION OF "RECOVERY IS POSSIBLE."

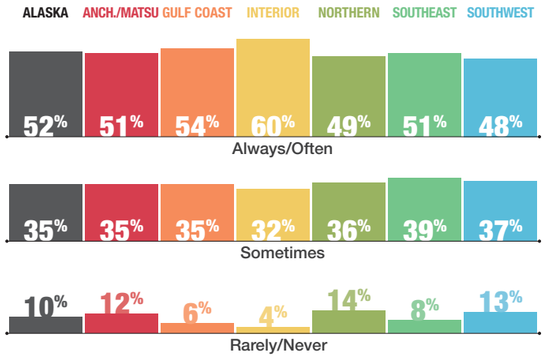
Statement: Do you think recovery is possible is . . . ?



SSRS 2018 Research Poll, June 18, 2018 - July 22, 2018

POSSIBILITY OF RECOVERY

Do you think it is possible for a person to recover from an alcohol problem?



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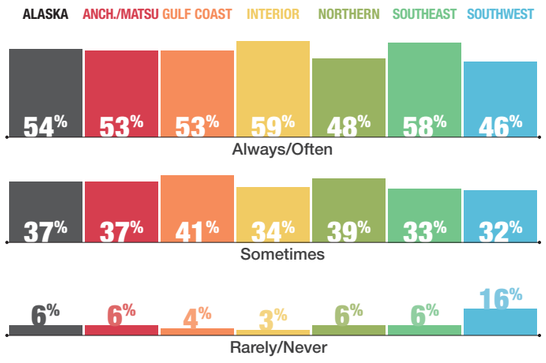
RELAPSE PART OF RECOVERY PROCESS

Do you think relapse is a part of the recovery process?



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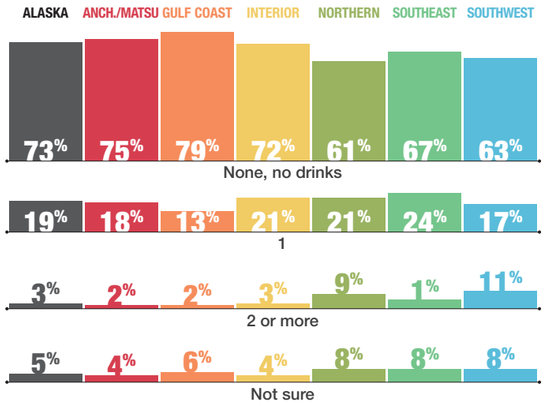
HOW MANY DRINKS IS SAFE WHILE PREGNANT?

How many drinks, if any, can a pregnant woman drink at one time without potentially causing harm to the developing baby?



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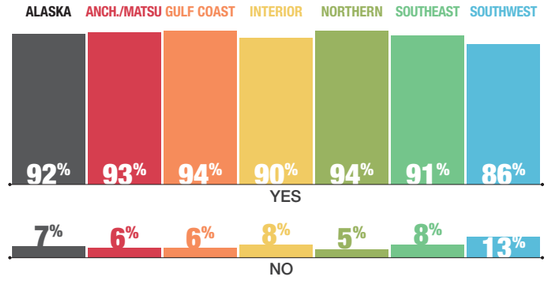
FEELING OF RESPONSIBILITY TO TALK TO SOMEONE DRINKING WHILE PREGNANT

If you knew a pregnant friend or relative was drinking alcohol during her pregnancy, would you feel a sense of responsibility to speak with them about their alcohol use?



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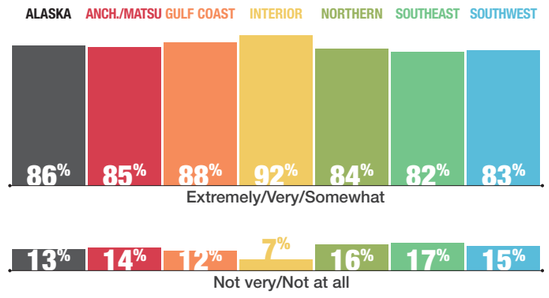
COMFORT LEVEL OF TALKING TO SOMEONE DRINKING WHILE PREGNANT

How comfortable would you be talking to a pregnant friend or relative about her alcohol use if she drank alcohol during her pregnancy?



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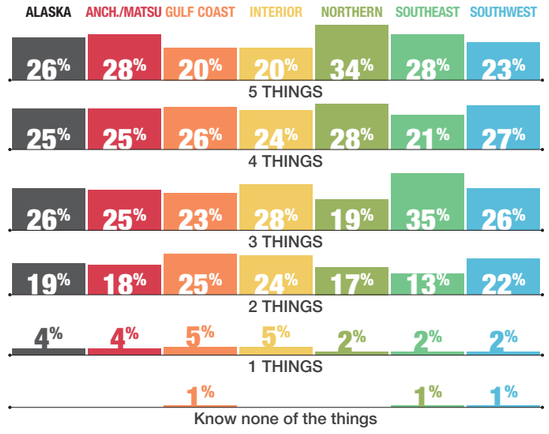
KNOWLEDGE OF HEALTH RISKS

How much do you know about health risks associated with alcohol?



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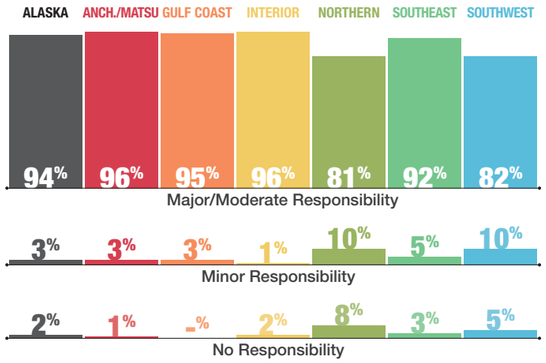
PERSONAL RESPONSIBILITY OF CONSUMER

How much responsibility do you think individuals have to get the help they need?



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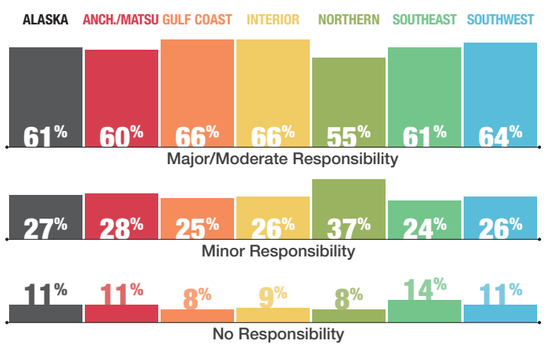
PERSONAL RESPONSIBILITY

How much responsibility do you feel you have to help others in your community?



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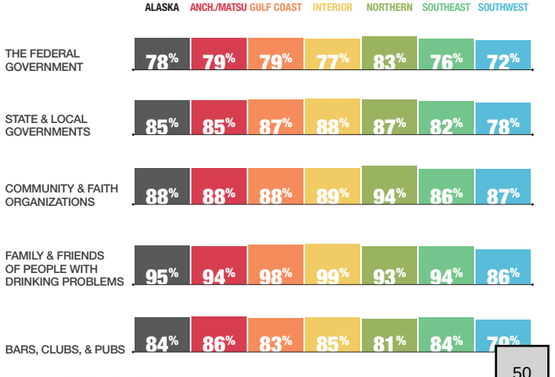
ORGANIZATIONAL RESPONSIBILITY

How much responsibility do you think the following groups have to reduce the harms associated with excessive drinking?



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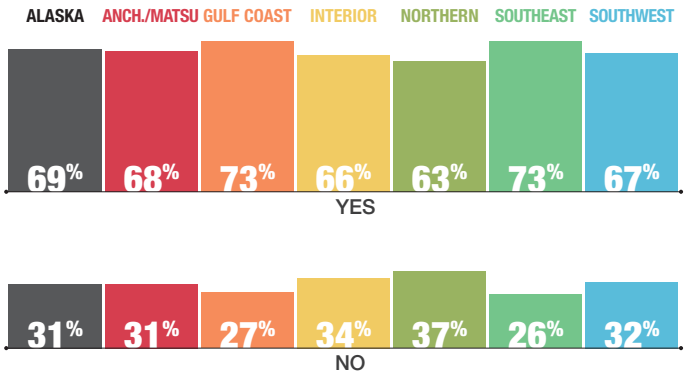
NEGATIVE IMPACTS

Have you ever been negatively affected by someone else's drinking?



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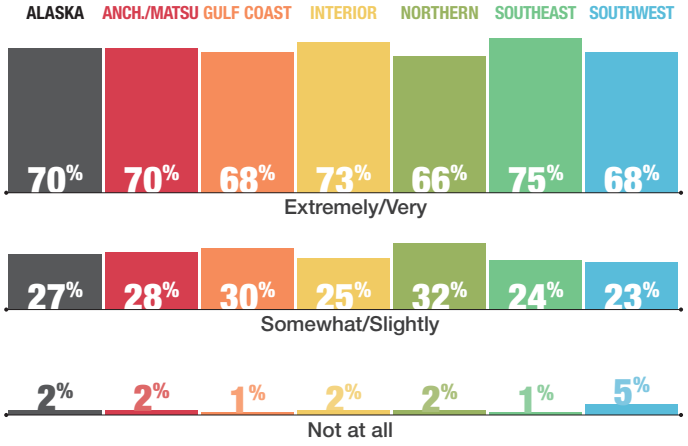
EFFICACY OF TALKING TO YOUTH

Would you say parents talking with their children and teens about the problems alcohol can cause is effective at reducing underage drinking?



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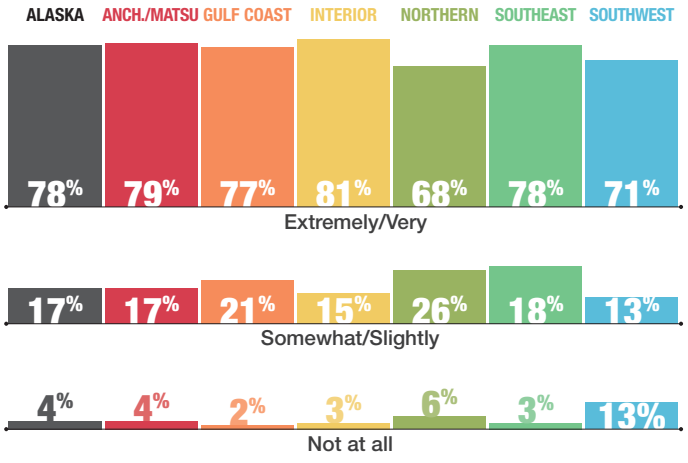
EFFICACY OF SETTING AN EXAMPLE

Would you say parents setting a good example of responsible alcohol use is effective at reducing underage drinking?



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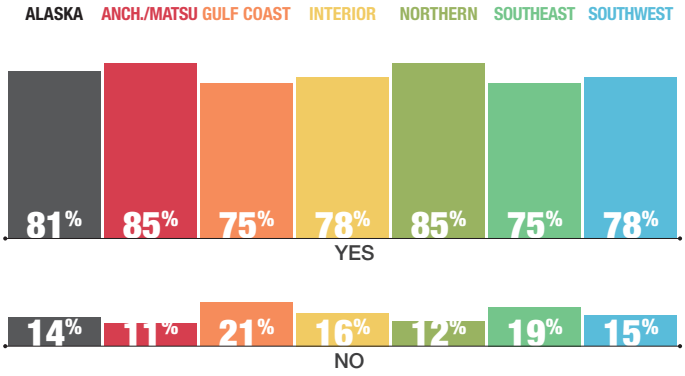
FEELING OF RESPONSIBILITY TO TALK TO A PARENT IF THEIR CHILD WAS DRI

If you knew a child or teen was drinking alcohol, would you feel a sense of responsibility to speak with their parents about their alcohol use?



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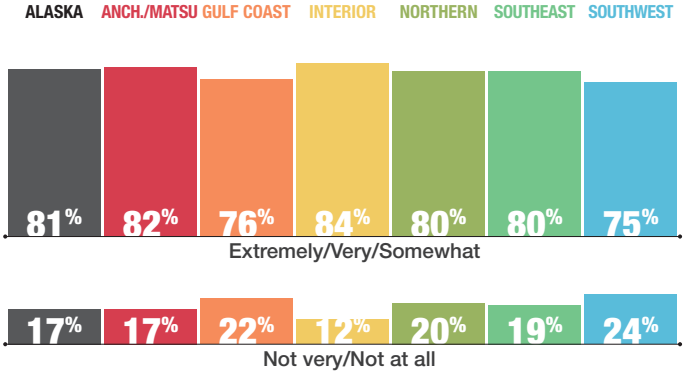
COMFORT LEVEL OF TALKING TO A PARENT IF THEIR CHILD IS DRINKING

If you knew a child or teen had been drinking alcohol, how comfortable would you be contacting their parents?



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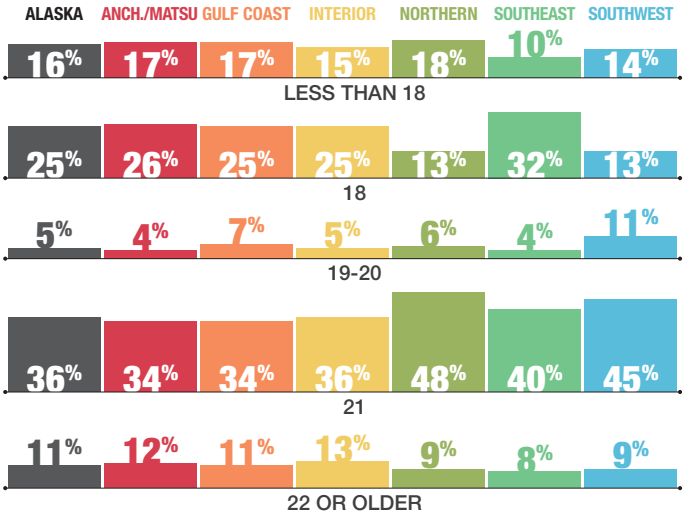
AT WHAT AGE IS IT SAFE TO HAVE A DRINK?

In general, at what age do you think it is physically safe for a young person to have a standard drink like one beer, a glass of wine or a shot of liquor?



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