KENAI PENINSULA • 2017

ASSESSMENT OF THE OPIOID EPIDEMIC

Central Peninsula | Southern Peninsula | Seward

Learn

Identify needs, services, gaps, and perceptions.

Engage

Educate and empower community members.

Connect

Connect the Kenai Peninsula, save lives.

change4theKenai
Connecting our Community

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KENAI PENINSULA ASSESSMENT OF THE OPIOID EPIDEMIC

CENTRAL PENINSULA • SOUTHERN PENINSULA • SEWARD

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Soldotna, Alaska 99669

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April 2017

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ACKNOWLEDGEMENTS

Change 4 the Kenai would like to than the residents of the Central Kenai, Homer, and Seward for making this joint Behavioral Health Needs Assessment possible. Special thanks go to the C4K coalition and the behavioral health community for providing their input on health needs and priorities through community meetings and other assessment activities. We would also like to thank the community agencies and organizations who provided meeting space, helped us reach out to their constituents and advocated for the health needs and concerns.

Thank you to leadership from the following partners:

BEHAVIORAL HEALTH NEEDS ASSESSMENT PARTNERS

Central Peninsula Hospital Behavioral Health Department

Cook Inlet Council Alcohol and Drug Abuse

Frontier Community Services

Ionia

Kenai Peninsula Community Care Center

Kenaitze Indian Tribe

Peninsula Community Health Services

ASSESSMENT PLANNING, DATA COLLECTION, AND PREPARATION

Alaska State Troopers

AKEELA

Anchorage 4 A's

Central Peninsula Health foundation

Central Peninsula Hospital

Change 4 the Kenai Coalition

City of Soldotna

Homer Needle Exchange

Kenai Adult Probation

Kenai Peninsula Borough Assembly

Kenai Peninsula Borough School District

Kenai Police Department

Kenai Public Health

Lee Shore

Ninilchik Tribal Council

Serenity House

Seward Community Health

Soldotna Police Department

Soldotna Professional Pharmacy

South Peninsula Hospital

EXECUTIVE SUMMARY

CONNECTING OUR COMMUNITY

Change 4 the Kenai is a coalition that is united to work toward connecting our community. C4K is currently dedicated to understanding the local increasing prevalence of drug use and the dire consequences. We plan to implement harm reduction programs and to break the stigma of addiction within the community through education.

ASSESSING THE KENAI PENINSULA OPIOID EPIDEMIC

C4K collaborated with Kenai Peninsula area health service agencies and other community partners to conduct the Kenai Peninsula Opioid Epidemic Assessment (KPA). The targeted service area included the communities throughout the Kenai Peninsula and grouped them overall into three main areas: Central Kenai Peninsula, Southern Kenai Peninsula, and Seward, representing a population of about 55,400 people.

The KPA consisted of two web-based surveys, voluntary focus group sessions, key stakeholder interviews from each area, and in person surveys with the at-risk population. Additional data sources included national, state and local community health databases; respective community needs assessments; and laboratory results.

THE CHALLENGE: DETERMINING NEEDS, RESOURCES & GAPS

After reviewing countless papers and performing several interviews and focus groups, C4K identified common themes toward Non Medical Use of Prescription Opioids (NMUPOs) and heroin use. Some incongruences in perceptions and mental health models compared to primary data led to some underlying questions about specific relationships between our community and addiction. Gaps in both data collection – mostly from unique populations – and resources were identified.

The community voice guided further phases of the KPA by establishing themes of concerns and specific questions.

1. *What is the prevalence of NMUPO and heroin use among youth and young adults on the peninsula? Who is at risk for developing opioid addictions?*
2. *Are rates of opioid abuse increasing over time? Are there any identifiable trends in use patterns?*
3. *Does connectivity play a role in addiction? Are those that are connected to community less likely to develop addictions?*
4. *What is the relationship between NMUPO and heroin? Does NMUPO lead to use of heroin?*
5. *Are adverse childhood experiences a significant factor in identifying those who are at risk for further addiction? Are they a better predictor of subsequent heroin use than NMUPO?*

OUR RESPONSE

The needs of the community in response to heroin and NMUPO use have been integrated into an implementation plan designed to address these needs with strategic initiatives. Through guidance from the community coalition, stewarding existing resources, strengthening partnerships and developing innovative programs we hope to make a significant impact on heroin and NMUPO use on the Kenai Peninsula. The

2017 Kenai Peninsula Assessment of the Opioid Epidemic

impact.

FINDINGS

These quick facts represent the major findings of the assessment. Each theme represents a unique area of the study.

Change4theKenai

Central Peninsula • Southern Peninsula • Seward

YOUTH

Opioid drug use in youth is generally higher on the Kenai Peninsula compared to the rest of Alaska.

From 9th - 12th grade, all usage trends increase.

Boys are more likely to use than girls.

YOUNG ADULT

Rx
It is unlikely that opioid prescription use turns into addiction.

Friends & Family
When young adults did abuse prescription opioids, evidence suggests that the drugs came from friends and family.

Messaging
Young Adults are exposed to messaging about drug use but there is room for improvement.

Storage & Disposal
Education on safe storage and proper disposal is largely needed.

COMMUNITY CONNECTIVTY

Young adults were more connected to schools and the community than expected.

The young adult surveys both demonstrated low rates of substance misuse in this age demographic.

ADVERSE CHILDHOOD EXPERIENCES

Adverse Childhood Experiences (ACEs) were a significant predictor of subsequent substance use and represent a stronger relationship with heroin than prescription opioid abuse.

HEROIN & NON MEDICAL USE OF PRESCRIPTION OPIOIDS

For people who use drugs, prescription opioids were popular before 2006 with use waning over the last 5 years. As opioids dropped off, heroin use steadily rose.

Data indicates that alcohol or marijuana use are better indicators of subsequent use of heroin than use of prescription opioids.

Methamphetamine use is seen more concurrently with heroin than other opioids.

Heroin

is the most common drug of choice for those entering residential treatment.

INTRODUCTION & BACKGROUND

Change 4 the Kenai

Connect Comm*unity*, save lives.

WHO WE ARE

Change 4 the Kenai is a coalition that is united to work toward connecting our community. C4K is currently dedicated to understanding the local increasing prevalence of injection drug use and prescription opioid misuse, with emphasis on the dire consequences. We plan to implement harm reduction programs and to break the stigma of addiction within the community through education.

2016 Community Walk-A-Thon for Awareness of Addiction & Recovery. Soldotna, Alaska

OUR VISION

We envision a healthy and safe community built on the foundation of independence that our residents embrace while connecting to ensure that everyone matters.

PROGRAMS AND SERVICES OF C4K AND PARTNERS

Heroin's Hooked Alaska
Not a seasonal problem

Educational Media Campaign

Effective Transportation

Transportation Task Force

GotDrugs?
dispose
unused
DEA

Drug Take Back Partnerships

GOALS OF THE COMMUNITY ASSESSMENT

The 2017 Kenai Peninsula Assessment of the Opioid Epidemic overarching goals are

The 2017 Assessment is designed to improve health through

- Increasing awareness of the social determinants of health;
- Identifying health improvement priorities;
- Providing measureable objectives and goals;
- Engaging multi sector stakeholders

This assessment is comprised of key topic areas. Each topic area outlines specific objectives with targeted measures for improving health outcomes and health behaviors.

INFORMATION GAPS

Change 4 the Kenai utilized multiple strategies to gather community-wide information including surveys, interviews, focus groups, and analysis of previous reports and studies. Great effort was put forth into looking at all key sectors of the Peninsula, however, youth response was lower than anticipated. The Kenai Peninsula Borough School District requires that all students have signed permission prior to taking part in any surveys or interviews. The return on such signature pages delayed the completion of a current YRBS study as well as efforts by Change 4 the Kenai to gather a broader representation of youth throughout the Kenai Peninsula. We were successful in providing a smaller sampling size from each geographical location.

KEY TERMS

METHADONE. Methadone is a full opioid agonist that works by occupying the same receptors in the brain as heroin and other prescription opioids. It is available in tablet or liquid form. It can be prescribed for pain management, to mitigate opioid withdrawal, or for Methadone treatment for opioid detoxification purposes.

NALOXONE (NALOXONE HYDROCHLORIDE). Naloxone is an injectable opioid antagonist that is used to reverse the effects of opioid use (such as slowed breathing and decreased heart rate). Nalaxone® can be found as the brand Narcan® and is commonly used to treat opioid overdoses, including overdoses from heroin, methadone, and prescription opioids.

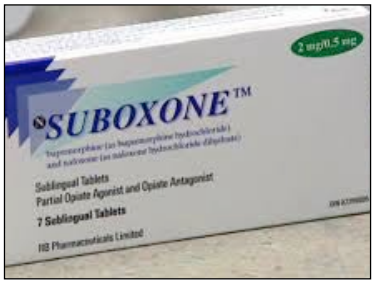
NALTREXONE. Naltrexone is an opiate antagonist that is used in the treatment of opioid dependence. An injectable long-activing version (Vivitrol®) was approved for the treatment of opioid dependence in 2010. Naltrexone works by blocking other opioids, so that an individual who is on naltrexone and attempts to take an opioid will not feel the desired effect of that opioid.

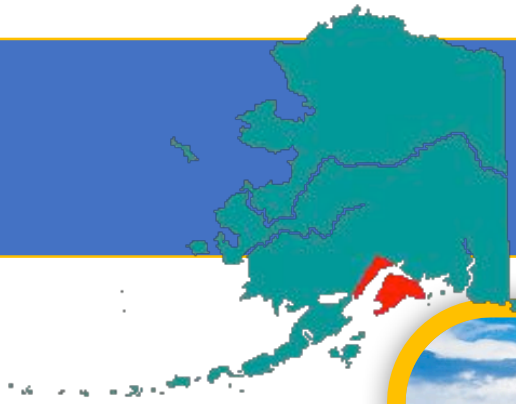
OPIATES. Opiates refer to the natural derivations from the opium poppy plant.

OPIOIDS. The term for full opioid and partial opioid agonists, including natural derivations and semi-synthetic forms of opium. Once absorbed into the body, opioids bind to opioid receptors in the brain. They produce depressant effects such as sedation, slowed respiration, and euphoric feelings.

PRESCRIPTION OPIOIDS. Prescription opioids include hydrocodone (Vicodin®), oxycodone (OxyContin®), propoxyphene (Darvon®), hydormorphone (Dilaudid), meperidine (Demerol®), and diphenoxylate (Lomotil®).

SUBOXONE®. Suboxone® is the brand name for the combination of buprenorphine and naloxone. It is intended to treat opioid addiction.





OUR COMMUNITY

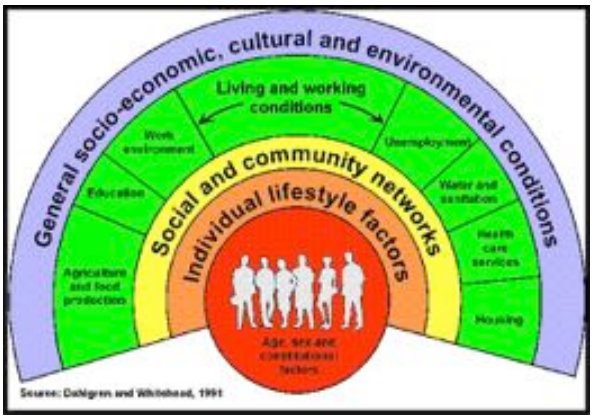
COMMUNITY SNAPSHOTS

Every community has a story. As unique as the individuals that make up the communities of the Kenai Peninsula, each location among this vast Alaskan terrain offers a rich history and independent views of socioeconomic data, community strengths and challenges, as well as trends. These community snapshots are designed to provide information from the perspective of the individual population.

Research demonstrates that improving population health and achieving health equity requires a broader approach than traditional goals of expanding access to health coverage and health care reform. Increased recognition of the importance of social, economic, and environmental factors that influence health guided Change 4 the Kenai to develop a framework for our community snapshots. This framework is designed to provide a multi-faceted view of each population as organized by geography, culture, and across life stages and is guided by the Social Determinants of Health.

SOCIAL DETERMINANTS OF HEALTH

The social determinants of health (SDH) are identified by the World Health Organization (WHO) and Healthy People 20/20 as the conditions in "which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life."[-]



The five identified key determinants are:

1. Economic stability
2. Education
3. Social and community context
4. Health and health care
5. Neighborhood and built environment

The Kenai Peninsula comprises an area of 16,013 square miles connected by two main highways: the Seward Highway, which extends 125 miles from Anchorage to Seward and the Sterling Highway, which connects to the Seward Highway at Tern Lake Junction and runs 138 miles to Homer. Over this vast terrain, several smaller communities and moderate size cities are home to an overall population of over 57,000 people. Extreme weather differences can be seen from one area of the Peninsula to another. Mountain passes and a lack of transportation routes separate many communities.

Each community is unique, hosting special events and being noted for attributes distinctive to its heritage and location. Community snapshots are vital to understanding the unique aspects of life across the Kenai Peninsula. By determining the social determinants of health in each area, we gain a better understanding of the socio-economic, cultural, environmental, social and community factors[-] in each location. We are able to begin assessing strengths, weaknesses, and areas of potential intervention and growth. Furthermore, we are able to compare these unique locations and identify overlapping strengths and weaknesses across the Kenai Peninsula.

OVERVIEW

GEOGRAPHICAL LOCATION

The Kenai Peninsula, often referred to as 'Alaska's Playground' extends 150 miles southwest from the Chugach Mountains south of Anchorage. The peninsula is separated from the Alaska mainland on the west by Cook Inlet and on the east by Prince William Sound. It's beautiful 9,000 square miles are adorned by glaciers, snow-capped mountains, and extensive coastline. The hub of activity and services can be found in the Central Peninsula cities of Soldotna and Kenai. Homer, a major fishing and tourism destination, is located at the 'end of the road,' following the Sterling Highway south of Soldotna. Seward, the gateway to the Kenai Fjords National Park and Harding Icefield, is located on the Prince William Sound side of the Peninsula.

HISTORY

The rich history of the area begins a millennia ago. Dena'ina Indians made their home on the Kenai Peninsula, as did Alutiiqa in the south and Chugaches in the east. Their largely subsistence lifestyle often consisted of pulling fish from the area's waterways and hunting. In 1741, Vitus Bering, a Dane sailing for the Russians was the first European to travel to the peninsula. In 1778, British explorer Captain James Cook sailed up the inlet that would later bear his name.

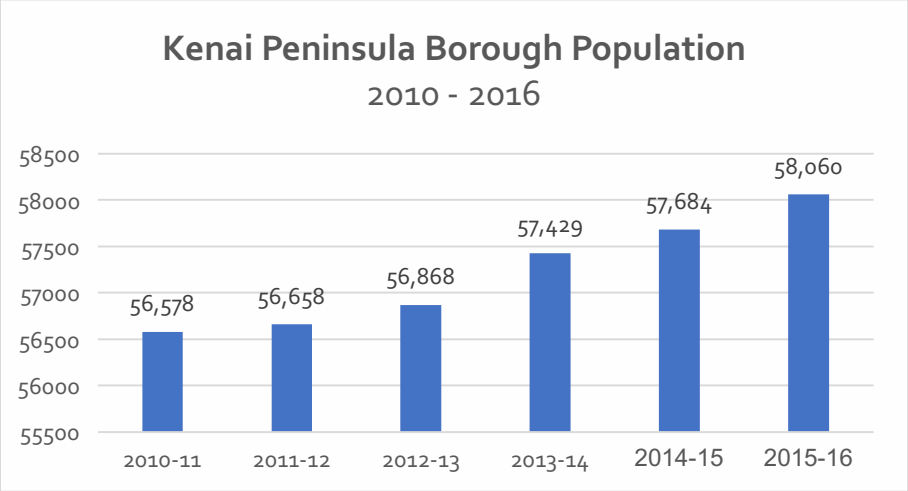
First white settlement on the peninsula was Russian, led by St. Nicholas Redoubt, who founded a fur trading post at the mouth of the Kenai River. Orthodox missionaries and fur traders arrived soon after. Native Alaskan and Russian cultures began to intertwine. In 1867 the United States established Fort Kenay when Alaska came under American rule. The area was mostly a commercial fishing village until 1957 when the nearby Swanson River became the site of Alaska's first major oil strike.



Kenai • Homer • Seward

POPULATION

The population from 2015 to 2016 for the Kenai Peninsula Borough had an increase of 376, a growth rate of 0.65 percent. A look into the social determinants of health (Economic stability, Education, Social and community context, Health and health care, and Neighborhood and built environment) may help us to identify unique factors in our communities that create risk for substance abuse and addiction for the Kenai Peninsula Borough as well as finding specific community risks.



Source: Alaska Department of Labor and Workforce Development, Research and Analysis Section.

CENTRAL KENAI PENINSULA

OVERVIEW

The Central Kenai Peninsula (CPK) is comprised of many smaller yet active towns. The cities of Soldotna and Kenai are the largest metropolitan areas and house most of the facilities for the area. They are often considered the 'hub' or 'seat' of the peninsula. The smaller communities of the Central Peninsula are Nikiski, Sterling, and Kasilof. The distance between these cities and smaller communities creates a risk for isolation and a lack of connection which can lead to an increase in substance use and addiction.

These towns are accessible from Anchorage and Seward via the Sterling Highway and the Seward Highway and by air via the Kenai Municipal Airport, which is the commercial air transportation gateway to the Kenai Peninsula Borough. Soldotna also has an airport which holds privately owned hangars and fuel facilities as the city does not operate any hangar facilities.

SOLDOTNA. The city of Soldotna was incorporated in 1960 and is nestled about 10 miles inland from the shores of Cook Inlet, on the banks of the Kenai River. It encompasses an area of 7.4 square miles. Soldotna's location at the center of the Kenai Peninsula offers residents and visitors access to nature, other nearby towns, and is driving distance to Homer, Seward, and Anchorage. According to the Alaska Department of Labor, the population is estimated at 4,376 for 2016. 11.1 miles from Soldotna is the city of Kenai.

KENAI. The City of Kenai is located on the Kenai Peninsula at the mouth of the world-famous Kenai River, known for its world-class King Salmon fishing. This 29-square mile city was also incorporated in 1960. The Alaska Department of Labor estimates the population of 7,098 in 2016. Kenai's motto, "Village with a past, City with a future," reflects the link between the long and rich history of native and Russian settlement culture and its opportunities for sustainable growth and development. 13.3 miles from Kenai via the Kenai Spur Highway is Nikiski.

NIKISKI. Nikiski is an unincorporated census-designated place (CDP) located on the Kenai Peninsula with a land mass of 69.9 square miles. Outdoor recreation and various playgrounds and picnic areas entice nearby residents and tourists alike to visit Nikiski. According to the Alaska Department of Labor, Nikiski's population is approximately 4,616 in 2016. Like Nikiski, Sterling is an unincorporated census-designated place (CDP) on the Kenai Peninsula.

STERLING. Sterling is located on the Sterling Highway about 20 miles east of the city of Kenai. Settlement in this town, previously known as Naptowne, began in August 1947 when the area was opened for homesteading prior to existence of the Sterling Highway. In October of 1954 the name was changed to Sterling, in honor of Hawley Sterling who supervised the engineering of the highway. Sterling encompasses 77.3 square miles of land and is along the junction of the Moose and Kenai Rivers. There are many campgrounds and cabins that provide a place for visitors to enjoy fishing, wildlife, and outdoor adventures. According to the Alaska Department of Labor, the population of Sterling is approximately 6,011 for 2016. The other census-designated place (CDP) included in Central Peninsula is Kasilof.

KASILOF. Kasilof is located 14.8 miles south of Soldotna on the Sterling Highway. In 2016, the Alaska Department of Labor estimated the population of Kasilof to be 532.

HISTORICAL SIGNIFICANCE

The local Dena'ina people originally called themselves Kahtnuht'ana- "People of the Kenai River." The Russians called them Kenaitze, from the Dena'ina stem "ken," which refers to flat land meaning the wave cut terrace Kenai is built on. In 1791, the Russians built Fort (Redoubt) St. Nicholas at Kenai, which was an outpost for trading fish and furs. The Russian Orthodox religion took root, and Kenai's oldest buildings are Orthodox related: A log rectory (1886), the Holy Assumption of the Virgin Mary Orthodox Church (1895), and the nearby log chapel (1906). The United States established Fort Kenay in 1869. Homesteading opportunities in the 1940s brought many families to the Kenai Peninsula along with the opening of the first road, the Sterling Highway, connecting Kenai and Anchorage in 1951. This access helped expand the communities. Things really took off in 1957 when Alaska's first major oil strike took place at Swanson Lake in Sterling.

ECONOMIC STABILITY

The economy is diverse with oil and gas exploration, commercial and sport fishing, seafood processing, transportation, retail, and tourism. The Alaska Department of Commerce, Community and Economic Development estimates that about 500,000 people visit the Kenai Peninsula each summer. A commercial dock with boat launch on the Kenai River also provides both an economic boost as well as recreational opportunities. Kenai is also home to the largest and busiest airport on the Kenai Peninsula. The Kenai Municipal Airport is a hub for freight services, regularly scheduled passenger airlines, and a float-plane base. The airport provides lease lots for both private and commercial activities.

According to the US Census (income and poverty), the poverty level for Kenai is 10.9% and the median household income (in 2015 dollars) was $62,236, per capita income was $34,627. The percentage of residents employed for Kenai is 63% in 2015 and there were 518 unemployment claimants, according to the Alaska Department of Labor.

The city of Soldotna states their poverty level is 5.2%, with children (under 18) at 8%. The median household income (in 2015 dollars) was $65,048, per capita income is $33,507. Soldotna had 61% of residents employed in 2015 with 268 unemployment claimants, according to the Alaska Department of Labor.

The US Census has the poverty level for Sterling at 10.1% and the median household income (in 2015 dollars) was $71,597, per capita income was $32,429. The percentage of residents employed for Sterling is 54% in 2015 and there were 290 unemployment insurance claimants, according to the Alaska Department of Labor. The 2016 average unemployment rate for the Kenai Peninsula Borough as a whole is 8.3%.

EDUCATION

The Kenai Peninsula Borough School District (KPBSD) serves the entire Kenai Peninsula. There are 44 public schools with 8,974 students that were enrolled in the FY 14-15 school year. Although the smaller communities of Kasilof and Sterling have local elementary schools, the high school students travel to schools in Soldotna or Kenai. Nikiski has a local high school as well. Connections home school program serves the entire Kenai Peninsula.

KPBSD has a student in transition program that works with local schools and organizations to find resources to help those families in transition. There were approximately 188 students peninsula wide enrolled in the program in 2015.

Opportunities for college or vocational opportunities in the Central Kenai Peninsula include the Kenai Peninsula College (KPC), the Alaska Christian College, and the New Frontier Vocational/Technical Center (NFVTC), a post-secondary training for various office occupations, all located in Soldotna.

According to the US Census, 89.7% of Kenai residents and 94.5% of Sterling residents are high school graduate or higher. For bachelor's degree or higher, the rate for Kenai is 22.2% and 16.1% for Sterling, percent of persons age 25 years+ (2011-2015).

SOCIAL AND COMMUNITY CONTEXT

The majority of services and activities can be found in Soldotna and Kenai. Although both cities lack a true 'city center' for gathering, there are a few parks in each city and a walkway along the river in Soldotna. Soldotna major facility for activities is the Soldotna Regional Sports Complex and in Kenai, the Kenai Recreation Center. The Dena'ina Wellness Center also has an exercise room for their beneficiaries.

Nikiski also has a recreation center and playground, and a large pool with a diving board and a 136' water slide that provide year-round activities to families. Other activities are trails, disc golf course, exercise rooms and courts, a community center, and ice rink.

The Sterling Community Center was built in 2013 to bring Sterling residents together and to invest in their children, families, and their future. The facility has a full-court gym, a multi-purpose room with computers/library, and a commercially-equipped kitchen.

Kasilof offers other accommodations as a result of the large fishing industry such as campgrounds and recreation areas in town as well as nearby locations. These include the Kasilof River State Recreational Site, the Crooked Creek State Recreation Site, and Johnson Lake State Recreation Area. Kasilof also has a local 'mom and pop' type grocery store and gas stations.

HEALTH AND HEALTH CARE

The health facilities for the Central Kenai Peninsula are mainly in Soldotna and Kenai. Facilities in Soldotna include: Peninsula Community Health Services of Alaska (PCHS), Central Peninsula General Hospital along with their Serenity House Treatment Center for mental health and substance abuse, Heritage Place, Family Medical Clinic, Alaska Family Medical Clinic, Peninsula Internal Medicine, Central Peninsula Rehabilitation, Foundations Family Resource Center, and several other local private clinics.

Kenai also has many health care facilities, (PCHS), Central Peninsula Family Practice, Peninsula Ear Nose & Throat, Kenai Public Health, and The Dena'ina Wellness Center. The main clinic of Medicenter is located in town in Kenai but they also have a facility on the Kenai Spur Highway close to Nikiski, Medicenter North.

Residents in Nikiski, Sterling, and Kasilof also travel to Kenai or Soldotna for their medical and other health care needs.

NEIGHBORHOOD AND BUILT ENVIRONMENT

The Alaska Department of Labor and Workforce Development reports an average single-family housing cost of $252,986, an average condo sales price of $221,700 for existing construction, and an average rent of $1,059 (including utilities) for the Kenai Peninsula Borough in 2016. They also report a weekly cost of $200.10 for food for a family of four with children ages 6 to 11.

Larger box and grocery stores can be found in Soldotna and Kenai. Those in outlying areas must travel to the main area for most shopping, although smaller 'mom and pop' type grocery stores can be found in smaller areas. During the months from May through September, Soldotna and Kenai hold several local farmers' markets for residents to access quality healthy grown produce.

Summers in Soldotna/Kenai are mild and winters are relatively warm compared to most Alaska communities. There are a large number of outdoor activities for the residents that include: fishing, hiking, hunting, camping, berry picking, clam digging, and canoeing. Access to the Sterling Highway makes a way for residents to access mountainous trails for cross-country skiing, sledding, and snowboarding for winter activities.

Transportation is an on-going issue for the Central Kenai Peninsula, there are no public busses or shuttles for residents. There is one available source that is contracted by the state for client rides, which is Central Area Rural Transit System (CARTS), and a local taxi agent Alaska Cab is contracted with the Frontier Community Services for a voucher program for clients who qualify for their services.

SOUTHERN KENAI PENINSULA

OVERVIEW

The Southern Kenai Peninsula (SKP) is a vast rural area in South Central Alaska which is accessible by road through the Central Kenai Peninsula via the Sterling Highway, by sea via the Alaska Marine Highway, and by air, the Homer Airport. The SKP is generally considered to be the areas of Ninilchik, Anchor Point, Happy Valley, and a few other smaller communities through and across the bay from Homer. Although our focus is on Homer, these smaller outlying communities contribute to the economy of Homer due to the fact that the major businesses and health care facilities are in Homer.

The City of Homer is located on the north shore of Kachemak Bay near the southern tip of the Kenai Peninsula at 'The End of the Road' and is described as 'Where the land ends and the sea begins.' The land area is 15 square miles and 10.5 square miles of water. Homer is known as the 'Eco and Adventure Tourism Capitol of Alaska' and is also the "The Halibut Fishing Capital of the World." Homer incorporated as a city in March of 1964. According to the Alaska Department of Labor, the estimated population was 5,252 in 2016.

HISTORICAL SIGNIFICANCE

The Southern Kenai Peninsula has a rich history full of culture, adventure, and creative settlement. It is full of "last frontier" flavor.

In 1896, Homer gained its namesake for Homer Pennock, a con man who promoted the area of Homer and the Homer Spit with promises of gold. The community was essentially a coal mining town but was abandoned between 1902 through 1915 due to a lack of coal markets. The town then became a center for fishing, farming, ranching, and homesteading. In 1915, homesteads brought in families, one particular family, Charlie Miller of Miller's Landing, where the first school opened in 1919. UAA's KPC Kachemak Bay

Campus offered its first classes in 1969. The creation of the Kachemak Bay State Park in 1971 contributed to the growth of tourism in Homer.

ECONOMIC STABILITY

The majority of the SKP data available is specific to the reporting area of Homer, as it is the largest town and hub for most services on the Southern Kenai Peninsula and also employs those residents from outside the city limits.

According to the US Census (income and poverty), the poverty level for Homer is 12.6% and the median household income (in 2015 dollars) was $55,849, per capita income was $30,664. The percentage of residents employed for Homer is 49% in 2015 and there were 217 unemployment insurance claimants, according to the Alaska Department of Labor. The 2016 average unemployment rate for the Kenai Peninsula Borough is 8.3%.

Although Homer is largely known for fishing and tourism, other major contributors to the economy are marine trades, education and health services, local and state government, leisure and hospitality, natural resources and mining, retail, and professional and business services. The City of Homer states that entrepreneurship is a key element to the economic equation.

Homer and the surrounding areas, like most communities on the Kenai Peninsula are highly dependent on industries that can have unpredictable and often boom and bust cycles. Commercial, sport, and subsistence fishing, all greatly impact the financial stability and home-life of many peninsula residents, as well as those who work on the North Slope that are affected by layoffs due to oil prices, production, and other limitations in the field.

The population is strongly influenced in the summer by transient workers, tourists, and 'snow birders'. The large influx of seasonal residents brings in over 100,000 visitors

EDUCATION

The City of Homer is served by the Kenai Peninsula Borough School District (KPBSD). KPBSD has 44 public schools with 8,974 students enrolled in the FY 14-15 school year. The number of students enrolled in the Students in Transition program for Homer was 90 in 2015. Further educational opportunities in Homer include UAA's KPC Kachemak Bay Campus.

According to the US Census, 95.9% of Homer residents are high school graduate or higher and 32.8% are bachelor's degree or higher, percent of persons age 25 years+ (2011-2015).

SOCIAL AND COMMUNITY CONTEXT

The City of Homer states that 'Homer has a plethora of non-profit organizations that enhance quality of life and provide wide-ranging volunteer opportunities.' The city prides itself on being an ambitious and forward-thinking community that embraces responsible economic development. Homer was the first community in Alaska to adopt a Climate Action Plan in 2007, gaining recognition for their emphasis on sustainability. The City of Homer followed up by developing an employee sustainability guidebook and a program to improve energy efficiency and conservation in all city buildings and facilities.

In 2008, MAPP of the Southern Kenai Peninsula (SKP), came together as a community health improvement coalition to develop and support a long-term vision of community well-being. MAPP stands for "Mobilizing for Action through Planning and Partnerships." Every participant in MAPP is a local resident who wants to make a difference for the Southern Kenai Peninsula. The first workgroups to address priority goals were Addressing Substance Abuse and Domestic Violence, Connecting Community Resources, and Healthy Lifestyle Choices. The community is focusing action around increasing family well-being and to promote family resiliency through 5 objectives: Enhancing Family Cohesion and supportive relationships

within families, increasing Role Models for children and youth, improving physical and mental health of caregivers, enhancing networks and social supports for families, and Increasing stability for families.

HEALTH AND HEALTH CARE

Homer is the hub for health care on the Southern Kenai Peninsula. Most SKP communities can access Homer's health care services by road and by air for those communities across Kachemak Bay (Seldovia, Port Graham, Nanwalek, and Halibut Cove). During times of harsh weather, clients and patients may not be able to get back home and may need to stay overnight in Homer. Many need help with transportation around Homer as there are no public busses or shuttles.

Healthcare services in Homer are considered "fairly comprehensive" by local assessments based on the remote rural location. The MAPP assessment for the South Kenai Peninsula lists the top five responses for what kept respondents from accessing services as: cost, schedule conflicts, not enough time, transportation, and lack of anonymity.

Healthcare facilities in Homer include: The South Peninsula Hospital, the Homer Medical Center, a VA clinic offered twice a week, and the Mountain Sea Midwifery and Wellness, LLC. There are three remote primary care clinics that provide limited services to the smaller outlying communities of Ninilchik, Anchor Point, and those communities across the bay from Homer.

NEIGHBORHOOD AND BUILT ENVIRONMENT

The Alaska Department of Labor and Workforce Development reports an average single-family housing cost of $252,986, an average condo sales price of $221,700 for existing construction, and an average rent of $1,059 (including utilities) for the Kenai Peninsula Borough in 2016. They also report a weekly cost of $200.10 for food for a family of four with children ages 6 to 11. According to the Kenai Peninsula Economic Development District, the average cost of food for a family of four is $277.31.

While grocery shopping is limited to Homer Safeway and Save-U-More, a summer farmer's market offers fresh grown produce through the High Tunnel Program and local gardens. Several small convenience stores are located throughout the SKP, providing residents who live outside Homer the ability to purchase limited goods without having to drive to Homer or Soldotna/Kenai.

Homer's climate is moderated by the Pacific Ocean, resulting in warmer winters and cooler summers than seen in places farther inland in Alaska.

CITY OF SEWARD

OVERVIEW

The City of Seward was incorporated in 1912 and is located on the east coast of the Kenai Peninsula at Resurrection Bay, about 125 highway miles from Anchorage. The distance between Seward and Kenai is 104.1 miles, via the Seward Highway and Sterling Highway. Seward is the gateway to the Kenai Fjords National Park. According to the Alaska Department of Labor, in 2016 the population was 2,663. The total population of Seward including the communities nearby is approximately 4,868.

HISTORICAL SIGNIFICANCE

Seward has a rich historical background. It was founded in 1792, when Russian explorer Alexander Baranof arrived by boat through Resurrection Bay. It is believed that the first ship built on the west coast of North America was built in Seward in 1793-1794.

The founders and settlers of Seward arrived in 1903 to build the Alaska railroad and the town was named in honor of William H. Seward, President Abraham Lincoln's Secretary of State, who negotiated the purchase of Alaska from Russia in 1867. In 1915, President Woodrow Wilson chose Seward as the main railroad route into Alaska's interior. The 1964 "Good Friday" Earthquake was 95 air miles northeast of Seward, which severely damaged the town and the rail yards. They are restored today, but remnants can still be seen along the waterfront.

Popular attractions in Seward are the annual Mt. Marathon footrace and Harding Ice Field. Fishing, kayaking, cruises, and sightseeing for whales and other marine life are common tourism activities. Locals also boast fantastic berry picking and hunting.

ECONOMIC STABILITY

The top industries of Seward include oil and gas, maritime, tourism, and state and local government.

Seward's CHNA states the median household income for the Kenai Peninsula Borough was $65,189 and children in poverty data was 11%. In 2015, the Alaska Department of Labor had 57 percent of Seward residents as employed and the number of unemployment insurance claimants was 173. The 2016 average unemployment rate for the Kenai Peninsula Borough as a whole is 8.3%.

EDUCATION

The City of Homer is served by the Kenai Peninsula Borough School District (KPBSD). KPBSD has 44 public schools with 8,974 students enrolled in the FY 14-15 school year. The current graduation rate for Seward is about 91 percent.

Further educational opportunities in Seward include AVTEC-Alaska's Institute of Technology, which is a CTE, a career and technical education center. AVTEC is a division of the Alaska Department of Labor.

SOCIAL AND COMMUNITY CONTEXT

The Seward Parks & Recreation Department facilitates recreational, educational, social and cultural activities for the community and visitors. Their staff is committed to protecting, improving and promoting the City of Seward's park lands and natural resources and they strive to improve the quality of life, the physical and mental well-being of individuals through positive opportunities and choices. The goal is to provide "Mountains of Recreation" to all residents and visitors to Seward. There are also programs and activities for youth at the Teen Youth Center (TYC) and after school programs and summer day camps.

HEALTH AND HEALTH CARE

Seward's Medical and Behavioral Health facilities include: Chugachmiut North Star Health Clinic, Glacier Family Medical Center, Seward Community Health Center, Providence Seward Mountain Haven Long Term Care, SeaView Community Services, and Seward Public Health Center. Most services are provided through the Providence Seward Medical Center. Prenatal care is limited and there is no delivery option locally, patients are sent to Providence Alaska Medical Center in Anchorage.

NEIGHBORHOOD AND BUILT ENVIRONMENT

The Alaska Department of Labor and Workforce Development reports an average single-family housing cost of $252,986, an average condo sales price of $221,700 for existing construction, and an average rent of $1,059 (including utilities) for the Kenai Peninsula Borough in 2016. They also report a weekly cost of $200.10 for food for a family of four with children ages 6 to 11.

There is one main grocery store in Seward which is Safeway. The local farmers' market known as the Seward's Grazing Moose Summer Market features Alaska grown produce yearly from June through October for residents to access healthy grown produce.

Seward's weather is similar to most coastal regions on the Kenai Peninsula. The average high temperature in January is 31 degrees Fahrenheit and the average high in July is 62 degrees Fahrenheit. Winter weather can cause challenges for transportation and freight for several months of the year.

Local transportation services in Seward are provided by the Seward Community Health Center's Transportation Assistance program. In 2015 from May through September there was a free summer shuttle provided by the Seward Chamber of Commerce, who also made arrangements with local cab companies to provide vouchers for residents who have difficulty with making appointments.

The Alaska Railroad provides year-round Seward-Anchorage-Fairbanks freight hauling and seasonal passage services. A small airport provides personal use, flight-seeing and charter services. Trucking services are provided similar to the rest of the state. The Seward Bus Lines offer year-round daily service to Anchorage. Taxis and shuttle bus services are provided year-round and include a local service for senior citizens.

A CULTURAL VIEW

The Kenai Peninsula is composed of a colorful array of unique cultures that overlap and intertwine. Since the European discovery of the Kenai Peninsula and subsequent settlement of Russian fur traders and missionaries, the Alaska Native and Russian cultures have influenced each other. For example, many native peoples converted to Orthodox religion when Russian missionaries arrived. Today hints of traditional subsistence living can be seen all throughout the peninsula. One unique emerging culture, Ionia (located in Kasilof) prides themselves on living off the land, utilizing subsistence skills and homeopathy.

Seward is home to the Qutekcak Native Tribe, a blend of Alaska's Native peoples from all over the state. Traditionally Seward was an active trading post for the Alaska Natives within Prince William Sound and the Kenai Peninsula. Most Alaska Natives in these areas at the time were Aleut or Alutiiq people. The Qutekcak Native Tribe is unique in that it welcomes more than just one Native population. Ninilchik Village Tribe, managed by the Ninilchik Traditional Council, traces its roots to the ancient indigenous people of the Southern Kenai Peninsula. They consider themselves Dena'ina culture (Athabascan speaking) with a strong influence from Russian and American traders and settlers. The Dena'ina culture is also celebrated in Soldotna and Kenai areas. Other nearby cultural groups include the Ahtna Athabascan and Yup'ik.

The total estimated population of the Kenai Peninsula about around 55,400 residents. Among this break down, American Indian comprise approximately 7% of the population while Alaska Native tribes people comprise about 4%.

There are four Russian Old Believer communities located on the Southern end of the Kenai Peninsula. Nikolaevsk, Razdolna, Voznesenka, and Kachemak Selo have tight knit communities with local churches and alternative borough school calendars that accommodate holy days. Many families rely on commercial fishing and carpentry as a living.

KENAI PENINSULA BOROUGH LIST OF NATIVE ENTITIES

Native Entity Within the State of Alaska	Native Village Corporation	Native Regional Corportation	Community Name
Native Village of Port Graham	Port Graham Corp	Chugash Alaska Corportation	Port Graham
Kenaitze Indian Tribe	Kenai Native Assoc., Inc.	Cook Inlet Region, Incorporated	Kenai
Native Village of Tyonek	Tyonek Native Corp	Cook Inlet Region, Incorporated	Tyonek
Ninilchik Village	Ninilchik Natives Assoc., Inc.	Cook Inlet Region, Incorporated	Ninilchik
Seldovia Village Tribe	Seldovia Native Assoc, Inc.	Cook Inlet Region, Incorporated	Seldovia
Village of Salamatoff	Salamatoff Native Assoc.	Cook Inlet Region, Incorporated	Salamatoff

COMPARISON TO STATE AND NATION

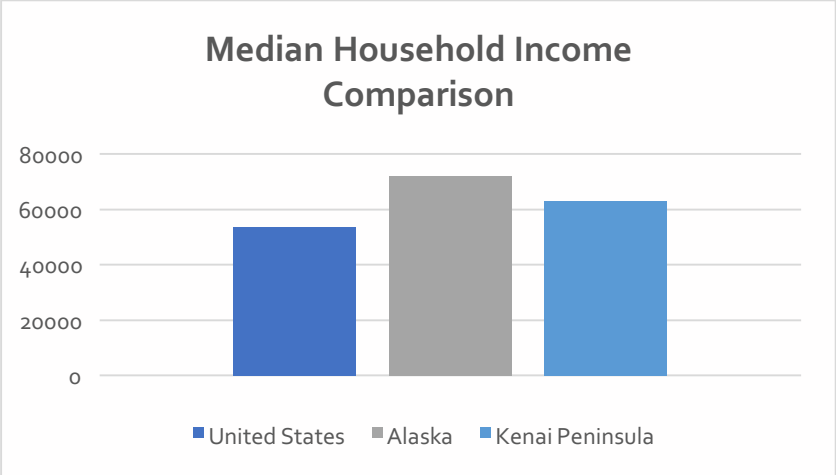
The smaller communities that together make up the Kenai Peninsula are each unique in their own ways. The Kenai Peninsula as a whole has many aspects that highlight its individuality when compared to the rest of Alaska and especially the United States. Understanding the people and geography is key to determining the significant community factors that are unique to the area.

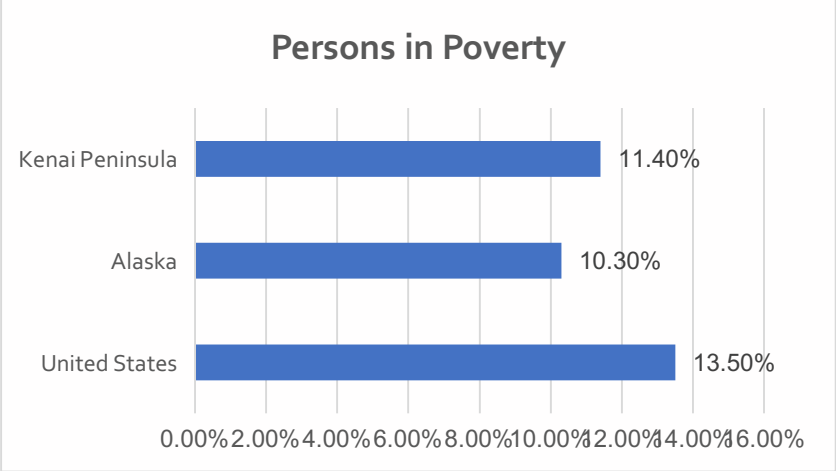
The following is a graphical comparison of the Kenai Peninsula to both Alaska and the United States.

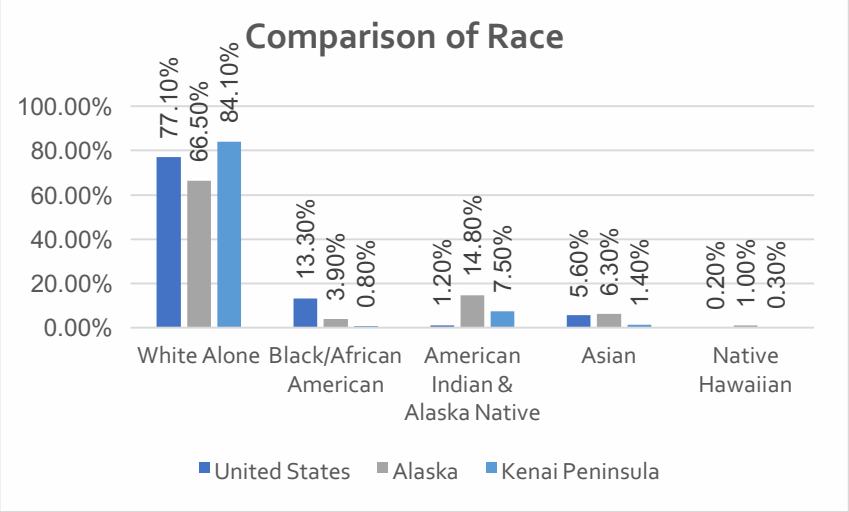
SOCIOECONOMIC SNAPSHOTS

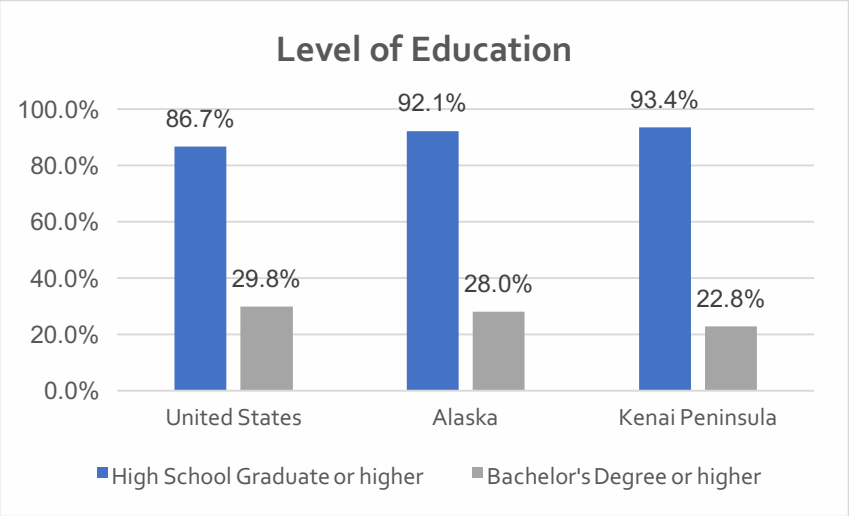
	United States	Alaska	Kenai Peninsula
Persons per households	2.63	2.79	2.54
Median Household Income	53,482	71,829	63,099
Median Gross Rent	$920	$1,131	$938
Persons living in poverty	13.5%	10.3%	11.5%
Persons with a high school diploma or higher	86.3%	91.8%	93.3%
College Graduates	29.3%	27.7%	23.3%
Mean travel time to work (minutes)	25.7	18.9	19.6
Veterans	20,700,711	70,370	5,949

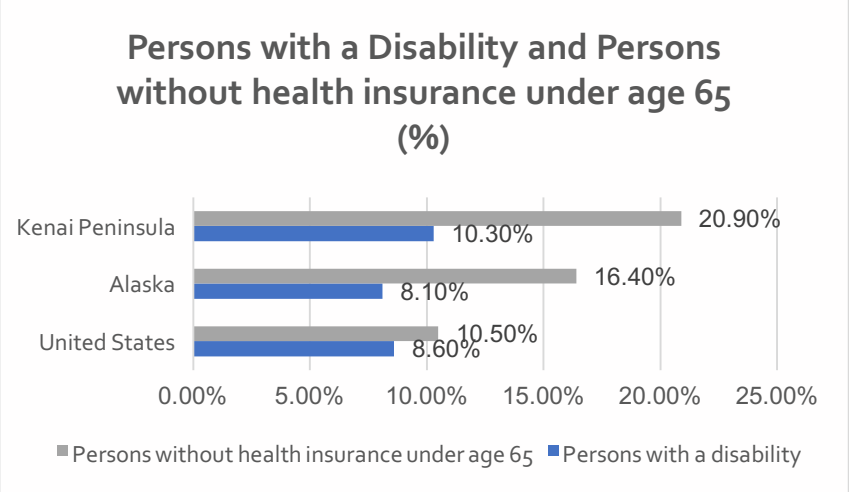
Sources: US Census Bureau, American Community Survey, MAPP of Southern Kenai Peninsula

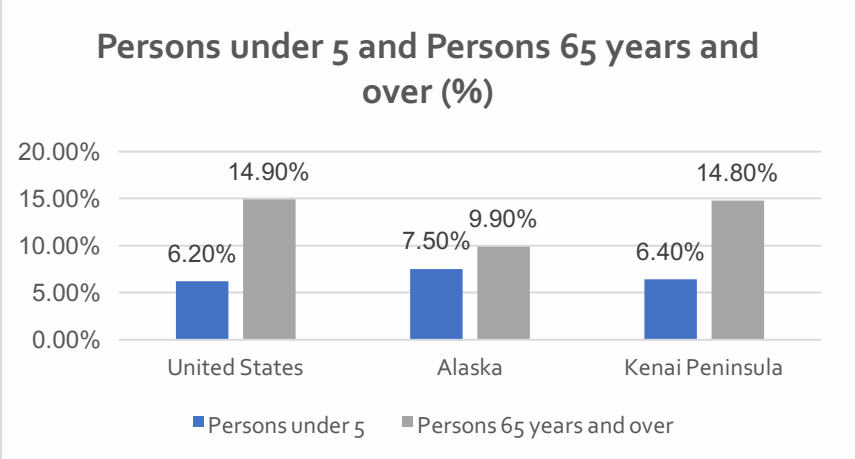

Median Household Income Comparison
80000
60000
40000
20000
0
United States
Alaska
Kenai Peninsula


Persons in Poverty
Kenai Peninsula
Alaska
United States
11.40%
10.30%
13.50%
0.00%
2.00%
4.00%
6.00%
8.00%
10.00%
12.00%
14.00%
16.00%


Comparison of Race
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
77.10%
66.50%
84.10%
13.30%
3.90%
0.80%
1.20%
14.80%
7.50%
5.60%
6.30%
1.40%
0.20%
1.00%
0.30%
White Alone
Black/African American
American Indian & Alaska Native
Asian
Native Hawaiian
United States
Alaska
Kenai Peninsula


Level of Education
100.0%
80.0%
60.0%
40.0%
20.0%
0.0%
86.7%
29.8%
92.1%
28.0%
93.4%
22.8%
United States
Alaska
Kenai Peninsula
High School Graduate or higher
Bachelor's Degree or higher


Persons with a Disability and Persons without health insurance under age 65 (%)
Kenai Peninsula
Alaska
United States
10.30%
20.90%
8.10%
16.40%
8.60%
10.50%
0.00%
5.00%
10.00%
15.00%
20.00%
25.00%
Persons without health insurance under age 65
Persons with a disability


Persons under 5 and Persons 65 years and over (%)
20.00%
15.00%
10.00%
5.00%
0.00%
6.20%
14.90%
7.50%
9.90%
6.40%
14.80%
United States
Alaska
Kenai Peninsula
Persons under 5
Persons 65 years and over

SUMMARY OF CHART COMPARISONS

- While the median household income for the Kenai Peninsula is slightly higher than the US, it is less than the State of Alaska.
- The poverty rate is also higher than the rest of the state.
- The Kenai Peninsula has a higher rate of residents under the age of 65 with a disability than both the US and State.
- The number of persons under the age of 65 without health insurance is double that of the US average and significantly more than the State average.
- High school graduation rates are higher than both the US and State averages.
- Young children and the senior population is quite similar to the US average.

METHODS

STRATEGIC PREVENTION FRAMEWORK

Change 4 the Kenai is utilizing the Strategic Prevention Framework (SPF) model developed by the Federal Substance Abuse and Mental Health Services Administration (SAMHSA). This planning process is based on a public health model and designed to build prevention capacity at the community level. The framework is a planning process for "preventing substance use and misuse." The five steps of the Strategic Prevention Framework are

1. Assessment of needs and resources
2. Capacity building
3. Development of a strategic plan
4. Implementation of effective prevention programs, policies, and practices
5. Monitoring and evaluation of outcomes

RETRIEVED FROM: WWW.SAMHSA.GOV/SPF

These five steps will guide us in our planning, implementation, and evaluation of our prevention efforts. The SPF emphasizes data-drive decision-making and outcomes-based prevention. Although it is presented here as a list, the SPF model is a circular process. There is overlap and review of the five components. For example, addressing capacity needs as listed in Steps 1 and 2 must take place throughout the SPF process. Likewise, plans for evaluation will continue throughout. Sustainability and cultural competence are addressed throughout each of the five steps.

NEEDS ASSESSMENT

The national opiate epidemic is becoming the number one health issue of our time. Local community health needs assessments support a growing concern for drug abuse throughout the Kenai Peninsula. Change 4 the Kenai chose to focus specifically on the heroin and non-medical use of prescription opioids (NMUPO) needs of our community by conducting a Kenai Peninsula Assessment of the Opioid Epidemic (KPA).

The following report outlines Change 4 the Kenai's dedication to gathering quality information, local data, and community support in order to assess the community's current behavioral health needs, resources, readiness, and prevention priorities.

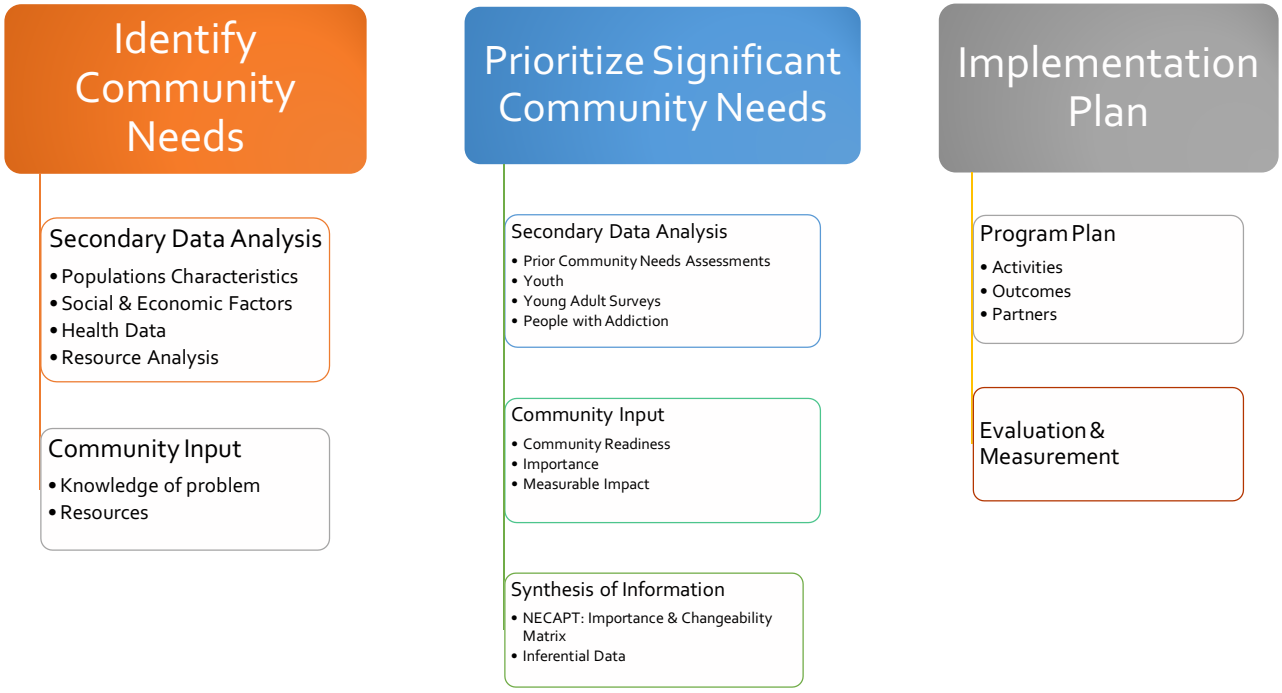
METHODS USED TO CONDUCT THE NEEDS ASSESSMENT

OVERVIEW

Change 4 the Kenai pursued an approach that was comprehensive, methodologically rigorous, inclusive, and open to the community's perspective on behavioral health care needs. To conduct the KPA in a manner that reflects best practices, C4K utilized the *TriEthnic model for Readiness Assessment* and the *Alaska Partnerships for Success Prevention of Non-Medical Use of Prescription Opioids and Heroin Use in Alaska Guidance Document* to support a structured process for obtaining community input on behavioral health care needs, perceived priorities, and helped establish criteria for the evaluation and measurement of progress.

FRAMEWORK FOR CONDUCTING THE KPA

The following model was developed to help guide the development of the 2017 Kenai Peninsula Assessment.



COMMUNITY BASED PARTICIPATORY RESEARCH (CBPR) APPROACH

The assessment used a mixed method data collection approach that included primary data such as key informant interview, community focus groups, and a community connectivity assessment. Secondary data included health outcomes, demographic data, behavioral data, and environmental data.

DESCRIPTIVE DATA

SECONDARY DATA SOURCES AND ANALYSIS

To further identify the behavioral health needs of the Kenai Peninsula, C4k conducted an analysis of publicly available data. Secondary data – including population demographics, mortality, health behavior, clinical care, and physical environment data – were used to identify and prioritize significant community needs. Data was compiled from a variety of state and national data sources and are reflected in the table below.

Population characteristics, socioeconomic, and health status data were also examined. Community-level data was compared to state and national data benchmarks. When available, data specific to low-income individuals, underserved minorities, and uninsured populations was examined.

SECONDARY DATA AND SOURCES USED FOR ASSESSMENT

Data Category	Description	Source
Demographic Data	Population change, age & gender, population density, median income, race/ethnicity, insurance, individuals with a disability, poverty, unemployed, education status	U.S. Census National Center for Health Statistics MAPP of the Southern Kenai Peninsula Providence Community Health Needs Assessment for Seward Central Peninsula Hospital Community Needs Assessment U.S. Department of Labor Community and Economic Development Alaska Department of Education and Early Development Alaska Department of Law
Health Behaviors Data	Mental health, alcohol use, tobacco use, injection drug use, opioid use	Central Peninsula Community Behavioral Health Needs Assessment Central Peninsula Hospital Community Needs Assessment MAPP of the Southern Kenai Peninsula Providence Community Health Needs Assessment for Seward Serenity House Treatment Center AKAIMS reporting
Clinical Care Data	Primary care physician data Emergency department data Residential treatment admission demographics Laboratory results for infectious disease Urinalysis drug screenings	Serenity House Records Assessment Central Peninsula Hospital Emergency Department Records Assessment U.S. Centers for Disease Control and Prevention Behavioral Risk Factors Surveillance System
Benchmark Data	Mortality rates, morbidity rates, health behaviors, clinical care data, and other various topics	Healthy People 2020

INFORMATION GAPS IMPACTING ABILITY TO ASSESS NEEDS DESCRIBED

The best available data was used to obtain the most meaningful comparison and analysis possible. Public data sources are somewhat limited by some information gaps:

- Unknown accuracy in recording when reviewing public data
- Small sample size
    - Remote areas not represented
    - Population data may not represent subpopulations
- Data from at-risk populations not received

Whenever possible, population data was examined for sub-populations including low-income, high-minority, and uninsured population. Information was also collected directly from people in recovery from addiction or current addiction where appropriate. Primary data collection from these populations is challenging; getting information to populations who may not have current mailing addresses, have unsteady homes and a lack of communication opportunities is a challenge as these are often the populations most at-risk. In order to reach more at-risk populations, a true gap in the information system, C4K conducted interviews face to face.

PRIMARY DATA: THE COMMUNITY VOICE

Primary data collection included quantitative and qualitative data gathered in several ways:

- Meetings with the KPA workgroup
- Key informant interviews with area health and community members
- Focus groups with area community members
- Community based online surveys
- In person surveys
- Readiness Assessment Interviews

CHNA WORKGROUP AND COALITION MEETINGS

The KPA workgroup was an active contributor to qualitative data collection. Using the previously described CBPR approach, monthly meetings were held with the workgroup at each critical stage in the assessment process.

KEY INFORMANT INTERVIEWS

Key informants are health and community experts familiar with populations and geographic areas throughout the Kenai Peninsula. To gain a deeper understanding of the health issues pertaining to our local community, key informant interviews were conducted using theoretically grounded interview guide. Interview content analysis was conducted to identify key themes and important points pertaining to each geographic area.

FOCUS GROUPS

Selection of locations for focus groups was determined by feedback from key informants, KPA team input, and analysis of health outcome indicators.

Focus groups were conducted to provide an in-depth look at and voice from the community. Focus group participants included community partners, local business owners, local government, law enforcement, health care providers, low-income participants and other interested citizens within each unique geographical area. Each focus group was tasked with having an unstructured discussion of the problems their community faced with regards to economic issues, drug and alcohol abuse, youth, transportation, health care and community events.

SURVEYS

Members of the community completed surveys regarding community topics. In order to represent as diverse a population as possible there were multiple ways to respond to the surveys. It was available in different formats:

- Online
- Social networking: Facebook & twitter
- Smart phone compatible
- Tablet compatible

And it was provided in different locations through advertising and travelling tablet:

- Community grocery stores
- Community events and wellness fairs
- Local community college
- Local medical clinics

Interviews allowed coalition members to gain perspective and learn about experiences, strengths and values of individuals in the community. The interviews and surveys helped to reveal what the community members want, how they view their resources, and what issues are involved in gaining access to resources and programs.

INFERENTIAL DATA

Inferential statistics provide us with techniques that allow us to make generalizations, or inferences, about our designated populations from the data we have collected. After careful examination of both secondary and primary data, two questions were considered.

Does a high Adverse Childhood Experiences (ACEs) score lead to drug use?

Change 4 the Kenai utilized statistical data tools such as chi-square values that allow us to assess the fit between observed data values from Kenai Peninsula residents in comparison to a sample of people who use drugs. T-Tests allowed us to analyze then compare two populations (Kenai Peninsula residents and people who use drugs), testing the difference between the samples and using ratio of the difference in means to determine if the observed outcomes are best described as chance occurrences or the result of the underlying phenomena of interest.

Does prescription pain medication abuse lead to heroin use?

Change 4 the Kenai analyzed potential correlations in the relationships between initial use of opioids and the initial use of heroin as reported on primary clinical records. We also reviewed any correlation in data from Urinary Analysis (UA) values of opioid/ heroin then heroin/methamphetamine levels in patients' results.

COMMUNITY READINESS

READINESS ASSESSMENT

Change 4 the Kenai completed readiness assessments throughout the Kenai Peninsula utilizing Colorado State University's Tri-Ethnic Center's Community Readiness Assessment Guidance Document. We carefully selected members of the community from key sectors including law enforcement, business, education, health, government, and involved citizens. 6 people were chosen for heroin-focused questions and 6 people were chosen for NMUPO-focused questions in each community (Seward, Central Peninsula, and Southern Peninsula) for a total of 36 readiness assessment interviews.

The following community members were selected for readiness assessment interviews from these sectors:

Community Sector	Central Kenai Peninsula	Southern Kenai Peninsula	Seward
School Personnel	■	■	
Law Enforcement	■	■	
Court System		■	
Tribal Government	■		
Health Professionals	■	■	■
Social Service	■	■	
Mental Health	■	■	■
People in Recovery	■		
Youth	■	■	■
Community Leader	■	■	■
Business Owners	■	■	■
Community Member	■	■	■
Media Member			■

Data from the community readiness assessments was utilized to provide a community readiness score in accordance with the Tri-Ethnic model and scoring rubric. In addition to the community readiness assessments, data and feedback was also analyzed from key stakeholder interviews, focus groups, online community surveys, and two town hall meetings. Key stakeholder interview and focus group members were selected from the same community sectors as previously listed; however, C4K ensured that individuals were not involved in more than one interview or focus group.

SUMMARY OF PRIMARY DATA SOURCES

Source	Instrument	Community Defined	Number Participating
CHNA Workgroup	Face to face meetings	Coalition members. Open to community. Many key stakeholders.	Average 15 per meeting
Key Informant Interviews	In person interviews	Community members selected from key community sectors: education, law enforcement, government, health professionals, social service, mental health, business owners, and other community leaders.	Heroin: 5 each for Central Kenai Peninsula, Southern Kenai Peninsula, and Seward for a total of 15 NMUPO: 5 each for Central Kenai Peninsula, Southern Kenai Peninsula, and Seward for a total of 15
Focus Groups	Small group discussion	Business owners School counselors First responders Nurses/Midwives Recovery community	60 adults
Community Surveys	Online Advertised through Facebook and in person at community events	Kenai Peninsula Residents	323 people
At Risk Surveys	In person	Persons at-risk for use Those in recent recovery	10
Readiness Assessment	In person	School personnel Law Enforcement Court System Tribal Government Health Professionals Social Service Mental Health People in Recovery Youth Community Leader Business Owners Community Members Media Members	Heroin: 6 each for Central Kenai Peninsula, Southern Kenai Peninsula, and Seward for a total of 18 NMUPO: 6 each for Central Kenai Peninsula, Southern Kenai Peninsula, and Seward for a total of 18

SYNTHESIS OF INFORMATION AND DEVELOPMENT OF IMPLEMENTATION PLAN

In the final phases of the process, the community survey results were summarized by the C4K workgroup and merged with results gathered from the analysis of public data. Significant needs that are critical, addressable, and have high levels of urgency in the community were matched with best-practice methods for addressing these needs, existing community programs and resources, and a system of assessment and reassessment to gauge progress.

Further details on methodology are included with individual reports in the appendix section.

METHODS TABLE

The following table outlines how information was applied to each section of the report.

Components of Needs Assessment	Methods
Community Profile	Secondary data outlined Central Kenai Peninsula demographics and population trends including population size; income and employment; geography and employment; and history and culture.
Incidence & Severity	Primary and secondary data was analyzed to assess the incidence and severity of the key issues of heroin abuse and NMUPO, mental health, and community connectivity throughout the Kenai Peninsula.
Issue Prioritization	Based on both primary and secondary data collected about the incidence and severity of each issue, the coalition followed a prioritization process to select a primary focus for the project. Prioritization considered the size and seriousness (severity, economics, social impact, and trends) as well as community engagement and likelihood for change. Coalition members scored each issue.
Community Perceptions	In 2016-17, C4K conducted multiple community surveys to gather the community's current perception of the area. Questions were chosen to represent the intervening variables previously identified in an effort to determine community readiness and overall prioritization toward community needs.
Community Readiness Assessment for IV Drug Use Prevention	A community readiness assessment for heroin use and NMUPO abuse was conducted using the Tri-Ethnic Center Community Readiness Model. A set of interview questions related to five dimensions of community readiness was utilized and coalition members conducted interviews with key informants representing different sectors of each area of the Kenai Peninsula (Central peninsula, Southern peninsula, and Seward). These sectors included health care, government, law enforcement, education and business owners.
Consequences of Heroin Use and NMUPO Abuse	Primary and secondary data was analyzed to identify consequences of drug abuse in Central Kenai Peninsula. Interviews with current or recent IV drug users was utilized to get an in depth, primary resource representation of life aspects before, during and in some cases, after drug use/addiction.
Risk and Protective Factors	Primary and secondary data was analyzed to identify risk and protective factors related to drug abuse in Central Kenai Peninsula.
Target Population	Secondary data and community perceptions were closely examined in relation to age, gender, and race of those at risk for drug abuse in order to guide selection of a target population for prevention efforts. Community focus group sessions were conducted to learn more about the community's readiness, resource availability, and target population for further planning for intervention strategies.
Resources Assessment	Coalition members identified community strengths and assets, community challenges and weaknesses, resource gaps, and other community resource factors to consider in prevention effort planning. This information was supported by other local resources such as public resource budgets and former Community Health Needs Assessments.
Synthesis Report	Data points were triangulated and synthesis of data collected allowed coalition members to identify the target population for prevention efforts, intermediate variables and other contributing factors to drug abuse on the Kenai Peninsula. Community readiness and resources assessment data was also summarized to guide recommendations for next steps.

THE COMMUNITY VOICE

COMMUNITY VOICE

The community voice plays an integral part of both understanding the issues of opioid use on the Kenai Peninsula as well as developing and organizing effective prevention efforts. Change 4 the Kenai feels that community perception balances out clinical data and community surveys. Information from key stakeholder interviews and focus groups from various communities throughout the Kenai Peninsula further detail community readiness and resident perceptions of the issues. This information allows us to develop a unique and customized opioid epidemic and prevention plan that directly fits the needs of the individual areas that make up the Kenai Peninsula.

Together the data, community readiness, and community perceptions paint a more comprehensive and thus stronger view of the issues, driving forces, and current resources. This view allows us to more efficiently target the most influential and needed areas. Including a strong community voice in our plan also garnishes greater community support and builds further coalition capacity as community members see first-hand that their views and efforts are respected.

SUMMARY OF COMMUNITY PERCEPTION

Key stakeholder interview questions and focus group notes are summarized in the following section. Information and community feedback was organized into six common themes:

- Substance Misuse
- Access
- Trends
- Community
- Stigma
- Resources

SUBSTANCE MISUSE

Each focus group had a list of substances that they shared as concerns in our community. Alcohol and marijuana were generally the first shared, followed by methamphetamine (meth), cocaine, and heroin. Central Peninsula stakeholders listed both heroin and meth as main concerns, followed by alcohol, prescription opioids and marijuana.

Surprisingly, most focus groups and stakeholders shared methamphetamine as a leading substance misuse on the Southern Kenai Peninsula. Many chose to point out that while heroin and prescription drugs were a concern, meth was a larger problem "at the end of the road." Treatment providers and first responders discussed this viewpoint, saying that they see more patients with an addiction to meth than to heroin. When probed why they thought that may be, it was unanimous that location and cost were high contributing factors. Meth is seen as being produced more locally in the rural areas, cheaper, and easier to come by than

other drugs. This thought was shared by the relatives of addicts. The teachers and counselors were concerned mostly with alcohol and marijuana as gateway substances to stronger drug abuse. A similar feeling was seen with Nikiski and Sterling residents – those living outside the larger metropolitan areas on the Kenai Peninsula.

> *"100% of folks that come onto probation are using drugs. Data says 30% of those are using meth or heroin. But, I feel like 9/10 times, they have or are using meth or heroin."*
>
> *– Probation Officer*

When asked about prescription opioid drug abuse, all groups agreed that it was likely a problem but they weren't hugely aware of any issues personally. The exception to this was the nurse/midwives group that sees patients regularly and has training in NMUPO detection. When asked if those who use heroin began their addiction with a medically prescribed opioid, very few felt this was the case. One police officer replied, "I see the commonality [between the use of both drugs] as pain – emotional and physical."

Marijuana use and growth has been legalized throughout the Alaska for well over a year now, yet the community remains very nearly split down the middle on the views of marijuana use. About half believe legalization of marijuana will lead to further substance abuse issues while the other half do not believe legalization will impact other drug use.

ACCESS

> *"How do people get heroin in our community?... it's everywhere."*
>
> *– At Risk Survey Responder*

The perception of drug accessibility was relatively the same throughout all interviews and focus groups. Heroin is available through illicit drug dealers and more commonly obtained in more rural areas. NMUPOs are seen as being accessed through doctors, family, friends and occasionally dealers.

The strongest discussion point related to youth's access. Many believe that youth access pills through theft from family as well as getting them from friends (who may have stolen them). A school nurse shared a story of how a young lady would go to her grandmother's house during lunch and steal pain pills a few at a time from the medicine cabinet to avoid detection.

> *"I dispense hundreds of thousands per year [of prescription opioids], tablet wise. That's just me; I know there is eight other pharmacies in the Soldotna/Kenai area. That's a lot for 20,000 people."*
>
> *– Local Pharmacist*

TRENDS

> *"When heroin sources go dry, we see prescription theft and loss numbers go up and vice versa."*
>
> *– Law Enforcement Interview*

Every group interviewed said they believe that drug use has grown significantly over time and seems to be growing faster in recent years. This is a staggering view of community perception when we consider that multiple facets of the community all view drug use as a growing concern.

In previous interactions with a school counselor, a story was shared about how heroin use in the schools is changing. This interaction provided a probe about trends for the new focus group. High school students are sharing that there has been a turn of events at parties where it is now common place to inject drugs around a bonfire; whereas in the recent past, those who wished to partake in "harder drugs" would go someplace more secluded. The generalization of the focus group was that the trend for youth is a growing acceptance or normalization of drug use.

COMMUNITY

> *"When truly engaged in family activities, even a discussion around the dinner table, people feel a connection to others that gives them strength."*
>
> *– Community Member*

In general, people from the Southern Kenai Peninsula view the rural communities as places that draw those who wish to make and/or sell drugs because of location (rural, "end-of-the-road," less neighbors) and lack of law enforcement numbers. No one felt that the community encouraged opiate use specifically, but poverty and location were mentioned several times in regards to what drove drug use. Other things that were shared as issues that contribute to drug use in our community was oilfield money, over-prescribing, seasonal economy, lack of connection, lack of family structure, childhood trauma, lack of leisure activities, lack of resources, isolation, ease of access, mental health issues being undiagnosed or self-treated, generational substance abuse, social acceptance.

When asked about things that work to keep people from using, many participants discussed family ties and community events. The business owner group, parent group, and teacher/counselor group all discussed family ties and engaging family-based activities as prevention efforts. "When truly engaged in family activities, even a discussion around the dinner table, people feel a connection to others that gives them strength."

Another point discussed was morality and how morals have changed over time. This tied into the questions on trends; however, in context it was discussed as a family-based effort to encourage good choices and keep people from using opiates. When families and the communities are encouraging moral choices, it was believed that those discussions and encouragements would influence youth decisions.

STIGMA

> *"Drug use is no longer seen as 'taboo' - just watch TV and you'll see drinking and drugs everywhere. It's like it's accepted, so now we accept it."*
>
> *– Community Member*

All groups felt that the stigma toward drug use had changed in that use was more accepted and tolerated as a social norm than it used to be.

The two medical-experienced group and the parent/relative group shared that they felt a change toward adults being more accepting and helpful to those in treatment for addiction. Ideas were shared about addiction being seen as a problem people needed help with, even though there was still feedback about people sometimes feeling like those with addictions were 'worthless.' This shows a change in stigma about addiction itself.

Another stigma discussed was that of the feelings of victims of drug users; community members are seeing a rise in theft, crime, vandalism, and a large population of people in jail or on probation. Concerns such as property loss and damage as well as qualified workforce were discussed.

The loss of many of our community members to suicide and overdoses builds another stigma around the community and drug use. It is impacting our schools as well, impeding the education process which affects our community in the long run when a large number of people come out of the school system unable to be productive members of society. Moral and ethical values decrease and contribute to the break down structure of our community. The theory is if we have fear and distrust of our neighbors, we will disconnect thus unraveling any goodwill that creates a healthy minded community.

> *"There is a misconception among our community members in the subtleness of NMUPO use. It is not your TV's version of what you think a drug addict looks like. It is so acceptable now. There is that bubble of people who need it for their daily life and they are not going to be the people you think they are. They still have far reaching consequences; it changes what motivates you, how you treat your family, how you live your life, how effective you are at your workplace, who you are. I think there are legitimate reasons for using opioids, but it is such a slippery slope."*
>
> *– Local Pharmacist*

RESOURCES

> *"The "DARE" program is largely ineffective due to the early age that it is implemented and that there is no continuing programs that level up with the kids."*
>
> *- Educator*

Education and awareness efforts was the most mentioned strategy, along with; healthy community activities, mental health, transportation, restrict prescriptions, family involvement, keep kids involved in healthy activities, mentorship, youth outreach programs, change the stigma of addiction, work as a community to change the idea that drug use is socially acceptable perception, and continuing education for leaders in the community.

> *"Support services such as; transportation, housing, job skills, and soft skills are so needed in our community. We need to teach people to be adults and set them up for success. We have very few options."*
>
> *– Youth Group Key Stakeholder Interview*

Homer and surrounding areas do not have a current drug-take back event. Most participants were not aware of efforts toward prevention or treatment. The nurse and midwives group was aware of the Homer Needle Exchange program. There were suggestions about better advertising for prevention efforts, more community tie-in, and drug prevention programs in the schools.

> *"This community (from Homer to Sterling) needs more things for people to do for cheap to keep them out of the dope house."*
>
> *– At Risk Survey Respondent*

COMMUNITY RECOGNIZED TRENDS

- Harder drug use has become more socially acceptable
- Many adults, including young adults, still view alcohol and marijuana as gateway drugs
- Methamphetamines are seen as the largest concern in the Anchor Point and Homer areas as well as other Kenai Peninsula areas
- A lack of law enforcement is seen as an open door for those who wish to abuse and sell drugs
- Family ties and community events are seen as a prevention
- Drug use effects businesses but drug-testing is financially costly for small businesses
- Prevention programs are not widely known on the Kenai Peninsula
- Community members are familiar with drug abuse and are supportive of prevention and treatment opportunities
- There is a connection between family relationships and an individual's resilience
- A healthy and involved community can help make stronger individuals
- Increasing education and prevention efforts for youth is highly encouraged

DEVELOPING A PLAN

STAKEHOLDER SUPPORT AND GUIDANCE

Developing a strategy to address substance abuse issues requires involvement from the community. The community voice is highly concerned about the knowledge of youth as well as the current level of community acceptance toward drug use. In order to engage the community in collaboration, C4K must work toward plans that incorporate these overarching community goals.

FRAMEWORK

PREVENTION

Change 4 the Kenai is dedicated to helping individuals meet the challenges of life by providing education and reinforcement toward healthy behaviors and reducing the risks that have shown to contribute to drug misuse and abuse. The community voice and surveys agree that targeting youth with education at an earlier age and continuing drug education through high school will help prevent use.

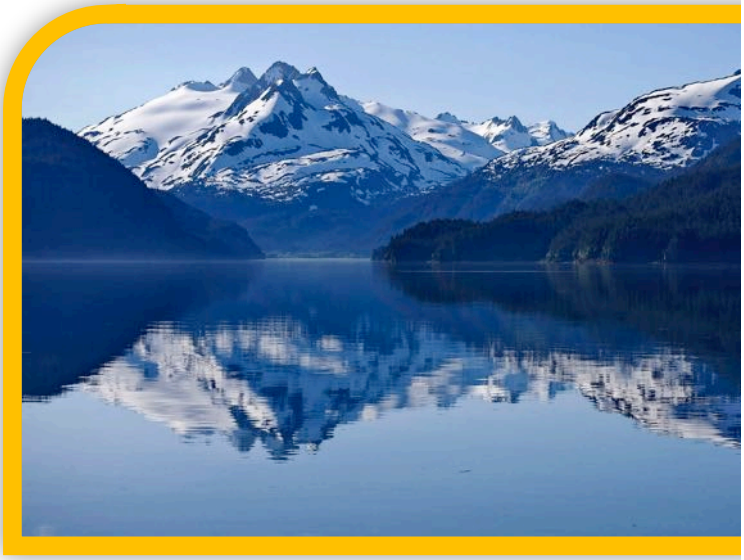
EARLY INTERVENTION

Decreasing risk factors related to substance abuse through education and awareness campaigns as well as providing specialized services are community-supported intervention plans.

TREATMENT & RECOVERY

A positive impact in the last two years has been the community's reaction to treatment and recovery programs. A change in the stigma toward addiction has shown positive effects – and the community feels it will continue to – with increased services and success stories.

PRIORITY ISSUE



PRIORITY ISSUE

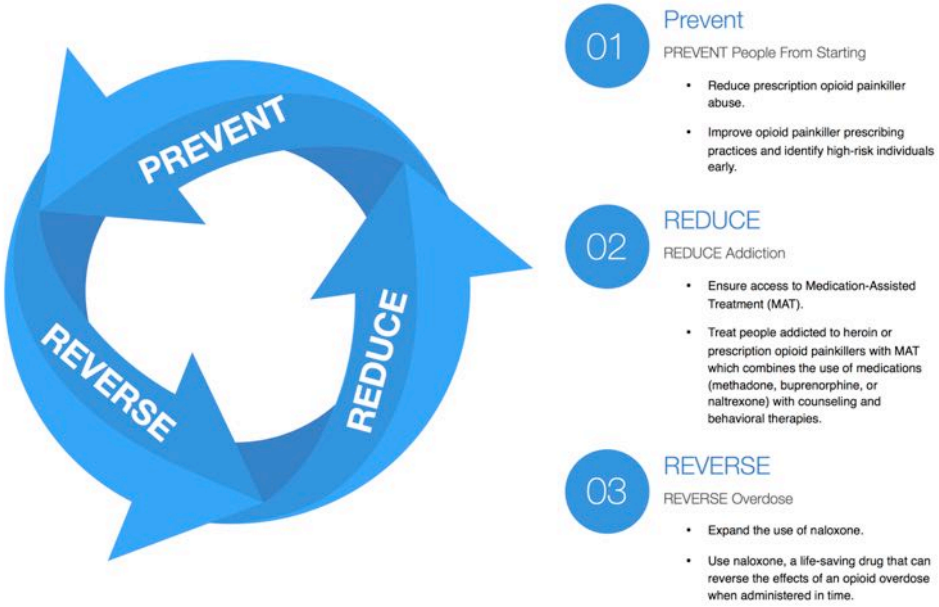
The US Surgeon General recently issued a call to action and Alaska Governor Walker declared a state of emergency intended to focus our attention on the issue of opioid addiction. Our nation has a complex history with addictions. We have looked at them as a moral, legal and/or social issues and resisted acceptance that addiction is one of the most significant HEALTH issues we face. While misuse has increased for nearly every substance, misuse of prescription opioids and heroin shows the greatest rates of increases in both use and adverse outcomes associated with use. Nationally over 30,000 people die each year (91 per day) of opioid addictions, this is a four-fold increase since 2000 (CDC, 2015).

Misguided drug policy of the 80s resulted in the "War on Drugs". This defined addiction as a legal issue and created significant social stigma that blocked access to effective treatment. The War on Drugs left behind a host of biases about addiction including a general populace belief that treatment of addictions cannot be effective and will be cost prohibitive. As our efforts to incarcerate our way out of addictions have failed, reform is sweeping the nation. Alaska's Senate Bill 91 is an example of this reform. This piece of legislation serves to decriminalize many of the poor decisions that often result from addictions and direct people with addictions into monitoring and treatment programs and away from incarceration. While it is exciting to witness this change, concern is growing as resource allocation is not following people from the legal to health care system. Currently it is estimated that less than one in five people who need treatment have access to treatment, gaps in health coverage continue to impact those with the greatest need for care, and overburdened systems default to providing ineffective and costly treatment in emergency department or other settings equally unprepared to manage this chronic health condition.

We find ourselves on the cusp of a health care epidemic when we are barely reaching consensus that addiction is even a health care issue. Addiction rates are skyrocketing and our under-established recovery systems are failing to absorb the growing numbers of people needing treatment. Safety net systems (Emergency Departments and Crisis Centers) are being pushed to meet needs that they were never designed to meet. Affected individuals cycle repeatedly through systems of care and new generations are being born into the problem with little realization that healthy lifestyles are even achievable. Hopelessness impacts those suffering from addiction, policymakers, and nearly everyone linked to the issue (families, law enforcement, medical providers, etc). While the situation is dire, it does not need to be. We have decades of research that confirms addiction is a treatable chronic brain disease and that prevention programs can successfully turn the tide of the exploding health crises. As a nation, we have proven that we can tackle problems of this magnitude. Fifty years ago, another surgeon general rallied for the political, scientific, and medical communities to join forces to combat the deadly consequences of smoking. Since then millions of lives have been saved by innovative programs and reformed social consciousness about tobacco use, we need to follow this lead to address opioid addiction.

CDC ROADMAP FOR LOCAL STRATEGIES

The Centers for Disease Control (CDC, 2013) outlined a comprehensive strategy to the management of the opioid epidemic. It provides a roadmap for the development of local strategies.



PREVALENCE ESTIMATES

Developing a regional opioid abuse prevention plan requires an understanding of the scope and local characteristics of the problem across our communities. C4K undertook a complex project to understand not only prevalence of opioid addiction on the Kenai Peninsula but also any differences unique to the sub communities and/or the patterns of consumption within our region. Where possible we have developed prevalence and consumption pattern estimates based on local data. Youth and adult data are reported separately with youth representing persons under 14-18 years old and adults focusing on 18-25 year old, except when looking directly at data from persons with addiction. In these situations, age range is defined for each data set.

YOUTH

In order to understand the scope of the opioid problem for youth, we need to know how many youth are in our communities. The Kenai Peninsula School District reports enrollment numbers as follows:

School	8th	10th	12th
Central Kenai Peninsula	427	367	394
Southern Kenai Peninsula	139	154	181
Seward	35	45	45
Connections Homeschool	53	54	87

Monitoring the Future (MTF) explores trends in the prevalence of various drugs of abuse for 8th, 10th and 12th grades. This study gives us data on adolescent heroin use; unfortunately, MTF only provides data for, "narcotics other than heroin" or "any prescription drug" for 12th grade students. While the category "any prescription drug" likely contains information about non-medical use of prescription opioids (NMUPO), it is not exclusive (amphetamines and sedatives are also included). Because of this confound, we reported only for "narcotics other than heroin".

NIH: NATIONAL INSTITUTE ON DRUG ABUSE

MONITORING THE FUTURE STUDY: TRENDS IN PREVALENCE OF VARIOUS DRUGS FOR 8TH GRADERS, 10TH GRADERS, AND 12TH GRADERS; 2013-2016 (IN PERCENT)*

HEROIN

	8th Graders				10th Graders				12th Graders			
Time Period	2013	2014	2015	2016	2013	2014	2015	2016	2013	2014	2015	2016
Lifetime	1.00	0.90	[0.50]	0.50	1.00	0.90	0.70	0.60	1.00	1.00	0.80	0.70
Past Year	0.50	0.50	[0.30]	0.30	0.60	0.50	0.50	0.30	0.60	0.60	0.50	0.30
Past Month	0.30	0.30	0.10	0.20	0.30	0.40	0.20	0.20	0.30	0.40	0.30	0.20

NARCOTICS OTHER THAN HEROIN

	8th Graders				10th Graders				12th Graders			
Time Period	2013	2014	2015	2016	2013	2014	2015	2016	2013	2014	2015	2016
Lifetime	-	-	-	-	-	-	-	-	11.10	[9.50]	[8.40]	7.80
Past Year	-	-	-	-	-	-	-	-	7.10	[6.10]	5.40	4.80
Past Month	-	-	-	-	-	-	-	-	2.80	[2.20]	2.10	1.70

**Data in brackets indicate statistically significant change from the previous year.*

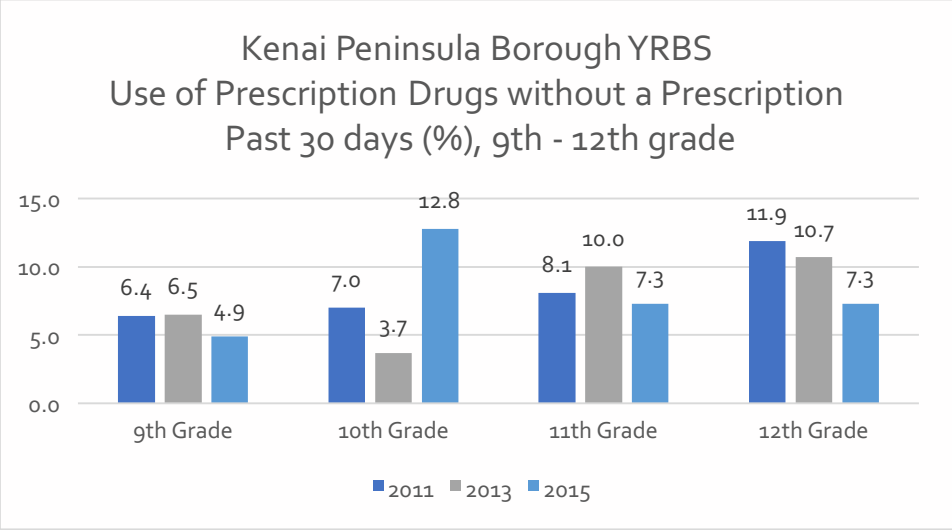
**Narcotics other than heroin "without a doctor telling you to use them."*

MTF gives us prevalence rates for lifetime, past year, and past month across 8th, 10th, and 12th graders. These numbers are all less than 1% for heroin use. If we use 1% as a high estimate there are 6.5 students in 8th grade, 6.2 students in 10th grade, and 7.1 students in 12th grade at risk for using, or have used heroin. A similar high estimate of "narcotics other than heroin" could be set at 11%. Since we only have data for 12th grade students this would be 78 students. Overall numbers from the MTF are inconsistent with antidotal reports of use from students but consistent with Stakeholder interviews with school staff. Monitoring the Future estimates are significantly lower than the Youth Risk Behavior Survey (YRBS) which looks at the same problem categories, in fact they are sometimes less than half of what is reported on the YRBS.

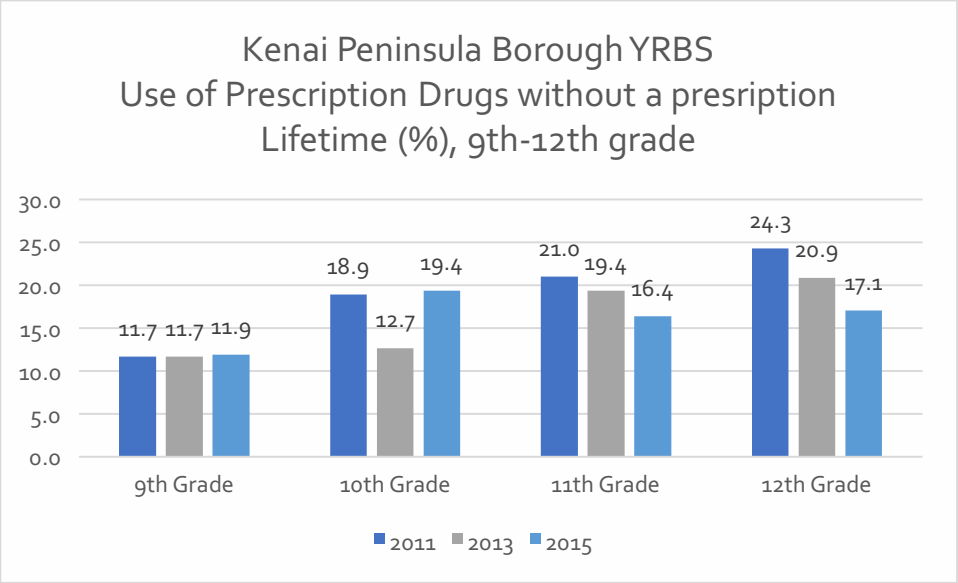
The Youth Risk Behavior Survey (YRBS) also provides us with data about high school aged use of opioids but this survey gives us data specific to the Kenai Peninsula, making it much more precise for the goals of the current assessment. It surveys drug use behavior in the 9th, 10th, 11th, and 12th grades and has been repeated every other year since 2011 for a total of three administrations through 2015.

PRESCRIPTION DRUGS WITHOUT A PRESCRIPTION • YRBS

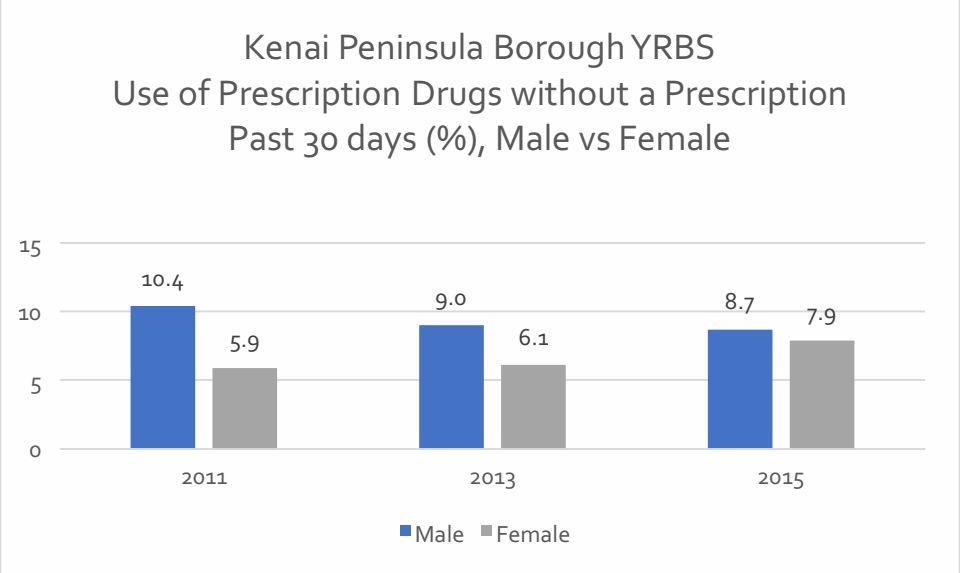
YRBS reports use of prescription drugs without a prescription for the past 30 days, and lifetime. Results are reported for 9th, 10th, 11th, and 12th grades. Interestingly, lifetime numbers are approximately double of past 30-day use rates suggesting that half of the youth that are going to use are currently using. Numbers double again if references across grade levels with the 12th grade students using at double the rate of 9th grade students, this increase appears to occur somewhat gradually across the 10th and 11th grades. These rates are significantly higher than those observed in Monitoring the Future. 2015 Monitoring the Future past month use for 12th grade is 2.10% whereas YRBS numbers for the same grade and timeframe are 7.3%. Comparisons of lifetime, 12th grade use MTF is 8.40% while YRBS rates are 17.1%. YRBS rates are much more consistent with what was reported in student reports but exceeded stakeholder reports (school principal).

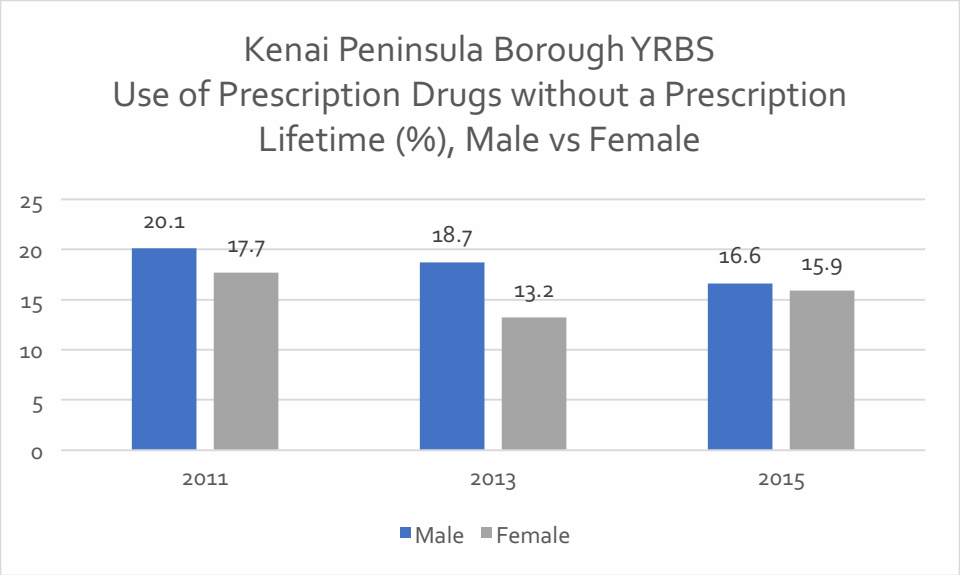


A frightening 20-25% of 12th grade students have used prescription drugs without a prescription in their lifetime.

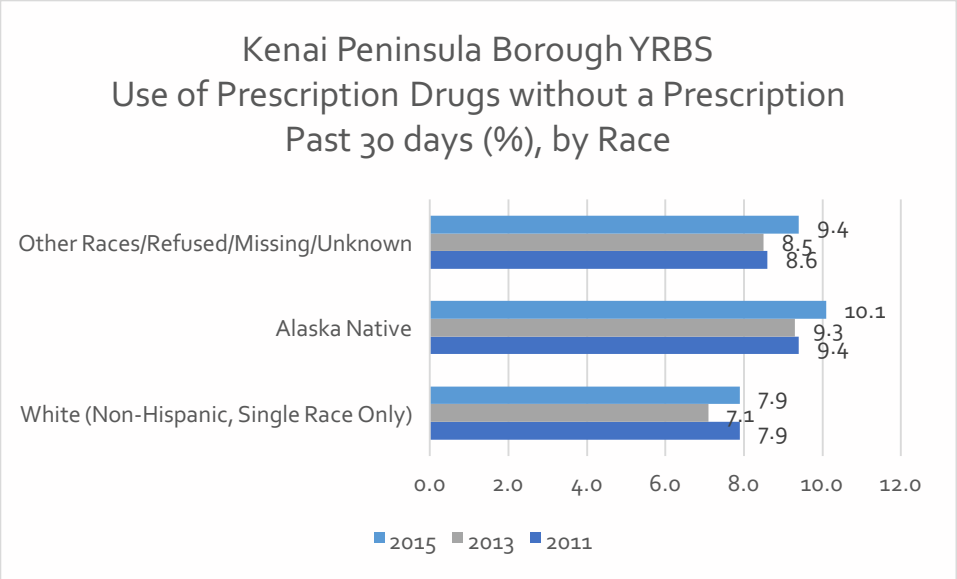


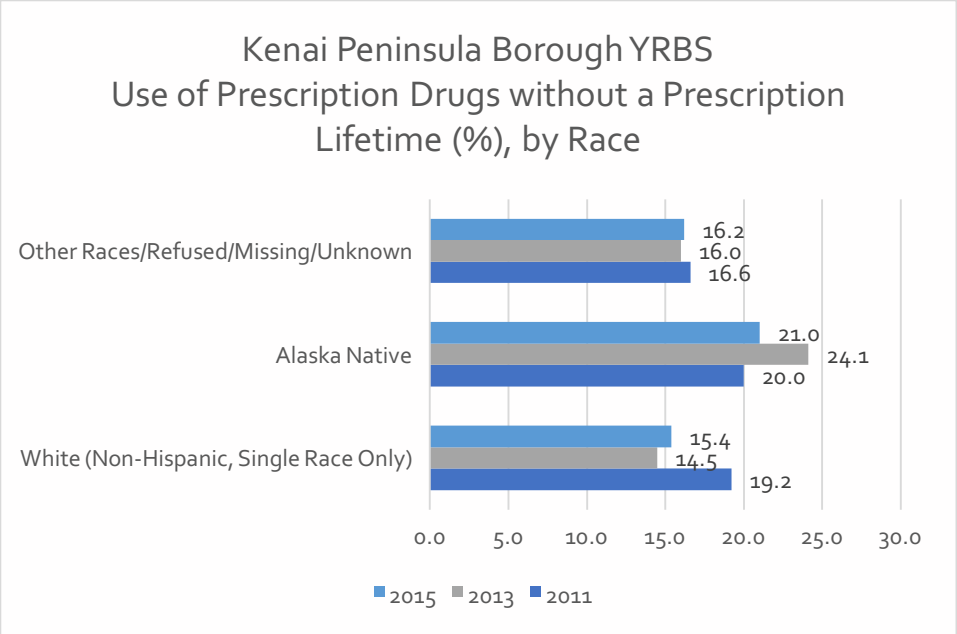
YRBS data tells us that males are much more likely to use prescription drugs without a prescription, (however that difference is greater at on past 30 days use than on lifetime use). This may be due to differential rates of use across genders or it may be a byproduct of females being more likely to be given a prescription of their own than males. With equal numbers of users, females getting more prescriptions would default males to using more prescriptions that were not prescribed to them.





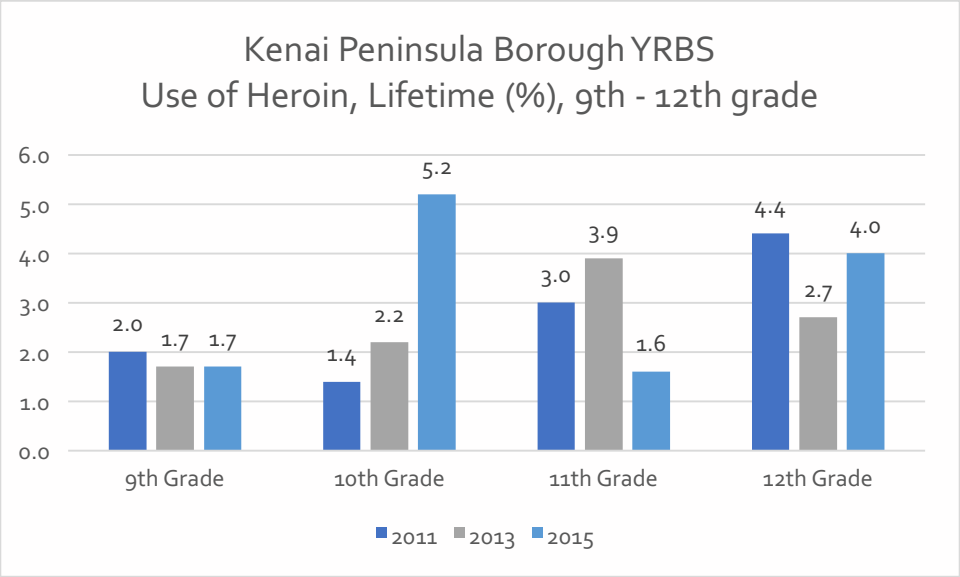
While minorities have higher percentages of use as compared to White/Caucasian, they make up a very small part of the population on the Kenai Peninsula. Much greater numbers of users are White/Caucasian.



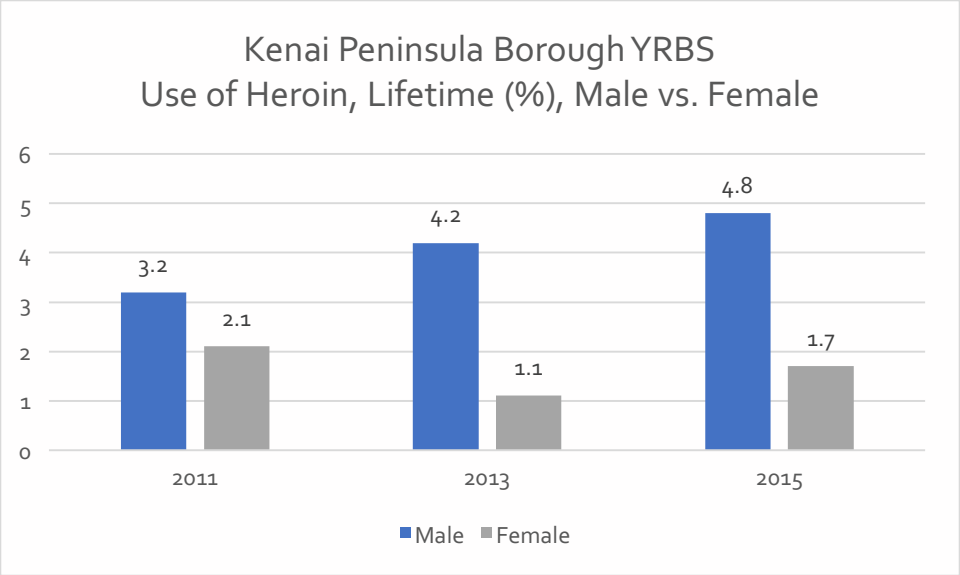


HEROIN • YRBS

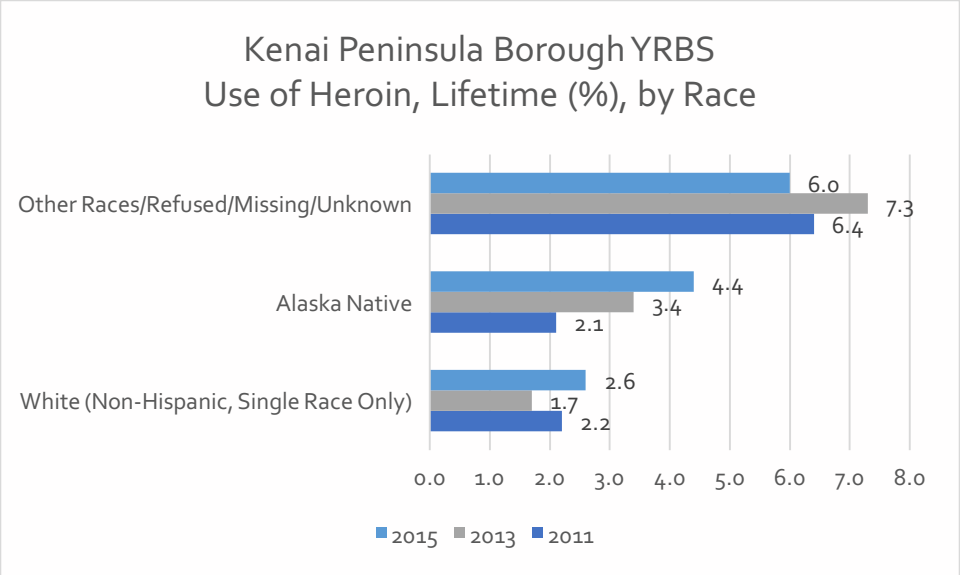
Lifetime use of heroin is tracked for 9th-12th grades. As with prescription drug use without a prescription, heroin use essentially doubles across the 4 years of school rising from a 9th grade approximation of 2% to a 12th grade rate of approximately 4%. The pattern of increase over the intervening years does not follow the gradual increase seen for prescription drugs but is much more jagged and indicated we do not have enough data stability to describe a trend. YRBS data is again much higher than the 1% rates reported in MTF.



Males are much more likely to report heroin use than females, use for males and therefor total use increased across the timeframe studies. Use for females did not increase from 2011-2015.

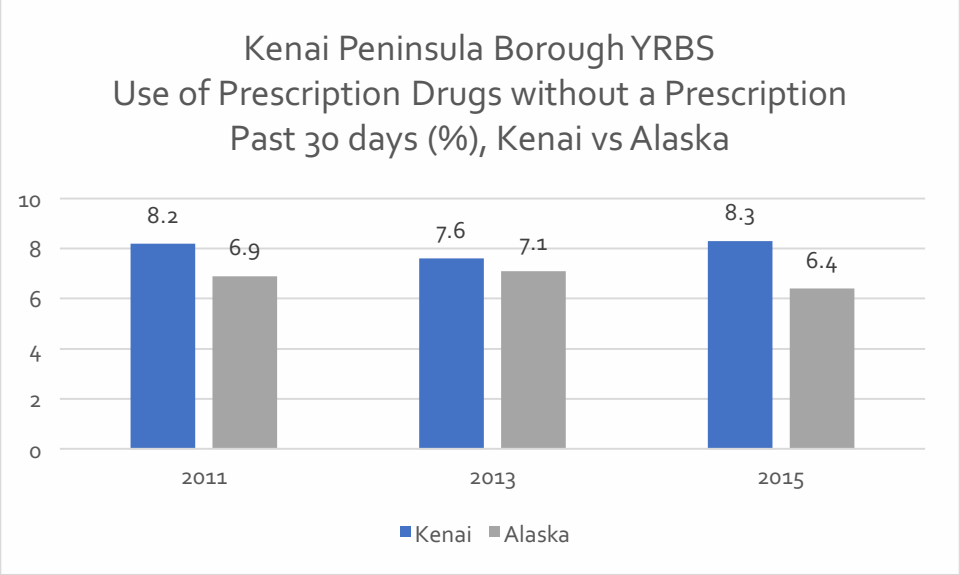


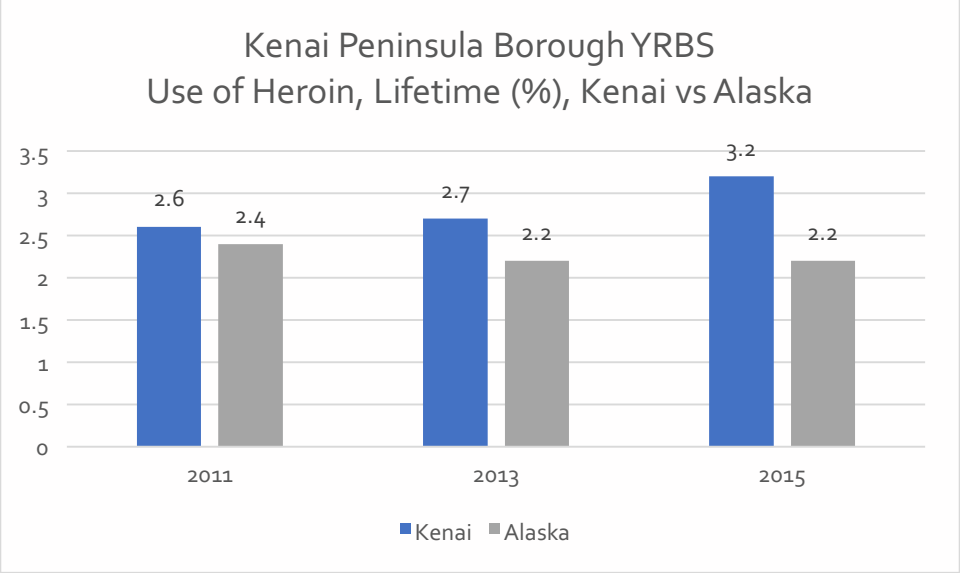
Heroin use demonstrated a relationship with race similar to prescription drug use without a prescription. While a larger percentage of minorities used heroin, minorities make up such a small part of the total Kenai Peninsula population. Most of the youth using heroin will fall into the White/Caucasian group.

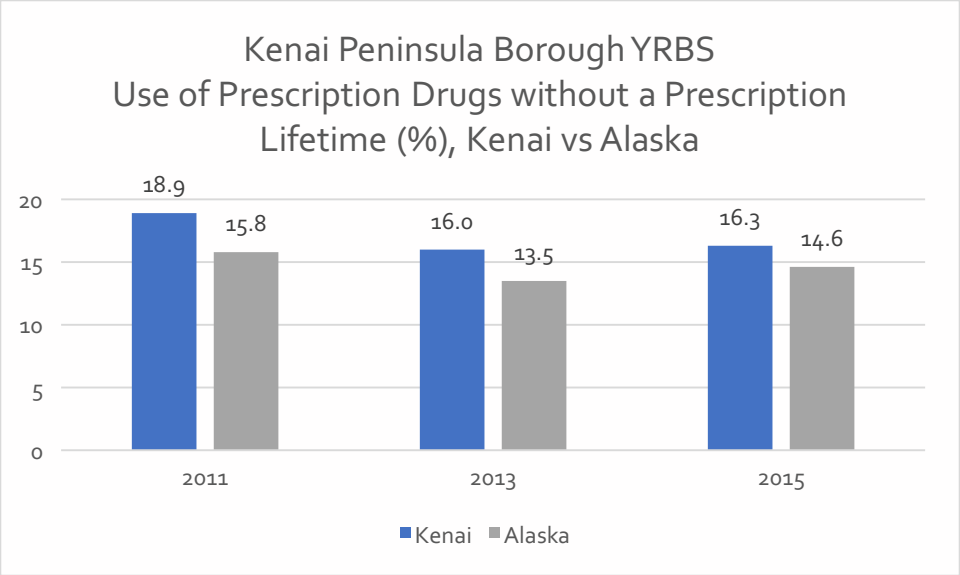


YRBS • KENAI VERSUS ALASKA

Kenai Peninsula youth roughly match statewide population data across time (2011-2015) for both lifetime use of heroin and lifetime and past 30 day use of NMUPO. There is no clear pattern of increase or decrease across time which is robust enough to be explained by anything other than chance. While Kenai Peninsula and statewide data follow the same general trends, Kenai Peninsula Youth endorse more drug use at each measurement time and for each drug. While differences range from 0.2-3.1%, the percentage of increase ranges from 8.3% to 16.4%. As this difference occurs at every time point and is fairly robust, we can conclude that Kenai Peninsula youth are more likely to engage in lifetime use of heroin or lifetime and past 30 day use of NMUPO than the statewide sample.







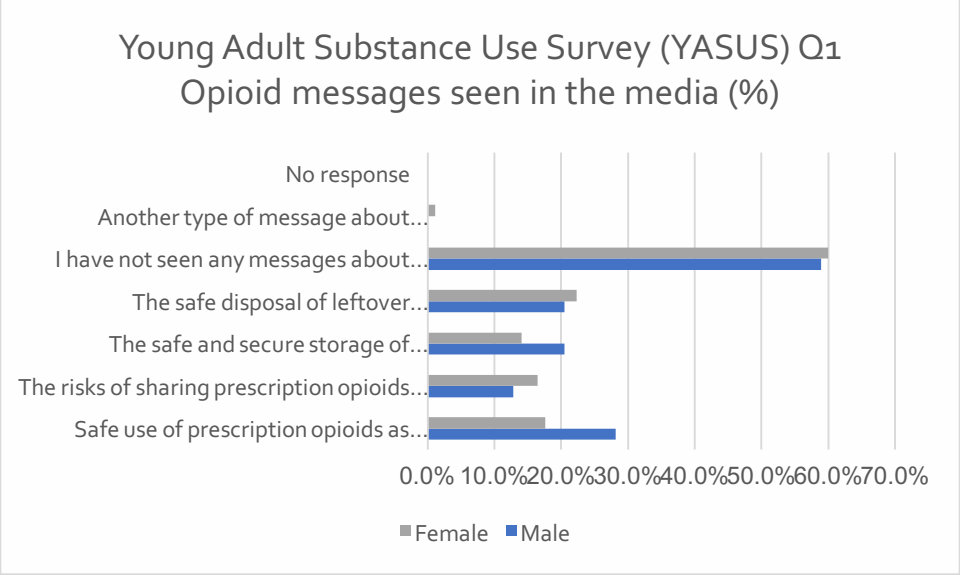
Looking across both data sources (MTF and YRBS) gives us a better estimate than each data source alone. MTF is a more gross measure, as it looks at national versus Alaskan data, but it is a more established measure with demonstrated reliability in its implementation. The YRBS is also a good measure but it has encountered some implementation pitfalls which link back to Alaska active parental consent law which requires parents sign for their child to participate in the survey versus the more standard approach where parents only sign to opt out of a school activity. This limits and biases the sample and may be inadvertently omitting youth from disadvantaged backgrounds. Additionally, sample size may ultimately impact sample generalizability and the tracking of trends in substance use across both yearly and grade data. MTF data is national data and may not directly map on to Alaskan experiences. Alaska's challenges in drug prevention are likely underestimated by both of these data sources and additional factors that amplify risk for opioid addiction are outlined throughout this report (use of other drugs, adverse childhood experiences).

YOUNG ADULT

While Change 4 Kenai has to rely on state and national data sources to track youth substance use, we are becoming increasingly capable of monitoring adult trends. To investigate adult trends in NMUPO and heroin use, C4K surveyed 18-25 year olds via a Facebook survey. This data supplemented the Young Adult Substance Use Survey (YASUS) provided by Data and Evaluation Technical Assistance Liaisons (DETAIL).

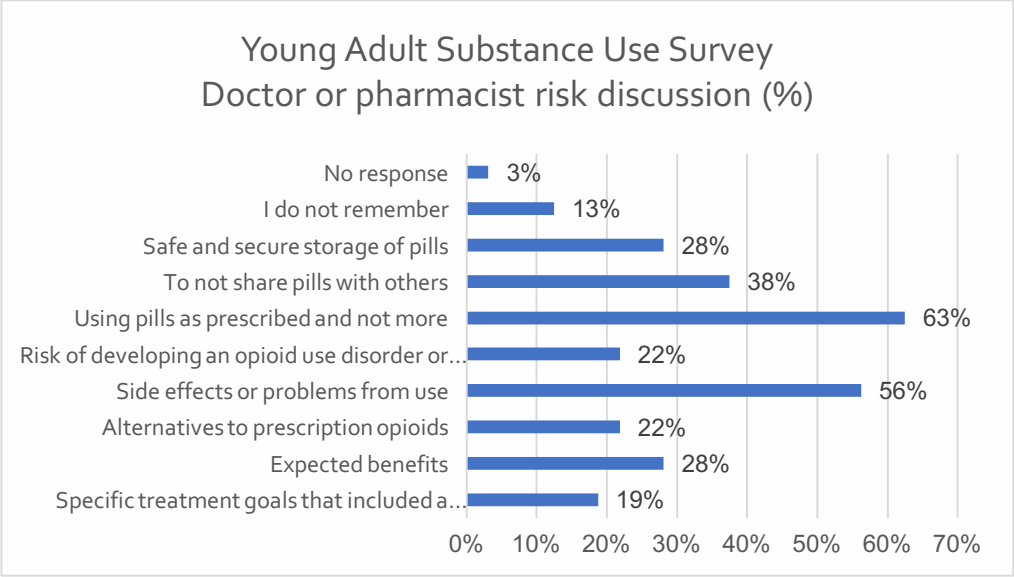
Young Adult Substance Use Survey (YASUS) was conducted via mail out questionnaires that were mailed to 18-25 year olds. Participation in the survey was incentivized with a $25 gift card. The initial mailing requested the survey be filled out on paper and subsequent mailings allowed for it to be done on paper or online. While this study was administered statewide, C4K was provided with data specific to the Kenai Peninsula. Ultimately 39 males, 85 females, and 1 transgender completed the survey. Global analysis of answers reveals that 15 participants (11%) had any misuse of prescription opioids, 8 reported any lifetime use of heroin, and 2 reported addictive behaviors or consequences linked to NMUPO or heroin use. This sample may be underrepresenting individuals at risk for misuse of NMUPO or heroin use because at risk individuals are extremely hard to reach with a mail out survey as they often have unstable addresses. Highlights from the survey are included in this report to inform the development of intervention programs.

Question one asked respondents if they had seen any messaging about prescription opioids on the radio, TV, or printed materials. Fifty-nine percent of males and 60% percent of females had not seen any messaging. Of those that saw messaging they were most likely to see messages about use of prescriptions as prescribed by the doctor or the safe disposal of leftover opioids. They were least likely to have seen messaging about the risks of sharing prescription opioids with others. Compared to state averages, Kenai residents were more likely to report having no exposure to messaging or information about safe disposal and much less likely to have heard messaging about safe storage, using as prescribed by a doctor, and the risks of sharing opioids.

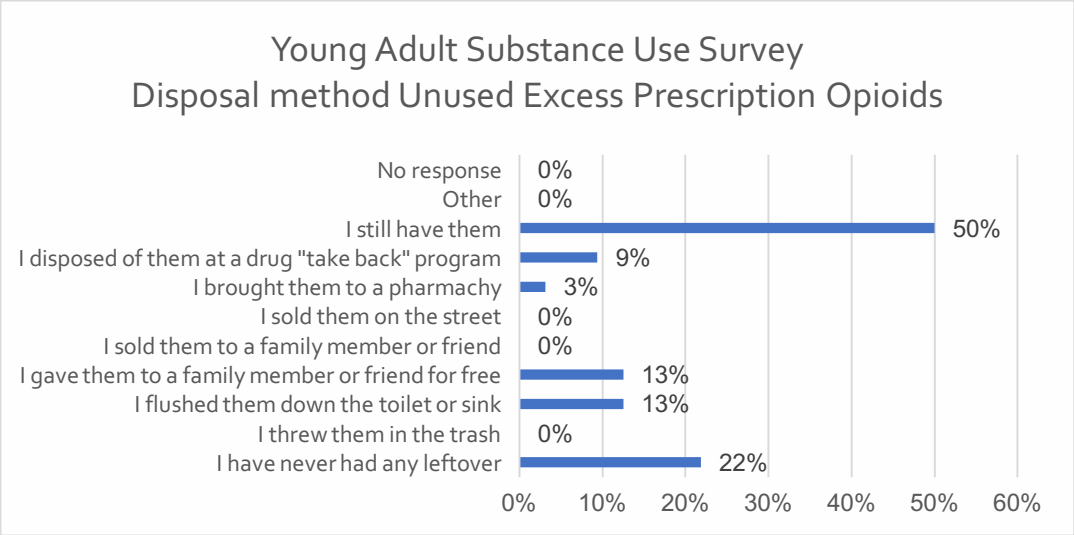


Females (46%) were more likely than males (28%) to have been prescribed opioids in their lifetime with females being twice as likely to have been prescribed them in the past three years (females 29%, males 15%). Interestingly, while 40% of the total sample had been prescribed opioids but only 11% went on to any type of misuse and the misuse cannot clearly be linked to the legally prescribed medications (potentially getting them from a friend or family and no clear evidence that the persons ultimately misusing NMUPO were the same subjects as those getting legal prescriptions). Only one female participant reported difficulties linked to her use of NMUPO. This data strongly suggests that most young adults, who are prescribed an opioid, use them as prescribed and do not progress to any type of addiction, making prescriptions for opioids a poor predictor of subsequent addiction.

The low addiction rates may be linked to doctors or physicians discussing risk with patients, 84% of those prescribed in the last three years recalled hearing some type of safety messages from a doctor or pharmacist. There remains room for improvement in both the quantity and the quality of the messaging. Only 22% reported having discussed options to prescription opioids, 28% received any information about the safe and secure storage of these medication. Diverted or stolen prescription opioids likely do contribute strongly to the rates of NMUPO. Participants were most likely to be given information about taking prescriptions exactly as prescribed (56%) or potential side effects (56%).



Educating people on safe storage and disposal of prescription medication may be the best avenue to prevent diversion and subsequent addiction. Fifty percent of the sample reported that they still had the medication, 22% reported using all their medication, 13% reported allowing them to be used by a family, and 9% reported taking them back to the pharmacy or to a drug disposal event. Providing options for appropriate disposal and education of the risks of storing excess medication could impact rates of NMUPO.

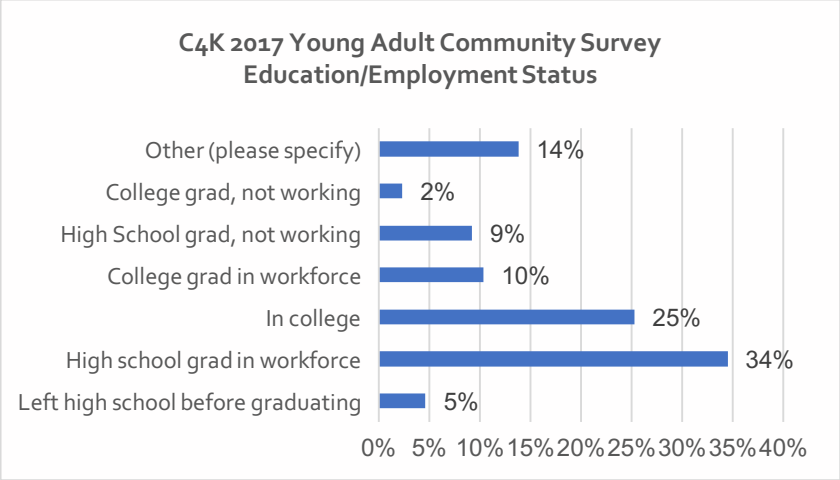


Eight participants reported lifetime use of heroin with only one reporting use in the past 30 days and one additional person reporting use in the last 12 months. Of the two responses for using heroin in the past year, only one experienced multiple life consequences (legal, health, family, financial) and both reported accidents involving themselves or others.

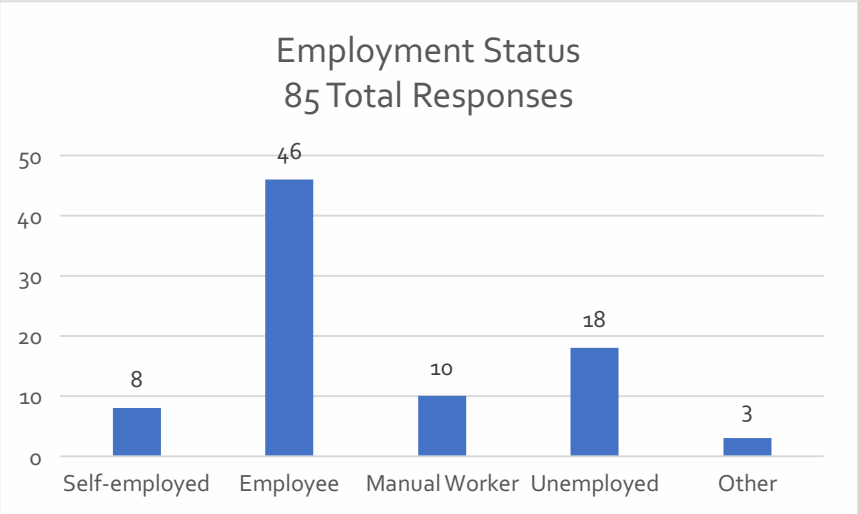
YOUNG ADULT COMMUNITY SURVEY • CONDUCTED BY CHANGE 4 KENAI

Eighty-eight young adults, between the ages of 18-25 years old, completed the survey which was administrated via Facebook. Participants in this study also received $25 gift cards. Using Facebook to administer the survey versus standard mail delivery, allowed access to a broader demographic of young adults. While many individuals with life instability may not have a fixed address, they do have Facebook accounts. Facebook allowed for directed advertisement of the survey allowing us to better balance the numbers of female versus male participants through selected placement of the survey link in materials of interest to each group. Fifty-five percent of study participants were female (45% male) providing a more balanced sample than YASUS which was 64% female. Data on living situation further indicate C4K reached the subpopulation missing from the YASUS. Fifty-six percent of the sample reported that they live independently off campus, this is the subpopulation which includes those with temporary addresses. An additional 33% live with a parent, 5% live on campus, and 6% reported their living situation as other. Text responses to other indicated they lived with roommates, rental, or a friend's home. The term 'live independently' caused them to pick other but they are actually living on their own, raising the rate of respondents living outside of family or college housing to 62%.

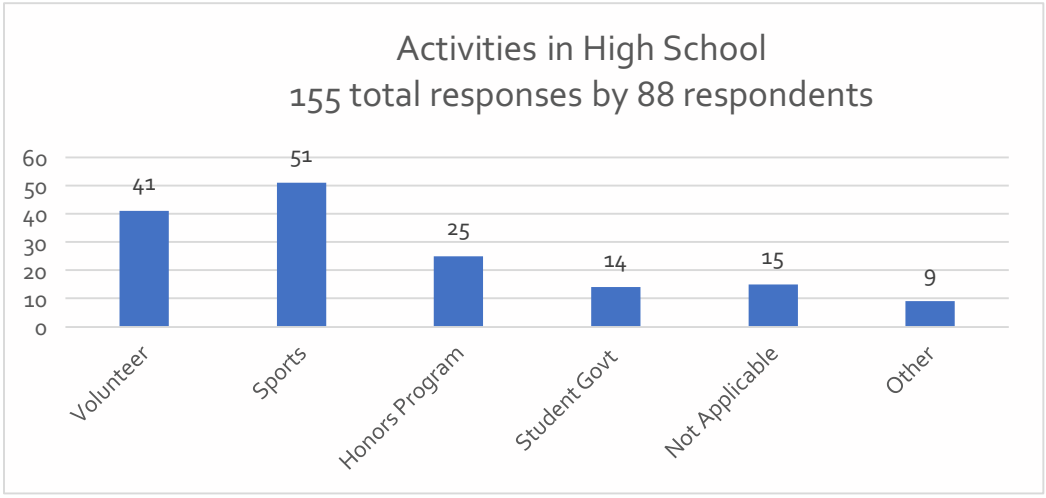
Additional demographics from the Young Adult Community Survey reveal that average age was 21.35 years, the range for ages was 17-25, with 18 years most commonly occurring. Thirty-four percent were employed high school graduates, 25% were currently in college, 10% had graduated college and were in the workforce, 11% indicated they were high school or college graduates not working, 5% did not graduate high school and 14% indicated other (GED, still in high school, trade school, not in workforce). Seventy nine percent of the sample identified as White/Caucasian, 11% Alaska Native, 5% American Indian, and 4% other.



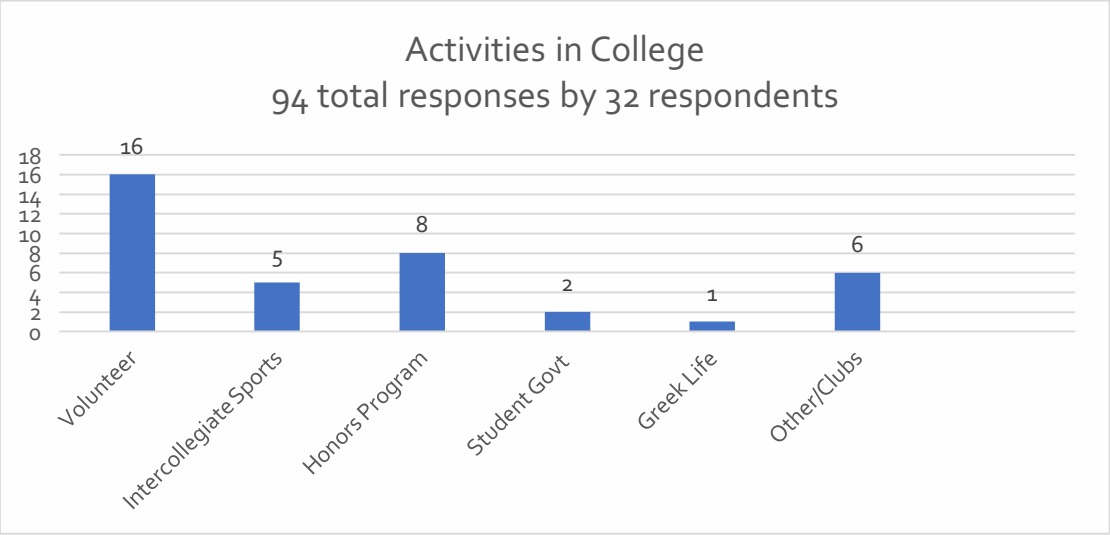
C4K was interested in community or school involvement as they represent community connectivity, which is a protective factor against addiction. Eighty-five respondents answered the item about employment which is the most common connection most people have to the community. The unemployment rate for this sample was 21% and may be higher than state averages due to enrollments in college.



Eighty-eight participants responded to a question about participation in activities in high school. As the question allowed them to click more than one response, a total of 155 responses were recorded with an average of 1.76 activities per student. The final question on connectivity looked at participation in community activities. All 88 subjects responded to this question producing a total of 123 response with an average of 1.5 activities per person. Frequency tables for connectivity questions are included below.



Thirty-two respondents are involved in college so only 32 responded to the question about participation in college activities. A total of 94 responses with students' averaging 2.9 activities per student. This is a highly-engaged subgroup.



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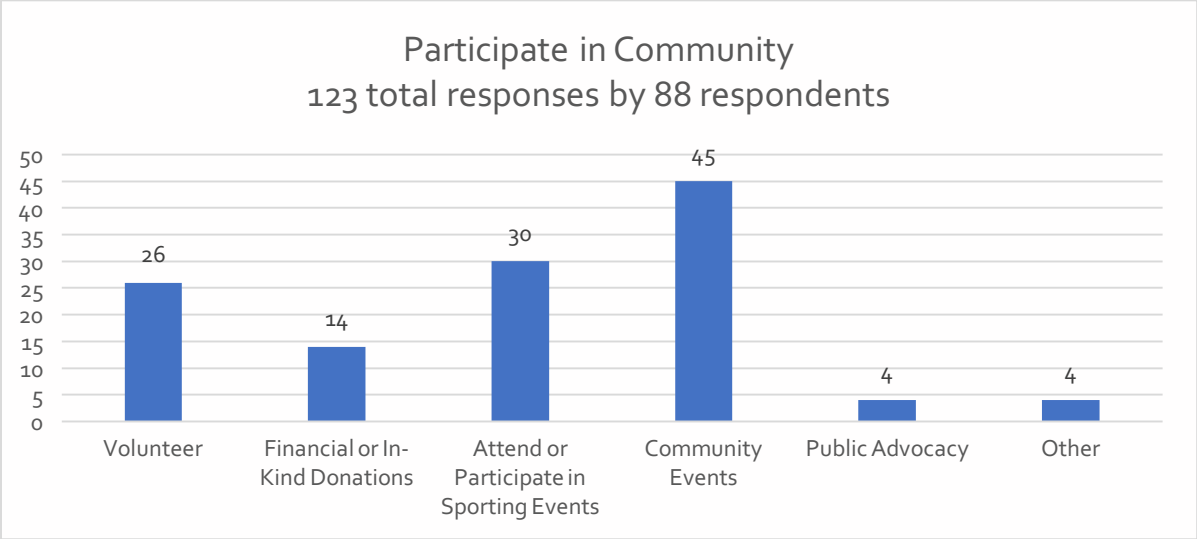
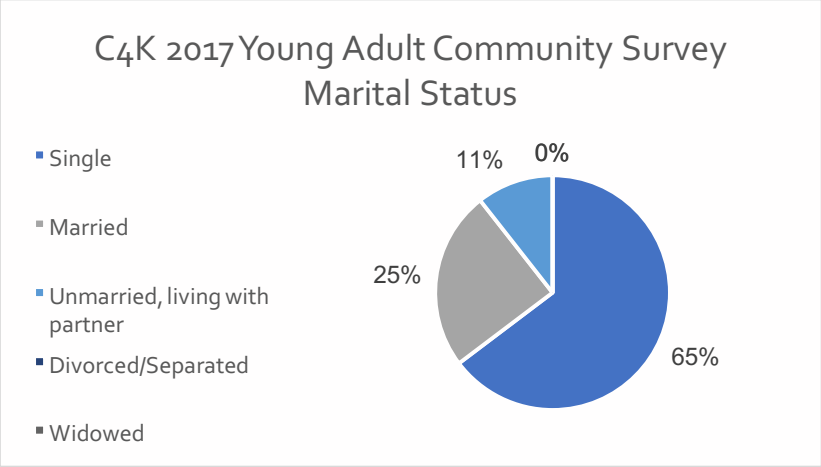
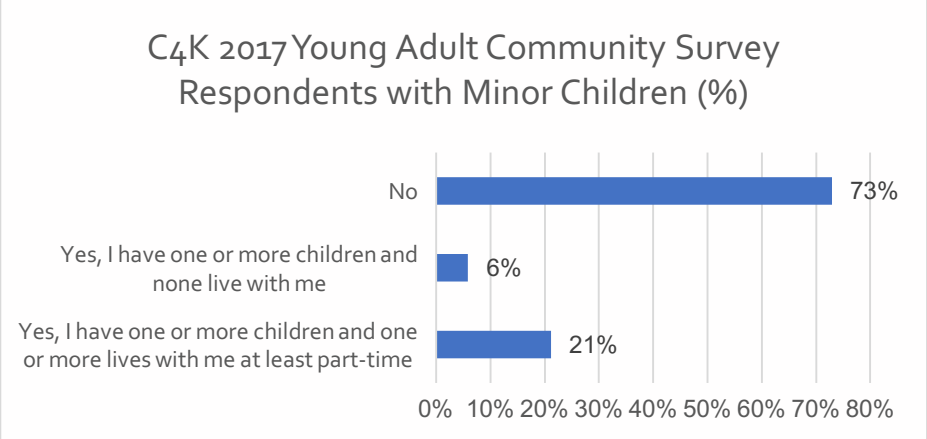


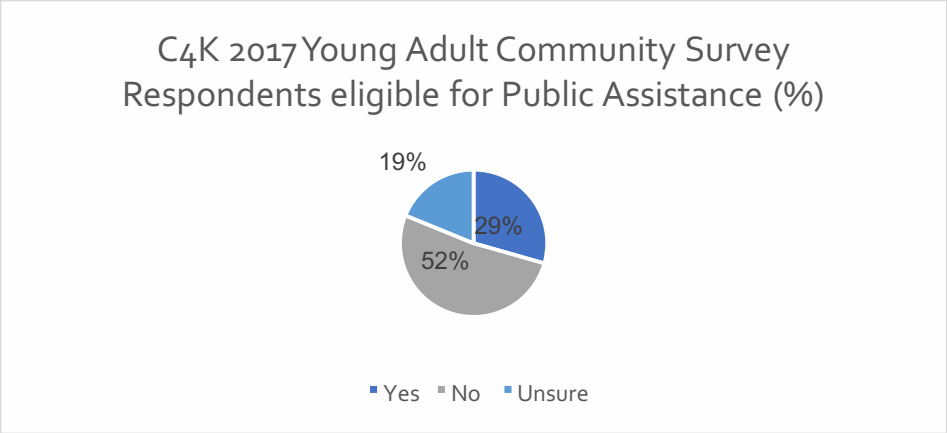
Sixty-five percent of the sample reported being single, 25% were married, and 11% live with a partner.



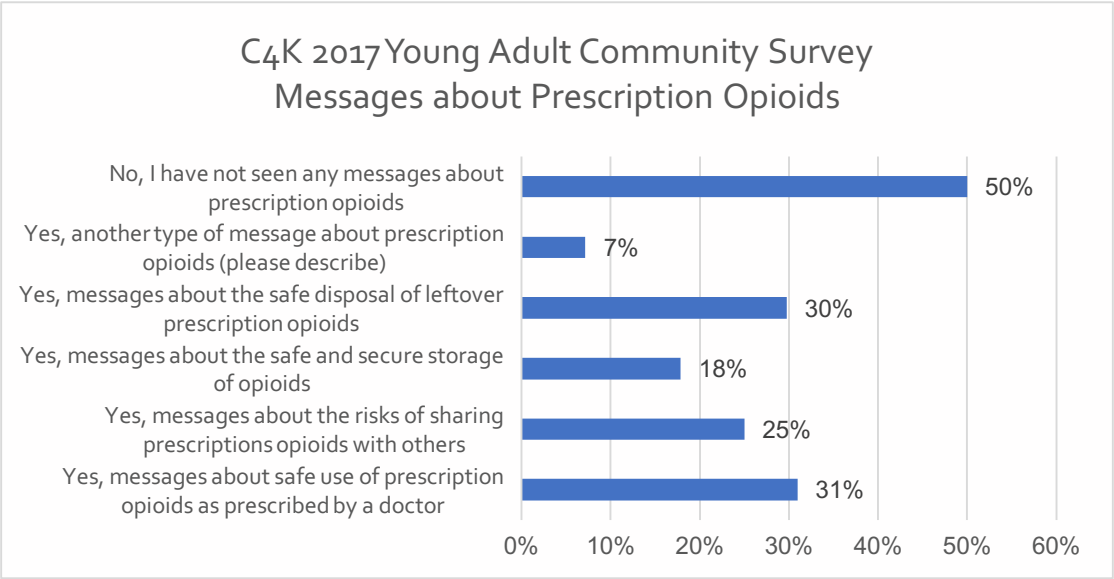
Seventy-three percent reported they had no children, 29% reported they have one or more children and the children live with them, 6% reported that they have one or more children and the children do not live with them.



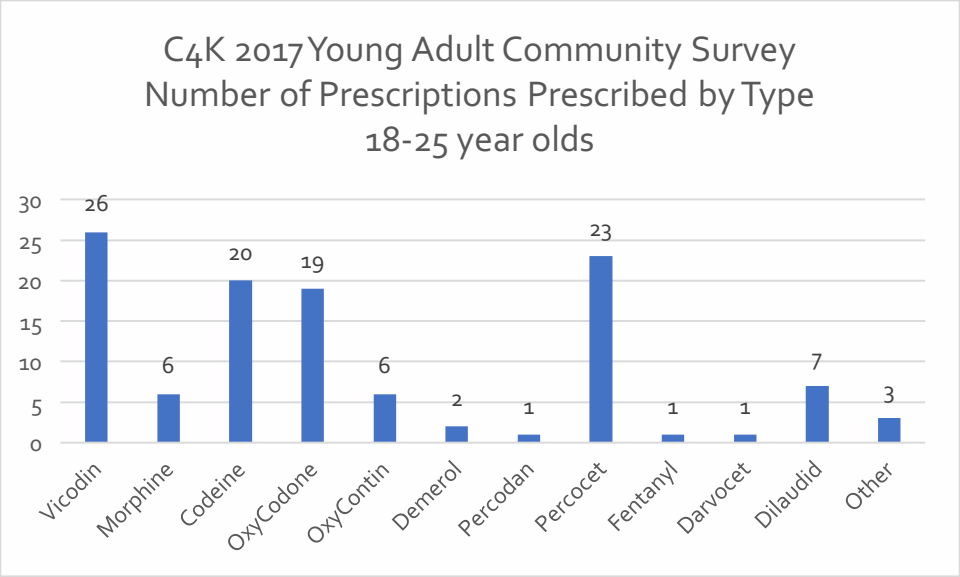
Twenty-nine percent were currently receiving public assistance, 52% reported no public assistance, and 19% were unsure if they receive any type of public assistance.



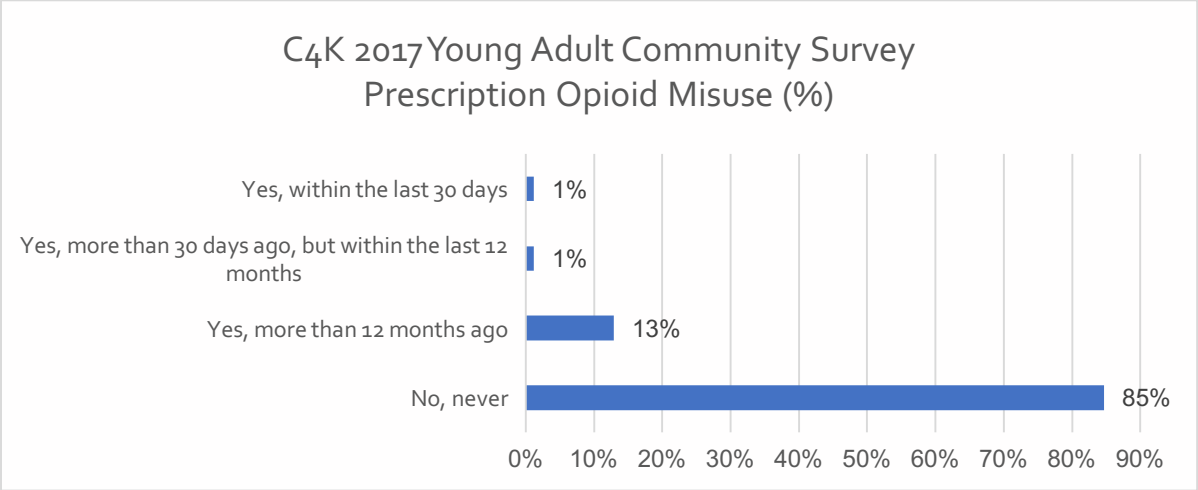
The Young Adult Community Survey contained an identical question to the YASUS, both surveys asked if the respondent had seen any messages about prescription opioids on radio, TV, or printed material such as posters and pamphlets. Respondents were to choose all that applied. While 60% of the YASUS reported not having seen any messaging, 50% of the C4K Young Adult Community Survey had not seen messaging. The two surveys may have reached different subgroups. Since the Young Adult Community Survey was completed on Facebook, to allow greater access to at risk populations, it is very promising to see that respondents were more likely than subjects in the YASUS to have seen messaging about prescription opioids. Participants in the Young Adult Community Survey were most likely to have seen messaging about safe use of prescription opioids or safe disposal of prescription opioids. They were least likely to have received messaging about the safe and secure storage of opioids.



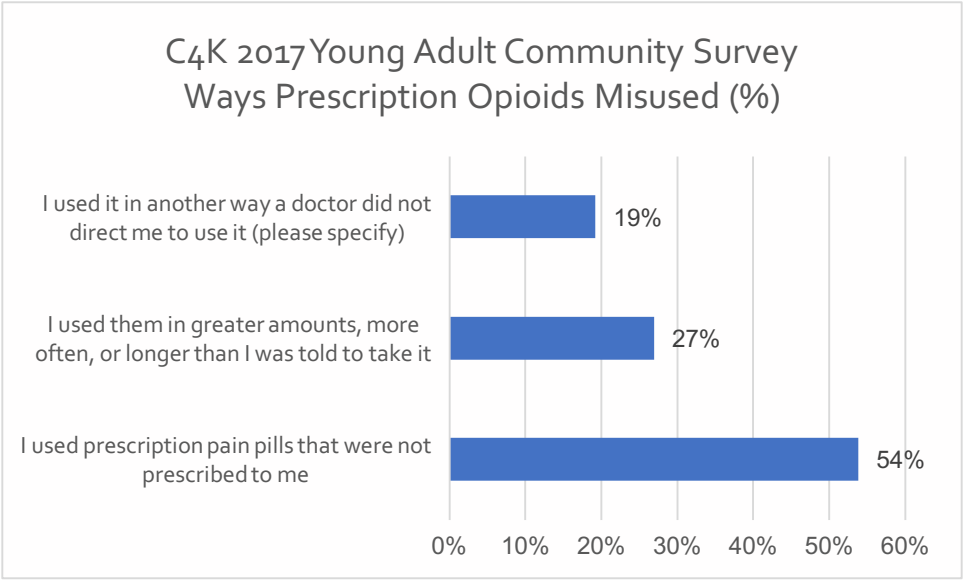
C4K's Young Adult Community Survey was successful in reaching a group with increased exposure to substances of abuse. Fifty-nine percent of the sample for this survey reported having been prescribed an opioid while 40% of the sample for the YASUS had been given a prescription. C4k's survey also allowed for the calculation of number of different types of prescription that had been prescribed, 7 individuals were prescribed 5 or more different types of opioid medication. While there could be legitimate reasons for these prescriptions, they are suspect in a population 18-25 years old as this group should be overwhelmingly healthy.



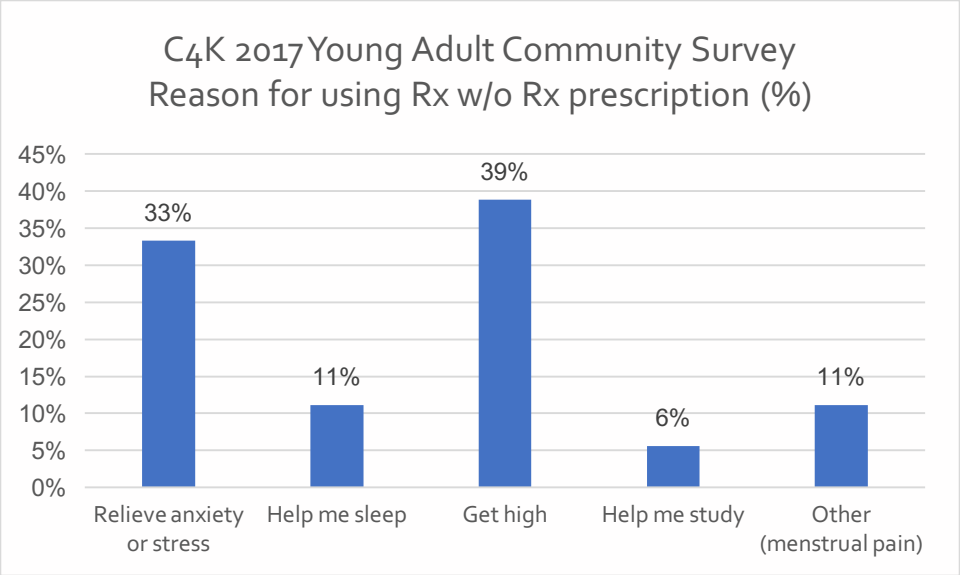
Eighty-five percent of participants reported they had never misused prescription opioids, 13% reported misuse 12 or more months ago, 1% reported misuse less than 12 months but more than 30 days ago, and 1% reported misuse in the past 30 days. This is a total of 13 of 88 participants endorsing some type of misuse. While more participants in this survey were prescribed opioids the difference in misuse rates between the two surveys only rose from 11-14%. Based on relatively small sample size and low base rate of use behavior this is not likely a significant increase. Two percent of the sample reported they had experience moderate life problems linked to their use and 4% reported that use of prescription opioids had created severe problems in their life. While these medications are commonly prescribed, prescribed medications uncommonly lead to misuse and even less commonly lead to addictions. Those who misuse prescription opioids are just as likely to get them from sources such as family or friends as from a doctor.



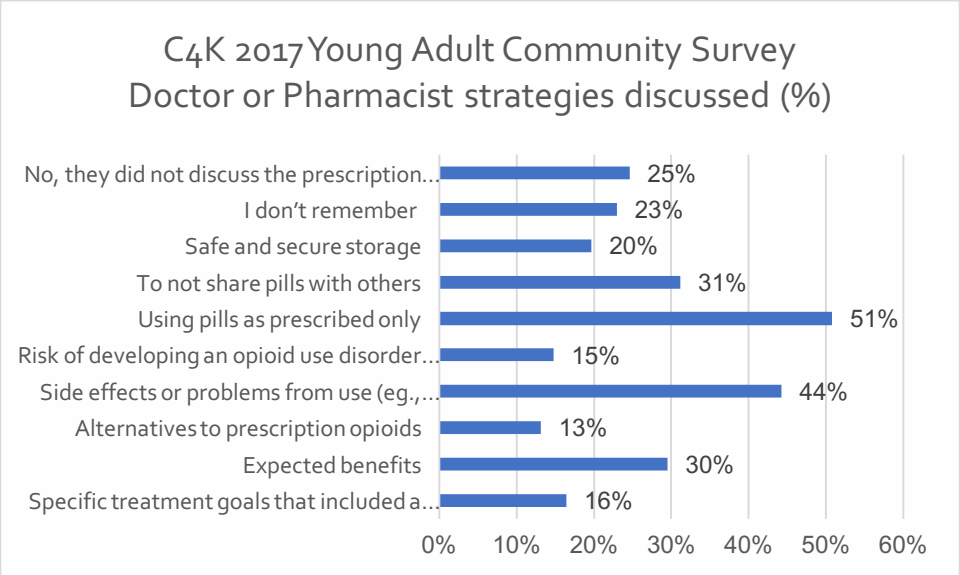
Questions about misuse of opioids and reasons for misuse only applied to a small percentage of respondents. While only 13 of 85 participants reported misuse of an opioid, 26 participants responded to the question about how they misused an opioid. When asked how they misused prescription opioids, respondents reported used prescription pills that were not prescribed to me 54%, used greater amounts, more often, or longer than I was told to (27%), used them in a way other than the doctor instructed me to (19%-text responses included smoking or for other pain problems).



When asked why they misused prescription opioids, 78% of the sample dropped out reporting this did not apply. Of the remaining 18 responses, 7 or 39% reported they intended to get high, followed by relieve anxiety or stress 33%, help me sleep 11%, other (menstrual pain) 11%, and help me study 5%.

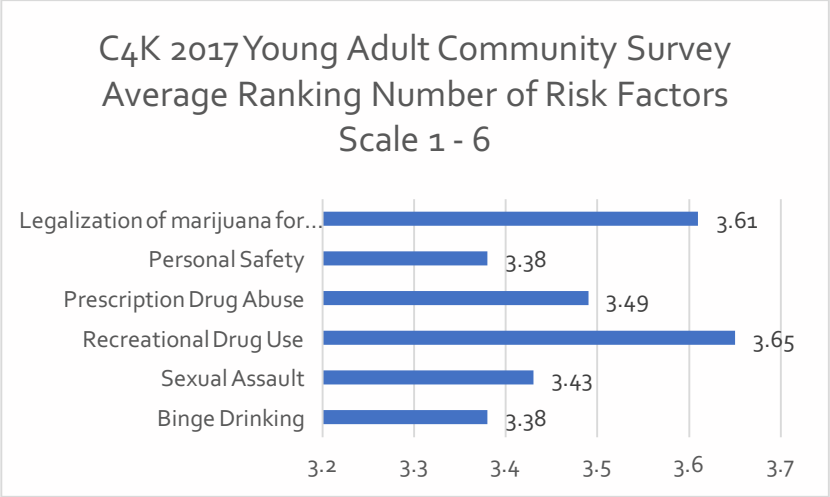


Another shared question across the two surveys asked participants to check all that apply among a list of recognized safe medical practice strategies. Participants were to respond if a doctor or pharmacist had talked with them about these strategies the last time they were prescribed opioids. Sixty-one respondents answered this question and generated 163 responses, indicating that each participant had been exposed to an average of 2.7 strategies. Most frequently occurring was discussion of using pills as prescribed (51% of sample received this messaging), followed by discussion of side effects (44%), and not to share pills (31%). Least likely to be discussed was alternatives to prescription opioids, only 13% of respondents reported that had a discussion about alternatives, risk of addiction, treatment goals, or secure storage. Seventy-five percent of respondents, who reported they were prescribed opioids, reported getting some type of strategy for safe use from a doctor or pharmacist.



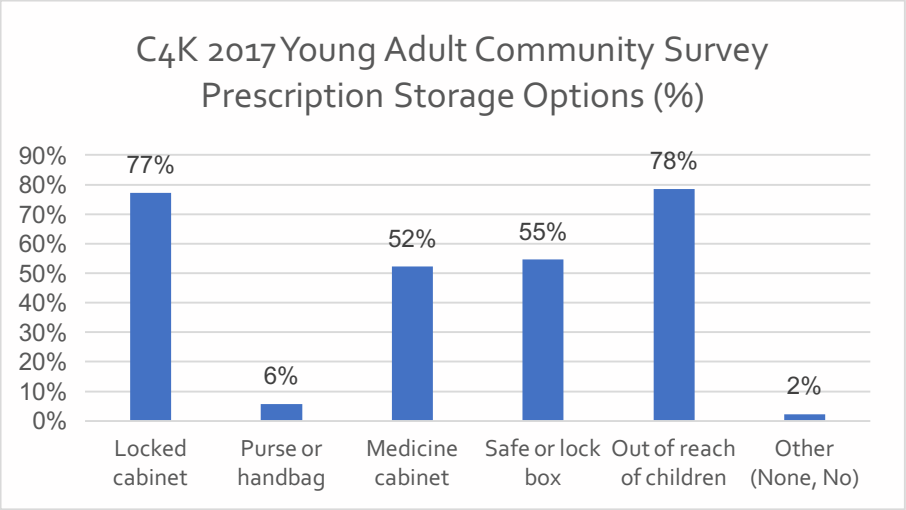
The reason opioids were prescribed was overwhelmingly post-surgical (62%) followed by an acute pain condition (14%) or other injury (14%), chronic pain was the least likely reason for an opioid prescription with less than 7% of the sample reporting they had been prescribed opioids for chronic pain.

Participants were asked to consider health, safety and well-being, and rate which of the issues were the most significant risks to their peer group in terms of the potential for physical or other harm. There was no agreement about risk associated with the six items (binge drinking, sexual assault, recreational drug use, prescription drug abuse, personal safety, and legalization of marijuana for personal use). Participants rated the items 1 to 6 in terms of risk. The average item ratings fell between 3.38 and 3.65 indicating that all items were rated both high and low by respondents with no clear preference of risk. Frequencies for each item by ranking are outlined below.

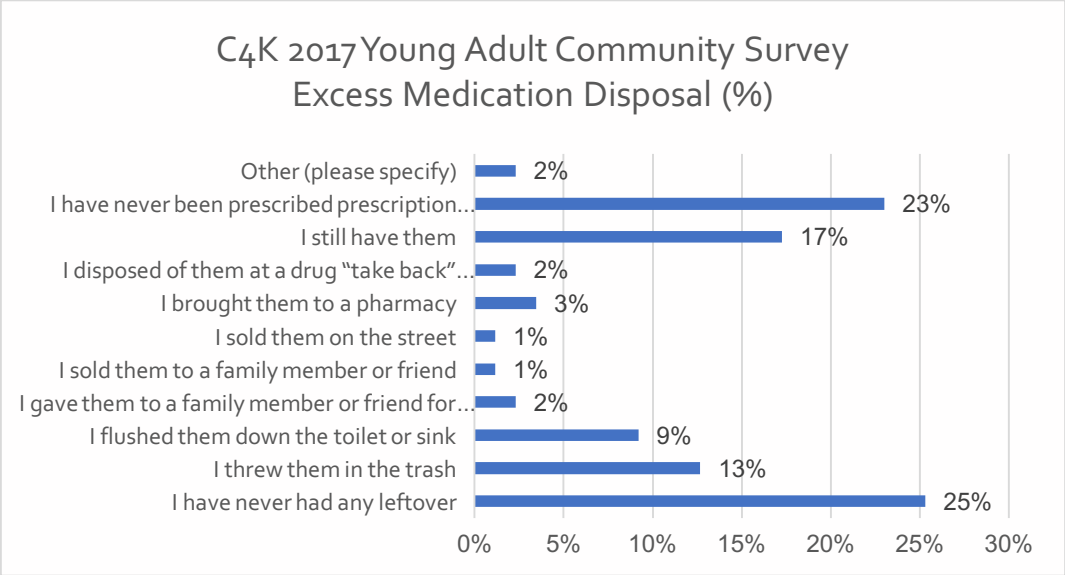


C4K was interested in perceptions of peers and personal risk with regard to drug of abuse. The survey asked respondents how much their friends would approve or disapprove of use of addictive substances. Averaging participant responses shows that alcohol and marijuana use are likely to be met with indifference, while using prescriptions that are not prescribed to you would fall between indifference and disapproval, and heroin use would bring disapproval. Participants were asked to rate the risk of perceived dangerousness of substances, on a scale of 1 to 5 with 1 being the lease risky in terms of the potential for physical or other harm. Substances were rated as heroin 4.91, methamphetamine 4.88, cocaine 4.45, ecstasy or molly 3.98, prescription pain pills 3.81, Attention Defect Disorder medications such as Adderall or Ritalin 3.52, alcohol 2.76, and marijuana 1.91. While heroin is clearly seen as a dangerous drug that will bring scorn from friends, prescription opioids were rated as much less risky and unlikely to bring negative feedback from friends. If young adults act on these beliefs, they will be somewhat isolated from heroin use but not from prescription opioids. In fact, 20% of the sample reported they would take prescriptions if offered them by a friend (18% for pain, 2% to get high).

Participants were asked to identify which of the following they thought was a safe place to store medications. The categories for this question were not mutually exclusive, 238 responses were coded on this item for the 88 respondents. The average respondent picked 2.7 of the options as "safe" for prescription storage. Participants were equally likely to select in a locked cabinet (77%) or out of reach of children (78%) and least likely to select in a purse or handbag (6%).



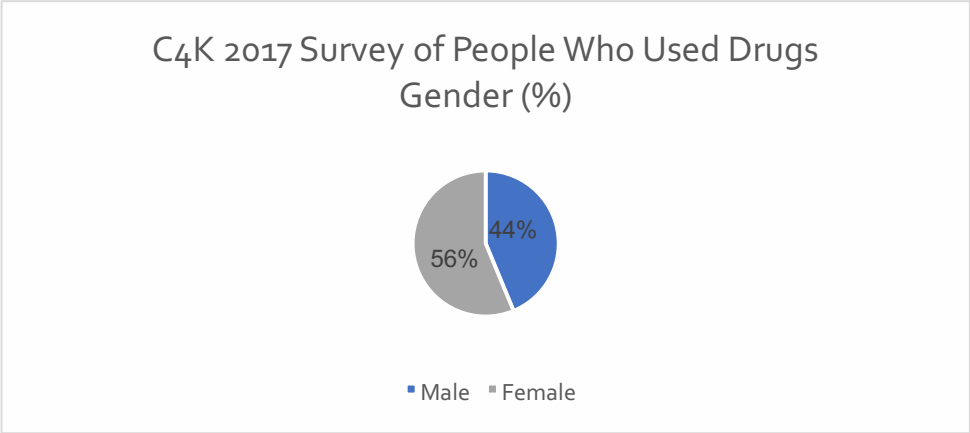
Unused medications are at risk to become diverted or misused in the future. Participants were asked what they had done with excess medication. Twenty-five percent reported that they did not have any leftover, 23% reported that they had never been prescribed an opioid. Seventeen percent reported that they still have the medication, 13% reported throwing them in the trash, 9% flushed them down the toilet, followed by brought them to pharmacy 3%, gave them to a family member for free 2%, drug take back program 2%, sold to friend or family 1%, or sold on street 1%.



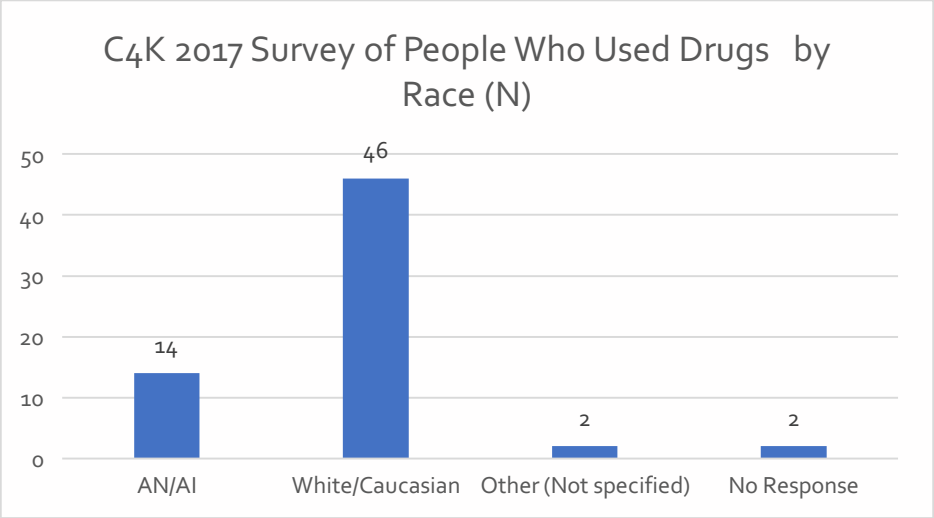
Only four respondents reported use of heroin greater than 12 months ago. No participants reported use of heroin in the past year. Participants were asked to rate the relative risk of prescription pain medications as compared to heroin use. Fifty-nine percent of participants reports them as equally risky, 36% viewed prescription pain medication as less risky than heroin, and 5% thought prescription pain medications were riskier than heroin.

COMMUNITY SURVEY OF PEOPLE WHO HAVE USED DRUGS

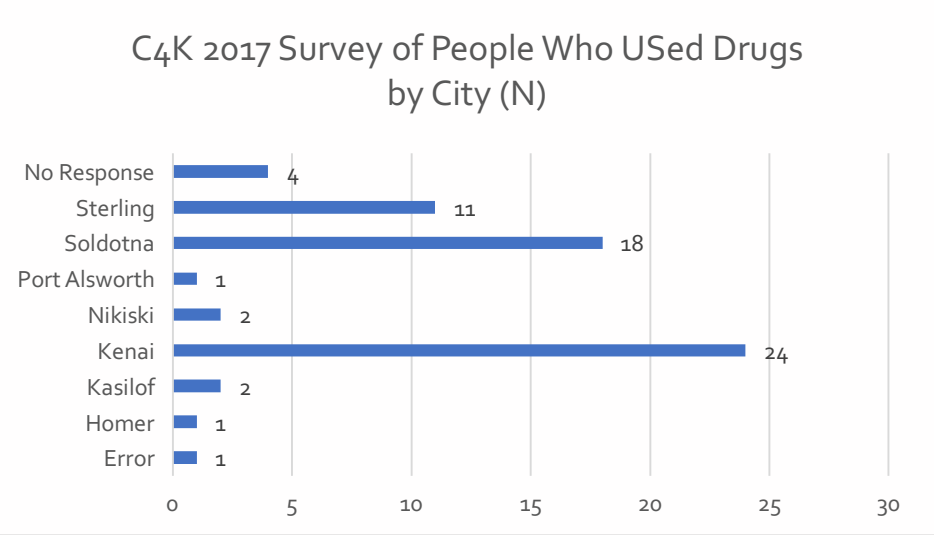
Surveys of young adults captured very few individuals who had actually used drugs. While they adequately represented the target group, they revealed little about opioid misuse which is the phenomena of interest. C4K was uniquely placed to be able to repeat the Young Adult Community Survey (YACS) with a sample of People Who Used Drugs (PUD). Sixty-four past or current drug users filled out the paper administered survey. They received the same $25 gift cards as the YACS. Survey participants were drawn from Serenity House Treatment Center, Cook Inlet Council on Alcohol and Addictions, Adult Probation, Recovery Community meetings, and a parenting class targeting people with addictions. While slightly more females completed the study, both sexes were well represented.



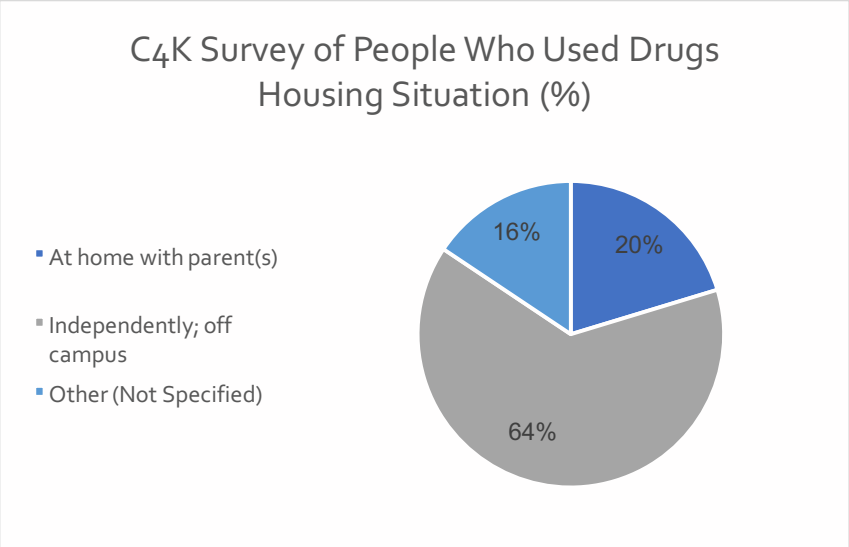
Participants ranged in age from 19-67 with a mean of 35 years and 34% of the sample falling under 30 years of age. Ethnicity matched that of the larger community and is graphed below.



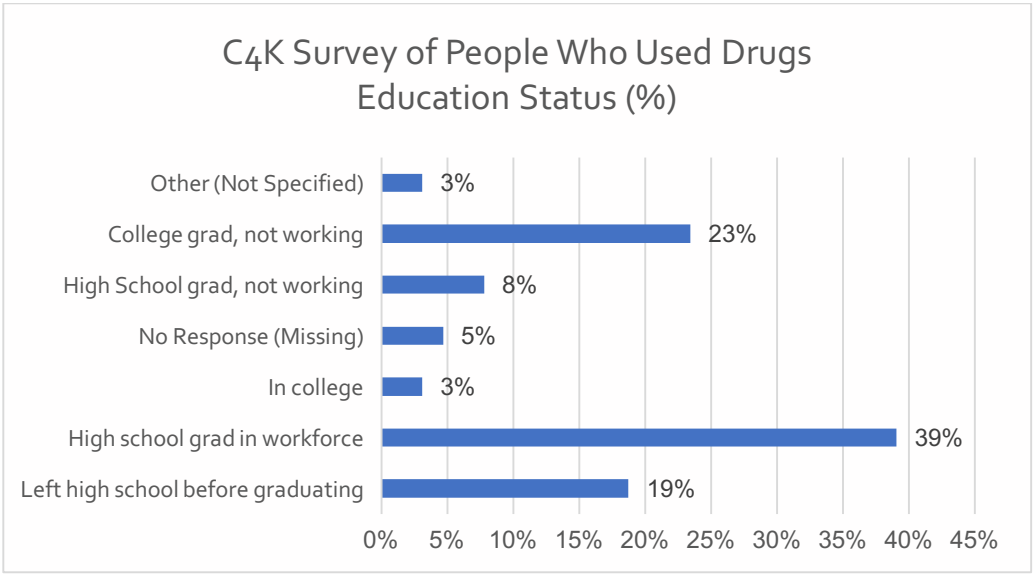
Most participants came from the Central Kenai Peninsula and additional subjects need to be recruited from across the Peninsula. This survey is actually still open at the writing of this assessment.



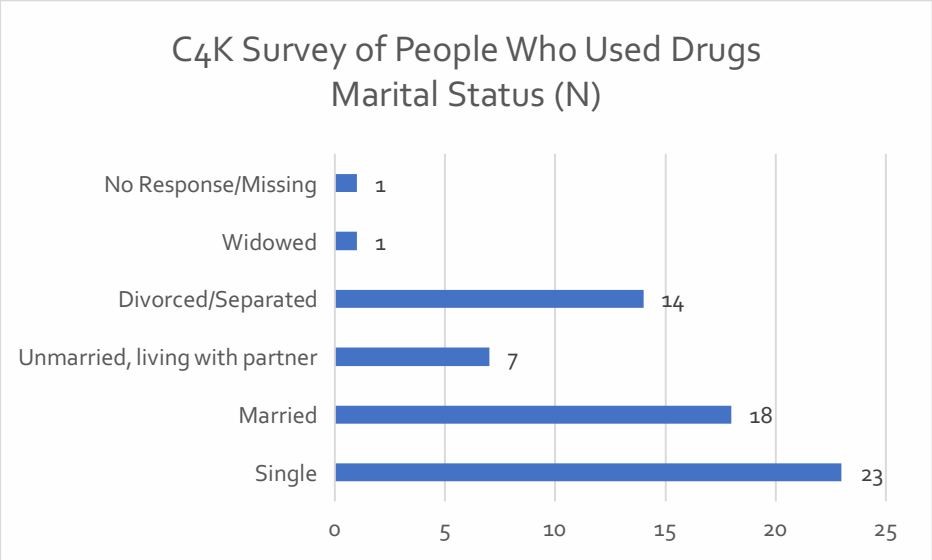
As with the YACS, "independently off campus" proved to be a confusing term and a number of respondents selected "other" and wrote in descriptors of independent living. The other category cannot simply be combined with "independently off campus" because not all respondents wrote in responses and some are currently in residential treatment programs. As would be expected, a larger percentage of this sample lived independently as compared to the YACS (56%).



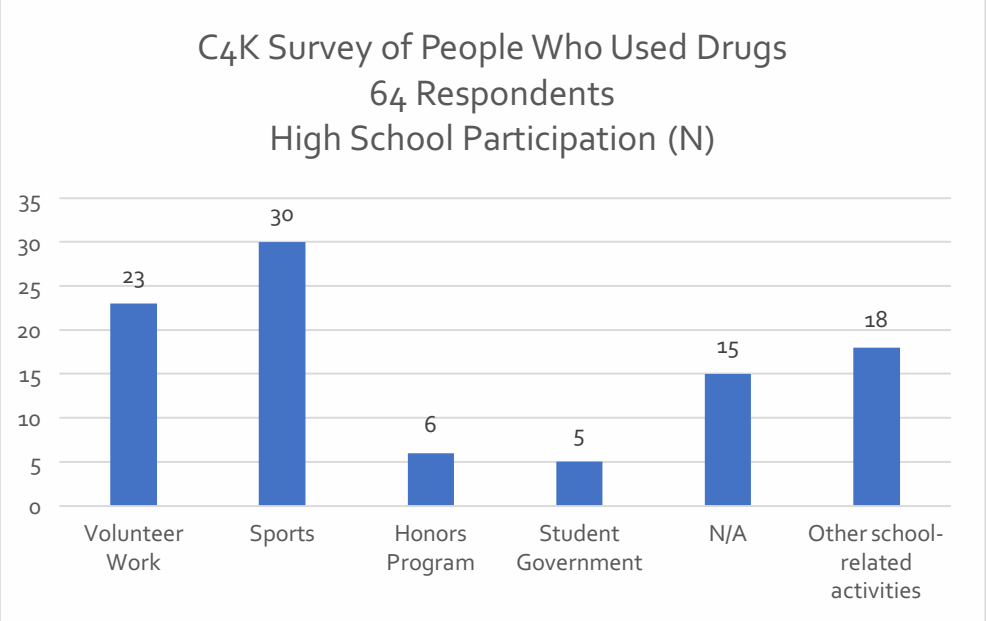
Educational status of this group varied greatly from that of the YACS. PUD were three times more likely to have left high school without graduating. While they were equally likely to be a high school graduate in the workforce, only 3% of PUD compared to 25% of YACS respondents were in college. Thirty-one percent of the PUD were in an unemployment category while only 11% of the YACS were not in the workforce.



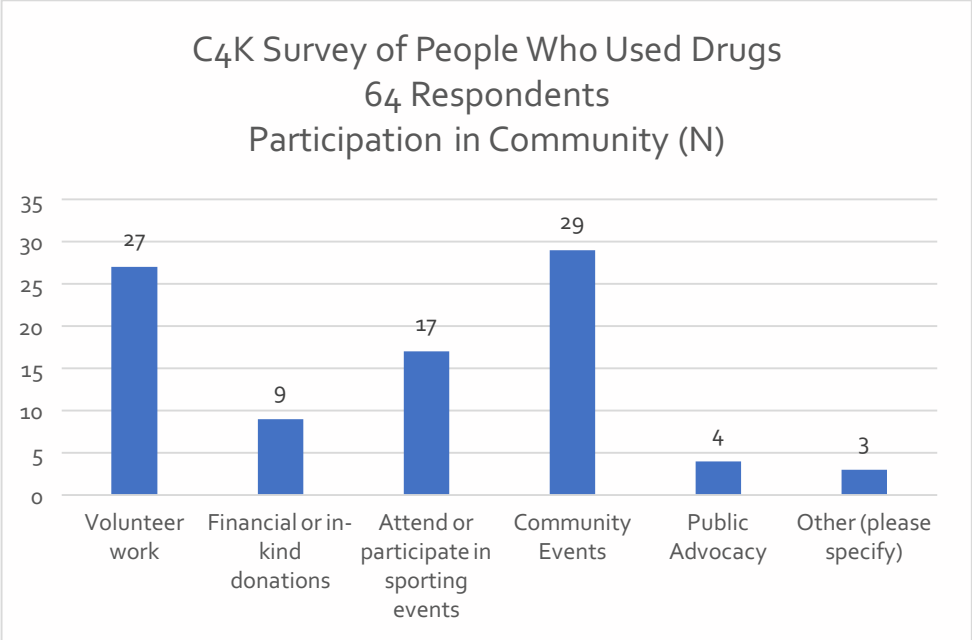
PUD were slightly less likely to be single but much more likely to be divorced or separated when compared to YACS participants.



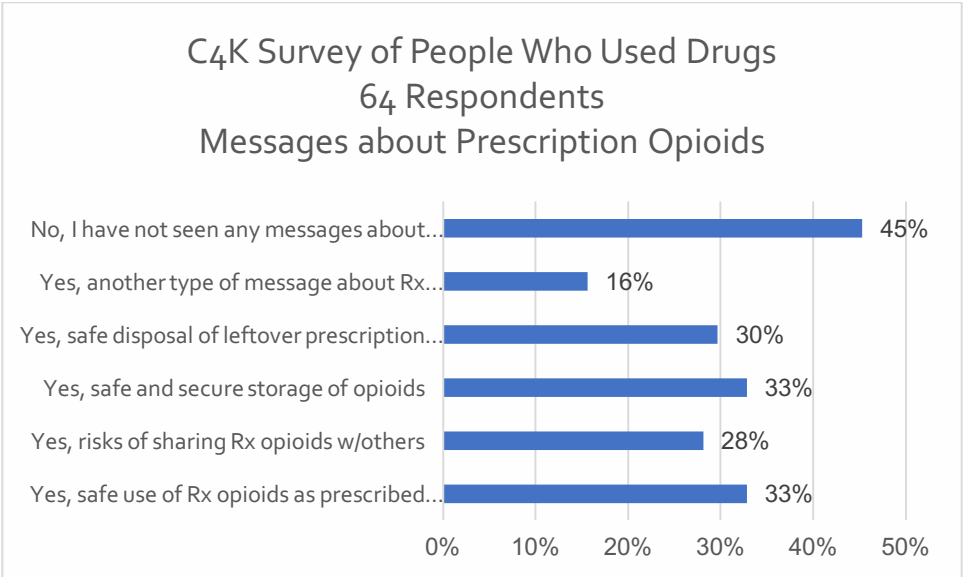
PUD were much less likely to have been involved in high school activities with an average of 1.5 activities per respondent compared to 1.8 activities per respondent for the YACS.



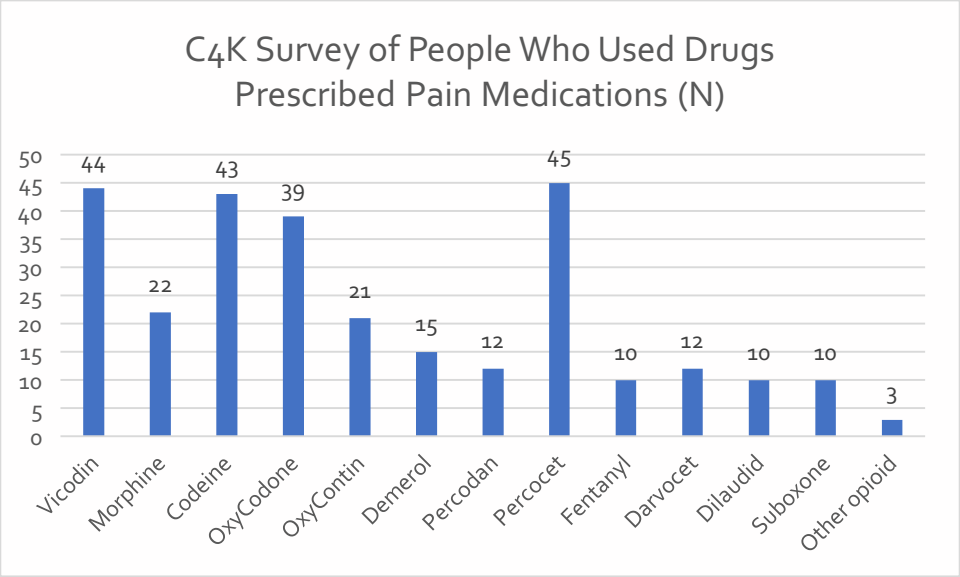
Community connectivity rates dropped only slightly for the PUD (1.4 per respondent) versus YACS (1.5 per respondent). However, a large percentage of PUD are currently participating in a treatment program, that encourages community participation, and this may have artificially increased rates of community participation for PUD.



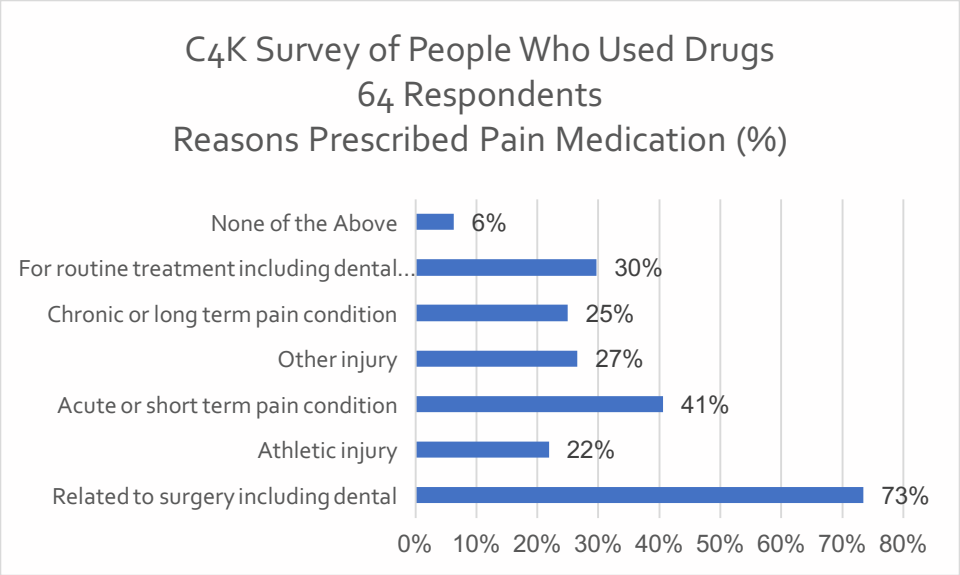
Respondents were asked if they have seen any messaging about NMUPO. The question asked them to consider print, radio, television, electronic or other sources of messaging and identify if they had been exposed to messaging about safe disposal, safe storage, risks of sharing, or safe use of prescriptions as prescribed by their doctor. Responses are graphed in terms of the percentage of the sample that had been exposed to each type of messaging. In this case 45%, or 29 of 64 respondents had received no messaging about prescription opioids. This is consistent across the two surveys and a major opportunity for intervention. Compared to the YACS, PUD were more likely to have received messaging about safe storage, all other messaging categories were consistent across both surveys.



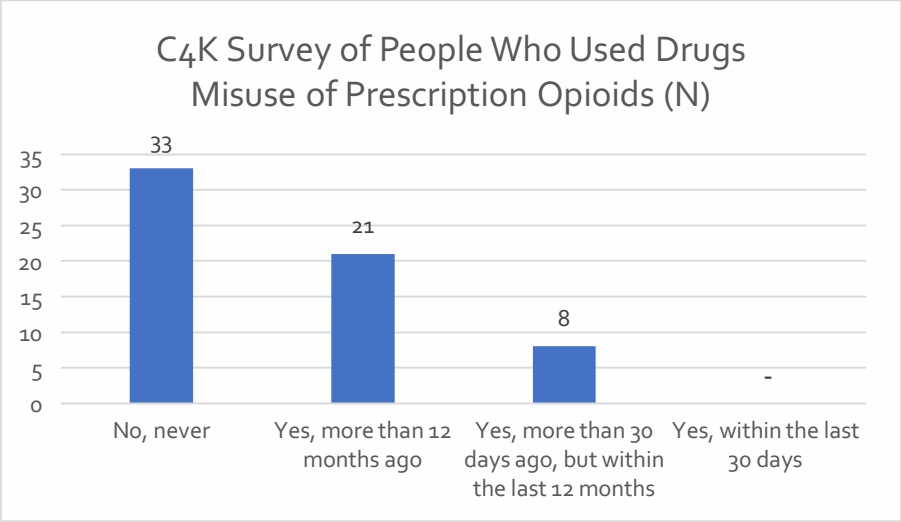
While the 18-25 year olds in the sample from the YACS had been prescribed an average of 1.3 types of pain medication, the respondents in the survey of PUD were prescribed an average of 4.3 types of pain medication per respondents. Multiple factors likely drive this massive discrepancy, 1) estimates suggest almost 50% of this sample has an addiction to opioids. Their addictions may be driving them to seek out multiple types of opioid prescriptions, 2) This sample is much older and could have experienced more health conditions requiring the appropriate use of prescription drugs, or 3) Use of multiple types of drugs could be the reason why respondents in this sample developed addiction.



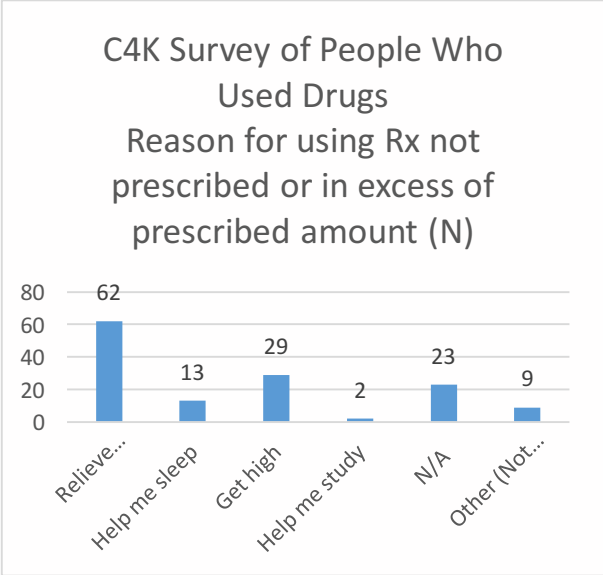
The non-addiction related reasons PUD took prescription opioids are graphed below. Again percentages represent the percentage of the sample endorsing each option. PUD were much more likley to endorse all of the following than YACS respondents. Being older may account for more medical issues, while PUD endorsed more items the same basic pattern remained. Surgery was the main reason for use of opioids, followed by accute pain or other injury. PUD were much more likely to select treatment for a dental issues or chronic long-term pain conditions as additional reasons they were prescribed opioids.

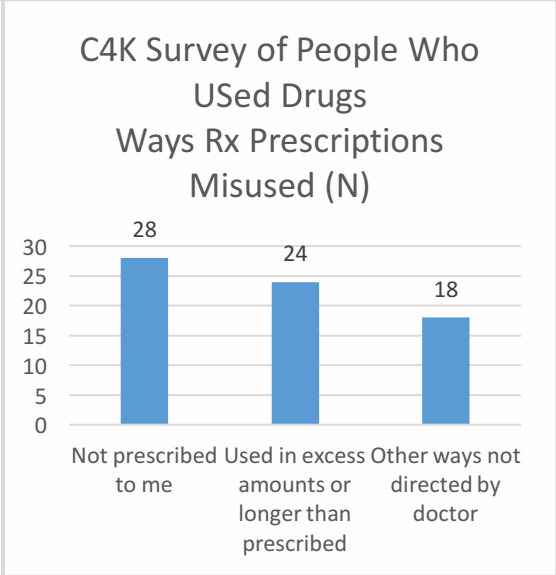


PUD were asked if they had a history of misusing prescription opioids. Forty-five percent of this sample had misused opioids, 13% in the past year and 33% more than a year ago. No one reported past month misuse of prescription opioids.

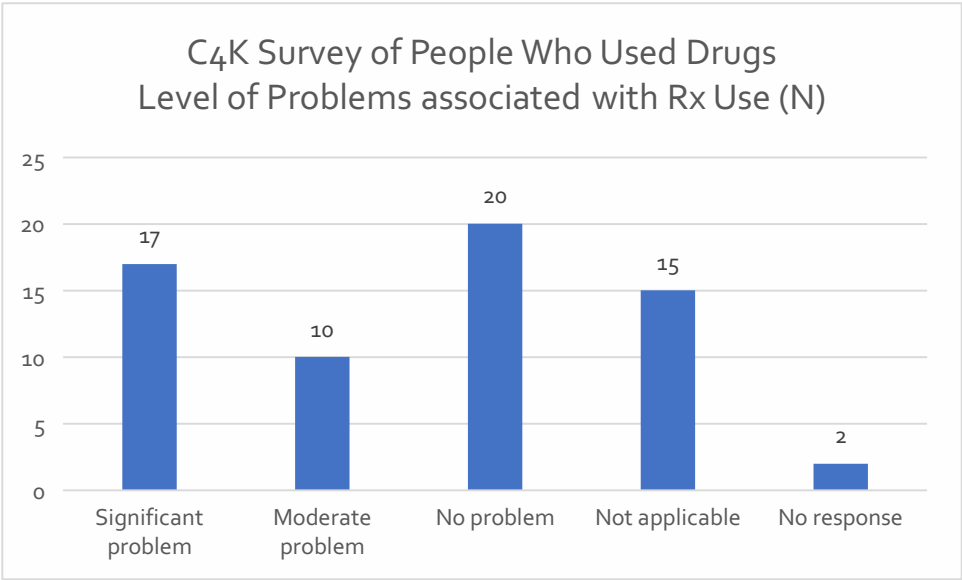


When asked how and why they misuse prescription opioids, PUD overwhelmingly reported they are misused to relive stress (62 of 64 respondents), followed by get high, and help with sleep. Participants were most likely to use prescriptions not prescribed to them, followed by in excess or longer than prescribed, and other ways not directed by doctor.

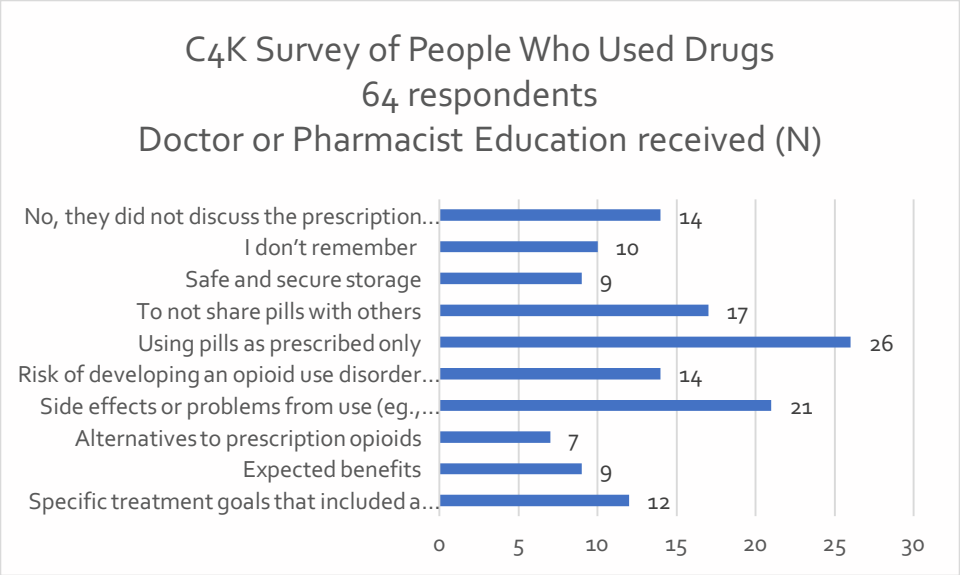




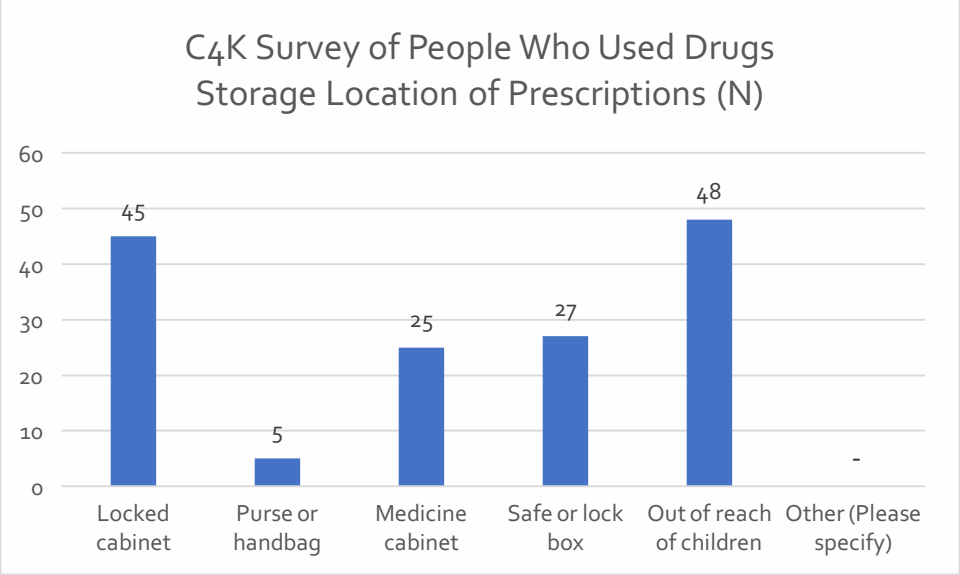
Twenty-seven percent reported they had experienced significant problems as a result of their misuse of opioids, 31% reported no problems, 23% reported not applicable, 16% had moderate problems, and 3% failed to respond.



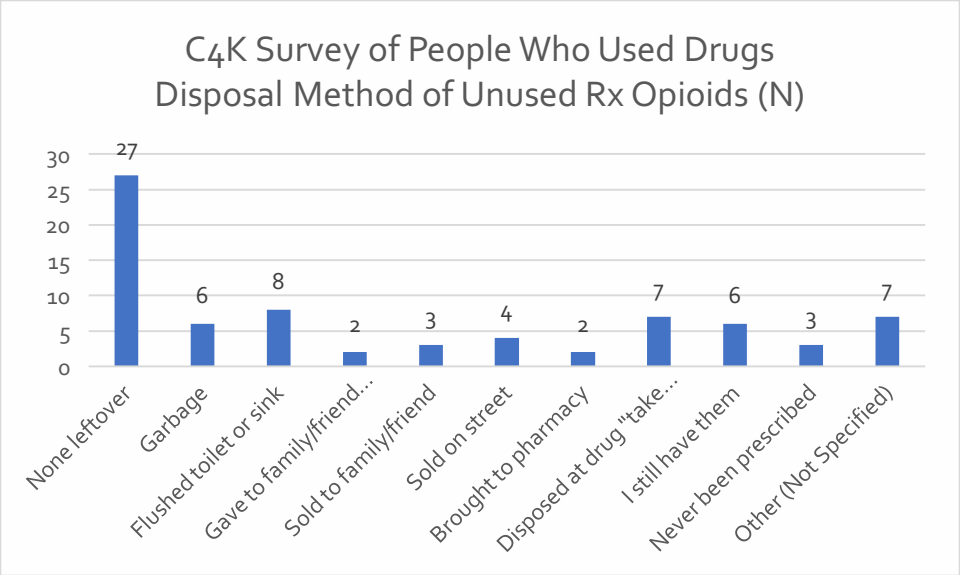
Being provided education about the risks of prescription opioid use is an important aspect of avoiding the development of addiction. C4K was particularly interested to see if PUD had been provided this information by a doctor or pharmacist. For those who reported receiving education (excluding no and don't know responses), they received an average of 2.9 messages per respondent which was similar to the 2.7 messages received by participants in the YACS.



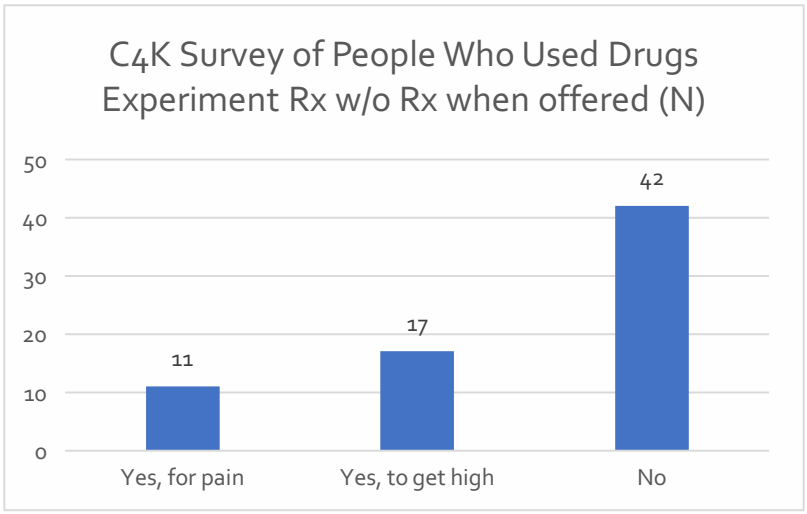
Safe storage of prescription opioids is a strategy to prevent diversion and misuse. This survey group has been prescribed a significant amount of opioids and often have acquaintances who continue to use drugs. Focus groups, with this population, indicated that there was a great deal of confusion about the appropriateness of purse or handbag and medicine cabinets as storage solutions. Respondents could select more than one option. Overall, they were most likely to endorse a locked cabinet or out of reach of children.



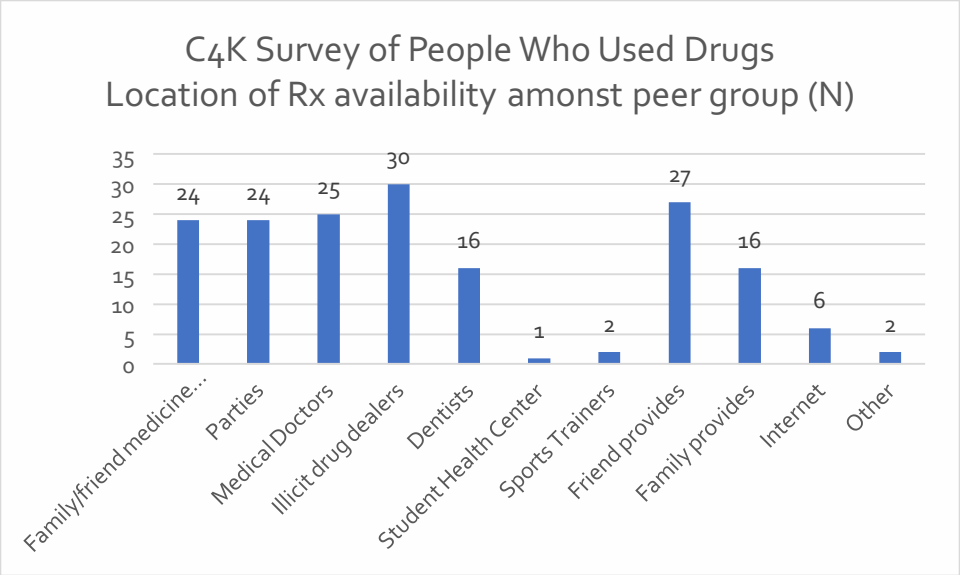
Safe disposal of prescription opioids is critical for preventing diversion and protecting our famous Kenai River. While 23% of the YACS reported never being prescribed opioids, only 5% of PUD had never had a prescription for opioids. It was not surprising that 42% (27 of 64) of respondents, with a history of addiction, reported not having leftover medication. Addiction is an inability to stop use so running out of medications is a frequent experience of this subgroup. In fact this group was almost twice as likely as the YACS to report no leftover medication. No clear preference stood out for the disposal options but a small number were sold. It is concerning that 9% of people with addiction still have prescription opioids in their possession.



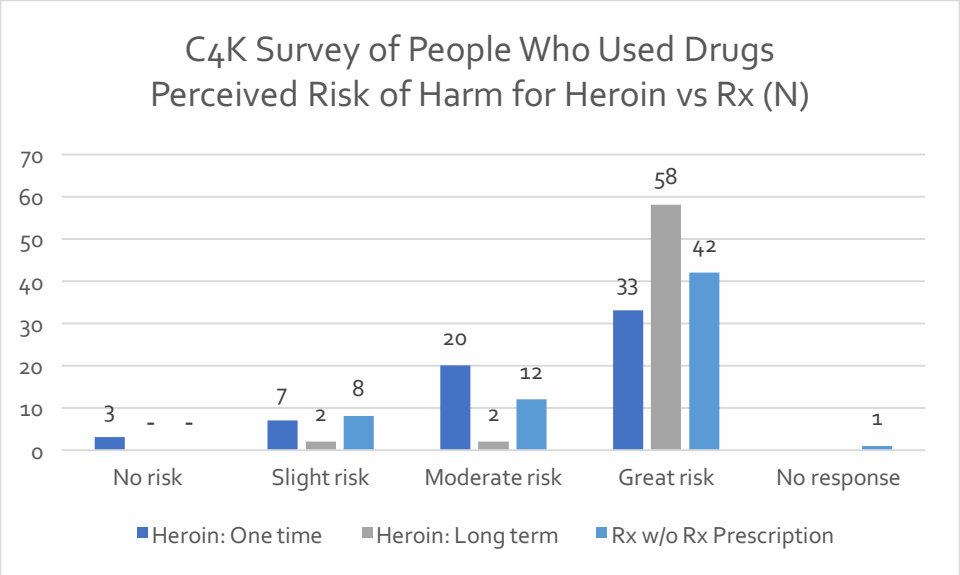
When asked if they would take prescription pain medication if offered to them by a friend or family member 66% of the sample reported they would not, 27% reported they would take them for pain, and 17% reported they would take them to get high.



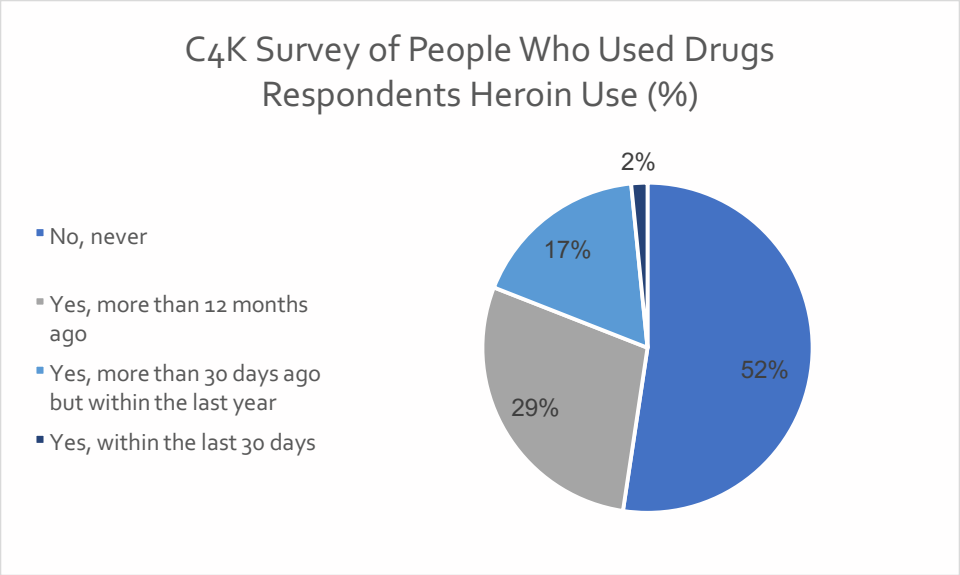
C4K was interested in the source of prescription opioids available for diversion. We were skeptical that doctors were the primary source for NMUPO and data supported this belief. Only 39% of PUD reported that doctors were a source of misused opioids. Primary identified sources of misused opioids were illicit drug dealers (47%) and friends (42%), with doctor rounding out the top three. Other significant sources were parties, medicine cabinets of friends and family, family providers, or dentists. Location from which opioids are obtained for misuse is also addressed later in this report under the intervening variables of social and retail availability.



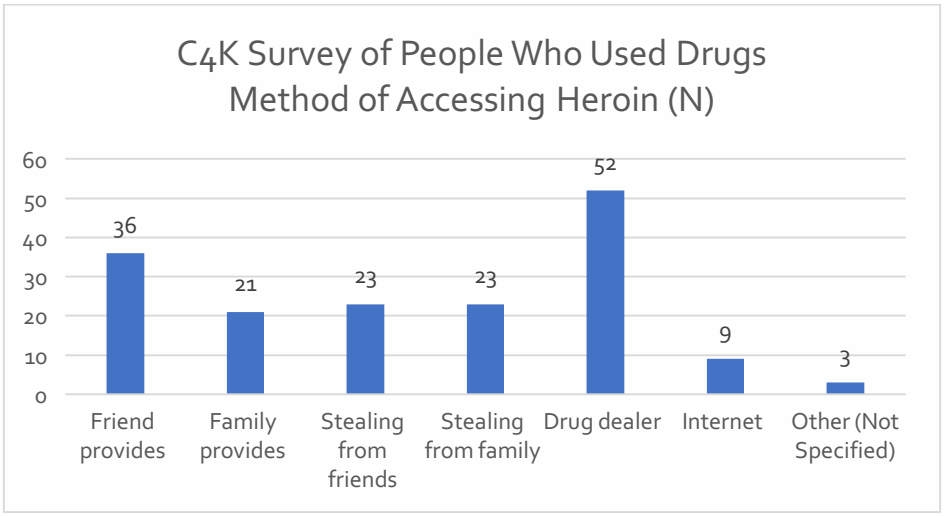
Respondents were asked to rate the risk of harm associated with prescription opioid misuse and heroin use both one time and long-term. The majority of respondents saw all three as of great risk but were more likely to consider prescription opioid misuse or one time heroin use as moderate or slight risk.



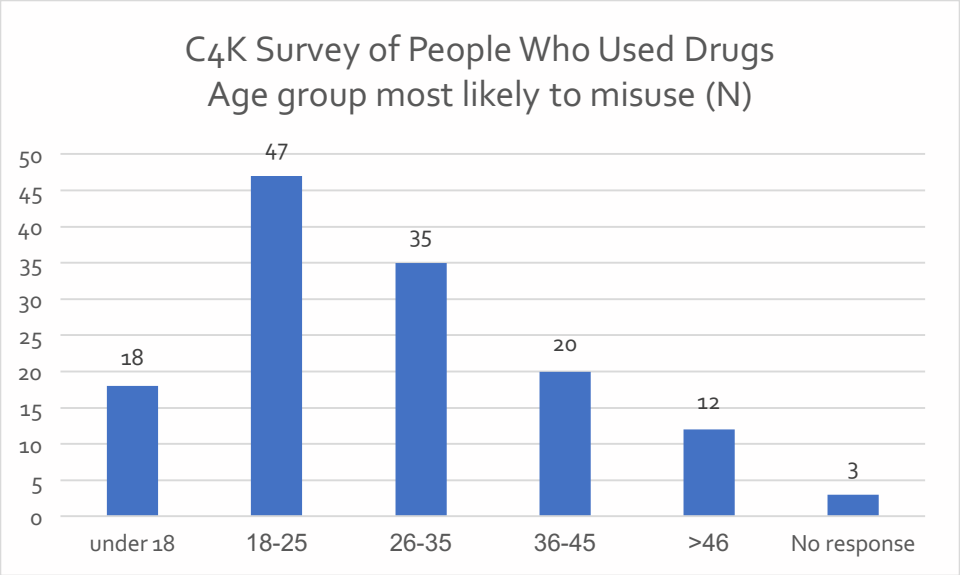
Fifty-two percent of the sample reported they had not used heroin. Two percent used in the past month, 17% used more than 30 days ago but in the past year, and 29% used more than one year ago. Percentage rates were similar across opioids with 45% of this sample reporting NMUPO and 48% reporting heroin use. It is likely that a large percentage of persons used both types of opioids with smaller subsections having used only NMUPO or heroin but not both.



All PUD participants responded to this item (even if they had not reported personal use of heroin) asking about locations or methods for accessing heroin. Drug dealers were seen as the most likely sources with 81% selecting this option. Remaining options were 56% friend providers, 36% stealing from family or friends, 33% family provides, 14% internet, and 5% other.



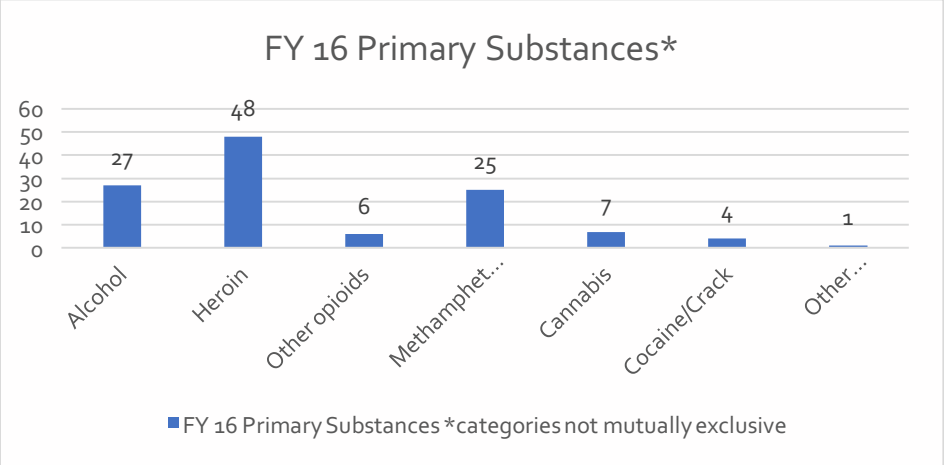
Based on their own experiences, respondents were asked to select which age group they believe is most likely to misuse opioids. Many respondents selected more than one age category so data has been analyzed to show the total percentage of the sample selecting each age category. Seventy-three percent of respondents selected 18-25 year olds as the age group most likely to misuse opioids. Fifty-five percent selected 26-35, 31% selected 36-45 years old, 28% selected under 18 years old, and 19% selected over 46 years old.



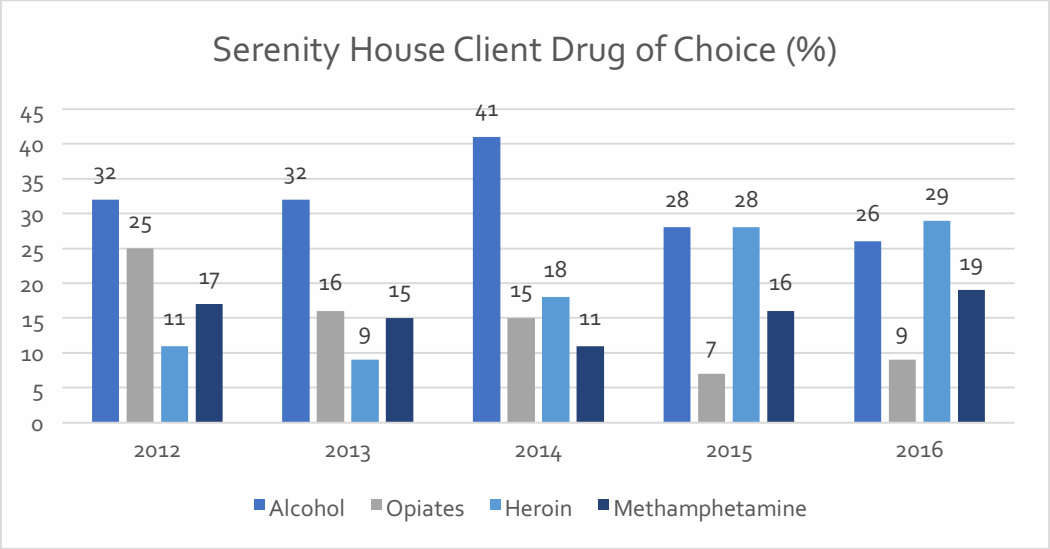
Substantial consistent information was collected across the samples of PUD and the YACS. C4K was interested in collecting data directly from PUD because the amount of YACS participants with any type of drug exposure was extremely limited. While there are small differences between the responses of the two groups, their convergence strengthens any findings derived from either survey alone. Specific overlap and disagreement is further discussed under the section for intervening variables.

PEOPLE WITH ADDICTIONS

Our primary data source for adult substance use is the Alaska Automated Information Management System (AKAIMS). This system allows us to track drug of choice for all admissions to Serenity House Treatment Center (SHTC).

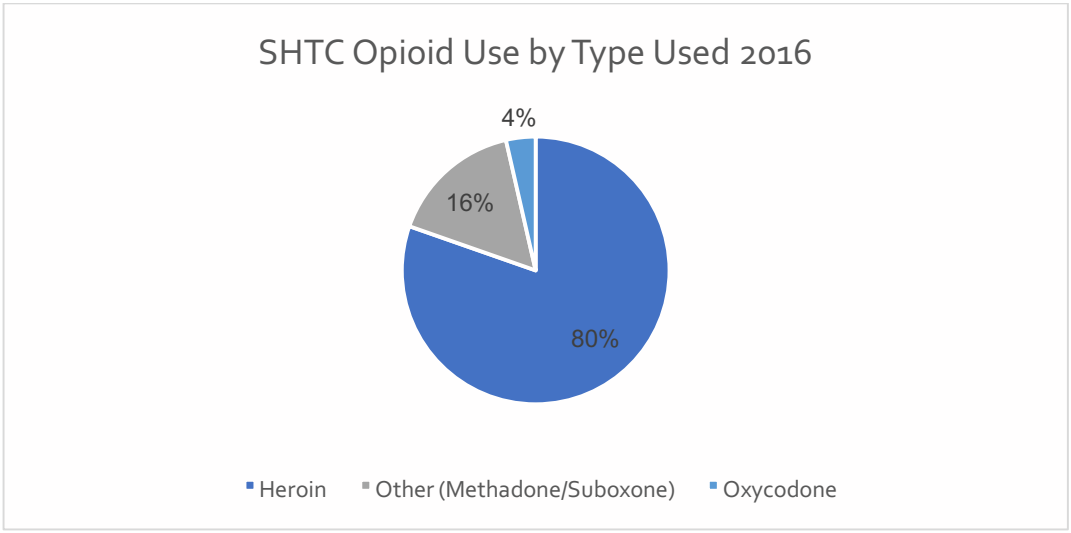


2016 data shows that heroin surpassed alcohol as a primary drug used by residential treatment admissions. Primary substances is a data entry field that records all substances for which the patient meets criteria for addiction. Drug of choice is a data entry field that tracks the one substance the patient indicates they prefer to use. Heroin also surpassed alcohol as drug of choice in 2016. Data from 2015 and the preceding decade show alcohol as the most commonly used primary substance and drug of choice.



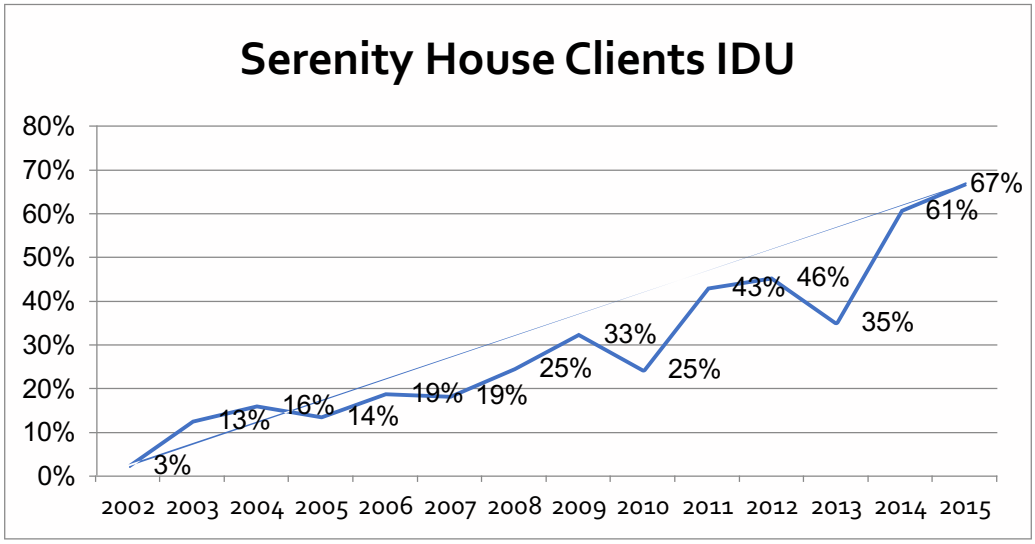
Heroin surpassed alcohol as "drug of choice" after a steady rise in prevalence that can be tracked over the past five years. This trend is paralleled by state data. The Division of Public Health reported that drug abuse treatment admissions, between the ages of 21-29 years old, reporting heroin as their drug of choice, increased by 74% between the reporting years 2009-2010 and 2012-2013.

Referencing the above figure, AKAIMS has multiple forced choice categories for tracking drugs of abuse. Prescription opioids could be counted in multiple categories (other opiates/synthetics, oxycodone, oxycontin) and the absence of a category specifically dedicated to measuring prescription opioid abuse may result in under reporting of the problem. Of the 54 clients reporting opioids as their drug of choice, only 20% are entered into a category that could represent prescription opioids and 80% indicate heroin use.



Injection drug use rates have also been rising in response to the heroin epidemic. Injection drug use is correlated with heroin use. Injection drug use rates among treatment center admissions are graphed below.

Over the past decade we have seen a 2166% (two thousand one hundred and sixty-six percent) increase in the rate of injection drug use with the fastest increases seen in the past 5 years.



Looking back to 2003 we see almost no opioid use amongst our population. In 2001, the Joint Commission on Health Care Accreditation implemented new standards for the management of pain in health care environments (physical-therapy.advancedweb.com). Pain was to be viewed as a vital sign and treated aggressively, with opioid medications. Alaska tends to lag behind the rest of the country but by 2005 we begin to see a substantial increase in Treatment Center admissions being diagnosed with Opioid Dependence. In 2007, the Kenai Peninsula responded to this growing problem and formed a coalition; Healthy Communities, Healthy People. Amongst other issues, this group focused on changing prescribing patterns of physicians and encouraged physicians to utilize pain contracts. Treatment Center admissions show the result, dropping numbers of diagnoses resulting from prescription medication use and increasing numbers of diagnoses for heroin dependence. As prescription drugs became scarcer, heroin came in to fill the gap.

Efforts to prevent prescription drug diversion had a very serious unintended consequence. When dependent users were unable to find prescription pain medication they switched addictions to heroin. By the time efforts were made to decrease the diversion of prescription medications, those medications had come to replace the role of marijuana as a "gateway drug", leading to more serious addictions. Prescription pain medication had become so readily available that prescriptions were more likely than marijuana to be the first illegal drug our youth used. The hole left by vanishing prescription drugs was financially very viable and gave rise to a lucrative heroin trade. Reflecting back only five years, our typical admission to residential treatment was someone who began use on prescription pain medications and transitioned to heroin use when those medications became harder to find. This is no longer the case and it is now a myth that heroin use results from prescription opioid use.

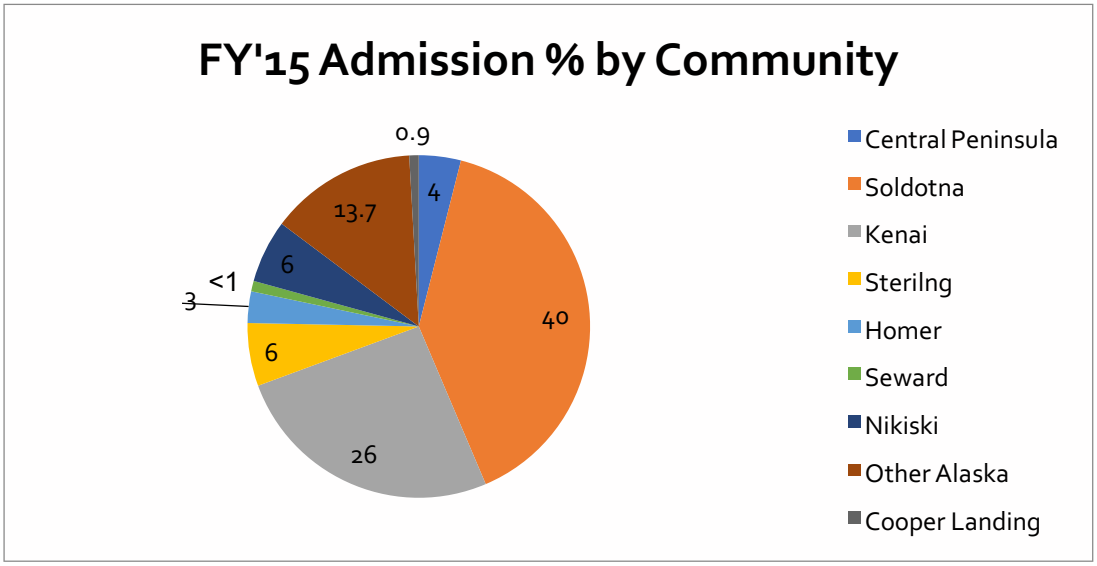
Most newly admitted heroin users did not turn to heroin when unable to find prescription medications. They initiated drug use with heroin; heroin replaced opioid pain medications entirely. Unfortunately, heroin has a number of aspects which make it more dangerous than prescription drugs. It is not labeled for dosage and can vary greatly in potency-increasing risks of overdose. Heroin is more readily paired with injection use. Heroin comes with a higher price tag and stronger withdrawal symptoms which drives users to injection use much faster. While our typical admission for treatment of injection pain medication had been using for at least 1 ½ years before injecting, we find many heroin users began injecting within 6 months of initial use of the drug. Not only does heroin lend itself more readily to injection use but users are also increasingly drawn to injection use. The current generation of users perceives injection use as "cleaner'. They underestimate

the medical risk of injection use and are drawn toward use that leaves no residue in their sinuses or lungs and no unpleasant smell on clothing.

Data from Serenity House Treatment Center is somewhat limited in that it samples only individuals with addictions of severity requiring residential treatment. While the sample does not come from the entire population of people who use drugs, the data does concur with what is observed in our larger healthcare system, and at state and national levels.

KENAI PENINSULA DRUG USE

Drug use looks different based on your perspective and placement within our community. As for perspective, the major economic engines of this area have created the conditions for significant socioeconomic splitting, our population can be described of consisting of economic have and have-nots. Describing drug use by community is a bit more challenging. The Kenai Peninsula consists of a land mass larger than the state of Massachusetts, which is sparsely populated with several major population centers, all of which have their own strengths and challenges. In an effort to describe drug use across our communities, a look at the home community of Serenity House Treatment Center admissions provides some insight into the relative contributions of each community to the injection drug use problem and allows us to look at demographic differences among users based on their community of origin. Below is a pie chart outlining the home communities of the 234 individuals admitted to our treatment program in the fiscal year 2015. As is observed, the major population centers nearest the treatment center would be expected to contribute the greatest number of admissions. The utility of this graph assists us in describing our admissions not comparing the severity of the disease across communities.



There are differences in drug use behavior based on where you are coming from in our community. Through respondent interviews, we have been able to define the characteristics of drug use in each of our communities. While this describes the stereotypical users, we realize all types of addictive behavior occur in all locations.

SOLDOTNA: Soldotna holds the Central Peninsula Hospital, Kenai Peninsula Borough/School District headquarters, and Fred Meyers which are major employers. Proximity to medical providers created a major problem with diversion of Opioid pain medications in Soldotna. Community efforts, in 2005-2008, to

address safe prescribing policies made less opioids available and the vacuum was rapidly filled by Heroin. Users in this community tend to be younger (20-28 yo), and from middle to upper class families. Many grew up in the community, initiated drug use in high school, and are the first generation of their family to present with disabling addiction.

KENAI: Kenai has some sources of income generation, as well, but its major contribution to drug use comes from multiple apartment complexes which cater to low income. Many of these rentals are filled with addiction and are known drug trafficking locations. Addiction referrals from Kenai typically come from low SES families and are experiencing multigenerational addictions. These individuals often have left high school early due to family dysfunction and lack the life skills needed to live outside of the chaos of a using world.

STERLING: Sterling is a smaller community and it has no real city center or industry beyond small local shops and some tourist amenities. It has a significant amount of senior housing and housing that runs "off the grid". Less drug trafficking occurs in the Sterling area but high isolation often fuels alcoholism and marijuana use. Our typical addiction treatment referral from Sterling is middle age to older, accustomed to living in substandard housing, and primarily addicted to alcohol. The remoteness of Sterling makes compliance with outpatient treatment programs very difficult.

CENTRAL PENINSULA: This area is comprised of the small communities of Ninilchik, Anchor Point, Nikolaevsk, and Kasilof. This area is very diverse; it experiences high visitor traffic in the summer and is extremely slow in the winter months. Residents often use large amounts of alcohol and marijuana. Drug-wise the most notable aspect of this area is the portion between Anchor Point and Homer. This area has become a distribution center for homemade methamphetamine and opioids (including Heroin). Drugs are often trafficked to Homer from this area. It is close to the strong market demand of Homer and yet out of range of the Homer Police; being under Alaska State Trooper enforcement this area is known for low probability for consequences of use due to low numbers of Troopers available to patrol a huge area.

HOMER: Homer boasts a healthy fishing industry which results in individuals with large amounts of disposable income and long periods in between paydays. This feast and famine economic culture drives drug use to extravagance and when the money is depleted, use becomes a matter of desperation. The community identity is tied to being able to drink or use hard. Homer identifies itself as "A drinking town with a fishing problem". Substance abuse treatment referrals from Homer are typically people with variable income sources and a strong vein of independence. Hard drug use, young adult to middle age users are common, and they often are multigenerational users who grew up in the area.

NIKISKI: This area contains the major elements of the oil industry on the Peninsula. Nikiski boasts an anti-government or independent approach to life that can be highly permissive of drug use. The oil industry keeps the population in transition and the community has lots of unmonitored areas that promote drug trafficking. Permissibility, combined with variable income and transient population, sets the stage for severe addiction. Typically, addiction treatment referrals from this area are unemployed from the oilfield, unskilled labors that are used to making large incomes but lack the skills to generate income outside of the unique situation created by the oilfield's need for manpower. They tend to be middle age and have a long history of addiction which worsens to include injection drug use before they seek treatment.

SEWARD: We know that our referrals do not accurately reflect the needs of Seward. While technically on the Peninsula, Seward is closer to Anchorage and much of their population goes to Anchorage for services. The referrals we do get from Seward paint the picture of multigenerational poverty and use. Primary issues tend to be alcohol and methamphetamine use with opioid misuse occurring less frequently in Seward according to referral data and respondent interviews.

COOPER LANDING: This area has a small contribution to our treatment center census. It actually contains the communities of Cooper Landing and Moose. The referrals we receive from this area tend to be

middle age or older with a long history of alcohol misuse added to other drug use. The addiction is often fueled by the isolated nature of these communities.

OTHER ALASKA: This comprises off the Peninsula referrals received by the Treatment Center and proportionately represents the rest of Alaska with the largest group of referrals coming from Anchorage and The Valley while some referrals come from many of the remote villages. These referrals tend to be young adults with significant, and often injection, drug use issues.

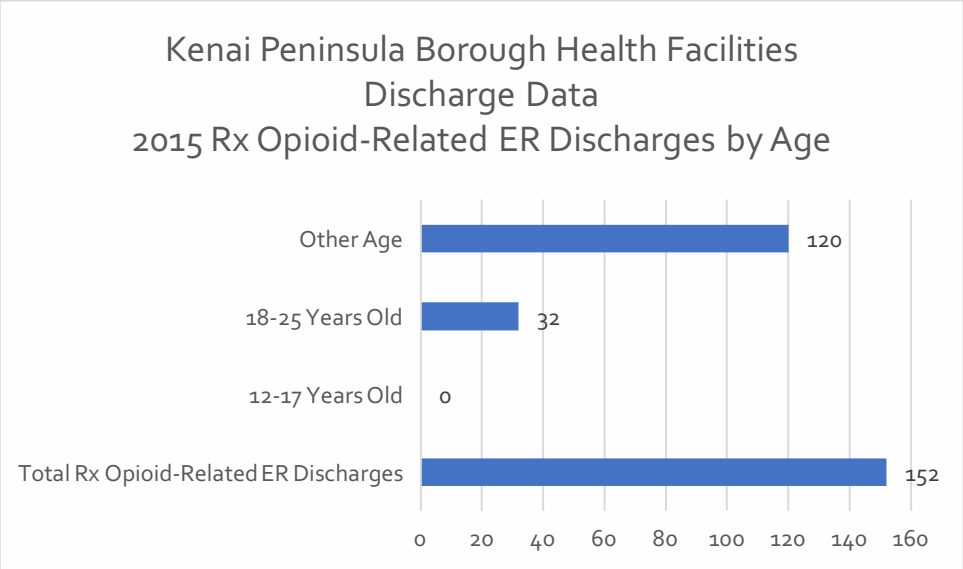
COMMUNITY IMPACT

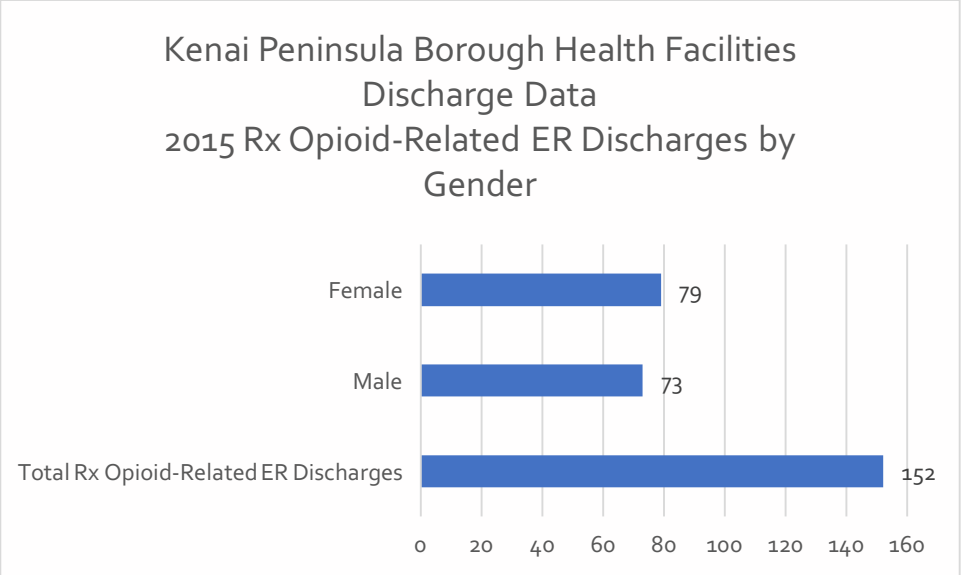
Serenity House Treatment Center is not the only place our community is feeling the pressure of the opioid epidemic. In fiscal year 2015 and estimated 1462 behavioral health patients were treated at Central Peninsula Hospital Emergency Department. This accounts for just over 9% of total emergency department visits and the largest diagnostic category was addictions (72% of total behavioral health visits). Of sampled patients completing urine drug screens, 38% were positive for an opioid. If extrapolated out to the entire population of ED visits with addiction this predicts 955 patients for the year with opioid use. Addictions complicated another 9% of total emergency department visits. These patients were being treated for a primary medical condition but also were intoxicated or treatment decisions were impacted by the presence of an ongoing addiction.

Change 4 the Kenai hopes to track the prevalence of addictions in primary medical clinics across the peninsula. Our efforts have been delayed by transitioning medical records systems and changes in administration at our local Federally Qualified Health Center. We believe this data is crucial in understanding the full scope of addiction severity within our community. Prescription Drug Monitoring efforts will provide data about the prescribing practices but not patient characteristic. We hypothesize that primary care settings are being called on to help an increasing number of patients withdraw from opioids, mange patients who present risk for drug diversion, and provide care to patients with medical conditions and complicating addictions.

Health facilities discharge data is outlined below. Notably this data did not map onto data obtained when full records review was conducted on our emergency department admissions. It shows overly low occurrence rates which are likely due to coding discrepancies, imprecise data collection methods, and low base rate of occurrences. This data may become more helpful as it is refined and gives trending information.

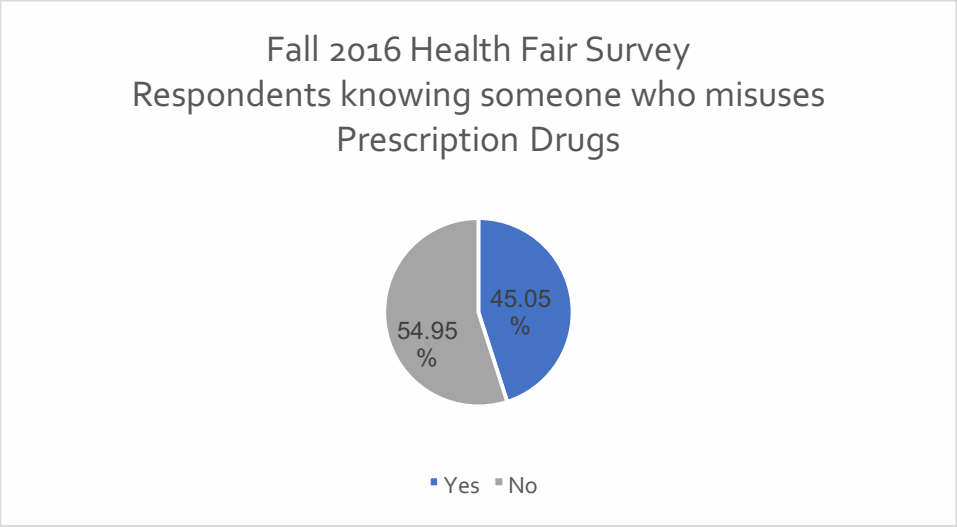
HEROIN-OPIOID RELATED ER DISCHARGES



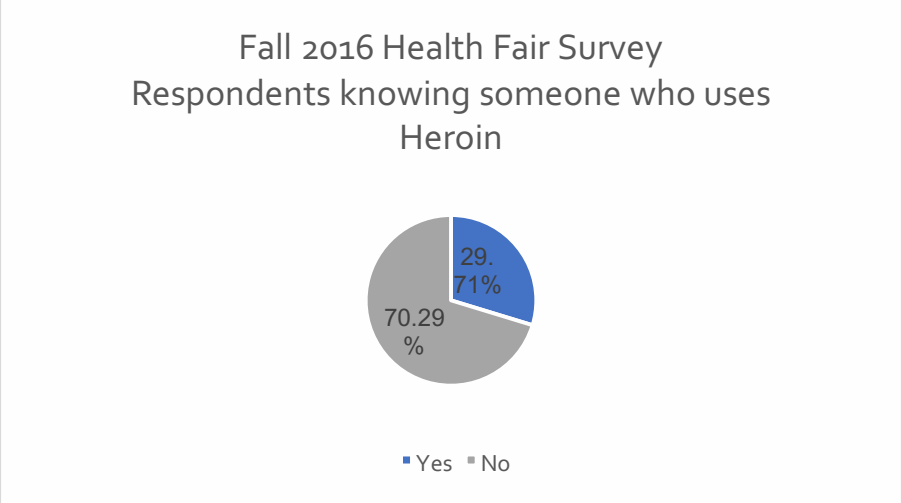


While prevalence data from health care settings is helpful, C4K was interested in the experiences of the general population. We surveyed participants at a two local health fairs, the Homeless Connect event, and released the survey over social media. 232 people completed survey questions (182 from combined health fairs and 50 from Homeless Connect) asking about familiarity with opioid addictions including knowledge of or connectivity to people who use drugs. Results are outlined below.

HEALTH FAIR DATA

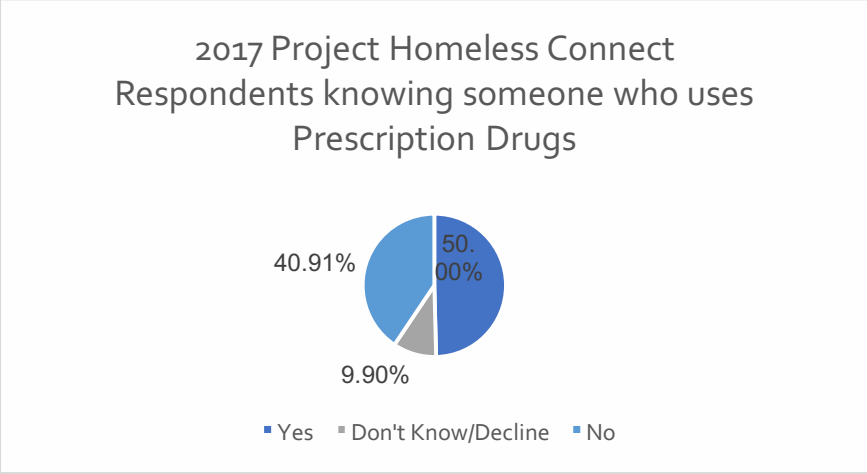


A shocking 45% of the Health fair respondents knew someone who misused prescription drugs and just under 30% knew someone who misused heroin.

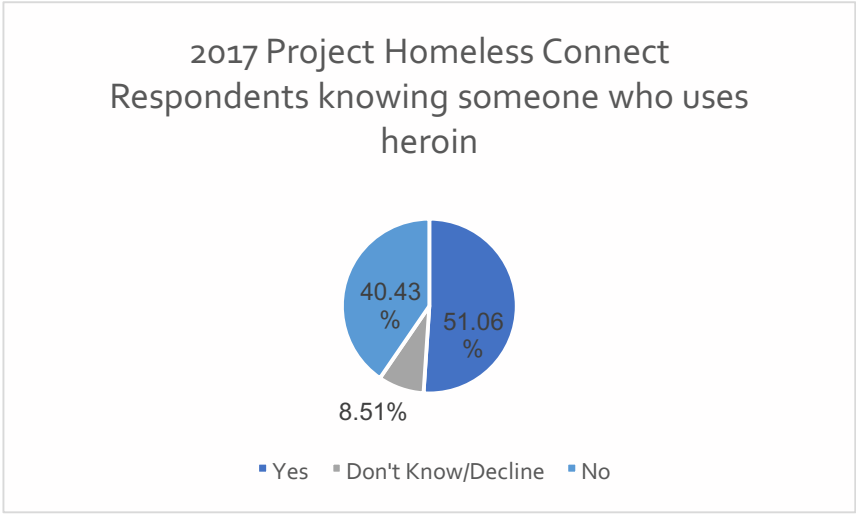


PROJECT HOMELESS CONNECT DATA

Project Homeless Connect is a yearly event that is designed to allow for counting of people in homeless situations in order to track homelessness and allow regions to apply for funding to support programs that address homelessness. Homeless people are invited to attend the event where they are given access to a majority of services they may benefit from all in one location. We anticipated this group would have more exposure than the general population to individuals who use drugs and that expected increase was observed.



Fifty percent of this subpopulation knew someone who misuses prescription drugs and 51%knew someone who misuses heroin. C4K was surprised to see more acknowledgement of heroin use than of prescription drug use but this matched the drug use profiles we saw when surveying individuals who use drugs.



Focus groups were conducted with first responders, counselors, nurse midwifes, business owners, and relatives of people who use substances. Groups universally identified that drug use is a growing problem in our community. Interestingly, many members brought up rising rates of methamphetamine use (this trend is also present in last 90- days of SHTC admissions) and the attractiveness of this drug in "end of the road"

settings where it can be manufactured. Participants also expressed changing morals; drug use becoming acceptable among youth and needle use becoming normalized instead of rare for using individuals.

It is difficult to track an exploding national problem and gain reporting consistency across measure of the problem. Additional State and National data could be helpful in determining prevalence but they are difficult to interpret in relation to each other. Many times, comparisons are made difficult by the combination of prescription opioids and heroin by one sources and the break out of the substances by another source. Date ranges, reporting year, age of respondents, and definition of use, abuse and addiction all make the convergence of data challenging.

EVALUATING RISK OF OPIOID MISUSE

In completing this assessment, the C4K team has watched countless podcasts and read everything from popular media to scientific papers on the opioid epidemic. These sources consistently describe a model of use that begins with someone going to a doctor for a legitimate injury, moves to abuse of prescription medication, and ends with injection drug use. We found this line of thinking problematic for many reasons. 1) When we looked through the case histories of individuals with heroin addiction, this did not match their drug use trajectories. In fact, only three of 141 admissions (76 with primary opioid addictions) in the past 24 months could even partially be mapped onto this model. 2) This model is heavily influenced by white privilege. While opioid use is up for all demographics, the group experiencing the greatest rate of increase is white, rural, young adults. It is more palatable to excuse the behavior of this group and create a faceless villain in "big pharma". 3) Referring to a national opioid epidemic assumes that NMUPO and heroin use are essentially the same problem seen on a spectrum of severity from opioid misuse to injection heroin use. They could be legitimate and separate trends in the larger picture of addiction, possibly even fueled by a third variable or variables. 4) We have solid knowledge about what "causes" addiction. Biological risk, Adverse Childhood Experiences (ACES), peers that use, and early initiation of substance use frequently beginning with use of alcohol or marijuana.

The majority of strategies currently proposed to address the opioid epidemic and stop the exploding death rates, which are often linked to heroin overdose, are dependent on the hypothesis that opioid dependence is a spectrum problem. It is assumed to begin with appropriate use of prescription medication, transition to misuse of prescription opioids, escalate to misuse of heroin when prescription opioids become hard to obtain, and transition to injection drug use as a product of increasing drug tolerance. We will refer to this as the spectrum model throughout the rest of this section. Prescriber education, prescription drug take back programs, and prescription drug monitoring programs are all dependent on the accuracy of this spectrum or progression process in order to impact opioid addiction…they all address supply of prescription opioids as a mechanism to end heroin addiction. If future data does not support the integrity of this model, substantial time will be lost in developing programs that truly turn the tide of opioid addiction and there is risk of substantial harm to medical patients and medical professionals as regulatory overreach impacts how care is delivered. C4K wanted to analyze this spectrum model of opioid addiction to determine the "degree of fit" this model holds.

Collecting data about NMUPO and heroin use created an opportunity to look at specific questions derived from the model discussed above. We determined that consumption patterns gave us the greatest amount of insight into the relationship between heroin and NMUPO.

EVALUATING RISK: CONSUMPTION PATTERNS

In order to look at consumption patterns, C4K analyzed drug use histories and urine drug screens from SHTC admissions. Fifty-four drug use histories were reviewed; lifetime use revealed 41% had used prescription opioids, 54% had used heroin, and 33% has used both prescription opioids and heroin. Alcohol and marijuana had a substantial role in opioid addiction. Data collection coded "age of first use" and it was possible for participants to have more than one first drug used if "age of first use" was recorded as the same for two drugs. Every participant identified alcohol and/or marijuana as their first drug used. Eighty-nine percent identified alcohol as the first drug they used, 50% identified marijuana, and 41% identified both alcohol and marijuana as first drug used. Age of first use ranged from 5-22 years with a median and mean equal to 13 years. First drug used by type of opioid used is outlined below.

Drug of choice	First use alcohol	First use marijuana	First use alcohol and marijuana
Rx opioids	91%	55%	50%
Heroin	90%	66%	55%

There are many ways to look at rates of opioid use in this population. You can look at rates of use of any type of opioid, use of specific opioids regardless of other drug use, rates of use of NMUPO and heroin, or each drug when the other is not present.

Used any opioid	Used heroin	Used NMUPO	Used Both Heroin and NMUPO	Used Heroin and not NMUPO	Used NMUPO and not Heroin
33 (61%)	29 (54%)	22 (41%)	18 (33%)	11 (20%)	4 (7%)

In this sample 11 patients reported using heroin and never having misused prescription pain medication, while only 4 had used NMUPO but not heroin. Most interesting are the 18 patients who used both prescription opioids and heroin. One third initiated use of prescription opioids and heroin simultaneously; the remaining two-thirds reported using prescription opioids first. Lag time between used of prescription opioids and heroin ranged from one year to 17 years with a mean of 4.6 years, median of 4 years, and most commonly occurring 1 year. Ultimately 12 of 33 (36%) opioid users follow the temporal pattern outlined in the spectrum hypothesis. That is they initiated use of NMUPO before heroin use. The remaining 64% do not fit this model.

Age of first use of an opioid was lower for prescription opioids with a range of 13-47 (M=21) years versus 16-40 (M=23) years for heroin. It is possible that those who used NMUPO before heroin simply used them first due to social availability. Looking at drug of choice for treatment admissions we see that there is a spike in NMUPO use in 2012-2013 followed by major upswings in heroin use. It may simply be that if a person started using prior to 2012-2013 they were able to obtain prescription opioids, if they continued using, the supply of NMUPO dried up and they transferred to heroin because it was what was available. If they initiated use later, they initiated with heroin use. Interestingly, for those with more than one year between

first use of NMUPO and heroin, all first use of NMUPO was before 2012 and 75% (8 of 10) began using heroin after 2012. The socially availability hypothesis does seem to explain their progression. Social availability does not explain use patterns for those with less than one year between use of NMUPO and heroin use or those with heroin use not preceded by NMUPO.

C4K also looked at urine drug screens on patients being admitted to SHTC. A total of 130 were completed by the CPH lab and 77 in the treatment center in 2016. The majority of these screens are negative as individuals are enrolled in a treatment program; however, 14 were positive for prescription opioids (oxycodone and methadone), 49 were positive for heroin, and only 4 were positive for both substances. A surprising trend was noted, patients screening positive for heroin were most likely to also test positive for methamphetamine. Fifty-eight percent of positive heroin screens also showed the presence of methamphetamine. This mimics data seen in most recent SHTC admissions; methamphetamine use is on the rise. Preliminary patient interviews attribute this rise to social availability of methamphetamine and methamphetamine's ability to counteract some of the long-term sedating impact of heroin. In this sample, methamphetamine use was a greater risk factor for heroin use than NMUPO.

Overall, part of our data is consistent with national trends which demonstrate that prescription opioid use is a risk factor for heroin use. Just over half of the heroin addicted patients we reviewed had a use pattern including prescription opioid use (18 of 29). However, detailed records review reveals that only two of this subset could be described as someone who developed addiction after an acute injury with legitimate opioid prescription that progressed to heroin use. Conversely, all could be said to begin addictive use with alcohol or marijuana. Social availability has moderately strong explanatory power for the consumption and progression of individuals with more than 12 months lag time between the development of NMUPO and heroin addiction. Additionally, concurrent methamphetamine use is a greater predictor of heroin use than concurrent NMUPO. Over one third of the heroin abusing patients in our sample denied ever having misused a prescription opioid and current use of heroin was most likely to be associated with methamphetamine use. Interviews with individuals who use drugs indicate that methamphetamine is frequently used to offset the unpleasant effect of too much heroin while NMUPO are used when heroin is not available to ward off withdrawal symptoms.

EVALUATING RISK: ENVIRONMENT

Adverse childhood experiences (ACES) have been correlated with many negative health outcomes including addictions. ACES scores of 4 or higher become substantial risk factors for behavioral health conditions. C4K reviewed intake assessments of 132 people with addictions to determine their exposure to ACES. Age range for people with addiction was 15-61 years with an average of 31 years. Twenty-five percent of the sample fell into the target range for prevention (18-25 years), supporting the value of preventative services before age 25. Fifty-seven percent of the sample was female and 43% were male. ACES Exposure rates for the people with addiction are outlined below and rates for the Kenai Peninsula and Statewide can be viewed at ibis.dhss.alaska.gov [calculated from the Behavior Risk Factor Surveillance System (BRFSS)]. The mean ACES score for people with addiction was 5.33 and is significantly higher than the Alaska ($x=2.08$) or the Kenai Peninsula ($x=2.11$) averages. A T-test was performed comparing the groups of people with addiction and the general population of the Kenai Peninsula $t(855)=130.55$, $p=.000$. There is a significant difference between the mean ACES scores for people with addiction and the general Kenai Peninsula. While this represents a quasi-experimental look at the issue, ACES scores and trauma histories are related to the phenomena of addiction.

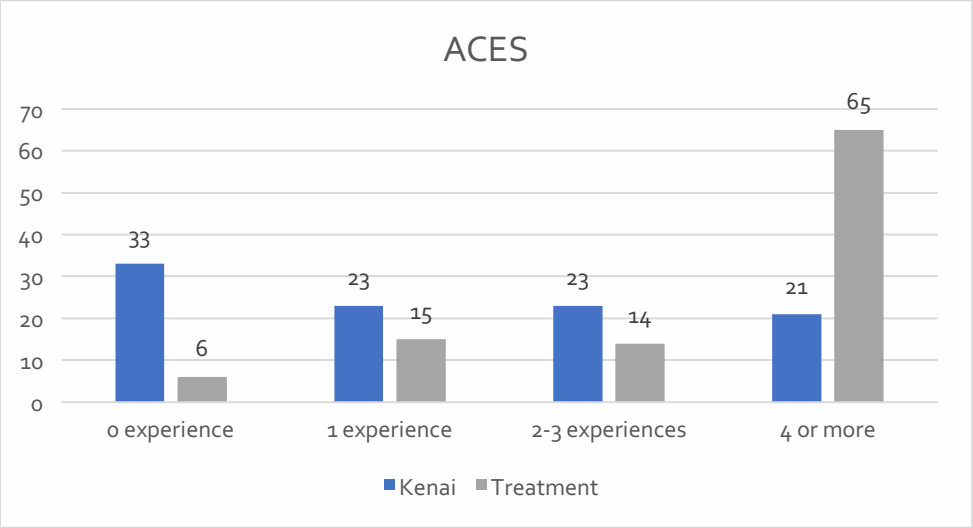
ACES SCORES FOR PEOPLE WITH ADDICTION

ACES category	Percentage of sample reporting exposure
Emotional neglect	23%
Emotional and verbal abuse	67%
Incarcerated household member	24%
Lived with someone who was mentally ill	47%
Parents divorced or separated	52%
Physical abuse	53%
Physical neglect	56%
Sexual abuse	37%
Substance abuse in household	68%
Witnessed abuse	52%
Total experiencing at least one ACES	94%

Fifty-four percent of the sample met criteria for Opioid Dependence, 14% for Amphetamine Dependence, and 32% for Alcohol Dependence. Additionally, 61% were injection drug issues and 38% were aware of their hepatitis C infection prior to high risk lifestyle counseling. Substance abuse in the household was the most commonly occurring ACES variable (68%) and the average ACES score for the subgroup with substance abuse in the household was 8.5 with 83% of the group scoring 4 or more. Being raised by a substance abusing parent creates a substantial risk for subsequent substance abuse in the next generation. Emotional neglect was the most infrequently occurring ACES variable (23%).

ACES * Location Crosstabulation					
			Location		Total
			Kenai	Treatment	
ACES	0 experience	Count	33	6	39
		Expected Count	19.5	19.5	39.0
	1 experiences	Count	23	15	38
		Expected Count	19.0	19.0	38.0
	2-3 experiences	Count	23	14	37
		Expected Count	18.5	18.5	37.0
	4 or more	Count	21	65	86
		Expected Count	43.0	43.0	86.0
Total		Count	100	100	200
		Expected Count	100.0	100.0	200.0

Chi-square was used to compare the observed frequencies of ACES scores between people with addictions and the general population of the Kenai Peninsula. For the purpose of comparison, categories were created for 0 experiences, 1 experience, 2-3 experiences, and 4 or more experiences. $\chi^2(3)= 45.077$, p=.000. This means that the observed frequencies of higher ACES scores among people with addictions are due to the underlying relationship between these variables and not a chance occurrence.



ACES scores are significantly higher for individuals with addiction as compared to the general population. This is consistent with past finding that ACES scores are positively correlated with adverse health outcomes.

CONSEQUENCES

CONSEQUENCES OF PRIORITY ISSUE

Our addiction treatment center is filled with opioid users and our emergency department, children's services and legal entities continually encounter the wreckage it creates. To prevent the adverse consequences of opioid use, we needed to define what said consequences are and identify the unique factors in our community that breakdown, creating environmental conditions which are ripe for the development of opioid addiction. C4K looked at the consequences of opioid use from two distinct angles. We looked at the direct impact of use on our community, families, and individual users and at the complicated issues that arise from use (infectious diseases, medical concerns, needle exposure, and law violations).

DIRECT IMPACT OF DRUG USE

COMMUNITY

The impact of opioid use in our communities is difficult to ignore. The National Institute on Drug Abuse (NIDA, 2014) estimates that drug abuse costs our society $193 billion dollars per year with $11-15 billion going toward health care (higher estimate generated by Office of National Drug Control Policy vs NIDA's lower estimate). Locally, escalations in drug arrests cover our local news sources and our local paper, The Kenai Peninsula Clarion, just completed a three-part series to educate or community on heroin use. Our mayor commissioned a Health Care Task Force to look at the heath needs of our Borough and develop a plan to meet those needs into the future. The most significant concern brought to our Task Force is the rising impact of drug use, specifically heroin use. The significance of this issue was forefront for family physicians, medical specialists, behavioral health care providers, and legal officials.

A preliminary look at Central Peninsula Hospital Emergency Department admissions provides data on the local community impact of untreated addiction. Eighteen percent of total admissions are for primary or secondary behavioral health diagnosis, most commonly addiction related. Those admissions generate an estimated $10 million dollars in medical claims, the majority of which become unpaid claims. This cost burden becomes the responsibility of the entire community.

The cost burden of medical care for addictions is outweighed by the legal and community annoyance facets of drug use. The price tag for drug related crime and social welfare is estimated at over $100 billion and rising faster than the growth of our general economy (Office of National Drug Control Policy, 2016). Nationally there are approximately 1.5 million arrests for illegal drug use accounting for approximately 15% of total arrests and nearly 80% of those arrests are for simple possession (Bureau of Justice Statistics). Simple possession arrests are often synonymous with arrests of users, not dealers and increasing possession arrests signals an increase in the amount of users and drug availability. The State Drug Enforcement Unit Annual Report (2015) shows that, in Alaska, 23% of drug arrests were for Heroin use. The most commonly diverted Rx narcotics are opioids, and together with Heroin, they account for the lion's share of intravenous drug use. In 2015, 233 Alaskans were arrested for heroin use and approximately 58% of the drugs seized were Heroin. The total street value of drugs seized in 2015 in Alaska was $4,320,861.00 and prescription drugs was $137,915.44. All of this is in addition to the social annoyance associated with the petty crime and community disruption caused by addiction. Walks through our local parks often uncover discarded drug paraphernalia, specifically discarded needles. The Nikiski Recreational District completed a fall clean-up of their recreational areas (parks, playgrounds, etc.) and this clean-up net 64 apparently used needles amongst other discarded drug paraphernalia (source: personal email, Public Health Nurse Sherra Prichard)

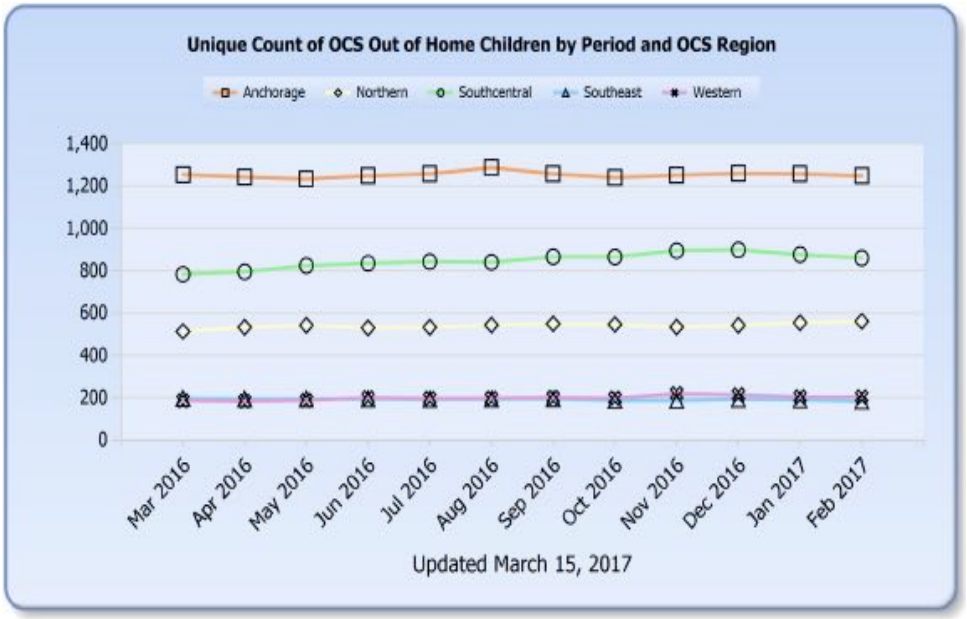
Local employers struggle to manage drug use amongst their workforce with many oilfield employers instating provisions to pay for addiction treatment and hold positions for any employee willing to seek treatment, as long as the employee turns themselves in before being caught at work with drugs or alcohol. Employer concerns are related to loss productivity due to drug related absence or poor performance, worker accidents resulting from intoxication, and worker disruption due to the use of a family member. The office

of Drug Control Policy (2004) estimated that in 2002 the societal cost from drug related illness topped $180 billion. Of this over $100 billion was from drug use related loss of worker productivity, this number was estimated to increase by 5.34% each year without intervention. We were unable to locate more timely data but this estimate would predict $160 billion in lost productivity in 2017.

FAMILY

The stigma of addiction touches all members of the family and drug addiction often results from a combination of heredity and environmental access to drugs. The National Center on Addiction and Substance Abuse at Columbia University estimates in 2005 that substance abuse is a factor in at least 70 percent of all reported cases of child maltreatment. Adults with substance use disorders are 2.7 times more likely to report abusive behavior and 4.2 times more likely to report neglectful behavior toward their children. Maltreated children of substance abusing parents are more likely to have poorer physical, intellectual, social and emotional outcomes and are at greater risk of developing substance abuse problems themselves (USDHHS, 2003). As many as two-thirds of individuals in treatment for drug abuse reported being abused as children (childhelp.org).

The multi-generational aspect of substance abuse results in a family's being hit generation after generation and entire native communities brought to their knees by addiction. Nearly 50% of the variability in the DSM IV diagnosis of addictive disorders is accounted for by heredity and this looks only at first degree relatives. The longer term generational impact is likely much greater. Children of individuals with addiction often follow their parents into the lifestyle of use or, are so appalled by parental use that they vow to never touch addictive substances. Unfortunately, this total abstinence often results in the next generation of their family being unprepared to manage the hereditary risk of addiction. In addition to hereditary risk, the children of individuals with addictive disorders suffer shame and embarrassment from their parents missing their school and social obligations or attending intoxicated. Our local Office of Children's Services estimates that parental drug use is responsible for 90% of cases in which children are ultimately removed from parental custody and placed for foster or adoptive care, terminating family bonds (conversation with Bill Galic, prior supervisor of Kenai Office of Children's Services). The table below highlights the growing number of youth in foster placements. The observed rise in foster care placements is correlated with increasing numbers of injection drug users.



Assuming that drug use is responsible for the largest percentage of placements, its impact on the disruption of childhood is of massive magnitude. All Adverse Childhood Experience (ACES) variables, associated with household dysfunctions (living with someone with addictions/mental illness, living with someone who went to jail, domestic violence, divorce), are elevated in the homes of youth whose parents use injection drugs. ACES scores, experiencing the above conditions combined with any type of abuse, is directly linked to adult health conditions and functioning (Alaska ACES).

INDIVIDUAL

Individuals experiencing addictive disorders are at higher risk for HIV, Hepatitis, and other infectious diseases. Injection drug use is responsible for approximately 10% of HIV cases; resulting in over 2,600 new cases of HIV per year (Aids.gov). However, nearly one-third of individuals with HIV have a history of injection drug use (Office of National Drug Control Policy, 2005). Hepatitis C (HCV) is a serious health concern, with up to 3.9 million people living with chronic hepatitis C infection in the United States (CDC, 2013). As of 2007, deaths associated with HCV have surpassed deaths associated with HIV in the U. S. CDC funded research (2013), began to report "similar findings across states: rising rates of hepatitis C infection among young injectors, both male and female, primarily White, found in suburban and rural settings, who started prescription opioid use (e.g., oxycodone) before transitioning to heroin injection" (p. 5). This defines the type of addiction this project endeavors to prevent.

In addition to infectious disease, addiction often causes secondary disease due to damage to organs or body systems (cardiovascular, respiratory, liver disease, neurological). The most common medical concerns at our hospital, associated with injection drug use, are endocarditis and injection site abscesses. Endocarditis can often require up to three months of hospital based antibiotic therapies administered at great burden to the health care system. People with addiction are also much more likely to suffer from other mental health issues such as depression, anxiety, and psychosis. Studies shows that at least one third of addiction patients also have at least one additional mental health issue (mentalhealthtreatment.net) and review of past admissions at Serenity House Treatment Center place that estimate much closer to two-thirds. Addiction is the root cause of preventable birth defects, including Fetal Alcohol Syndrome and many other birth complications linked to neonatal abstinence syndromes. Opioid users are often unable to safely stop use of the drug during pregnancy due to the high risk of fetal demise associated with withdrawal. These women are often maintained on methadone through special programs but when those projects are full; they remain dependent on street drugs for the duration of the pregnancy. Finally, persons with addiction are much more likely to lose their lives than individuals without addictive disorders. One in four deaths is attributable to addictions and addiction stands as the greatest contributor to preventable death in our country (NIDA, 2015).

Our choice to highlight the medical consequences of opioid use for the individual is in no way intended to minimize the significance of the legal, occupational, and family consequences they endure. As described in the preceding sections, the legal implications of drug use bring a terrible burden on our communities, but that burden is even more significant for the individual users. As long as we continue to look at addiction as a legal issue, instead of recognizing it is a health issue, we will continue to operate a costly, inefficient, revolving door legal system. We will also continue to deal with the multigenerational trauma created by untreated addiction.

ISSUE BASED IMPACT OF DRUG USE

POTENTIAL MEDICAL COMPLICATIONS OF IV DRUG USE

Data collection is remarkably difficult for medical consequences of opioid drug use. Differences in hospital based diagnosis and coding result in difficulties identifying an exhaustive list of cases even when reviewing complete hospital records. Additionally, fatalities are often not taken to hospitals and cause of death is not

linked to drug use but respiratory or cardiac failure. Tracking hospital visit resulting from drug use is equally challenging. C4K reviewed 25% of Emergency Department contact on FY 2015. One quarter of dates were randomly selected from each fiscal quarter and all visits on the selected day were review. Overall, 9% of visits were for a primary behavioral health issue (i.e., panic attack, overdose, withdrawal) and another 9% involved behavioral health issues as a causal factor (i.e., abscess) or treatment complication (i.e., injury with intoxication). Regardless of the data challenges, the medical consequences of opioid use are relatively straightforward, particularly if the drugs are injected. The numerous possible health repercussions of using a syringe to inject substances are contagious disease, infections, overdose, and injury from impairment.

HEPATITIS C

According to the National Action Plan for Viral Hepatitis (2016), all Viral Hepatitis is responsible for 12,000-18,000 deaths per year. Beginning in 2007, death from HCV outpaced deaths from HIV. Hepatitis (HCV) is transmitted through blood exposure so IDU places one at significant risk of contracting the disease. IDU is directly responsible for 12% of HCV cases. Hepatitis can persist undetected for many years before manifesting as chronic liver disease, cirrhosis, or liver cancer (National Center for HIV, 2016). HCV thought to impact 3.2 million people living inside the United States; however, only 45% of infected person know their status. Not knowing their status could result in IDU passing the virus on more readily. Beginning in 2007, HCV was responsible for more deaths than the more highly recognized HIV epidemic.

The Alaska State Department of Epidemiology (2015) estimates that needle sharing results in at least 675 new cases of HCV in Alaska each year and is the primary driver in the rising HCV infection rates across the state (pictured Below). Tracking HCV infection is challenging in Alaska due to differences in screening practices and frankly, statewide insufficient resources for virus identification. In spite of real tracking issues, we know that the Gulf Coast Region of Alaska has the highest per capita infection rates in our state. Change 4 Kenai's target area falls squarely in this high risk region for HCV. Almost 24% of Alaska's HVC cases are in this region which only holds 11% of the state's population (population determined by Depart of Labor, 2016).

NUMBER OF ANNUAL REPORTED CASES OF HEPATITIS IN ALASKA

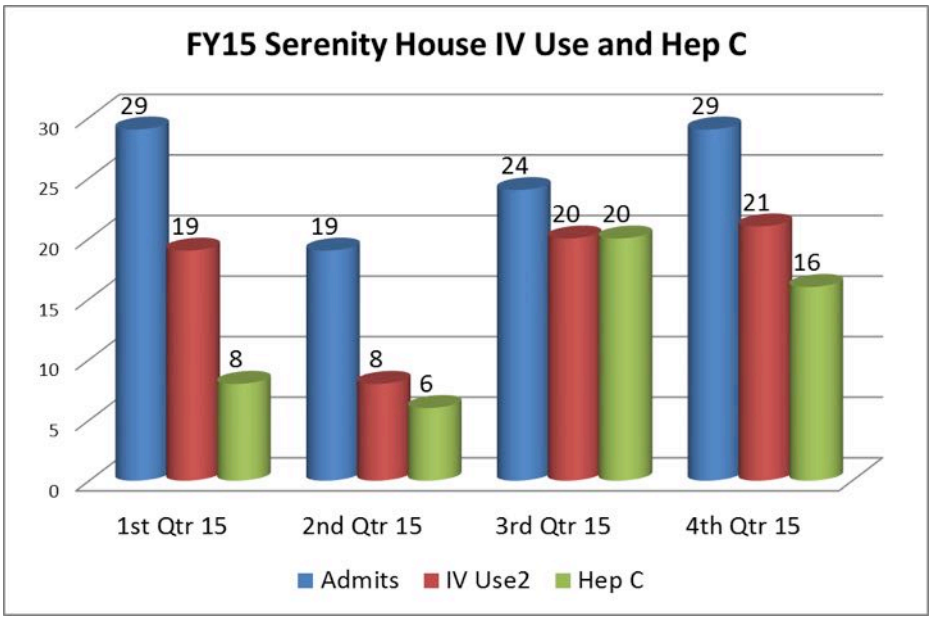
JANUARY 1, 2000 TO DECEMBER 31, 2015

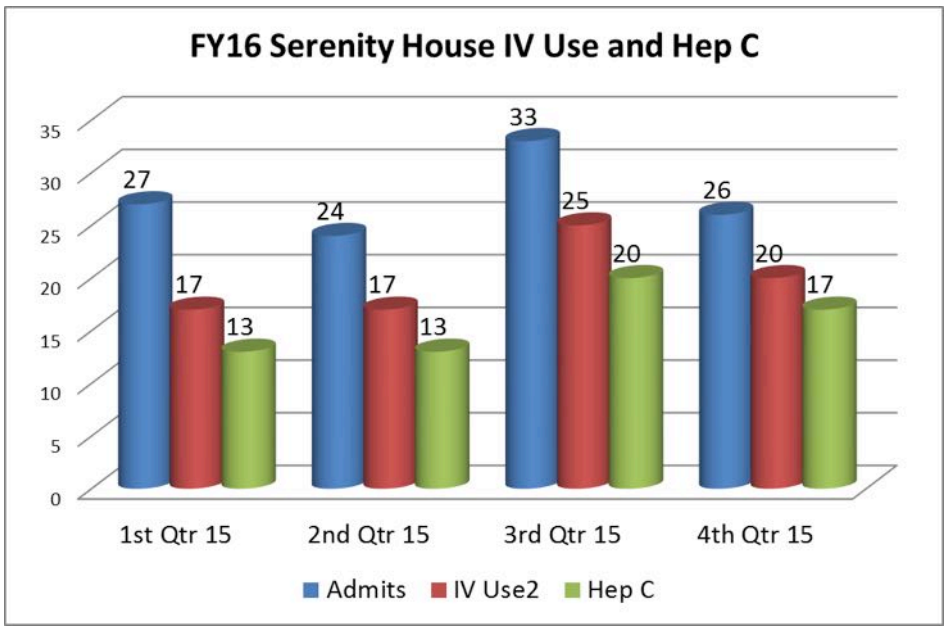
Year	Hepatitis A	Hepatitis B	Hepatitis C *
2015	4	3	1638
2014	1	3	1270
2013	1	1	1052
2012	1	1	1023
2011	2	3	1106
2010	5	5	609
2009	2	4	808
2008	5	11	1006
2007	5	8	1005
2006	2	9	1046
2005	4	8	982
2004	2	11	937
2003	8	8	829
2002	12	11	747
2001	13	9	746
2000	16	14	726

* Numbers for hepatitis C represent newly reported cases (acute and chronic) for each year. Case counts are provisional and subject to change.

HEPATITIS C BECAME REPORTABLE IN JANUARY 1996

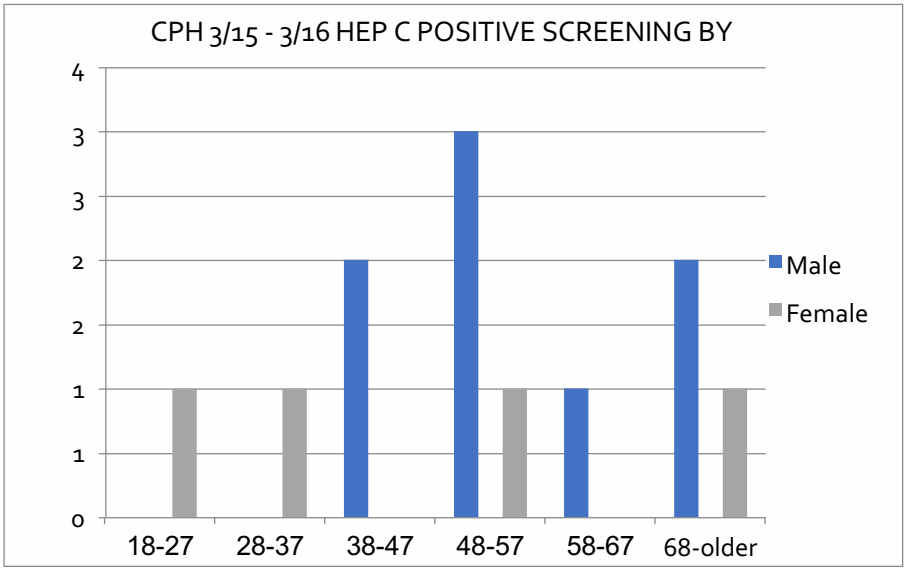
Alaska's Hepatitis C rates have more than doubled in the last 15 years and if we use state level data and population estimates to derive case rates for the Kenai Peninsula we estimate 286 new cases of hepatitis C in our community in 2014 with at least 118 of those cases resulting from injection drug use. This increase is clearly reflected in the experiences of our local residential addiction treatment center, Serenity House. Fifty seven percent of 2015 and forty nine percent in 2016 admission tested positive or were known to have hepatitis C. These positive cases follow the state trend with the majority of them falling in the 18 to 30-year-old age range (24% statewide).

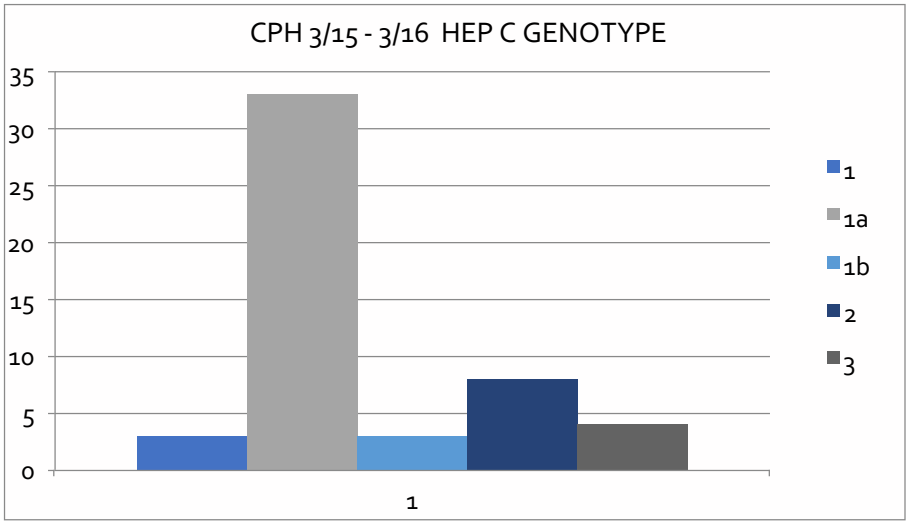




Central Peninsula Hospital is not the only local resource capable of testing (Medicenter, Denaina, Public Health, and Peninsula Community Health) for HCV and HIV, but as the community hospital we believe it conducts a majority for the testing. From March of 2015 to March of 2016, 252 screens were conducted and

23 were positive (new diagnosis). The primary referral source for testing was women preparing for childbirth and tests were done to protect the health of the infant. All available data suggests that the amount of testing conducted is insufficient to identify the number of affected individuals. While 23 new diagnoses were identified, 51 genotype screenings and 271 tests for viral loads were conducted for individuals who already knew they had the virus. Age parameters at diagnosis for infection are graphed below. The primary target age for this project falls below the average age for diagnosis but C4K believes the age at which people contract the disease is in the target age range.





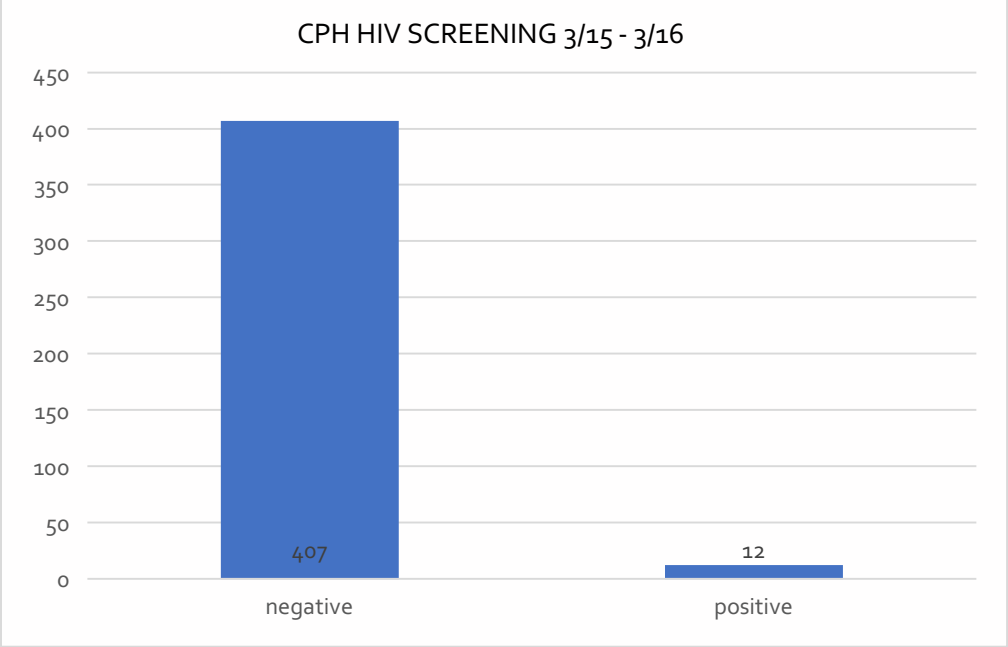
Three quarters of injection drug users who test positive for HIV are also co-infected with HCV.

HUMAN IMMUNODEFICIENCY VIRUS (HIV)

HIV is a virus spread through certain body fluids that attacks the body's immune system, specifically the CD4 cells, often called T cells. Over time, HIV can destroy so many of these cells that the body can't fight off infections and disease; resulting in loss of life from secondary disease (CDC, 2016). More than 1.2 million persons in the United States are living with HIV, and roughly 15% of those infected are unaware of their

status (State of Alaska, 2014). In 2014, an estimated 44,073 people were diagnosed with HIV and 45% of the new cases occurred in the southern states. HIV is not evenly distributed in our country; more cases occur in urban and southern areas. Alaska falls in the lowest infection rate category reported nationally, states with infection rates of 428.1-3,365.2 per 100,000 persons (CDC, 2016). In spite of our relatively low occurrence rate, Alaska cannot be lax with regard to HIV. Testing in Alaska is not ideal and HIV rates differ by region and ethnicity. Additionally, HIV comes with a high price tag. While the ultimate cost is loss of life, estimated yearly costs for medications alone range from $14,000 to $20,000 (cost Helper Health, 2016)

From January 1, 1982 through December 31, 2015, 1,680 cases of HIV were reported to the State of Alaska Section of Epidemiology (SOE) resulting in a statewide incidence rate of 5.7 cases per 100,000 persons (State of Alaska, 2015). Analysis of cases between 1982 and 2011 demonstrates that between 10-17% of HIV cases result directly from injection drug use (Alaska HIV Plan, 2016); however, this is likely a low estimate, injection drugs may be involved in additional cases but simply unreported. The available data also preceded the explosion of injection drug use in our communities; providing further evidence that 17% is an underestimate of the percentage of HIV cases resulting from injection drug use. HIV is unequally divided across men and women in Alaska with between 73-88% of the cases occurring in males. This is a direct consequence of the high infection risk amongst men who have sex with men. The average age at time of diagnosis falls in the range of 25-34, with nearly all cases diagnosed between 14 to 45. The large age gap is attributable to data instability resulting from the relatively low base rate of case occurrence. The Gulf Coast region of Alaska is home to 37 individuals living with HIV which is 5% of the state's cases. Central Peninsula Hospital performed 429 HIV screens resulting in 5 positive screens (table below). Sixteen individuals routinely come in for testing of viral loads. Keeping exposure rates low and preventing new case is a high priority of C4K's focus on decreasing the adverse impact of injection drug use.



ABSCESSES, CUTANEOUS INFECTIONS, SCARRING AND NEEDLE TRACKS

"Skin infections are extremely common in intravenous drug abusers, with 11% of intravenous drug users reporting at least one abscess within the past six months. One study estimated that up to 89 percent of injectable substances sold on the street are contaminated with at least one pathogen, often bacteria and fungi, with 61 percent of heroin samples containing 160-37,000 organisms per gram.

Contaminants in substances combined with generally non-sterile equipment and poor hygiene, increase the risk of a possible abscess or skin infection significantly. Sterilizing needles and cleaning the skin before injection can help reduce the possibility of an abscess forming, but these practices cannot prevent the effects of contaminants in the drugs themselves." (UCLA, 2016)

C4K was largely unsuccessful in identifying emergency department visits for drug related abscesses in a manner sufficient to lend itself to cumulative analysis. This is because abscesses occur in the human body for many reasons and searches by diagnosis "abscess" reveal far too many false positives. Abscesses are also commonly treated as an outpatient procedure or, frightening, treated by a senior member of the drug user's cohort. Four current Serenity House clients (out of 12) reported treatment of abscesses by a "friend" and sharing antibiotics with other users. As treatment involves lancing and packing this is a concerning trend. When they are treated in CPH's emergency department, it is commonly a user with multiple abscesses or an abscess they have been unsuccessful in treating on their own. Treatment provided varies from inpatient two week long stays for intravenous antibiotics to discharge with prescription for oral antibiotics and referral to wound care.

"It is estimated that more than three-quarters of intravenous drug users eventually develop scars in a vascular distribution, with more than half still displaying those scars even after more than five years of sobriety. "Pop scars," round- or oval-shaped permanent scars, are very common, and can stigmatize abusers for the rest of their lives" (UCLA, 2016).

ENDOCARDITIS

"Endocarditis, a condition characterized by inflammation of the interior lining of the heart, can occur from repeated intravenous drug use. Most drug users inject substances into veins that drain into the right side of the heart, and as a result, the right-sided heart valves can develop endocarditis. Bacteria from poorly sanitized needles can also lead to endocarditis. Left untreated, endocarditis can damage or destroy heart valves and can lead to life-threatening complications." UCLA, 2016).

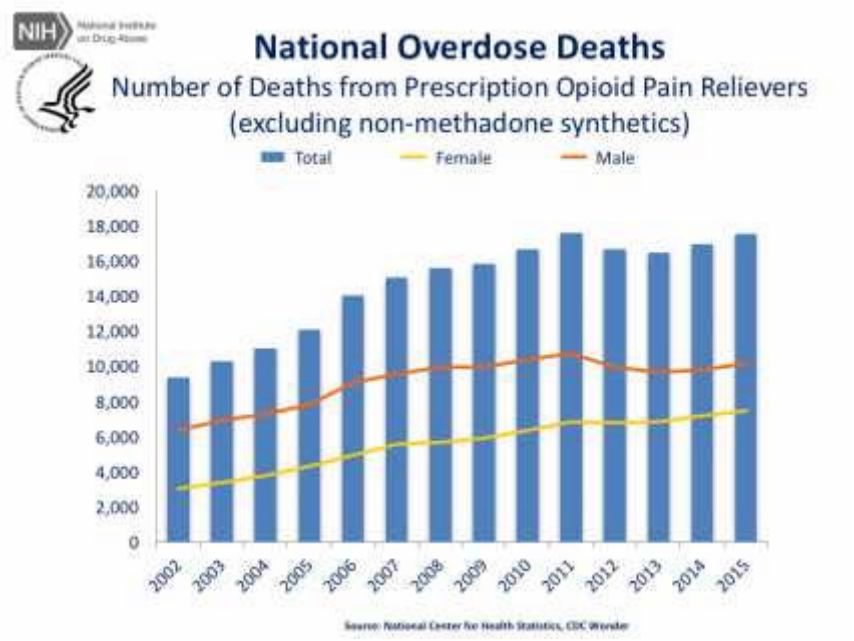
C4K was not able to develop an exhaustive list of endocarditis visits but did identify 4 Emergency visit related to this issue in the selected timeframe (FY 15). Cases received the following diagnosis: acute pyelonephritis, bacteria endocarditis, systemic inflammatory response syndrome, bacteremia, tachycardia, RLL pneumonia, septic endocarditis, congestive heart failure, and tricuspid valve vegetation. Coding differences and delays result from the diagnostic process and delay in growing cultures for diagnosis. In addition to culturing the bacteria, echocardiogram is needed for diagnosis and must be done inpatient. (C4K also attempted to search for cases by this procedure code but it is a widely-used procedure for all types of heart disease). For these identified cases treatment costs ranged from $64,455 to $416,515 and all four cases were uninsured patients and ultimately resulted in uncompensated care totaling $674,879.

OVERDOSE RISK

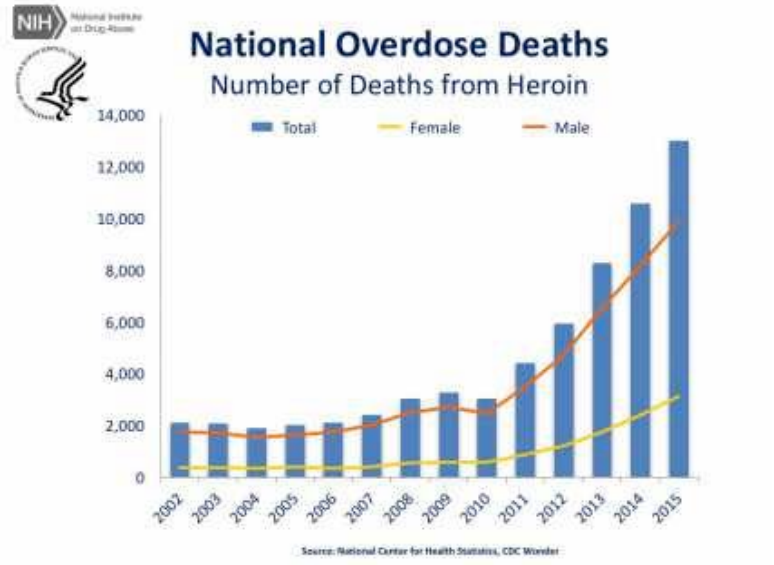
Opioids are often administered via injection and injection drug use greatly increases the risk of overdose as compared to other methods of drug administration. Injection users are unable to calculate their dose or do anything to mitigate the amount they used after injection. Drugs of unknown purity are injected directly into the blood stream and have a near immediate effect on the users. In comparison, smoking requires absorption into the blood through the lung tissue, snorting requires absorption through nasal tissue, ingesting requires absorption by the gut; all other means of use allow for the body to impact the rate of absorption and allows for some degree of dosing control. For example, food in the system slows the absorption of orally taken drugs and their impact can be mitigated by stomach pumping or introducing bonding agents to block absorption. Overdose most commonly occurs when users "step up" to injection use

and fail to adjust for the increased potency due to method of administration or underestimate the purity of the substance they are injecting.

Rising rates of injection drug use are the major contributor to the overall rising death rate among users. Injection drug use is most commonly linked to heroin, prescription opioids, and lesser so to methamphetamines. The National Institute of Health (NIH, 2017) provides us with pictorial representation of death rates amongst heroin and prescription opioid users.



National Overdose Deaths—Number of Deaths from Prescription Opioid Pain Relievers. The figure above is a bar chart showing the total number of U.S. overdose deaths involving opioid pain relievers from 2002 to 2015. The chart is overlaid by a line graph showing the number of deaths by females and males. From 2002 to 2015 there was a 3.4-fold increase in the total number of deaths.



National Overdose Deaths—Number of Deaths from Heroin. The figure above is a bar chart showing the total number of U.S. overdose deaths involving heroin from 2002 to 2015. The chart is overlaid by a line

graph showing the number of deaths by females and males. From 2002 to 2015 there was a 6-fold increase in the total number of deaths.

Alaska reports 14.5 drug induced deaths per 100,000 people compared to the national average of 12.9 per 100,000 people (State of Alaska, 2014). On the local scale, it is very difficult to track deaths from overdose. Overdose deaths are responded to by our local authorities and treated as a crime scene until cause of death is determined. Cause of death often does not specify "overdose" but references the body systems responsible for expiration. None of this data is available through our local hospital; deceased individuals go straight to mortuary or death investigation leaving no local hospital record. While unable to track deaths from overdose, C4K was able to track overdose events. Between March 30, 2014-March 31, 2015 there were 119 individuals treated for overdose at Central Peninsula Hospital's Emergency Department (note: individuals may be duplicated if they experienced more than one event). The past month, March 2016, there were nine cases of overdose; seven resulting from IV drug use and 3 suicide attempt (note: one event in both categories). Narcan was successfully used to resuscitate 7 of the cases which were linked to opioids and there were no fatalities. Alaska's recent decision to increase the availability of Narcan is likely to save the lives of many injection drug users (Juneau Empire, 2016).

INJURY RISK

Drug use impairs coordination and decision making; users are more likely to make impulsive choices which result in dangerous activity and coordination challenges from drug use make dangerous activities not typically seen as having risk.

According to the 2013 National Survey on Drug Use and Health (NSDUH), an estimated 9.9 million people aged 12 or older (or 3.8 percent of teens and adults) reported driving under the influence of illicit drugs during the year prior to being surveyed. The National Highway Traffic Safety Administration's (NHTSA's) 2013-2014 National Roadside Survey found that more than 22 percent of drivers tested positive for illegal, prescription, or over-the-counter drugs. NSDUH data also show that men are more likely than women to drive under the influence of drugs or alcohol and a higher percentage of young adults aged 18 to 25 drive after taking drugs or drinking than adults 26 or older (SAMHSA, 2014). A 2010 nationwide study of fatal crashes found that 46.5 percent of drivers who tested positive for drugs had used a prescription drug, 36.9 percent had used marijuana, and 9.8 percent had used cocaine. The most common prescription drugs found were (Wilson, 2010):

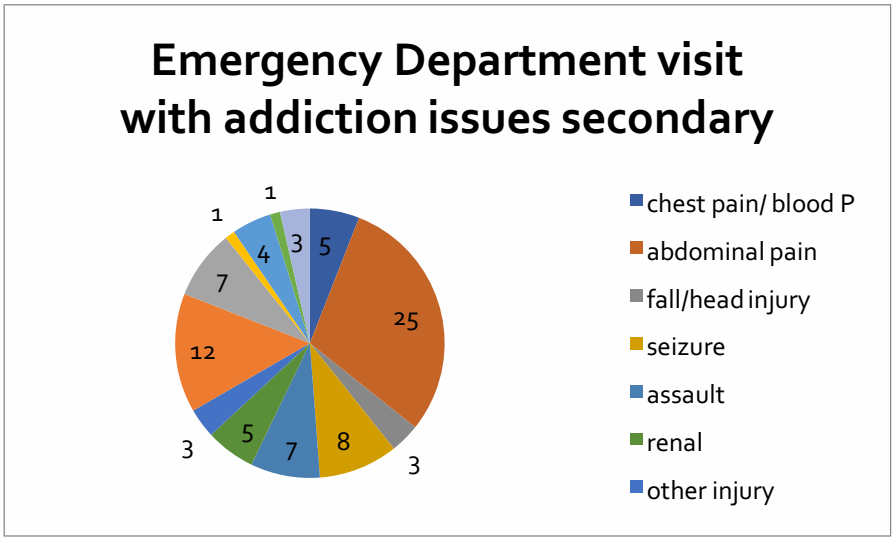
- alprazolam (Xanax®)—12.1 percent
- hydrocodone (Vicodin®)—11.1 percent
- oxycodone (OxyContin®)—10.2 percent
- diazepam (Valium®)—8.4 percent

In Alaska, we only have access to data for injury related to Alcohol use and are forced to draw conclusions about risk associated with opioid use or any drug use from the available data. The top five reasons Alaskan's are hospitalized due to alcohol related illness are outlined below.

TOP FIVE HOSPITALIZED INJURY CAUSES ASSOCIATED WITH ALCOHOL USE OCCURRENCE IN ALASKA, BY GENDER, ATR 2006-2010 *

Cause of Injury with Alcohol Male (N=3,701)	Cause of Injury with Alcohol Female (N=2,291)
Assault 890 (24%)	Suicide Attempt 964 (42%)
Falls 789 (21%)	Falls 520 (23%)
Suicide Attempt 615 (17%)	Assault 250 (11%)
Motor Vehicle 327 (9%)	Motor Vehicle 172 (8%)
All-Terrain Vehicle/Snow Machine 302 (8%)	Poisoning 83 (4%)

C4K reviewed Central Peninsula Hospital's Emergency Department admissions for FY 2015 and found that 9% of all admissions were for a medical issue but included a behavioral health condition as a contributing or confounding factor. Overall the primary presenting issue was abdominal pain, accounting for 25% of visits. While addiction issues appeared in the record, less than one quarter of visits were directly linked to use (head injury/fall, car accident, assault, orthopedic injury).



NEEDLE EXPOSURE

Opioids are often used intravenously and consequences of drug use can center on the needle itself. What risks do they carry? Where they come from and where the go after use? Needles are the vehicle for infectious disease transmission and if unclean, can introduce the bacteria which promote abscesses and systemic infections. When users cannot access clean needles they use them over and over again until they become too dull to puncture skin. The practice of bending the tip of used needle quickly gets abandoned when the supply of needles becomes short. Serenity House Treatment Center reports that they frequently intercept needles with which there has been an attempt to straighten for reuse. The more frequently needles are used and shared the more disease risk that becomes associated with each needle.

In addition to the damage needles do to users, needles become a community problem. C4K heard countless stories of families going out to enjoy local parks and encountering drug paraphernalia. Public Health has been partnering with city clean-up efforts to minimize the risk associated with encountering needles in our parking lots and parks. Clean-up volunteers are trained on how to safely dispose or needles and provided

sharps containers. Public Health remains on hand to remove anything volunteers are uncomfortable touching. Public Health Nurse, Sherra Prichard provided the following feedback from a clean-up event:

> *"The sharp containers came back around 3:30 for the celebration. The total number of sharps included approximately 39 needles and one razor blade. One community member stated "I didn't even believe I would be picking up anything today, and I filled the sharps container." She then thanked me for the opportunity to get the needles safely disposed. Another community member stated their club "went out yesterday also picked up approximately 25 more needles in the Nikiski community", she also reported that they did not have access to or know where to access proper sharps containers or how to dispose of them, unfortunately those sharps ended up in a glass bottle in the transfer facility. Many community members explained the significance of having the presence of public health nurse at this community function and the importance of awareness and protection of children and community members from environmental hazards in the Nikiski Community."*

Needle stick injuries are increasingly common. Local Adult Probation provided training to their officers to decrease the likelihood of needle stick and reported that this action was in response to three sticks that occurred during searches of parolees. Serenity House Treatment Center staff report being highly aware of the risk of needle stick when searching the belongings of new admissions. In ten year's they had one needle stick incident but seize needles much more frequently over the last 36 months. Local police have the risk of needle stick at the forefront of their minds when searching individuals for potential arrest.

Sadly, it seems that most needles float around in our community and spread disease until they ultimately make their way to unsafe disposal. Central Peninsula Hospital will provide sharps containers and will take back needles but this effort is predominately aimed at diabetic supplies and not actively advertised. The 4-As group in Anchorage reported taking back 2,917 needles from the Kenai Peninsula in FY 2015. Needles should ultimately be incinerated as medical waste and not disposed of in landfills. Incineration closes the risk of ongoing disease exposure while disease can remain active in a landfill.

Safe disposal of needles is directly tied to how needles are obtained. Communities that tightly regulate needle purchases seem to encounter more difficulty with re-used, shared, and poorly disposed of needles. Kenai has no options for needle exchange. C4K interviewed local pharmacies about their sale practices. The pharmacy survey report is included below.

LOCAL PHARMACY SURVEY REPORT

SURVEY CONDUCTED VIA IN-PERSON INTERVIEWS

There are seven local pharmacies, three in Kenai and four in Soldotna. Six are chain or box store pharmacies and one is a stand-alone locally owned pharmacy.

THREE BEAR'S – KENAI

Survey respondent – Pharmacist Huey

Three Bear's is an Alaskan based wholesale warehouse grocer. The pharmacy is managed and store policies are made by the pharmacist. They do not sell syringes without a prescription. Huey was very direct in his annoyance with drug addicts in our community. They have heightened security within the store to prevent theft from individuals believed to be in active addiction. They have not had a big problem with finding used syringes in the store or parking lot. The restrooms are not easily accessible and require employee guidance to access. Employees have not had any training on handling infectious waste.

SAFEWAY – KENAI

Survey respondent –Pharmacist Susan

Safeway pharmacy is inside the grocery store. The pharmacist is the manager and pharmacy policy is to not sell syringes without a prescription. Safeway does have sharps containers in the restrooms. These containers are frequently stolen or broken into. Syringes are found in the bathrooms and parking lots. The pharmacist was not aware of any special training given to employees about risk of infection from dirty syringes.

WALMART – KENAI

Survey Respondent – Pharmacy Tech Laura

Walmart is a franchise and the pharmacy is managed by franchise management. Walmart sells syringes in 10 packs or by the box of 100. They do not have a limit on purchases and do not require identification for purchase. Walmart has had a big problem with used syringes found in the store on the floor, in the bathroom, on shelves, and the parking lot. They have had numerous arrests made in the parking lot of injection drug users in the act of injecting. Laura estimated they sell 1000 syringes or more per week.

FRED MEYER – SOLDOTNA

Survey Respondent – Pharmacist Doug

Fred Meyer is a big box store. The pharmacy is managed by the pharmacist. They will sell syringes in 10 packs or by the box of 100. Until 2016 customers were required to provide state identification that was copied along with a 10 pack of the product purchasing. This photo copy was then signed and dated by the customer and faxed to the Soldotna Alaska State Trooper office. This was a deterrent from many customers completing the sale. Doug stated that the Troopers had asked them to do this and they had agreed and it was not policy. We are happy to report that following our interview the pharmacy changed this practice and no longer sends any information to law enforcement. Doug stated that they had some problems with finding used syringes in the store and parking lot. He went on to volunteer that Fred Meyer has a system in place that alerts when dispensing of narcotics exceeds a specific number. He stated that he had already been alerted that this location had exceeded the 35, 000 limit for Oxycodone by the 24th of the month. This number was based on quantity of pills dispensed and not specific dosage amounts.

SAFEWAY – SOLDOTNA

Survey Respondent - Pharmacist Susan

Safeway pharmacy is inside the grocery store. The pharmacist is the manager and pharmacy policy is to not sell syringes without a prescription. Safeway does have sharps containers in the restrooms. These containers are frequently stolen or broken into. Syringes are found in the bathrooms and parking lots. At this location a man was found dead due to overdose from drug injection in the public bathroom. The pharmacist was not aware of any special training given to employees about risk of infection from dirty syringes.

SOLDOTNA PROFESSIONAL PHARMACY – SOLDOTNA

Survey Respondent – Cashier

Soldotna Professional Pharmacy is locally owned stand-alone pharmacy. They do not sell syringes without a prescription and have signs posted letting customers know. They are a busy but small store. They have not had a big problem with syringes found in the store or parking lot. The amount of traffic and the location of this store contribute to the lack of waste found. They do sell sharps containers but do not dispose of waste.

WALGREENS- SOLDOTNA

Survey Respondent – Pharmacist Ian

Walgreens pharmacy opened approximately one year ago in our community. The pharmacist first response to the survey was "Our course I want clean product used in my community". Walgreens sells syringes without a prescription in 10 packs or boxes of 100. There is no limit on purchases. Identification is required to show proof of age over 18 years old. No copies of identification are taken or reported to any entity. They have not had any reported syringes found on the property. The parking lot was clean. I did not notice sharps containers in the restrooms. Ian reported they have regular customers that purchase syringes. He estimated sales of over 2000 syringes per week at this location.

C4K determined that there is substantial room for improvement in our community with regard to access to clean needles, secure storage of needles, safe needle practices, and needle disposal. Other than those needles collected by public health, incinerated by Central Peninsula Hospital, or returned over 150 miles to 4 As in Anchorage needles remain an active health risk for our entire community.

LEGAL IMPLICATIONS

C4K found that tracking the legal problems created by opioid use is challenging. Legal reporting is much more highly correlated with available police resource that it is with local drug activity. Trends are meaningless, as are month to month arrest rates, and cumulative arrest numbers. Legal data has flaws beyond inaccurate representation of local behavior; it is also greatly impacted by the court process and classifications of illegal behavior. Drug use is involved in many more legal matters than those which result in charges of possession or sales. Many property crimes and financial crimes are the direct result of the desperation of the drug users needing to get money to buy their next "fix". Violence and other assault charges often result from poor decision making and impulsivity due to drug use. C4K hoped to be able to identify drug use in the legal system through arrests in which drugs or alcohol is involved. While there is a data field on the dispatchers report for drug involvement, that field is not reliably filled in or easily accessible in a format that allows for tracking. Original charges poorly correlate with ultimate convictions due to the bargaining process. Conviction rates are reported as statewide data. Ultimately, C4K determined that the

most valuable data is the simple number of people involved with the justice system at each level (misdemeanor, felony, and in custody).

In Alaska, the Alaska Safety Action Program (ASAP) serves as an intermediary between the courts and treatment programs to ensure that offenders complete their required treatment. It functions like a misdemeanor probation services and most of its clients are on some type of informal probation. ASAP is operated by Akeela on the Kenai Peninsula. Akeela program administrator, Finnley McKenna is active on the C4K planning committee. Akeela reports that in 2016 they had 307 individuals under their supervision. Misdemeanor probation historically had little involvement with heroin use because the crimes associated with more extreme drug use were previously prosecuted at the felony level. Finnley reports she has observed a significant change with regard to the drug use patterns of new referrals. Injection drug use has become so prevalent and normalized that injection users are now commonly getting plea bargained down by the courts to misdemeanor charges. In fact, it is now so common for ASAP to receive referrals for injection drug users, they have started tracking them. Akeela reported that for FY 16, 32% of their referrals are confirmed drug users and 33% of those referrals are known to be injection drug users. Akeela cautions the interpretation of this data as they believe it far underestimates the degree of the problem.

Kenai has 411 people on felony probation, 116 women and 295 men. Six probation officers track all of these individuals, many of whom have high contact needs. In 2015, 54% of probationers statewide were re-incarcerated on petitions to revoke probation (PTRP). PTRP were for technical (no new crime) violations 72% of the time. These PTRPs are overwhelmingly for drug use.

In the last decade, Alaska's incarceration rates have grown 28% which is outpacing population growth fourfold. "Non-violent offenders, low-level drug, and property offenders are filling up Alaska's hard prison beds" (pg. 5, 2015 Recidivism Plan). According to the recidivism plan, this increase in the prison census results from four variables, 1) Increased numbers of un-sentenced offenders which are predominately incarcerated on 4th degree or C felony charges for misconduct involving a controlled substance. 2) Increases in the average length of incarceration. 3) Increased incarceration of non-violent offenders. These are typically class C felony drug crimes or drug crimes with a 47% increase in incarceration rates for felony drug offenses. These same offenders are serving longer sentences. 4) Increased probation violations resulting in re-institutionalization. Again, this increase is likely resulting from drug use. As of June 30, 2015, 427 individuals were housed at the Wildwood Correctional Complex. This number does not account for all of the Kenai Peninsula's incarcerated as Wildwood holds only presentence to medium custody inmates. Higher custody and inmates with longer sentences are typically housed in Alaska's other facilities or in Arizona. Notably, C4K received several but unconfirmed reports that the majority of our heroin is coming through distribution routes created when Kenai Peninsula inmates return from Arizona, where the drug is entering the US.

Whether looked at from a national, state or local level as misdemeanor, felony, or in custody it is clear that our drug policies focusing on corrections based consequences have failed. The "War on Drugs" started in the 80s has failed and left new management and tracking issues. C4K determined that legal reform is necessary and in process but outside of the scope of our current endeavor.

COMMUNITY FACTORS

COMMUNITY FACTORS

C4K worked with focus groups to identify and prioritize community factors that create unique circumstances which influence the intervening variables targeted by the Partnership for Success grant program (retail and social availability and knowledge of health risks). Social determinants of health were adapted from Healthy People 2020 and used as a guide for selecting community factors. Community factors were applied to each intervening variable and group participants selected the three community factors they believed have the biggest impact on each intervening variable.

Social Determinants of Health

- Economic stability
- Neighborhoods and built environments
- Health and healthcare
- Social and community context
- Education

Ultimately six community factors were identified. All six community factors are significant for all three intervening variables and both substances of abuse. In fact, their impact extends far beyond this issue if focus. C4K determined that the community factors were best described independent of the intervening variables and independent of heroin or NMUPO. Understanding the community factor is essential to understand how it impacts our local drug issues. Fracturing discussion of community factors across intervening variables lead to redundancy and made the report less clear for the reader. The following section defines these community factors and is the lead into discussion of intermediate or intervening variables.

ECONOMIC INSTABILITY AND COMMUNITY DISORGANIZATION PROVIDING REFUGE FOR ILLEGAL ACTS

This community factor is heavily based on the social determinants of *economic stability* and *neighborhood and built environments*. The Kenai Peninsula is highly invested in economic activities which are linked to natural resource production. These economic activities are vulnerable to rapid changes, resulting in continual boom and bust cycles on the Peninsula. The main industries are oil, fishing, tourism, and healthcare. Healthcare is the fastest growing, yet it faces an uncertain future due to larger political pressures. The oil industry has experienced incredible swings with 2 of the 4 major operating plants closing in the past 10 years. Oil industry growth is expected to slow but new development is also springing up; political uncertainty plagues this industry also. The commercial fishing harvest fell from a value of $54 million in 2011 to $39 million in 2013. Fishing closures, resulting from low numbers of King salmon, resulted in strong restrictions on fishing times and many long-term fishing families have been driven toward bankruptcy. An estimated 30,000 families rely on the personal use fisheries and these could also become at risk. Fishing closures also place pressure on sport fisherman which makes up a large percentage of the tourism trade. Further evidence of economic instability comes from Department of Labor (January 2017) unemployment rates at 6.5% while the national numbers are 4.8%. It is estimated that 7,500 Peninsula jobs are seasonal. Over the past three years, the unemployment rate has fallen an average of 3.7% each summer (comparison of January to June numbers) supporting the high rate of seasonal jobs. Only 70% of Kenai Peninsula workers reported being employed all four quarters in the past year. In addition to instability from unemployment and seasonal work, shift work adds instability to families. A large portion of Peninsula employees work away and work shifts such as two weeks on followed by two weeks off. While it is unclear exactly how many people work these types of shifts, we do know how many people are employed in the industries that frequently create these work patterns (4.8% natural resources, 6.3% construction, 20.3% utilities).

The sheer size of the Peninsula creates risk factor for becoming disconnected. It consists of 24,800 square miles and 16,000 square miles of land, it extends 150 miles into the Gulf. City planning is a major barrier to connection. Neither of the hub communities has an identifiable main street or city center for gathering. While the community of Kenai has 19 parks, multiple interviews with residents resulted in them being able to identify a maximum of five and average of three. When space exists, it is not well used or promoted. It is as if city planners looked at all this land and focused on keeping everything spread out without realizing the need to create shared spaces to have community. Transportation difficulties exacerbate the spread-out phenomena. One respondent reported, "never have I been, somewhere with so many places at the end of the road". Gravel pits and abandoned dwellings provide cover for parties and become "drug houses" where users congregate. Nikiski even has a homeless encampment that is built around drug use and known as "The Zoo". Similar encampments spring up seasonally, particularly near the canneries. Climate adds another layer of complexity. With average winter temperatures at high of 25 and low of 8 and only six hours of daylight in January it is hard to connect in outdoor spaces. Not only do communities not foster connection, community events are often not targeted at residents. For example, the Kenai Chamber of commerce has 22 activities on its calendar of events, 19 of those events occur during the tourist months of June, July and, August.

This community factor has the biggest impact on the social availability of both NMPOU and heroin and the perceived risk of harm associated with heroin use. Economic instability fuels the illegal drug trade. When money is short more people are willing to sell their prescription medications or fraudulently seek medications to sell. The value of all opioids is increased as the misery of a "bust" drives demand. The "boom" side of the cycle brings easy money and excesses, especially with illegal drugs like heroin. When drugs are viewed as an escape (bust cycle) or a reward (boom cycle) little focus is placed on the risks of use.

LACK OF ACCESS TO MEDICAL AND BEHAVIORAL HEALTH SERVICES

The Central Peninsula Hospital (CPH) Needs Assessment identified a trend for under- or uninsured patients to rely on the emergency department for routine medical care instead of accessing sliding fee scale services provided at our Federally Qualified Health Center. Mental health services are often requested in the Emergency Department even though they have no resources to meet these needs. Almost 10% of visits to the Emergency Department at Central Peninsula Hospital are for a primary behavioral health issue. While many factors drive this, it is clearly influenced by the lack of access to psychiatry. Wait times for Psychiatry visits can exceed three months and access to counselors is often out at least a month. The CPH Needs Assessment reported that 18% of respondents had no medical check-up or routine visit with a physician in the past two years. Sixteen percent of respondents reported having unmet medical needs and not seeking treatment due to cost. Additionally, 6.3% of respondents reported needing but not getting treatment for a mental health condition in the past year. A total of 51% of residents reported that they had some health problems or were not well. There are multiple primary care physicians in the community but most are not taking new patients or limiting Medicaid patients in their offices. Those clinics, that do serve Medicaid, experience multiple weeks wait times for new patients. While healthcare (including mental health) services are available, there may be barriers to under or uninsured patients accessing them. Not all individuals have access to care.

This community factors fell under the social determinant of *health and healthcare*. While we know quite a bit about the healthcare of the community, we struggled to find data about health. Health is not just the absence of illness. Health encompasses the way in which we live in our communities, the food we eat, exercise, and leisure. Health is impacted by livable spaces, access to locally grown food, and community events that build connection to our community and fellow residents. Kenai Peninsula communities tend to be spread out, isolated, and heavily reliant on outside goods which are barged or flown in. A Central Peninsula healthy food coalition, walkable spaces initiative, and Wednesday markets are all relatively new

health activities but they are heavily dependent on small groups of engaged and invested participants. Burn-out or relocation of key players could end these activities and without additional support they will not be disseminated across the Peninsula.

This community factor most strongly impacts the intervening variables of retail availability of NMPOU and perceived risk of harm from NMUPO. When community members with medical needs cannot access needed medical care, less medications are prescribed and patients do not receive education about the risks of using prescription pain medication.

INDEPENDENCE FOSTERING DISCONNECTION AND UNHEALTHY SOCIAL NORMS

This community factor defines our *social and community context*. Many people who live in Kenai were not born in Alaska, this result in disconnection from family and children growing up without the supports of extended family. For many people "church families" come to replace their original families filling some of the connectivity needs but others moved to the "end-of-the road" and do not invest in developing local connections. Not only do residents select "end-of-the road" living but 29% of residents actually live alone. Per the 2010-2015 Census, the Kenai Peninsula has 22,161 households; the number of non-family households with house owner living alone is 6,336 (3,712 males and 2,615 females).

This independent mindset does not value community. Failure to invest in community has consequences for the individual and the community. Community connectedness is essential for developing resiliency in times of hardship. It results from knowing your neighbor and being invested in each other's lives. Connectedness is often viewed in opposition to the independent, "end-of-the–road" approach to life many Alaskans highly value. Not reinvesting in community causes "communities" to become disconnected and lacking in the services people need to thrive. Many factors have led to our current state of disconnect. In researching this issue, it became clear that there has been a better sense of connectivity here in the past. It seems that we are just the wrong size for connectivity.

One respondent remarked that when the Peninsula (population) was a bit smaller, people seemed to know each other better and look out more for each other's children. People from larger communities readily identify that Kenai is missing the subgroups of people with shared interests that bring connection in larger communities. When those subgroups do develop, around areas such as children's sports, it is remarkable how drawn people are to those activities. The same can be said for community events; even though they are few, most community events have tremendous turnouts. It is as if without realizing its importance, people crave that connection. Technology plays an interesting role in this debate; some people believe it keeps them more connected while others believe it limits their connectivity. Regardless of the side you come down on, it is difficult to argue that digital connection is the same as in person connection. However, for people with family living at a distance it offers a means to connect.

The YRBS assesses social norms and gives us feedback into some of the risk factors unique to the Kenai Peninsula. Limited legal resources, popularizing high school athletes with drug issues, marijuana legalization, and parents using drugs created a norm of permissibility with regard substance use. YRBS data identified community risk factors of family and community norms that fail to reinforce pro-social activities but reinforce antisocial act. School counselor interviews revealed that drug use, even use of heroin is becoming normalized amongst our teens.

This community factor was identified to impact all three intervening variables linked to availability. Retail availability is impacted by the overarching cultural norms linked to immediate gratification and unwillingness to tolerate even minimal pain. NMPOU have become the expected manner of managing discomfort. The increasingly normative way we look at opioid use is impacting the social availability of NMUPO and heroin.

MULTIGENERATIONAL SUBSTANCE USE AND FAMILY DYSFUNCTION

While this community factor is also defined from the *social and community context* social determinant of health, C4K focus group participants felt it was distinctly different from the disconnection created by overreliance on independence and unhealthy social norms. Sixty-eight percent of the people with addictions entering our treatment center had experienced the ACES variable associated with growing up in a home with parents with addictions. This experience is extremely common among our youth. Social norms legitimize substance use and many parents see nothing wrong with using drugs in front of or even with their children. Focus groups discussed use among the family system and the socially normative aspects of growing up within an addiction household. Questions and responses were as follows: C4K, "What parental role modeling did you have growing up?" "When I turned 14 my dad gave me a bunch of cocaine and beer." "I knew that I was getting pot or other drugs for my birthday and Christmas since I was about 8 years old." "My parents were the first people I got high with." "I was afraid of the police growing up. I would cry if I saw a police car. My family never trusted the police. When I was in DARE at school I was so scared. My whole family has addiction."

Multi-generational substance abuse can be tracked through Serenity House admissions. Reviewing the 1032 unique individuals admitted to residential treatment at Serenity House from February 2001 to March 2016 we counted all the parent child relationships, sibling relationships and multigenerational relationships. Approximately 54 sibling groups, 118 related individuals, were known to Serenity House Treatment Center. This represented 11.43% of total admissions. There were 61 parent child relationships with both using, 6% of the admissions. Three of those 61 parent child relationships had both biological parents and at least on child admitted to Serenity House in the time frame. One multi-generational relationship occurred with a grandfather, his son, and two grandsons receiving treatment during this time period. It is likely that the true occurrence of family use is higher than reported due to "missed" relationships being absent from calculations.

This community factor was selected as one of the top three factors for social availability of NMUPO and perceived risk of NMPUO and heroin. Growing up with drug use creates knowledge of how to access and use drugs along with a tendency to underestimate the risk of using behavior.

ABUSE AND NEGLECT IMPACTING ABILITY TO TRANSMIT HEALTH INFORMATION

Notably this factor has substantial overlap with multigenerational substance abuse and family dysfunction. It differs because it is linked to the social determinant of *education*, whereas the preceding community factor is about *the social and community context*. The family is the primary vehicle for the transmission of social and cultural knowledge. While the previous factor focused on the impact of modeling and even initiating children into substance use, this factor focuses on the failure to pass on health knowledge. Complicating this, the guilt and shame children bear keeps them from speaking out as they seek to "protect" the family. When families become broken, children have to deal with the impact of abuse and neglect. They also miss out on important life skills and health education. It is difficult to determine what knowledge is being address by family but focus on health behaviors is often lacking for people who develop addictions. Families differ greatly with regard to their comfort in discussing the issues. Almost all of our recovery focus group members intended to educate their families about drug use and risks and tell their children about their use; however, most reported they have not had those discussions with their parents.

It seems that the incongruence of living in active addiction blocks transmission of information about what a healthy life should look like. Poor to no messaging about health behaviors sets children up for challenges in developing their own values and building skills for their life. When asked what could be done to address this,

one focus group member reported, "Awareness, it seems like people don't believe it until they are in it or see it. We need a national campaign like tobacco or teen pregnancy."

If families fail to transmit health knowledge, the responsibility falls to schools. Schools are often ill equipped to meet this need and the responsibility shifts to community. In some circumstances the law will step in to redirect someone's behavior but often it is peers that teach normative behavior. Many community members lack the skills needed to plan for and address their own health. Focus group members felt this community factor was most significant for the intervening variables of perceived risk of harm for NMUPO and heroin. There is often no mechanism for individuals to learn about the risks of use.

MEDICAL UNCERTAINTY AND INCONSISTENCIES LINKED TO CHANGING PROVIDER BEHAVIOR AND LAWS

Medical providers have been targeted as the "cause" of the opioid epidemic. Inarguably some physicians have overprescribed, sometimes out of a misguided desire to help and sometimes purely for profit motives. Provider behavior has been the focus of substantial scrutiny and this has led to improvements in care. Physicians have self-policed, protocols have been developed (medication contracts), and avoiding addiction has become a focus of care. Unfortunately, the ongoing pressure on providers has made it easier for them to simply opt out of treating pain patients. Pain patients are already struggling to find services and each time a provider leaves the community their pain patients are shunned by other providers simply because of the pressure involved in providing care to individuals with chronic pain.

While the number of providers willing to treat chronic pain is falling, the number of patients in pain is not. This may be a factor driving some toward addiction and is an extension of the problem seen with lack of access to care. Nationally this phenomenon is leading to adverse patient outcomes. Patients are hoarding medications expecting future scarcity. The stress of accessing care creates anxiety and depression; it is even linked to patient suicides (Pain News Network (PNN), 2017). Additional federal regulations are about to be implemented and the Prescription Drug Monitoring Program puts a substantial unfunded burden on providers. While these efforts may limit diversion of prescription opioids, they also create real limits on the services a group of voiceless patients rely on.

C4K focus group members identified this community factor as significant for the intervening variables of retail availability of NMUPO and social availability of heroin. When appropriate pain management is not available the retail availability of NMUPO drops and the market for socially available heroin becomes stronger. A strong market base drives more cartel activity ensuring a steady supply of opioids enters our community.

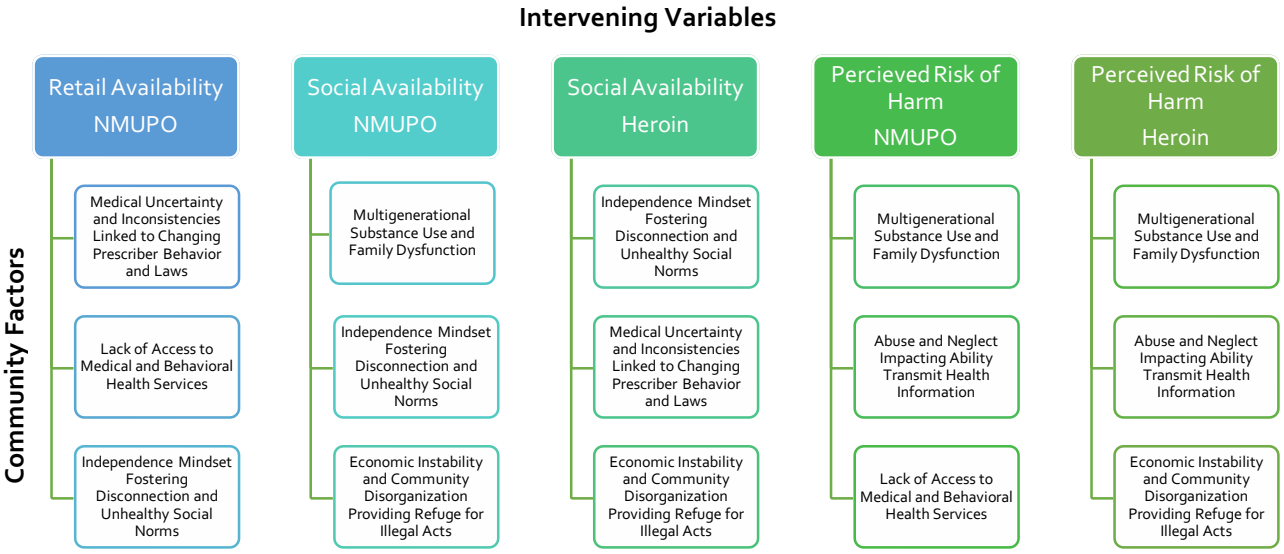
SUMMARY

C4K identified that lack of community connection is at the heart of the community factors identified in this section. Since its inception, C4K has been working to address community connectivity as a mechanism to drive community change. The link between community connection and behavioral health outcomes is easy to see. When a person becomes isolated they lose the built-in resiliency that comes from living in a community. If we are unconnected, there is simply no one there to help us in times of crisis. This places us at greater risk for adverse outcomes such as, depression, or suicide. This exercise of identifying community factors and intervening variables created focus points for our efforts and will drive the development of strategies to decrease drug use in our communities.

The identified community factors underlie connectivity and also create increased risk for adverse behavioral health outcomes. If it is too difficult or too costly people will not go to community gatherings or even seek needed medical care. Living in a boom and bust economy places tremendous stress on community members and creates a continual population migration. Living in a community because of a high paying job, yet under the continual risk of having to leave the community when jobs dry up, results in low level of community re-investment. Job loss also places one at risk of becoming uninsured and not being able to afford preventative

medical care. Difficulty accessing primary behavioral health and medical care services, whatever the reason, is linked to all types of adverse health outcomes. The importance of connection has been lost by the current generation of Kenai residents. We have mistakenly placed the important Alaskan value of independence at opposition to interdependence and forgotten that we need to invest time in developing both for healthy lives. Healthy communities' foster healthy families and unhealthy communities impact the well-being of families. Broken families perpetuate substance abuse, create childhood trauma, and fail to impart critical knowledge needed to become an active member of society. Breakdown of family systems drive adverse outcomes for individuals but may require community solutions, including increased connectivity, to repair.

RELATIONSHIP BETWEEN INTERVENING VARIABLES & COMMUNITY FACTORS



Resources

- Acute care and two critical access hospitals
- Federally qualified health center
- Tribal physical and behavioral health center
- Three tribal village clinics
- Two community mental health centers
- Family practice and specialty medical clinics
- Two public health centers
- Public schools in all communities
- Three outpatient addiction treatment providers with multiple locations
- Limited public transportation
- Residential addiction treatment
- Withdrawal management-pending
- Six senior centers
- Two teen centers
- Three recreation centers
- Community parks and green spaces
- Boys and Girls clubs
- Two domestic violence centers
- Two homeless shelters
- Ten pharmacies
- All communities on road system
- Five airports
- Three sea ports
- Active refinery and oil industry
- Shopping and dining options

Coalition Resources

- Core group of committed members
- Effective leadership
- Members trained in SPF process
- Research and assessment team
- Informed leadership
- Blended funding and fundraising capability
- Partnership with CPH Health Foundation

INTERVENING VARIABLES

INTERVENING VARIABLES

RETAIL AVAILABILITY

Retail Availability: easy access to opioids through providers or dealers

Notably retail availability applies only to prescription opioids as there are no legitimate retail options for heroin.

The Prescription Drug Monitoring Program (PDMP) is designed to track prescriptions written for total volume of narcotics prescribed, individuals with multiple prescriptions and/or multiple providers, and high dose prescriptions. C4K has been unable to get current data from the PDMP but we were previously able to obtain data for 2014 and 2015.

Number of patients receiving prescription(s)	2014	2015	Change
CII	134,524	202,141	50%
CII,III	154,831	238,581	54%
CII, III and IV	243,546	429,185	76%
Number of patients exceeding 5/5 threshold ***Pharmacy board defines 5 providers and 5 Rx in 3 months**	**2014**	**2015**	**Change**
CII	313	61	-81%
CII, III	365	71	-81%
CII, III and IV	525	103	-80%
Number of patients exceeding 10/10 threshold	**2014**	**2015**	**Change**
CII	4	1	-75%
CII, III	4	1	-75%
CII, III and IV	5	1	-80%
Description of painkillers greater than 100mg (MED), per day	**2014**	**2015**	**Change**
Adult	117	89	-24%
Youth	2	1	-50%

C4K partnered with Soldotna Professional Pharmacy and local police to host a prescription drug take back event on October 22, 2016. The event was heavily advertised in social media, local radio, and print advertisings (newspaper and flyers). Participants were also recruited from a co-occurring health fair and incentivized with entry in a drawing for airfare. Drugs taken back amounted to eight boxes equaling 307 pounds. Future success of take back events will be measured by public awareness of the event and public knowledge of safe disposal.

C4K elected to focus our presence at the 2017 Central Peninsula Hospital Health Fair on safe medication storage and disposal. While over 75 people visited our booth, most were interested in the issue of disposal but unconcerned about storage of medications in their home. Only one person expressed concern about the safety of medication storage, reporting having large numbers of high dose narcotics following the at home

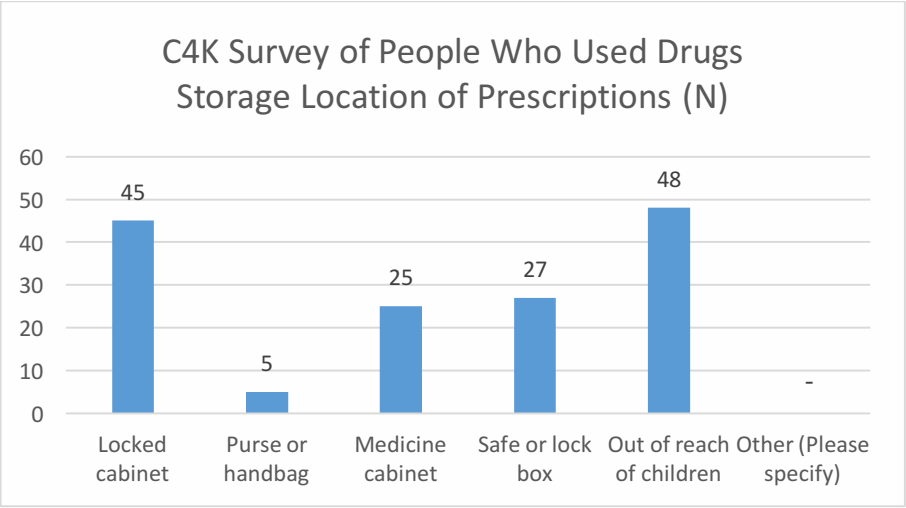
death of a loved one. Overall, it appears that people may underestimate the chance of having medications stolen, believing that they are not at risk.

C4K conducted a *Young Adult Community Survey* (YACS) with 88 between 18-25 years old via Facebook. The same questions were administered to a subset of 64 *People Who Have Used Drugs* (PUD) via a paper survey. To clarify for the reader, responses are first presented for the *Young Adult Community Survey* in black following those responses, the responses from *People Who Have Used Drugs* are entered in violet, and summary statements are in green.

Participants were asked where prescriptions should be stored. Respondents could mark more than one answer and the 88 respondents marked a total of 238 responses, averaging 2.7 responses per participant. Respondents were most likely to endorse in a locked cabinet or out of reach of children with 77% of the 88 respondents selecting each of these options. Fifty-five percent of respondents selected safe or lock box, 52% selected medicine cabinet, and 5% selected purse or handbag.

On the survey of *People Who Have Used Drugs* (PUD) 64 respondents marked a total of 150 responses, averaging 2.3 responses per participant. Respondents were most likely to endorse out of reach of children with 75% of the 64 respondents selecting this option. Seventy percent of respondents selected in a locked cabinet, 42% of respondents selected safe or lock box, 39% selected medicine cabinet, and 8% selected purse or handbag.

Overall there were no significant differences between the two groups for the preference of medication storage.



Ease or difficulty of access to opioids was assessed by asking participants how easy or difficult they believe it is to get prescriptions opioids in our community (from friends, family, or other non-medical sources. The majority of respondents (51%) reported that they were not sure how hard or easy it is to get prescription narcotics in their community. Seventeen percent reported very easy: could be accessed within four hours, 17% selected easy; could be accessed within 24 hours, 11% selected medium: could be accessed within a couple days, and 5% reported it would be difficult: could be accessed within a week. No one selected very difficult to obtain.

The majority of PUD respondents (37%) reported that they were not sure how hard or easy it is to get prescription narcotics in their community. Thirty-two percent reported very easy: could be accessed within four hours, 13% selected easy; could be accessed within 24 hours, 6% selected medium: could be accessed

within a couple days, and 2% reported it would be difficult: could be accessed within a week, and 7% selected very difficult to obtain. Three percent elected to skip this item.

Major differences between the two surveys were a much larger percentage of PUD were able to estimate how difficult it would be to obtain prescription opioids. This group was also much more likely to report that they could be addressed very easily and endorsed more items on the opposite end of the spectrum, endorsing very difficult.

Participants were also asked how easy or difficult they believe it is to get prescription opioids from a doctor with no medical need. Again, the majority of respondents (62%) reported they were not sure. Twelve percent reported that it would be easy, 10% reported it would be difficult, 8% selected medium, 6% selected very difficult, and 1% selected very easy. It appears that responses to this question where heavily based on perceptions and less based on the actual experience of getting medication from a doctor to get high.

While the majority of PUD respondents (37%) reported, they were not sure this value was significantly lower than from the young adult survey. Respondents in this survey were also much more confident that drugs could be obtained from a doctor with relative ease. Thirty-two percent reported that it would be very easy compared to the 1% from the previous survey. Thirteen percent reported it would be easy, 6% selected medium, 7% selected very difficult, and 2 % selected difficult.

The major difference between survey respondents on this question fell in extreme ends of the distributions. Identical to the previous question, PUD were much more likely to respond very easy and they were less likely to select a difficult response when evaluating how difficult it is to obtain drugs. They were also much more likely to answer that they were informed on this item.

SUMMARY: RETAIL AVAILABILITY

Retail availability was assessed via the Prescription Drug Monitor Program, a prescription take-back event, health fair participation, and surveys of young adults and PUD. While no one data source is perfect, C4K believes that this convergence of information gives use direction on the selection of strategies to address this intervening variable and a basis from which to evaluate the impact of future efforts to impact retail availability of NMUPO.

SOCIAL AVAILABILITY

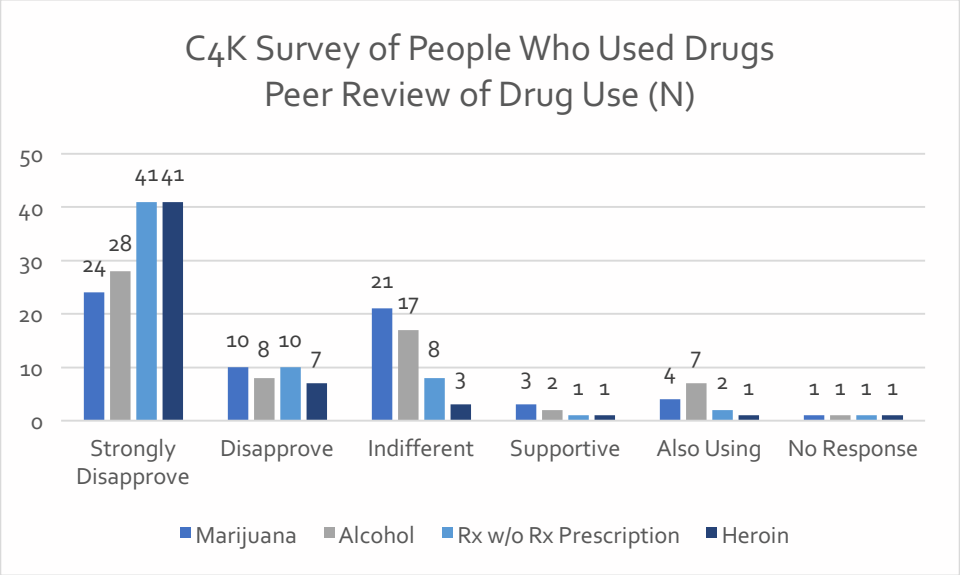
Social Availability: obtaining opioids through social sources, such as friends, family, & relatives

Nearly every focus group reported concerns about changing social norms in the direction of drug use becoming more acceptable. Several groups also discussed the growing normalization of injection drug use and misperceptions that needle use is somehow more sterile than other routes of administration. Increased social acceptability, belief that injection drug use is "cleaner", and lack of risk of detection (from the smell of smoking drugs on clothing) are all social factors that drive injection use of opioids. As drug use becomes more socially acceptable, the social availability of drugs is enhanced.

The *Young Adult Community Survey* (YACS) and survey of *People Who Have Used Drugs* (PUD) asked about social norms, avenues for drug access, and difficulty of access. Answers are documents in the same alternating black/violet/green as for retail availability.

Only one question from the *Young Adult Community Survey* addressed social norms. Participants were asked how their friends feel about their use of specific drugs. This item was given a score of 1 for strongly disprove, 2 disprove, 3 indifferent, 4 supportive, 5 also using. For marijuana (3.12) and alcohol (3.22) scores fell between indifferent and supportive, for prescription drugs not prescribed to you (2.24) between disapprove and indifferent, and strongly disapprove for heroin (1.1).

PUD were asked the identical question. For marijuana (2.2) and alcohol (2.2) scores were indifferent, for prescription drugs not prescribed to you (1.6) between strongly disapprove and disapprove, and strongly disapprove for heroin (1.3). Below is a graph of approval by drug type for PUD.

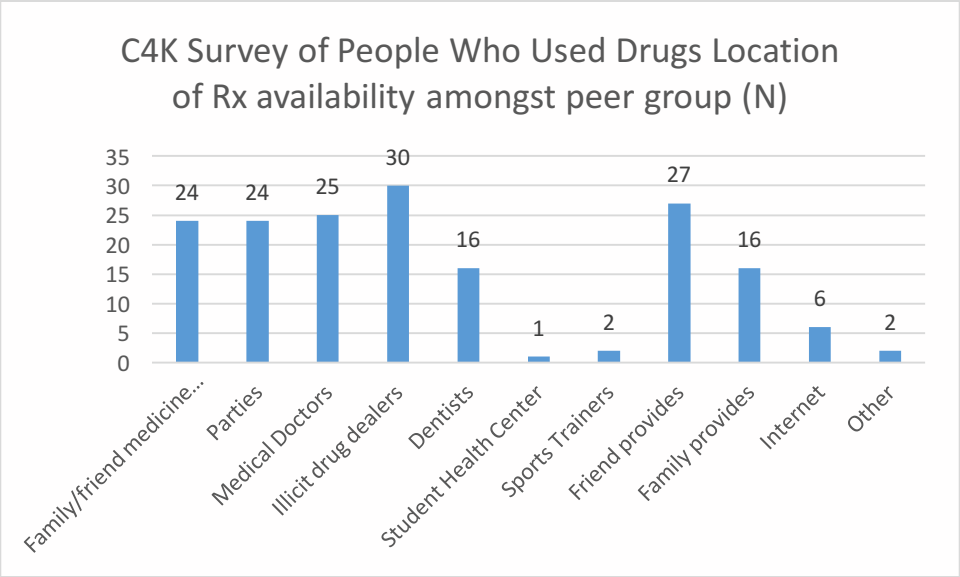


Surprisingly, PUD responded peers would tend more toward disapprove for all items but heroin and the difference for heroin is insignificant and likely due to sampling error. PUD likely reported their friend would disapprove of substance use because this sample was heavily weighted with people who have entered recovery and surround themselves with recovering peers.

Participants were asked where they thought prescription pain pills are most readily available and accessed among their peer group based on their own experiences and those of other's they have observed. Respondents could select more than one answer for this question and 213 responses were coded for the 88

respondents averaging 2.4 options per respondent. In order from most to least: the medicine cabinet of friends and family (48% of 88 respondents selected this option), parties (47%), Illicit drug dealers (45%), friend providers (34%), medical doctors (30%), family provides (20%), internet (7%), dentists (6%), other (6%). Notably less than one third of participants ranked medical doctor as a source of misused prescription opioids.

Again, respondents could select more than one answer for this question and 173 responses were coded for the 64 respondents averaging 2.7 options per respondent, only slightly more than the YACS. Percentages reported represent percent of sample selecting this option. In order from most to least: Illicit drug dealers (47%), friend providers (42%), doctors (39%), family or friends medicine cabinet (34%), parties (34%), family provides (25%), dentists (25%), internet (9%), other (3%), sports trainers (3%), student health (2%). Notably just over one third of participants ranked medical doctor as a source of misused prescription opioids. Table below outlines responses for all PUD on this item.



The overall rankings of source for prescription drugs were very similar between the two samples. PUD saw the medicine cabinet of friends/family and parties as less of a source than the YACS. Friends, family, doctors, drug dealers, and dentist were all more likely to be identified as a source by PUD drugs than by the YACS.

Anticipating that participants would rank friends or family high on the previous item, participants were asked how difficult is it to get prescription opioids from a friend or family member to get high. Fifty-seven percent of the sample reported they were not sure, 18% reported medium, 12% reported easy, 7% reported difficult, 4% very difficult, 2% very easy.

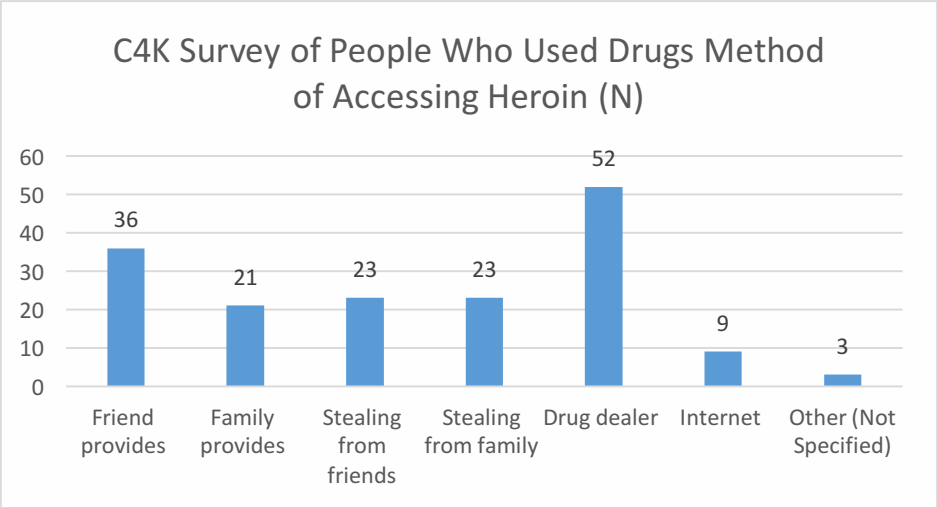
Thirty percent of the sample reported they were not sure, 13% reported very easy, 14% easy, 13% reported medium, 16% reported difficult, 14% very difficult.

PUD reported nearly equal percentage in each difficulty category. Equal categories indicates that there was no consistent phenomena of interest being measured. In most cases these respondents were entering recovery which often requires building new friends and ending connection with using friends and family. It is likely they simply responded randomly to this item. YACS responses followed the pattern of a normal curve with fewer responses on the extreme ends. While there was no bias in either direction this is a realistic representation of the phenomena.

Shifting questions from prescription pain pills to heroin, participants were asked how people get heroin in our community. Participants could make multiple selections. On this item, 172 responses were recorded for the 88 respondents averaging 2.0 responses each. The highest ranked option was drug dealer, and this

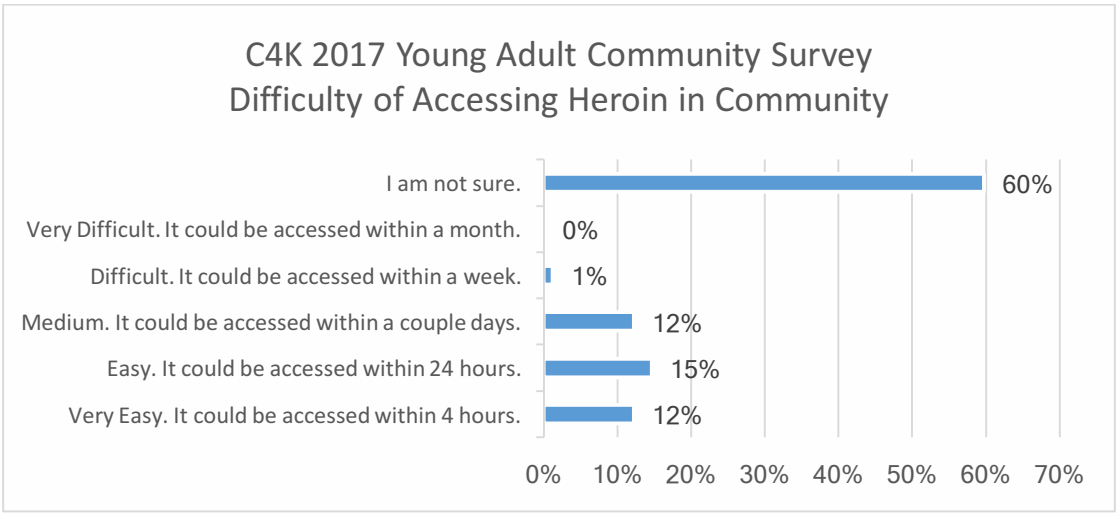
option was selected by 76% of the respondents. It was followed by friend provides (41%), stealing from friends (26%), stealing from family (23%), family provides (14%), internet (9%), and other/don't know (7%).

On this item, 166 responses were recorded for the 64 respondents averaging 2.6 responses each. The highest ranked option was drug dealer, and this option was selected by 81% of the respondents. It was followed by friend provides (56%), stealing from friends (36%), stealing from family (36%), family provides (33%), internet (14%), and other/don't know (5%). Responses from this group are graphed below.



Larger percentages of the sample of PUD addressed every item and these participants endorsed more items per respondent. Interestingly, although they endorsed more items, items were endorsed in the same order as YACS. Both groups saw the resources in the same order as options to obtain heroin.

Finally, the *Young Adult Community Survey* asked, "How difficult is it to get heroin where you live?" Sixty percent of respondents reported they were not sure, 15% reported easy: it could be accessed within 24 hours, 12% reported very easy: it could be accessed within 4 hours, 12% medium: it could be accessed within a couple days, 1% difficult: it could be accessed within a week, 0% very difficult: it could be accessed within a month.



Thirty-three percent of PUD reported they were not sure, 41% reported very easy: it could be accessed within 4 hours, 20% reported easy: it could be accessed within 24 hours, 2% medium: it could be accessed within a couple days, 2% difficult: it could be accessed within a week, 2% very difficult: it could be accessed within a month.

PUD were much more likely to provide a rating for this item than select not sure. They were also more likely than YACS to select easy or very easy for accessibility of heroin. If their responses reflect reality, heroin is plentiful in our community.

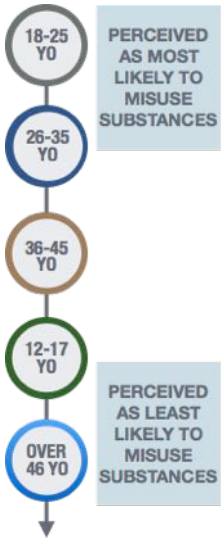
In early efforts to look at drug use, C4K focused on the risk of using peers as a factor that leads to personal use. The initial surveys (conducted at health fairs and homeless connect) contained the following items.

1) Do you personally know someone who misuses prescription opioids?
    a. 208 yes
    b. 139 no
2) Do you personally know someone who uses heroin?
    a. 302 yes
    b. 181 no
3) Would you know where to go to get treatment for addiction?
    a. 249 yes
    b. 85 no

Assuming using peers creates a route for social access to prescription opioids and/or heroin, 60% of our sample knows someone who can access prescription pain pills and 63% know someone who can access heroin. On a positive note, 75% reported that they knew how to get treatment for addiction.

Write in responses from surveys indicate that while participants indicated they knew how to access treatment, they really may not. Write in responses included Emergency Department or 911. This is consistent with what was observed in C4K's analysis of Emergency Department admissions, 9% of cases were there for a primary behavioral health issue. A large percentage of community members may not be able to access care for themselves or a loved one.

One of our most interesting data entries on availability came from users, one of whom reported "Three phone calls max and I can have heroin in my hand". Most users (over 70%-Per Serenity House records) report one or fewer sober friends and many report that parents or significant others also use.



The survey of *Persons Who Used Drugs* contained two additional questions to evaluate how "normative" drug use has become in the lives of people who have used drugs.

Participants were asked do you think most Alaskans use opioids less than prescribed, exactly as prescribed, more than prescribed, or don't know. Most respondents selected more than prescribed (72%), no one selected exactly as prescribed.

Additionally, participants were asked which age group is most likely to misuse opioids and allowed to select as many responses as they liked. The 64 respondents provided 135 responses, averaging 2.1 responses per participant. In order of likelihood to misuse substances the age groups were ranked in the following order 18-25 years old, 26-35 years old, 36-45 years old, 12-17 years old, and over 46 years old.

SUMMARY: SOCIAL AVAILABILITY

In evaluating social availability C4K first looked at social approval or social norms associated with opioid use. While both survey groups agreed that peers would disapprove of heroin use, YACS respondents rated peer opinions as moving toward indifference with regard to NMUPO. PUD felt their peers would disapprove of use of any opioid but this may be due to their status in recovery. Agreed on sources of NMUPO were parties,

drug dealers, friends; while PUD were less likely to see family and friends medicine cabinets as a source. Approximately one-third of both groups thought that doctors could be a source of prescription opioids intended for misuse. Heroin was rated as highly accessible in our community by the group of PUD while the majority of the YACS respondents reported they were unsure about the ease of accessing heroin. Drug dealers followed by friends are likely the source of heroin. The opioid problem is pervasive, a community survey revealed that opioid abuse is impacting the friends and loved ones of over half of our community and the group most impacted is young adults. C4K was highly successful in generating data about the intervening variable of social availability and has solid data to track trends and evaluate the impact of prevention efforts.

PERCEIVED RISK OF HARM

Perceived Risk of Harm: perception that misusing or abusing opioids is harmful

There are three likely sources for individuals to learn about the disease risk associated with drug use: community, family, and peers. To evaluate the knowledge transmitted by community, C4K looked at school district offerings on drug addiction and contagious disease. Our local district provides the Drug Abuse Resistance Education Program (DARE) as youth transition to Junior High. C4K was not able to interview youth due to consent issues but did interview young adults about the DARE program. Focus group members (addiction recovery and general community) acknowledged completing DARE, unless home schooled, but did not agree that it impacted their decision to use drugs in any manner. In multiple cases the school district is sharing counselors across 5 schools so it is doubtful that the counselor can provide much education about drug issues of any type. The same was said of school based health course, which is the only other effort made to educate youth about drugs. Additional community resources include Public Health, Healthcare Providers, and community leaders yet in our community none of these resources have a focused program to provide drug education. C4K established that the failure of families to communicate knowledge of health risks is a local community factor that drives addiction risk. This leaves peers as the primary source of knowledge about health risk for many of our youth.

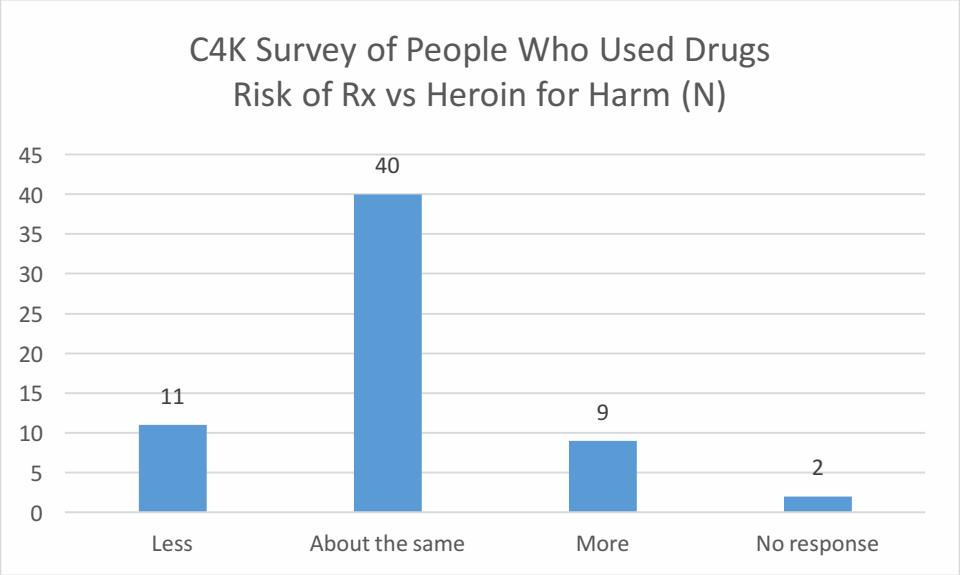
Some of the most frightening information C4K obtained was related to peers sharing knowledge of hepatitis C and HIV. Globally, focus groups of people with addiction revealed a lack of knowledge with regard to personal risk and a massive underestimation of the long-term health consequences of drug use, specifically injection drug use. The following recovery member quotes were selected to demonstrate the concern. "When you are done (ready to stop drug abuse), you just go get the meds and get rid of your Hep C or AIDS or whatever". Belief in a 100% cure rate for Hep C and HIV. "It's like, I have Hep C, you have Hep C, so were good to go (share needles)." No understanding of cross contamination, multiple disease subtypes or other blood borne illness. Additionally, we heard myths about infection prevention linked to burning or rinsing the tips of needles to avoid contamination or not pulling blood to avoid contamination. In fact, approximately ¼ of recovery member focus group participants still held incorrect information regarding the transmission of hepatitis.

Notably, there is a point in addiction where the disease of addiction is so advanced that the health risks have minimal to no impact on use. Engaging in risky behaviors does not necessary indicate a lack of knowledge about the risk of those behaviors.

C4K was interested in assessing how young adults perceive the risk of harm associated with use of prescription pain pills and heroin. The *Young Adult Community Survey (reported in black) and survey of Persons Who Used Drugs* (reported in violet) contained four questions which addressed perceived risk of using specific drugs and factors that could impact drug use.

Participants were asked if they viewed pain medication as more or less dangerous/risky than heroin in terms of the potential for physical or other harm. Fifty-nine percent selected about the same, 36% felt pain medications were less risky and 5% thought pain medications were riskier than prescription medications. When asked about their responses participants reported that "both can create serious addictions" and "pain medications seem safe, that is why they are riskier. You think they are safe then you're hooked. It happens easy. I have seen it in my friend."

Sixty-six percent of PUD selected about the same, 18% felt pain medications were less risky and 14% thought pain medications were riskier than prescription medications. Responses are graphed below.



PUD were only slightly more likely to rate heroin and NMUPO as equally risky. While PUD split their remaining responses between heroin and NMUPO being more dangerous, YACS respondents were more likely to rate heroin as more dangerous than NMUPO.

C4K was interested in comparative risk rating for opioid use. Participants were asked how much people risk harming themselves physically or in other ways when they use heroin one time, use heroin for a long time, or take prescription drugs not prescribed to them. Ratings were on a scale from 1 to 5 with 1 being least risky. Ratings for both groups are listed below.

PUD ranked the risk only slightly higher than YACS and in the same order.

Heroin one time	**3.45**
Heroin long term	3.83
Prescription drugs not prescribed to them	3.31
Heroin one time	3.53
Heroin long term	3.90
Prescription drugs not prescribed to them	3.55

The tendency to see heroin as drastically more risky than other drugs reappeared in the third question of risk. Participants were asked to rank on a scale of 1 to 5 with 1 being least risky in terms of the potential for physical and other harm, how dangerous they perceived each of the following drugs. From lowest to highest risk, drugs were given the following scores for risk: marijuana 1.91, alcohol 2.76, Attention Deficit Disorder (ADD) medications 3.52, prescription pain pills 3.81, ecstasy or molly 3.98, cocaine 4.45, methamphetamine 4.88, and heroin 4.91.

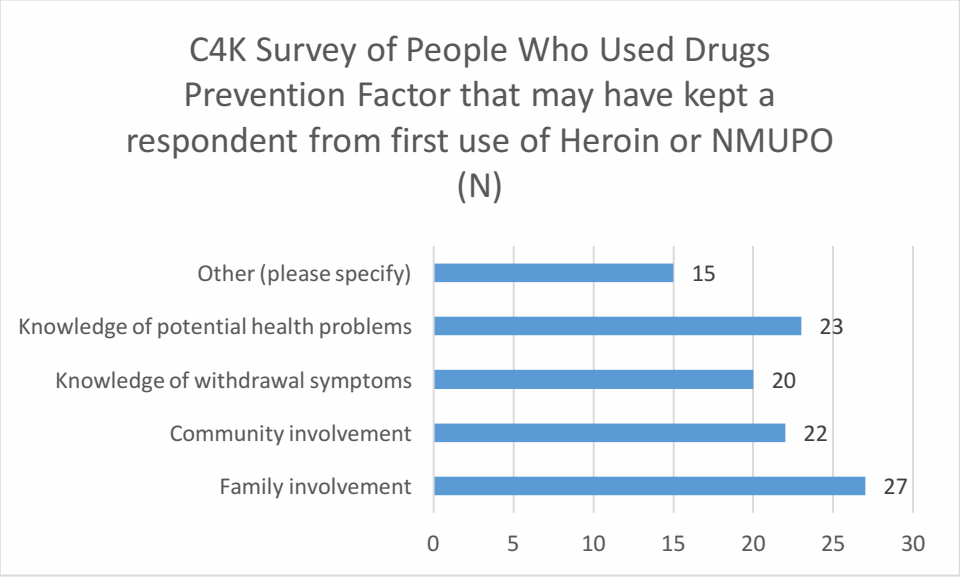
PUD ranked them as follows; drugs were given the following scores for risk: marijuana 2.6, ADD medications 3.78, alcohol 4.12, ecstasy or molly 4.25, prescription pain pills 4.27, cocaine 4.32, methamphetamine 4.54, and heroin 4.57.

Interestingly, the sample of PUD rated drugs except heroin, methamphetamine, and cocaine as more dangerous than the YACS, they rated these drugs as less dangerous than the YACS. Possibly the familiarity PUD have with illegal drugs caused them to lower their ratings of risk for these drugs. It is an interesting contrast against their higher ratings of pain pills, molly or ecstasy, ADD medications, alcohol and marijuana. Alcohol was rated much more dangerous by the group of PUD.

The final question, addressing health risk, asked *w*hat would have kept you from using heroin or non-prescription use of prescription drugs in the first place. Even though only 13 respondents reported misuse of an opioid and 4 reported heroin use, 132 responses were received for this item, which indicates it was filled out by a number of respondents that have not actually used drugs. Potential options were ranked in the following order: knowledge of potential health problems, family involvement, knowledge of withdrawal symptoms, community involvement, other. These items could inform future prevention efforts and media campaigns.

PUD ranked potential options in the following order: family involvement, knowledge of potential health problems, community involvement, knowledge of withdrawal symptoms, other.

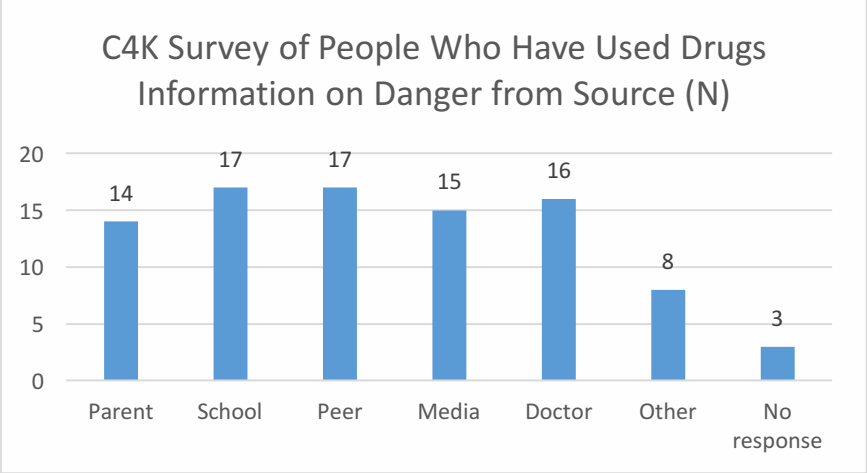
PUD ranked the items related to connectivity (family and community) higher than the YACS. Rankings from both groups could inform future prevention efforts and media campaigns. Ranking from PUD are graphed below.



In addition to the questions asked on both surveys, PUD were asked if they knew the signs or symptoms of physical withdrawal (86%%agree/14%disagree), if they knew the signs/symptoms of overdose (82%agree/18%disagree) and if they knew where to go for help if they or a friend experienced problems with prescription pain pills (87%agree/13%disagree).

In order to assess their ability to respond to overdose, PUD were asked a series of questions about use of narcan. Narcan is used to reverse an opioid overdose. Thirty-eight percent reported they did not know what narcan is used for and 6% of respondents incorrectly identified it as a medication to treat detoxification or prevent addiction. Only 36% correctly identified it as a medication that would reverse prescription pain pill overdose and 45% correctly identified it as a medication to reverse heroin overdose. An overwhelming percentage of this sample, who have used drugs and continue to have peers and family who use drugs, did not know about this potentially lifesaving medication.

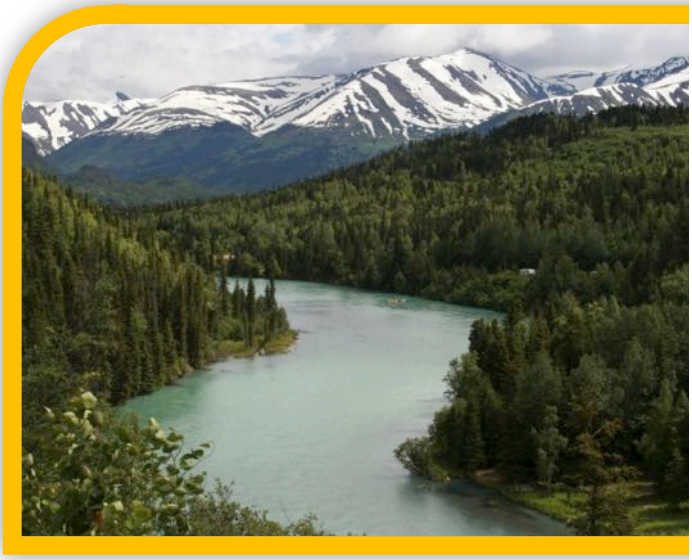
Finally, participants were asked if prior to using drugs, were they given information (from any source) on the dangers of opioid drug use (51%agree/45%disagree). If they reported getting information, they were asked for the source of that information and sources of information are graphed below. They were also asked if a doctor or pharmacist had ever spoken with them about the dangers of opioid abuse (28%agree/69%disagree).



SUMMARY: PERCEIVED RISK OF HARM

Data on perceived risk of consequences for NMUPO and heroin is frightening. Responses from the focus groups globally demonstrated a lack of knowledge about disease risk and personal risk of disease. We found very few resources exist in our system for educating people about the risks of opioids. Almost half of PUD reported no exposure to information about risk before they started using and they were even less likely to have heard about risk from a doctor or pharmacist. Both YACS and PUD survey respondents view heroin as more dangerous than NMUPO, especially if used long-term. Groups disagreed about the risks associated with using other types of drugs. Narcan education is greatly needed in our community. C4K believes that the data collected on this intervening variable give us a solid foundation from which to develop strategies to address the problems of heroin and NMUPO use in our community.

COMMUNITY READINESS ASSESSMSENT



COMMUNITY READINESS ASSESSMENT

OVERVIEW

Change 4 the Kenai utilized the *Tri-Ethnic Center for Prevention Research's Community Readiness for Community Change Model* to evaluate the levels of community awareness, understanding, and concern of NMUPO and heroin use across the Kenai Peninsula.

The five community areas measured for readiness are

1. Community Knowledge About the Issue
2. Community Knowledge of Current or Recent Efforts
3. Leadership in the Community
4. Community Climate
5. Resources Related to the Issue

Change 4 the Kenai included community readiness throughout the data gathering process. Data is included from surveys, town hall meetings, key stakeholder interviews, focus groups, and the formal readiness assessment interviews. Coalition members interviewed a minimum of 12 individuals per the community areas of Central Peninsula, Southern Peninsula, and Seward. Half of the interviews focused on NMUPO and the other half focused on heroin use. A mirrored selection process was followed where we tried to select community members from various sectors of each area including pharmacists, community leaders, law officials, teachers, and those in recovery. Following the completion of the surveys, a task group scored the answers to the questions utilizing the Tri-Ethnic Center's anchored rating scales.

STAGES OF COMMUNITY READINESS

The nine stages of community readiness, as presented by the *Tri-Ethnic Center for Prevention Research's Community Readiness for Community Change Model:*

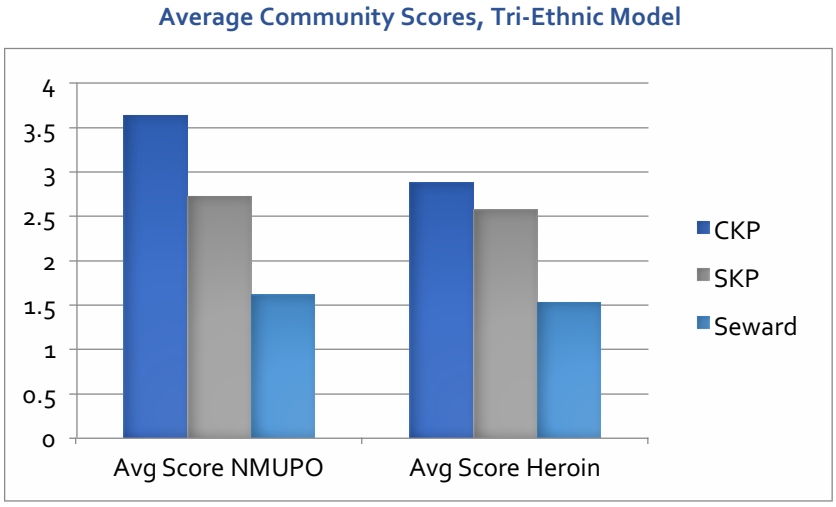
> *"Heroin is big problem on the peninsula and Anchorage."*

> *"My knowledge of drugs came from family members with addiction issues."*

1. •No Awareness
2. •Denial/Resistance
3. •Vague Awareness
4. •Preplanning
5. •Preperation
6. •Initiation
7. •Stabilization
8. •Confirmation/Expansion
9. •High Level Community Ownership

COMMUNITY READINESS SCORES FROM TRI-ETHNIC CENTER MODEL

The following graph is a comparison of scores across the three main community areas that make up the Kenai Peninsula; Central Kenai Peninsula (CKP), Southern Kenai Peninsula (SKP), and Seward.



COMMUNITY READINESS SCORES FOR NMUPO PREVENTION & EDUCATION

Central Kenai Peninsula

Community Area	Score
Knowledge of Efforts	2.417
Leadership	3.583
Community Climate	4.67
Knowledge of Issue	4.5
Resources	3.0
Overall Score	3.634

Southern Kenai Peninsula

Community Area	Score
Knowledge of Efforts	3.33
Leadership	3.17
Community Climate	2.9
Knowledge of Issue	2.2
Resources	2
Overall Score	2.72

Seward

Community Area	Score
Knowledge of Efforts	2.06
Leadership	1.16
Community Climate	1.28
Knowledge of Issue	1.61
Resources	1
Overall Score	1.61

COMMUNITY READINESS SCORES FOR HEROIN PREVENTION & EDUCATION

Central Kenai Peninsula

Community Area	Score
Knowledge of Efforts	2.5
Leadership	3
Community Climate	3.84
Knowledge of Issue	3
Resources	2
Overall Score	2.868

Southern Kenai Peninsula

Community Area	Score
Knowledge of Efforts	2.67
Leadership	3.0
Community Climate	3.33
Knowledge of Issue	2.17
Resources	1.67
Overall Score	2.568

Seward

Community Area	Score
Knowledge of Efforts	2.07
Leadership	1.71
Community Climate	1
Knowledge of Issue	1.85
Resources	1
Overall Score	1.526

COMMUNITY READINESS RESPONSE THEMES

The Central Kenai Peninsula demonstrates a higher community readiness than the other areas. We believe that part of this may be explained by Change 4 the Kenai's presence in this area for the previous 2 years. Other coalitions and community groups are also active in the largest area on the peninsula. Homer and surrounding areas had similar scores for heroin and NMUPO readiness. There are current needle exchange programs and proactive measures in the Homer area. Seward had the lowest readiness scores, but one key informant interviews have shown that many residents feel disconnected from other areas on the peninsula. Resources and community climate are viewed as especially low in this area. Seward has less medical care in the area and relies heavily on tourism in the summer, two areas that may affect the community's perception of resources and climate.

Two youth respondents shed interesting light on community readiness in their unique population. One was in high school and the other 12-years-old; one from Southern Peninsula and one from Central Peninsula. Both reported that they heard little about either NMUPO or Heroin use in school. One youth stated "heroin use isn't very wildly discussed around me but I know that it is happening around me and I may not know it." Youth perception of community leaders is different from that of many adults. Their readiness interviews showed that they believe drug use is "not talked about in the community." Both youth agreed that they don't believe anyone would oppose helping addicts.

A majority of the readiness assessment interviews shared a common theme: those affected by or involved with substance abuse were more knowledgeable about the issue and much more likely to be actively involved in working toward community-level change. It was also frequently noted that no one in the community would oppose efforts, unless it was a money-based (funding, taxes, etc.) disagreement. Another common theme was the idea that more education was needed for the community.

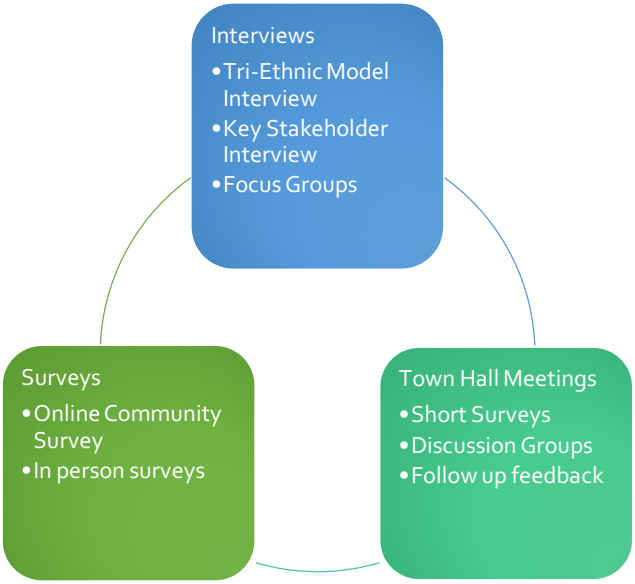
Resources are an area that were scored fairly low in all assessments. Most communities scored resources at around a 2, denoting there are 'very limited resources available for further efforts'. We feel this is an area for further community education and outreach that also ties into knowledge of efforts.

Why were scores higher for NMUPO than heroin? Our coalition workgroup was surprised to notice that scores for NMUPO were higher in all three locations. We believe that this can be explained with three main factors. First, our recent community activities include a Fall Prescription Drug Take-Back event where Change 4 the Kenai teamed up with Alaska State Troopers, local police, and Soldotna Professional Pharmacy. This event was widely publicized and involved educational components. Second, several people interviewed believed the public had limited knowledge about the signs of drug use or consequences, but they would list the number of public that were aware of the drug problem as 'most'. This is likely due to news coverage of drug-related crime and accidents. Third, national media campaigns have been targeting NMUPO; one example was a press conference with President Obama and musician Macklemore – who later went on to publicize a song "Drug Dealer" that focuses on misuse and overprescribing of prescription drugs.

COMMUNITY READINESS SUMMARY

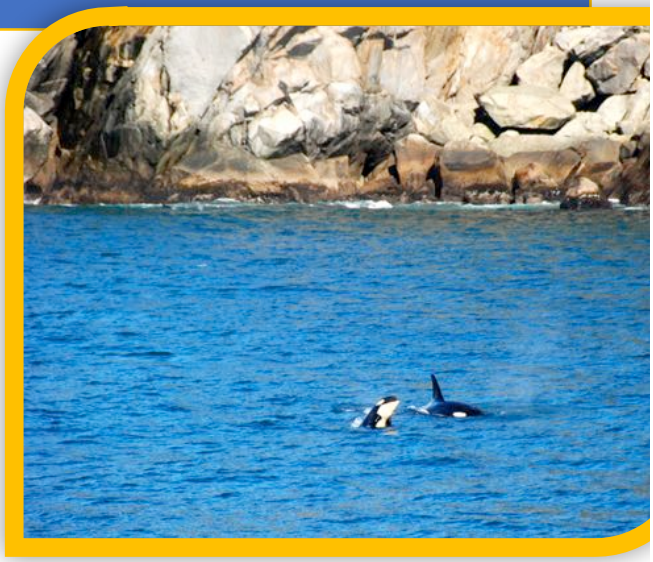
The following summary includes information gathered from all primary data collected during this assessment. Secondary data was not considered at this time as we were looking for the most current sense of community climate.

Data Sources



READY FOR ACTION. A frequently expressed opinion and common theme has become that the community is aware of the problem and is ready for action. The community coalition frequently wants to be 'active' and working toward the problems; community members at the town hall meetings were ready to create and implement strategies; focus groups have great ideas and want to move forward and be active. However, our tri-ethnic model interviews demonstrate that while a core group of individuals that are directly and heavily impacted by the issues may be ready for action, greater work is needed in educating and preparing the entire public so that community-wide differences can be made. We are aware there is a problem, leadership is willing to move forward, a clear plan of action that includes education and resources needs to be developed.

RESOURCES & GAPS



COMMUNITY RESOURCE ASSESSMENT

This community resource assessment examines programs and services provided by agencies and organizations along with other community resources to determine the effectiveness of existing programs, the ability of our community resources to build a protective environment, unique community strengths, and gaps or issues that address the prevention or reduction of NMUPO and heroin use in our community. Change 4 the Kenai examined local resources across the peninsula, conducted interviews and focus groups, and utilized surveys to gain a comprehensive view of resources and needs both within the substance abuse prevention and mental health system as well as throughout the community. This allows us to view aspects of community connectivity that may help strengthen prevention efforts and rehabilitation.

We want to increase and strengthen programs that address the risk factors associated with NMUPO and heroin use on the Kenai Peninsula as well as develop strategies to address identified gaps in resources. In addition, we want to increase protective factors that buffer risk and help to develop resilience in children and youth:

- Opportunities to form relationships with peers, family, school and community.
- Opportunities to participate and contribute with peers, family, school and community.
- Skills to be able to make use of the opportunities available.

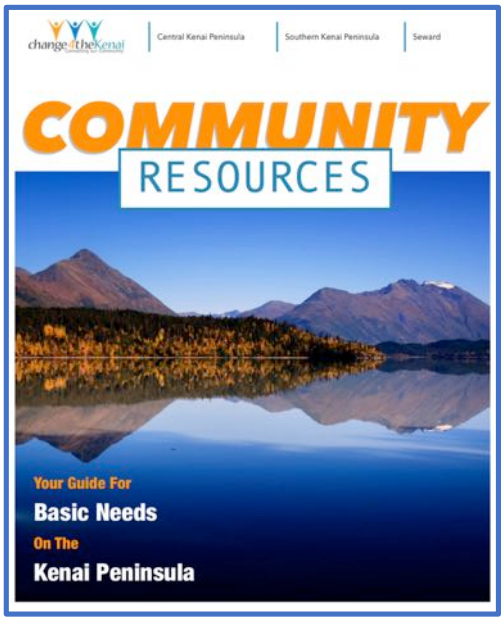
In addition, we want to increase protective factors that buffer risk and help to develop resilience in youth and adults.

COMMUNITY RESOURCE GUIDE

A detailed community resource assessment was completed for the entire Kenai Peninsula. As part of the assessment, a resource guide was developed for the community and is available in print (see appendix) and online at www.kenairesources.info. The online resource can also be accessed through the QR code (bottom right).

The Community Resource Guide was developed by the Change 4 the Kenai community coalition to

- Connect community members with available resources
- Assist public services, volunteers, and business members to identify the needs of families and connect them to available resources.



VISIT THE DIRECTORY ONLINE BY SCANNING THE QR CODE BELOW

PROTECTIVE FACTORS

Change 4 the Kenai identified key areas that represent community domains, risk factors, and protective factors. A resource analysis allowed us to identify unique community factors, gaps, current resources, and potential strategies to address resource gaps.

STRENGTHENING FAMILIES

PRENATAL AND INFANCY PROGRAMS. Prenatal and early infancy care and parent education are offered through at least 5 different programs in Homer, Soldotna/Kenai, and Seward. These programs provide parent education, screenings, and help uniting with other resources. Many are sponsored through Head Start, SPROUT, and local Native tribal programs. The largest challenge for families is transportation as parents in rural areas throughout the peninsula may have a challenging time reaching the programs that do exist. Advertising for these programs can also use improvement, as not all community members are familiar with the early childhood programs that are available.

FAMILY THERAPY. There are at least 10 therapists that advertise working with family therapy on the Kenai Peninsula, with others that may also provide services. Barriers to receiving care appear to be transportation for those living rurally, insurance/financial challenges, and a stigma against seeking counseling.

DOMESTIC VIOLENCE RESPONSE NETWORK. The Alaska Network on Domestic Violence and Sexual Assault extends services to the Kenai Peninsula. Each main area of the Peninsula also has at least one local support group. The LeeShore Center provides a locally-based 24-hour crisis line.

CRISIS OR EMERGENCY SERVICES. Larger towns offer city police while the Alaska State Troopers have posts throughout the peninsula. Each area also has emergency response. Smaller areas have volunteer fire and EMS stations.

MEDIATED OR COURT INVOLVED SERVICES. Courts in both Kenai and Homer as well as court-appointed services are available for the community.

DISABILITY-RELATED SERVICES. Several services are available from multiple organizations, creating a nice network of both community support resources and live-in facilities. Barriers to this resource include insurance or other economic factors, transportation, and at times openings for live-in facilities are limited. The facilities themselves report difficulty hiring and maintaining qualified employees.

SUBSTANCE ABUSE SERVICES. Each larger area hosts AA and NA support groups, however, formal programs for substance abuse care are limited. Gaps include no detox facility, limited care beds, and a lack of a youth facility on the peninsula. Transportation and lack of financial resources is also a challenge for those needing help but not being able to afford it or those needing to travel to Anchorage or out-of-state for care.

MENTAL HEALTH CARE. While quality services are available, many survey and interview respondents report an often nine month wait time for services.

REFUGEE OR IMMIGRANT FAMILY SERVICES. Currently immigrant family services are limited to mostly support through the school district, however, immigrant immersion is not as affluent on the Kenai Peninsula as other areas of the state.

SENIOR SERVICES. Many of the resources available for community members with disabilities also provide programs for older adults. The larger communities as well as smaller communities such as Anchor

Point, Ninilchik, Nikiski and Sterling offer extensive programs for low-cost meals and companionship through programs at local senior centers.

OTHER RESOURCES. Veteran services are offered in most communities across the peninsula.

SCHOOL – COMMUNITY PARTNERSHIPS

EARLY CHILDHOOD EDUCATION PROGRAMS. Early childhood education programs not only provide guided education for the youngest members of the community, they also provide a safe and often subsidized quality care option for working parents. Several groups provide quality programs in the larger areas, including SPROUT which has parental education parents as well as young child classes; Kenaitze Early Childhood program, as well as others. Unfortunately, ECE programs and day care in general are lacking in smaller/rural areas.

MENTORING/TUTORING PROGRAMS. There are extensive mentoring and tutors available through the Connections Homeschool Program, community schools group, and the colleges.

BEFORE AND AFTER SCHOOL PROGRAMS. Before and after school programs tend to vary depending on the school and school population, although most offer sports opportunities. There are also wrestling and other sports available on a community-level. Many parents would like to see more programs like the Boys and Girls Club in smaller areas.

EMPOWERING YOUTH FOR SUCCESS • AGES 12-18

CLASSROOM CURRICULA FOR SOCIAL AND EMOTIONAL COMPETENCE PROMOTION. The Kenai Peninsula Borough School District (KPBSD) has trained psychologists and counselors that offer guidance to students who are recognized as needing additional emotional and social support. However, these programs are often not taught to the majority of students.

COMMUNITY TEEN-FOCUSED PROGRAMS. Community programs such as 4-H and FFA offer alternative options for all youth, although enrollment is generally only a couple hundred or less peninsula youth. Larger communities have teen centers available. Some have offered skate-parks but often these become problematic with drug and alcohol use.

SUBSTANCE ABUSE SERVICES. Youth-specific substance abuse services are non-existent; most youth are referred to Anchorage for treatment.

ECONOMIC SECURITY AND STABILITY

FOOD INSECURITY. There are many programs available statewide and in each community to help with those needing food. Fresh fruits and vegetables, milk, and some other groceries can be extra expensive and more difficult to find.

HOUSING. Housing and heating assistance are available but housing assistance is limited to one main organization for the entire peninsula.

INCOME & EMPLOYMENT PROGRAMS. The income and employment programs available are statewide. Each larger area has an unemployment and benefits program; however, offices are often full of people waiting beginning at open time and employees complain about being understaffed.

HEALTH INSURANCE. Health insurance has been a challenge for many Alaskans. Data shows that since 2010 when the Affordable Care Act first impacted Alaska, uninsured residents has fallen by 25%. Recent Medicaid expansion (2016) covered additional Alaskans, however still many still are not insured.

CULTURAL APPRECIATION

Several cultures are celebrated and provide support to their member groups. Ionia is a unique group that works with other groups with a focus on nutrition. CIRI, Kenaitze, and Chugachmiut are just a few of the Native Alaskan or Indian groups represented on the peninsula. The four Russian Orthodox communities are often close-knit and follow their long heritage.

LOCAL POLITICS & PREVENTION ORGANIZATIONS

ORGANIZATIONS. Wildwood Prison was recently hailed as leading the State of Alaska with their vocational work release program that connects prisoners with regular jobs in the community.

LOCAL GOVERNMENT. Local governments are active in the larger areas. Smaller areas are represented through the boroughs. Chambers of Commerce, including those in small areas like Seldovia and Anchor Point, encourage and organize community activities.

COMMUNITY WELLNESS

PRIMARY HEALTHCARE NEEDS. Most residents on the peninsula reported having access to primary healthcare at the larger cities, although transportation to facilities was often difficult.

WELLNESS ACTIVITIES. Wellness activities are often rare or expensive. Some communities offer special opportunities like $5 yoga once a week or inexpensive workout groups.

RECREATION. Recreation activities are often expensive or challenged by poor weather. However, summer offers a plethora of outdoor activities like hiking and fishing that are economical for residents.

CENTRALIZED MEETING PLACE. The communities on the Kenai Peninsula, with the exception of a few smaller communities, lack a community square to bring people together. Efforts are in effect to try and create these meeting places, with teen centers opening and centralized parks in some communities.

THE TREATMENT GAP

We view the community as a whole, considering the aspects that can build strength and resilience in our citizens. There is a substantial gap between the number of Kenai Peninsula residents who need addiction treatment and the capacity of local facilities to deliver this treatment. Addiction is a treatable disease, but access to treatment is very limited. The barriers of public transportation, cost, and qualified professionals further challenge access.

SUMMARY

STRENGTHS

Throughout the Kenai Peninsula residents strongly agree that the Alaskan way of life – independence and appreciation of the outdoors – is a healthy strength shared by most residents. Several towns throughout the Peninsula have dedicated groups and coalitions working to improve life and in many areas, working specifically on drug prevention. The level of community readiness to work on prevention and treatment options is very high. People are aware there is a problem and are willing to work toward solutions.

WEAKNESSES

The lack of behavioral health services, detox services and transitional living for all ages are seen as a significant gap in the Kenai Peninsula health system. Specialty care was mentioned as sparse and difficult to access for low-income individuals and families. Long wait times (sometimes 9 months or greater) for mental

health care and substance abuse care are a significant challenge to those attempting access to services. The disparities in location of services contribute to access problems.

A lack of health education in several sectors of the community is a concern for most citizens. This includes a lack of education in substance dependency issues for medical care professionals. It also includes limited substance abuse education and prevention education in schools and the community as a whole that target youth. Pre-release programs at local correctional centers as well as limited re-entry programs are another education weakness.

When asked which population groups have the most challenges, low-income populations were generally identified as having the most significant barriers related to economics, transportation, and stress. Many survey and interview respondents related challenges back to the social determinants of health.

BARRIERS

COMMUNITY NEEDS INDEX

Dignity Health and Truven Health developed and has made widely available for public use a Community Needs Index (CNI) that measures barriers to health care access by county/city. The index is based on five social and economic indicators:

INCOME BARRIER

- Percentage of households below poverty line, with head of household age 65 or more
- Percentage of families with children under 18 below poverty line
- Percentage of single female-headed families with children under 18 below poverty line

CULTURAL BARRIER

- Percentage of population that is minority (including Hispanic ethnicity)
- Percentage of population over age 5 that speaks English poorly or not at all

EDUCATION BARRIER

- Percentage of population over 25 without a high school diploma

INSURANCE BARRIER

- Percentage of population in the labor force, aged 16 or more, without employment
- Percentage of population without health insurance

HOUSING BARRIER

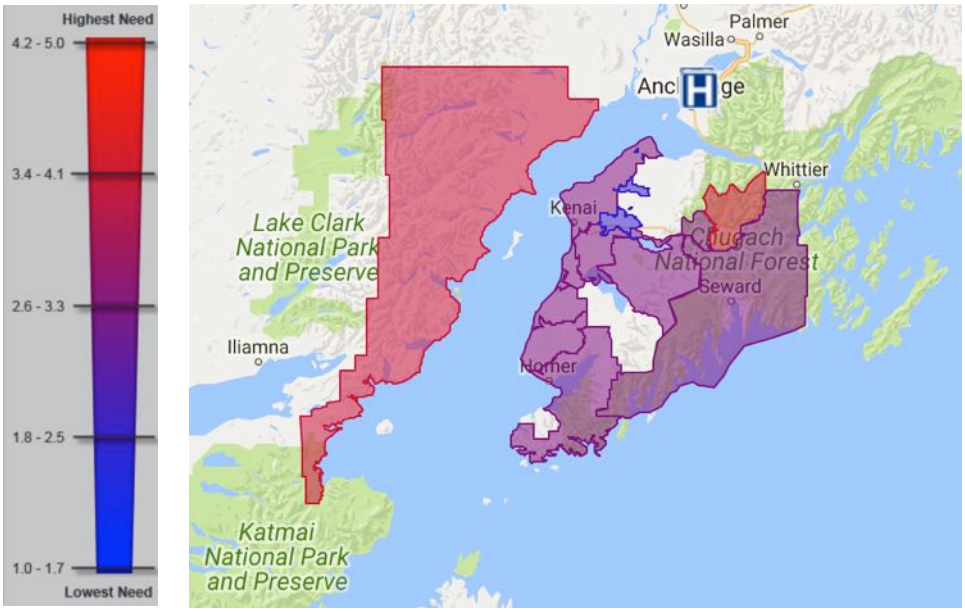
- Percentage of households renting their home

KENAI PENINSULA COMMUNITY NEEDS INDEX RESULT

The CNI calculates a score for each ZIP code based on these indicators. Scores range from "Lowest Need" (1.0-1.7) to "Highest Need" (4.2-5.0).

Based on the Kenai Peninsula, the weighted average CNI score was 2.8 and the median CNI score was 3.

Community Needs Index Scale Kenai Peninsula Map Results



BARRIERS SUMMARY

All communities shared common barriers in access to healthcare, economy, and transportation. Access to healthcare is a broad challenge on the peninsula as for some residents it means that the specialized treatment or doctor they need to see may not be within a 200-mile radius of where they live. For others access to healthcare means a lack of insurance coverage. Even with Medicaid expansion in 2016, many residents still have no insurance coverage. Furthermore, local emergency departments share concerns about being overburdened especially with those who could better specific care elsewhere.

Transportation is a core component that is integral to healthcare access. The Kenai Peninsula suffers multiple transportation barriers including geographical, weather, no public transit, other public transportation limited, and costly private transportation. Many transportation routes are challenged by winter weather for over half of the year. One main highway through the peninsula can spell disaster in case of the need or major evacuation. Most areas have a complete lack of public transportation, especially affordable transportation and bus routes. Public transit is nonexistent between peninsula towns and limited within them. Even when access to transportation may not be a challenge, cost of transportation does pose a secondary barrier. Vehicles and upkeep are more expensive, gas and fuel are often more per gallon than other places in the nation, and insurance costs are typically higher.

Beyond healthcare, there were significant barriers in the health realm mentioned including health literacy and stigmas against addiction. A lack of alcohol or drug-free family-friendly events reduces healthy family interactions within the community. Stigmas against addiction have developed common feelings of negativity toward addicts, as seen greatly in reaction to crime where community members will blame crime

on 'crack pots,' and those in the health field that feel a nuisance and frustration when dealing with patients under the influence of alcohol or drugs.

UNMET NEEDS

SOCIAL DETERMINANTS OF HEALTH. Interviewees indicated that health issues related to the social determinants of health are problematic, in communities farthest away from the central areas of Kenai/Soldotna and Homer. Despite the presence of several tertiary care centers, poverty in these areas remains a significant concern – and contributes to obesity and lack of healthy food options, poor housing, transportation challenges and other problems. Limited access to preventive and behavioral health services affects rates of smoking, chemical dependency, and reliance on hospital emergency rooms. Crime and violence are perceived as rising. Low income residents were identified as the most likely population to experience health problems directly related to the social determinants of health. Methods of health service that respect cultural, economic, and sociological differences among communities was another unmet need. Reliable public transportation was widely cited as a need for all areas.

ACCESS ISSUES. Interviewees cited the inability to access available health and social services barriers to improving community health outcomes. Lack of knowledge of available services, gaps in health insurance coverage (e.g., high deductibles and lack of coverage for self-employed), transportation, and providers not accepting Medicaid are examples of access barriers. Many indicated that social determinants of health also present significant access barriers and disproportionately affect the community's low socio-economic status groups, minority populations, elderly adults, and adolescents. Adolescents were mentioned frequently as a group in need, given a lack of mental health resources (beds and psychiatrists).

CONDITIONS AND CARE OF THE ELDERLY. The needs of a growing elderly population were mentioned by many interviewees as a significant community issue. Seniors with multiple chronic conditions, at risk for falls, with Alzheimer's disease and dementia, experiencing social isolation, with gaps in pharmaceutical coverage, and in areas with limited transportation options were identified as most at risk.

ECONOMICS. Economic factors are greatly impacted by the boom and bust cycle of the oil and gas industry as well as fishing and tourism. This can create a challenge and stress on families during down cycles.

MENTAL HEALTH AND ACCESS TO BEHAVIORAL HEALTH SERVICES. A large majority of those interviewed identified poor mental health and inadequate mental health resources as a significant need across communities. Populations experiencing the greatest challenges include children and adolescents, the homeless, and incarcerated individuals. Additional beds, more trained psychiatrists and social workers, enhanced training and services for law enforcement, better integration of mental health into physical health services, better training of primary care physicians in addressing mental health issues, and more mental health advocates who could help patients access services all were cited as important needs.

SUBSTANCE ABUSE. A large majority of those interviewed identified the abuse of opiates including heroin and fentanyl as a significant health concern. Abuse was cited as a widespread and growing issue, affecting individuals in every age and socioeconomic class. The over- prescription of pain medications by physicians and drug availability contribute to the epidemic. Interviewees also stated that accessing drug rehabilitation facilities is challenging. Additional substance abuse treatment resources are needed to help connect emergency room patients with appropriate follow-up services.

LARGEST SHARED CONCERN. Throughout the communities, the largest shared concern was demonstrated in substance abuse and mental health. It is clear that throughout all areas of the Kenai Peninsula, the two areas of mental health and substance abuse are widely accepted as the two largest areas

of unmet needs. The following graph is from a summary report from all the most recent Community Health Needs Assessments performed by various organizations in Homer/Southern Peninsula, Central Peninsula, and Seward.

The following table is a graphic summary of the main concerns of each peninsula community as summarized by multiple community needs assessments and reports. The overlap of concerns among all three communities is substance abuse and mental health concerns. There is also a strong secondary correlation with access to healthcare (which includes access to mental health care and substance abuse counseling, detox, and other programs), transportation, and local economy.

OVERLAP OF SUMMARIZED COMMUNITY CONCERNS

	Central Peninsula	Southern Peninsula	Seward
Access to Healthcare			
Economy			
Substance Abuse			
Mental Health			
Transportation			
Chronic Disease			
Youth Health			
Obesity			
Low Use of Preventative care			

The Kenai Peninsula is a diverse community with people who face different challenges and need specialized interventions. The following table represents most of the gaps, potential resources, and possible strategies shared by survey respondents, key informant interviews, focus groups, town hall meetings, and coalition work groups as they relate to the identified intervening variables/community factors.

RESOURCE AND GAPS TABLE

Intervening Variable	Community Factor	Resource Gap	Possible Resources	Strategies to Address Gap
Retail Availability	Medical Uncertainty and Inconsistencies Linked to Changing Prescriber Behavior and Laws	Public Transportation	Acute Care & 2 Critical Access Hospitals	Education for prescribers and providers
		Healthcare Provider Services	Tribal Physical & Behavioral Health Center	Increased preparation of substance abuse treatment specialists
	Lack of Access to Medical and Behavioral Health Services	Rural healthcare infrastructure challenges	4 Tribal Village Clinics	Expand access to non-opioid therapies for pain management
	Independence Mindset Fostering Disconnection and Unhealthy Social Norms	Disseminating of information regarding new federal rules, laws and regulations	2 Community Mental Health Centers	Increase access to Nalaxone
		Not understanding benefits & value of connection	4 Outpatient Addiction Treatment Providers with Multiple Locations	Develop programs to assist individuals with substance use disorders to access available services including transportation programs as well as funding and support for low-income individuals to access care
			15 Pharmacies	Revise patient satisfactions systems (e.g., HCAHPS and others) to more appropriately reflect methods of assessing patient satisfaction with provider pain management
			Road System	Identify legislative best practices to support and implement harm reduction strategies in rural areas
			5 Airports	Digital and printed community resource guide
Social Availability NMUPO	Multigenerational Substance Use and Family Dysfunction	Limited city centers for community gathering	6 senior centers	Enhance stakeholder coalitions
			2 Teen centers	Improve data collection and intelligence sharing among prevention, treatment, and law enforcement agencies
	Independence Mindset Fostering Disconnection and Unhealthy Social	Limited media coverage	3 recreation centers	

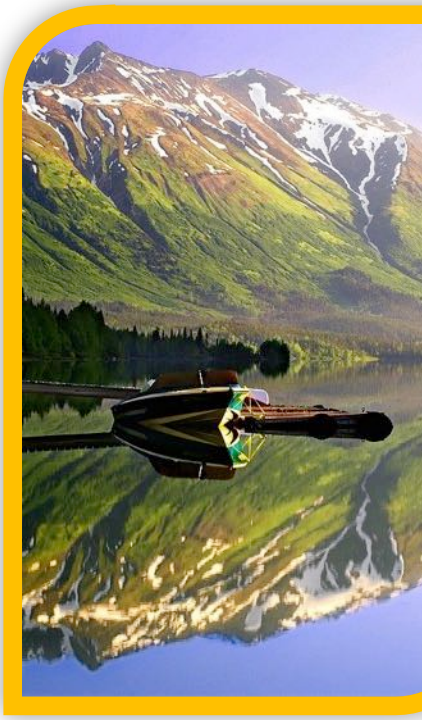
	Norms Economic Instability and Community Disorganization Providing Refuge for Illegal Acts	Public transportation limits ability to have pro-social involvement No local television stations Communities are widespread Prevention education limited in schools Limited before & after school programs for youth; youth left unsupervised Community planning for boom & bust economic cycles	Boys & Girls clubs 2 Domestic Violence Centers Community parks and events Public schools in all communities	Establish a collaborative information sharing environment across agencies Identify legislative best practices to support and implement harm reduction strategies in rural areas Advertise and foster community events to promote connection Parental support and education programs Improve knowledge of how to access substance abuse treatment Media campaigns geared toward healthy community norms Community youth programs that aim to develop social and emotional competence and build resiliency
Social Availability Heroin	Independence Mindset Fostering Disconnection and Unhealthy Social Norms Medical Uncertainty and Inconsistencies Linked to Changing Prescriber Behavior and Laws Economic Instability and Community Disorganization Providing Refuge for Illegal Acts	Limited city centers for community gathering Limited media coverage Public transportation limits ability to have pro-social involvement No local television stations Communities are widespread Prevention	6 senior centers 2 Teen centers 3 recreation centers Boys & Girls clubs 2 Domestic Violence Centers Community parks and events Public schools in all communities	Expand law enforcement partnerships and community support Expand access to treatment services through the development of an appropriate and sustainable continuum of outpatient and, as appropriate: ✓ inpatient care including medication assisted treatment ✓ psychosocial treatment programs ✓ mental health services ✓ and integrated primary, substance use ✓ and mental health services Improve knowledge of how to access substance abuse treatment

		education limited in schools Limited before & after school programs for youth; youth left unsupervised Community planning for boom & bust economic cycles Rural law enforcement infrastructure challenged with wide geographical range		Community youth programs that aim to develop social and emotional competence and build resiliency
Perceived Risk of Harm NMUPO	Multigenerational Substance Use and Family Dysfunction Abuse and Neglect Impacting Ability Transmit Health Information Lack of Access to Medical and Behavioral Health Services	Limited city centers for community gathering Limited media coverage Public transportation limits ability to have pro-social involvement No local television stations Communities are widespread Prevention education limited in schools Limited before & after school programs for youth; youth left unsupervised Community planning	6 senior centers 2 Teen centers 3 recreation centers Boys & Girls clubs 2 Domestic Violence Centers Community parks and events Public schools in all communities	Raise public awareness about the dangers of prescription opioid misuse Reduce stigma by changing the public's understanding of substance use disorder Community-based prevention system designed to improve the community's response to youth problem behaviors School-based curriculum for 5th graders on up that focuses on reducing risk factors and increasing protective factors Media & educational campaign to encourage safe use, safe storage, and safe disposal of prescription medication Educate teachers with classroom-based management strategies that are designed to socialize children and reduce disruptive classroom (and later community) behavior while recognizing and building resiliency

		for boom & bust economic cycles		Community youth programs that aim to develop social and emotional competence and build resiliency
		Rural law enforcement infrastructure challenged with wide geographical range		Use improving community connectivity and health as a recruitment method for medical health professionals
		Insufficient numbers of healthcare providers		Educate community members and leaders on the importance of making communities healthy, engaging, and accessible
Perceived Risk of Harm Heroin	Multigenerational Substance Use and Family Dysfunction	Limited city centers for community gathering	6 senior centers	Raise public awareness about the dangers of heroin
	Abuse and Neglect Impacting Ability Transmit Health Information	Limited media coverage	2 Teen centers 3 recreation centers	School-based program to promote personal and social skills-building resilience
	Economic Instability and Community Disorganization Providing Refuge for Illegal Acts	Public transportation limits ability to have pro-social involvement	Boys & Girls clubs 2 Domestic Violence Centers	Educate teachers with classroom-based behavior management strategies that are designed to socialize children and reduce disruptive classroom (and later community) behavior
		No local television stations	Community parks and events	Community youth programs that aim to develop social and emotional competence and build resiliency
		Communities are widespread	Public schools in all communities	Develop programs designed to develop and support youth substance abuse into college age; youth to young adult education and support continuity
		Prevention education limited in schools		Target at-risk and current users with harm reduction street outreach education, discussion and counseling
		Limited before & after school programs for youth; youth left unsupervised		
		Community planning		

	for boom & bust economic cycles	Reduce legal and regulatory barriers to development of needle exchanges, increase funding to support these programs, locate programs in convenient locations to ensure access by rural opioid users, and provide education to insure safe use Given the substantial risk for the transmission of HIV and HCV through intravenous opioid use, increase public health surveillance of prescription opioid and heroin use in rural communities to track populations of users; methods use (e.g., injection, inhalation, and smoked); types of opioids used; and rates of HIV and Hepatitis-C prevalence in these populations Media campaign geared toward healthy community norms

RECOMMENDATIONS



RECOMMENDATIONS

The heart of this assessment is that it truly embodies community-based participatory research; recommendations were developed from a melding of generated data and input from coalition members and focus group participants. In order for multiple participants to produce a coordinated set of recommendations, C4K needed to adapt a framework that could shape a community response to the opioid epidemic. Successful models for promoting health behaviors often focus on information dissemination, teaching specific competencies, and implementing change through social functions and activities. More succinctly, coalition members identified the scope of a media campaign, focus areas for community-wide and targeted educational activities, and community events or other forums to share information. Ideally community member will *watch* information about opioid misuse prevention, *learn* skills to reduce opioid misuse, and have *hands-on* experience with opioid prevention activities. Recommendations are combined for NMUPO and heroin as community solutions require interventions that impact substance misuse regardless of type of drug involved.

WATCH

MEDIA CAMPAIGN

C4K identified that a media campaign would allow for the sharing of information gleaned from this assessment and information aimed at decreasing the availability of opioids, improving community health and enhancing knowledge of the risks associated with substance misuse. A successful media campaign would be placed so that youth and young adults are exposed to messaging. Ideally Facebook, Instagram, and blogs provide avenues to share information. The media campaign should have levels three levels 1) information with community-wide appeal, 2) messaging targeted at youth and young adults, and 3) highlighting upcoming special events that include prevention aspects.

Community-wide messaging should focus on decreasing the stigma associated with addiction, end the perpetuation of myths associated with opioid use (i.e., prescription drugs are safe), and increase community knowledge of health risks associated with opioid misuse. This messaging should also focus on sharing information about the risks associated with Adverse Childhood Experiences (ACES) and use of alcohol and marijuana as these were highly correlated with subsequent heroin use. Promoting livable community interventions and family friendly events is also of paramount importance; these activities build connectivity and insulate against risks of opioid misuse.

The media campaign should also contain messaging directed specifically at the targeted population of youth and young adults. These efforts should include local, believable models that can easily be related to by this generation. Models should be engaging in activities unique to this age range or specific to the Kenai Peninsula (fishing, boating, Kenai events). Ideally this media campaign will direct listeners to the targeted

educational activities (defined below) or promote a skill (i.e., developing values, resisting pressure to use drugs, practicing new behaviors to master).

Promoting how to get help for yourself or a loved one with addiction is an important component of community education. Community members lack knowledge on available resources and how to access those resources. Our goal would be for it to be easier to find treatment than it is to find opioids.

The final phase of the media campaign should highlight special events. Examples included the prescription take-back events, Community Overdose Prevention Education (COPE) classes, or health and community fairs where C4K has targeted programs such as education on medication disposal, Narcan use, avoiding opioid misuse, or getting addiction treatment for a loved one.

LEARN

EDUCATIONAL ACTIVITIES

When possible, educational offerings should map onto already established best practices or evidence-based models. Prior to execution all educational activities should have identified goals, a teaching plan, and outline the desired behavior change. Materials should be peer reviewed and team taught when possible. These guidelines will enhance the sustainability of activities, enhance their transferability, and avoid inadvertently transmitting misinformation. Small community educational activities are particularly vulnerable to extinction when one or two key players are removed from the project, C4K hopes these simple directives will avoid resources being used on activities with short life spans.

COMMUNITY OVERDOSE PREVENTION EDUCATION (COPE). This is a series of four classes which provide education on the disease of addiction, the truth about drugs, decision making and parenting, and prescription drug misuse. Participants learn to recognize and respond to an opioid overdose and get financial assistance to purchase Narcan.

Community-wide education of the disposal of prescription medications is needed. Medicine cabinets are a source of diverted opioids. Many Peninsula residents to not know how to safely store or dispose of unused medications. C4K can provide education on safe storage options and disposal strategies. CHPA Educational Foundation (knowyourotc.org) provides educational materials, free of charge, that can be used to provide this education.

Targeted education is needed to promote engagement in community to foster the development of community and insulate families against ACES. The institute for local self-reliance has developed a toolkit to assist communities in building infrastructure to promote economic prosperity and improve quality of life. Multiple ACES training exists and combining the issues for dissemination crates motivation for change at the level of the family and a roadmap for how communities can support those changes.

Healthcare providers would benefit from education on the appropriate use of opioids to manage pain. Physician should receive training to assess the benefits of chronic opioid use in patients, identify patients that would benefit from these interventions, and educate and monitor patients to avoid development of addiction. Adjunct healthcare providers (nurses, physical therapist, counselors) would benefit from education on the management options other than opioid use for chronic pain and additional training on appropriate uses of opioids. The Providers Community Support Systems for Opioid Therapies (PCSS) are developing best practices in provider training.

Youth and young adults would benefit from focused education on opioid misuse and life skills training to help insulate them against factors that can lead to misuse. C4K was unable to identify a source of health behavior education is our community or schools. Weaving this education into community events or school

activities would increases its sustainability and reach more target population participants. SAMSHA's *Too Smart to Start* program gives a guideline for the development of these educational activities.

HANDS ON

COMMUNITY EVENTS OR RESOURCE DEVELOPMENT

Prescription take-back events help decrease the amount of prescription drugs available for diversion. C4K can support these activities through advertising, recruiting additional pharmacies to participate and assistance with event staffing. They are a great opportunity to promote the work of the coalition and provide education about storage and disposal of unused medications. In addition to take-back events, C4K can promote use of Soldotna and Kenai Police's medication disposal boxes and work with Homer and Seward Police to develop similar options in those communities. Rx Destroyer is a commercially available product that allows for safe disposal of medications at sites outside of police stations. C4K could work with Kenai Peninsula College, Senior Centers, hospice, and treatment providers to increase disposal options.

The Kenai Peninsula hosts several well attended community events. These events present opportunities for education about the risks of opioid misuse, how to access treatment services, overdose response, and safe medication storage and disposal. They are also venues to share about the need for community connectivity, ACES prevention, and promotion of targeted education and skill building activities. Sample events include:

- Health fairs
- Community Specific Events (i.e., Homer Halibut Derby, Soldotna Progress Days)
- Wednesday and Farmer's Markets
- Kenai Peninsula Fair
- Town Halls
- Recovery Promotion events

The ongoing development of the Resource Guide, which was initiated to complete this assessment, would benefit community members and healthcare providers. Having an easily accessible guide of available resources will make it much easier to find treatment and other needed services. This guide needs development to include more resources from outlying communities.

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APPENDIX

APPENDIX A

FOCUS GROUPS

Introduction

Focus groups provide insights into how people think and provide a deeper understanding of the addiction challenges in our communities. Our focus groups are group interviews that allowed us to capture deeper information by encouraging group interaction, connections, and allowing for observation by the facilitator. Methodology was designed by a Change 4 the Kenai coalition task force to develop a baseline of questions for all interviews. Community members from many Southern Peninsula locations were included to provide a view of the area and not one specific town. Russian Old Believer and Native Alaskan cultures were also represented.

Methodology

Conceptualization. In order to better understand the community's views and experiences about heroin and NMUPO's, the Change 4 the Kenai coalition task force selected study population sample groups that would represent the problem from several different angles.

Open-ended questions were developed for all user groups with specific guided questions utilized in specific groups when time allowed. Questions and script are available in the appendix.

Facilitation. Facilitators utilized a script and opened the meeting with a general question to encourage comfort in participants. Discussions were guided by the scripted questions, however, facilitators allowed focus groups to drive their own direction and depth of response. Groups had 4-8 participants.

Analysis. Response notes were organized into larger categories and then analyzed and discussed.

Introduction, to be explained by the facilitator:

- *"During the next hour we will be discussing the opioid misuse problem in our communities in order to develop ways to address it.*
- *You are the ones who really know the community. There are no right or wrong answers, give your honest opinions. If there are questions you are uncomfortable answering, we can skip them.*
- *Throughout this discussion, I will be using the term "opioid." An opioid is a substance that is a prescription medication (pill), and prescribed for pain relief. Heroin is also an opioid. Common opioid prescription pain relievers include OxyContin, Vicodin, and Percocet.*
- *By keeping the groups small we hope that everyone will have a chance to speak. Please be respectful of the opinion of others.*
- *We will keep the things that you say anonymous. That means your name won't be connected to what you said. When we report the results of this assessment, names will not be used. We will be taking notes during the focus group but your names will not be associated with your responses in any way. Please feel free to review my notes prior to leaving.*
- *Does anyone have any questions before we begin?"*

Introductions

- First names
- Brief ice breaker (how you heard about the focus group, group specific question)

For *ALL* Groups

- What types of substance misuse do you see in this area?
- Have you noticed any trends in the use of drugs and alcohol in this area?
- Have you noticed any changes in the use of opiates over time (pills and heroin)?
- Is there anything about this community that you think makes it more likely for people to use opiates?
- Is there anything that you think is working well to keep people from using opiates?
- Do you feel like the stigma toward drug use has changed over time? How?
- Can you share examples of resources this community currently has to help with substance abuse and prevention? Resources that could be added?
- Can you think of anything else that could be done to prevent opiate use?

For *Business Owners*

- What has your experience been with people with substance use disorders?
- How has drug abuse affected your business? (Probes: have you lost inventory due to theft, employees unreliable, had to let employees go?)
- What policies do you have in place for drug –use and drug testing?
- How do you think current laws affect your business? (Probes: theft penalties too strict or too relaxed)
- Is there anything else that you think it's important for us to know?

For *those involved with youth (Teachers, Counselors, Youth Group Leader)*

- What are some of the things that you think your youth worry about?
- Do you think the kids you work with worry about drugs and alcohol? (Probes: What do they worry about specifically?)
- Have you heard about youth in your school or group using drugs (friends, classmates, friends of friends?)
- What do you think are some reasons kids might try using drugs?
- What drugs do you think are popular right now among young people?
    - If they are aware of drug use: Where and when do they use them? How do you think they get them? If pills, how do you think they get them?
- What do you think about someone taking pills that another person's doctor gave to them?
    - (Probes: Do you think some pills are safer than other pills? Which ones? What about pills compared to drugs and alcohol?)
    - (Probes: Do you know anyone who takes pills? Are people around you using them?)
- If we could do one thing to prevent youth drug use/abuse, what should it be?
- What didn't we ask that we should have?

For *Police and First Responders (EMT/Fire)*

- What has your experience been with people with substance use disorders?
- Have you received any information or training regarding overdose and/or Narcan?
- What has been your experience with people who were overdosing? (Probes: What happened? How did you come upon the person? How did you respond?)
- What is your understanding of the Good Samaritan Law? (Probe: What do you think about it? How has it changed the way you do your job?)
- Before we finish, is there anything else that you think it's important for us to know?

For *Treatment Providers*

- What opiates are your clients using? Are there any patterns or changes over time?
- Based on what clients tell you, what do you think drives overdose?
- What has been your experience with overdose in your workplace? (Probes: Did you know what to do? What did you do? What happened?)
- What has been your experience with Narcan? (Probes: Has your agency provided training? Has it ever been used on a client? How has it affected your work? Do you know how to use it?)
- Have you identified anything that helps people seek treatment?
- What treatments do you see as most effective for opiate addiction? Why?
- Is there anything else that you think it's important for us to know?

KEY STAKEHOLDER INTERVIEWS

INTRODUCTION

Stakeholder interviews are conversations with members of the community that allow the coalition to see the community from the eyes of others. These unique perspectives can answer questions or provide clarity about challenges or certain sectors of the community.

COMMUNITY SECTORS INTERVIEWED

Schools/Universities

City/Borough/Tribal Government

Law Enforcement

Tribal Elders

Health and Medical Professionals

Social Service

Mental Health and Treatment Services

Clergy or Spiritual Community

Business Community

Media

Community at Large

Youth

METHODOLOGY

Questions for the key stakeholder interviews were designed to address several areas of community surrounding heroin and opioid misuse. Interviews were conducted face-to-face or over the phone when needed. The coalition work group identified stakeholders who should be familiar with heroin and opioid misuse in the community and represented a variety of community facets. A minimum of 6 interviews were conducted in each geographical area for both NMUPO and heroin, separately.

EXAMPLES OF KEY STAKEHOLDERS INTERVIEWED

Teachers

Business Owners

Medical Personnel

Pharmacists

Local Government

Probation Officer
Police Officer
Police Department Clerk
Corrections Officer
Volunteer and Mother in Recovery
Youth Pastor
RN Case Manager in Recovery
Public School Nurse
Criminal Justice Tech

Parent (12-year-old)
Native Community
Recovery
Community/Parent/Native Community
Public School Principal
Walk Participant

Civil Servant
Kenaitze Indian Tribe

APPENDIX C

OPIOID USER INTERVIEW RESEARCH

BACKGROUND

The goal of this interview series is to gain a better understanding of the many facets of life that drive or are affected by drug use. To follow the daily life and life history aspects that have influenced behavior and choices, we need to speak with current or past drug users to gain their unique and personal perspective.

Populations that may be difficult to reach due to physical locations, who may not wish to be contacted or are actively trying to conceal their identity are often referred to as 'hard to reach' or 'hidden populations.' Examples of other hard to reach populations include the homeless, faith-based communities, migrants and drug users[i]. Given that these groups are difficult to locate and communicate with, traditional sampling techniques may not prove useful when attempting to recruit for research-based interviews or surveys. Due to the under researched nature and their specific experience with the nature of the research, these populations may be those most at benefit of research findings.

In order to reach these populations, a range of alternative sampling techniques has been devised to successfully access and recruit members. Many of these techniques have been reviewed in previous literature[ii]. We have selected the methods we believe most useful and realistic our study as well as the most safe and comfortable for the individuals being interviewed.

Our research has several distinct challenges. First, our research for the Kenai Peninsula will require us to cover nearly 170 miles by road. Many small towns are found throughout the borough including, but not limited to, Seward, Kenai, Soldotna, Sterling, Nikiski, and Homer. Second, the nature of small town life will make random sampling highly difficult. To get the most accurate representation of this unique and important subset of the population, we plan to utilize three forms of sampling: snowball, respondent-driven, and privileged access interviewing. Informed, trained, and well-suited peer researchers will be the driving factor in successful research.

SNOWBALL SAMPLING

This method involves acquiring a sample through referrals from individuals who know others or who share the same characteristics of interest. This develops a chain of recruits and is considered to be a good method when gaining information on a sensitive issue such as drug use. A limitation to this method is that the sample gained will not be random, thus making it difficult to make a generalization of the findings to the whole population[iii]. This method is a strength for our coalition as we have active peer support already in place; thus, trust and security would be high.

RESPONDENT DRIVEN SAMPLING

In order to address issues of bias that may occur in a chain referral method such as the snowball sampling, respondent driven sampling (RDS) utilizes an agent such as a teacher, parent, neighbor, or peer to target an individual and then also offers an incentive for participating in the interview or survey[iv]. While similar to snowball sampling, it is presumed that multiple agents will provide introductions to individuals who may or may not know each other.

PRIVILEGED ACCESS INTERVIEWING

This method is most appropriate for the quick collection of data from diverse networks of drug users[v]. The criteria for privileged access interviewing (PAI) is that the interviewer had existing contacts within the subculture, they had a personal experience that made them non-threatening to the participants, they were suitably trained for interviewing, and they had a stable enough lifestyle now that making contact with drug users will not be damaging to them[vi]. With a strong network of peer support and trained professionals we feel that our coalition can effectively obtain interviewers that strongly meet these requirements.

PEER RESEARCHERS

Training. Interviews will be held by interviewers that have undergone training in interview procedures as well as how to recognize if their interviewee comes under duress and needs to be referred to a professional social worker.

WELFARE SCREENING

Access to trained mental health professional.

LONG-TERM STORAGE

Notes will be typed and interview sheets with handwriting will be destroyed. Interview subjects will be identified by a number such as subject '14'. Any recordings will be transcribed then erased so that voices cannot be traced. Typed notes and transcriptions will be kept on the secured network. No identifiable information will be available on the notes. Demographic data will be stored in separate files from the interview notes.

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APPENDIX D

PENINSULA RESOURCE GUIDE

THE FOLLOWING IS THE COMMUNITY RESOURCE GUIDE FOR THE KENAI PENINSULA.

It can also be found online at www.kenairesources.info or by scanning the QR code below:

change4theKenai
Connecting our Community

Central Kenai Peninsula | Southern Kenai Peninsula | Seward

COMMUNITY RESOURCES

Your Guide For

Basic Needs

On The

Kenai Peninsula

Directory

INTRODUCTION

The Community Resource Guide was developed by the Change 4 the Kenai community coalition to

- Connect community members with available resources
- Assist public services, volunteers, and business members to identify the needs of families and connect them to available resources.

HOW TO USE THIS GUIDE

Categories and subcategories are identified and color coded under a larger theme according to resource need. Visit our website www.kenairesources.org to find links or search for services.

Critical Needs
- Crisis Intervention
- Emergency Support
- Abuse
- Housing
- Clothing
- Food

Health
- Physical
- Dental/Vision
- Prescription
- Women's Care
- Substance Abuse
- Mental Health

Family Needs
- Disabilities
- Teen Issues
- Education
- Family & Children

General Supports
- Bereavement
- LGBTQA
- Older Adults
- Transportation
- Legal Services
- Financial

CRITICAL NEEDS

CRISIS INTERVENTION

EMERGENCY SUPPORT

ABUSE

HOUSING

CLOTHING

FOOD

CRITICAL NEEDS

"Small acts, when multiplied by millions of people, can transform the world."

- Howard Zinn

CRITICAL NEEDS

IN CASE OF EMERGENCY DIAL

911

LAW ENFORCEMENT

ALASKA STATE TROOPERS

CENTRAL PENINSULA

Soldotna	(907) 262-4453

SOUTHERN PENINSULA

Anchor Point	(907) 235-5511
Ninilchik	(907) 567-3660

SEWARD

Seward	(907) 224-3346

POLICE DEPARTMENTS

CENTRAL PENINSULA

City of Kenai	(907) 283-7879
Soldotna	(907) 262-4455

SOUTHERN PENINSULA

Homer	(907) 235-3150
Seldovia	(907) 234-7640

SEWARD

Seward	(907) 224-3338

FIRE & EMS SERVICES

CENTRAL PENINSULA

Soldotna Fire (CES)	(907) 262-4792
Kenai Fire Department	(907) 283-7666
Nikiski Fire Department	(907) 776-6401

FIRE & EMS SERVICES, CONT.

SOUTHERN PENINSULA

Anchor Point Fire and Emergency	(907) 235-6700
Homer Fire Department	(907) 235-3155
Kachemak Emergency Services	(907) 235-9811
Ninilchik Fire Service Area	(907) 567-3342
Port Graham Fire	(907) 284-2203
Seldovia Volunteer Fire	(907) 234-7812

SEWARD

Seward Volunteer Fire	(907) 224-3445
Bear Creek Volunteer Fire Department	(907) 224-3345

EMERGENCY MEDICAL SERVICES

CENTRAL PENINSULA

Central Peninsula Hospital	(907) 714-4404

SOUTHERN PENINSULA

South Peninsula Hospital	(907) 235-8101

SEWARD

Providence Emergency Clinic	(907) 224-2846
Seward Community Health Center	(907) 224-2273
Seward Volunteer Ambulance Corp	(907) 224-3987

ANIMAL CONTROL

Kenai Animal Shelter	(907) 283-7353
Soldotna Animal Shelter	(907) 262-3969
Homer Animal Shelter	(907) 235-3141
Seward Animal Shelter	(907) 224-7495

POISON CONTROL

Available 24 hours a day	(800) 222-1222

ROAD CONDITIONS

Online: 511.alaska.gov	Call: 511

WEATHER

Online: weather.gov/arh	(800) 472-0391

UTILITIES

CENTRAL PENINSULA

Homer Electric Association	(907) 283-5831

SOUTHERN PENINSULA

Homer Electric	(907) 235-8551

SEWARD

Seward Public Works Department	(907) 224-3338
Seward Electric	(907) 224-4073

IN CASE OF EMERGENCY DIAL

911

CRISIS LINES

Alaska Careline Crisis Intervention	(877) 266-HELP
www.carelinealaska.com	
Teen Crisis Line	(877) 266-4357
National Suicide Prevention Lifeline	(800) 273-8255
Seward Crisis Line	(907) 224-3027
Domestic Violence & Sexual Assault Crisis Line	(907) 362-1843
Report Child Abuse	(800) 478-4444
The LeeShore Center	(907) 283-7257
South Peninsula Haven House	(907) 235-8943
Central Peninsula Counseling Services	(907) 283-7511
www.suicide.org	

KENAI PENINSULA BOROUGH SCHOOL DISTRICT

Online: kpbsd.k12.ak.us	*(907) 714-8888*

School Closure Information:

KPBSD Mobile App

Facebook

Twitter: @KPBSD

Map of Kenai Peninsula Borough Schools.
Courtesy of *kpbsd.k12.ak.us*

HOUSING

Central Peninsula

The LeeShore Center
Phone: 907-283-9479
Crisis Line: 907-283-7257
leeshoreak.org

Services: *Emergency shelter, transitional living center, child care assistance program, and a clothes closet.*

Salvation Army
Alaska Division - Kenai Peninsula
201 N Forrest Drive
Kenai, AK 99611
907-283-4035
westerns.salvationarmy.org

Services: *Provides clothing, household goods, thrift store. Financial assistance for rent/utility may be available.*

AHFC Public Housing Assistance
44539 Sterling Highway Suite 201A
Soldotna, AK
(907) 260-7633
http://www.ahfc.us

Services: *Rental assistance to low income families.*

Rural Housing 283-6640

Southern Peninsula

Kenai Peninsula Housing Initiatives
3751 Sterling Highway
Homer, AK 99603
(907) 235-4357

Services: *Financial assistance for housing/utilities to individuals experiencing sudden loss of income or unplanned financial set-back.*

Salvation Army & Thrift Store
268 E Pioneer Avenue
Homer, AK 99603
(907) 235-8923
www.salvationarmyalaska.org

Services: Provides clothing, household goods, thrift store. Financial assistance for rent/utility may be available.

AHFC Public Housing Assistance
3670 Lake Street Suite 400
Homer, AK
(907) 235-2447
http://www.ahfc.us

Services: *Rental assistance to low income families.*

Seward

AHFC Public Housing Assistance
200 Lowell Canyon Road
Seward, AK
(907) 224-3737
www.ahfc.us

Services: *Rental assistance to low income families.*

STATEWIDE SERVICES

Energy Assistance
(800) 470-3058
hss.state.ak.us/dpa/programs/hap/

Weatherization Information
(800) 478-8080
www1.eere.energy.gov/wip/wap.html

CLOTHING

Central Peninsula

Salvation Army
Alaska Division - Kenai Peninsula
201 N Forrest Drive
Kenai, AK 99611
(907) 283-4035
westerns.salvationarmy.org

Services: *Provides clothing, household goods, thrift store. Financial assistance for rent/utility may be available.*

Kenaitze Indian Tribe
150 North Willow Street Suite 33
Kenai, AK 99611
(907) 335-7200
www.kenaitze.org

Services: *Offers financial support for food, clothing, shelter, utilities, child care, and burial expenses for low income Alaska Native American/ Indian Individuals.*

The LeeShore Center
Phone: 907-283-9479
Crisis Line: 907-283-7257
leeshoreak.org

Services: *Emergency shelter, transitional living center, child care assistance program, and a clothes closet.*

Kenai Peninsula United Way
508 S Willow Suite D
Kenai, AK
907-283-9500
kpuw@ptialaska.net
national.unitedway.org

Southern Peninsula

Helping Hands
7746 Milo Fritz Road
PO Box 438
Anchor Point, AK 99556
(907) 235-0707

Services: *Clothing and household items available for purchase by donation.*

Salvation Army & Thrift Store
268 E Pioneer Avenue
Homer, AK 99603
(907) 235-8923
www.salvationarmyalaska.org

Services: *Provides clothing, household goods, thrift store. Financial assistance for rent/utility may be available.*

Pick N' Pay
(907) 235-8436
stjohnthebaptistcatholicchurch.org

Services: *Sell gently used clothing, toys, small household goods. Donations available for homes lost to fire.*

Seward

The Compassion Closet
809 Fourth Avenue
Located in the Church of the Nazarene
Seward, AK
(907) 224-7052
sewardnaz.org/about

Services: *Clean, gently used clothes available to those in need.*

SeaView Community Services Public Assistance Program
302 Railway Ave
Seward, AK
(907) 224-5257

Qutekcak Native Tribe
Public Assistance Program
221 Third Avenue
Seward, AK
(907) 224-3118
www.sewardaknatives.com

FOOD

Central Peninsula

Kenai Peninsula Food Bank
33955 Community College Drive
Soldotna, AK 99669
(907) 262-3111
foodhelp@ptialaska.net
www.kpfoodbank.org

Services: *Food available for those in need. Available through agencies from Seward to Homer!*

Women, Infants, and Children (WIC) Program
(907) 283-4707

Services: *Supplemental food program for low income women, infants and children up to five years old.*

Love I.N.C. & The Family Hope Center
44410 Kalifonsky Beach Road
Soldotna, AK 99669
Mailing Address:
PO Box 3052
Kenai, AK 99611
NEEDS LINE: 907-262-5140
peninsulaloveinc.com

Services: *A national, faith based charity work to assist income qualified families to address needs for basic goods such as food, clothing, shelter, and employment.*

Salvation Army
(907) 283-4035

Soldotna Methodist Food Pantry
(907) 262-5140

Free Nutrition & Food Budgeting Info. (907) 262-5824

Southern Peninsula

Homer Community Food Pantry
770 East End Road
Homer United Methodist Church
Homer, AK 99603
(907) 235-1968

Services: *Provides emergency food and financial services to individuals and families in need.*

Women, Infants, and Children (WIC) Program
3446 Main Street
Homer, AK 99603
(907) 235-5495

Services: *Nutritional education for pregnant women, breastfeeding, vouchers for free food.*

Share the Spirit
PO Box 3214174
Homer, AK 99603
(907) 235-7466

Services: *Food vouchers, basic living needs like diapers, eyeglasses and medicine.*

Seward

He Will Provide
2101 Seward Highway
Seward, AK 99664

Services: *Provides food for those in need.*

Alaska Family Nutrition Program
Seward WIC Clinic
201 Third Avenue
(907) 224-9186
www.hss.state.ak.us/dpa/programs/nutri/WIC

Alaska GROWN

STATEWIDE SERVICES

Public Assistance (Food Stamps)
(907) 283-2900
www.dphhs.mt.gov/programsservices

Health

PHYSICAL

DENTAL/VISION

PRESCRIPTION

WOMEN'S CARE

SUBSTANCE ABUSE

MENTAL HEALTH

HEALTH

Health

PHYSICAL HEALTH

Central Peninsula

Central Peninsula Hospital
250 Hospital Place
Soldotna, AK 99669
(907) 714-4404
www.cpgh.org

Services: *Medical, behavioral health, outpatient, lab, family birth center, and more.*

Peninsula Community Health Services of Alaska
230 E Marydale Ave
Soldotna, AK 99669
(907) 262-3119
www.pchsak.org

Services: *Medical, dental, behavioral health.*

Kenai Public Health Center
630 Barnacle Way #A
Kenai, AK 99611
(907) 335-3400
http://dhss.alaska.gov/dph/Nursing/Pages/Kenai-Public-Health-Center.aspx

Services: *Family planning, immunizations, school screenings, well child exams, health education and more.*

Kenai Peninsula Community Care Center
320 South Spruce Street
Kenai, AK 99611
(907) 283-7635
http://www.kpccc.com

Southern Peninsula

South Peninsula Hospital
4300 Bartlett Street
Homer, AK 99603
(907) 235-8101
www.sphosp.org

Services: *18 bed acute care hospital and 28 bed long term care. Emergency care, imaging, lab, birthing center, and more.*

Seldovia Village Tribe (SVT)
206 Main Street
Seldovia, AK 99663
(907) 234-7898
www.svt.org

Patient offices in Homer, Anchor Point, and Seldovia.

Services: *Drug and alcohol prevention, housing, community health, veterans support, and more for Alaska Native populations.*

Ninilchik Traditional Council
PO Box 39368
Ninilchik, AK 99639
(907) 567-3370
www.ninilchiktribe-nsn.gov

Services: *Mental health, alcohol, and substance abuse outpatient treatment and counseling services.*

Seward

Providence Seward Medical Center
Seward, AK
(907) 224-5205
http://alaska.providence.org/

Services: *Emergency services, laboratory, radiology, swing bed program, therapies, and more.*

Seward Community Health Center
417 First Avenue
PO Box 2895
Seward, Alaska 99664
Phone 907-224-2273
(907) 224-CARE
www.sewardhealthcenter.org

Services: *Family medicine, urgent care, wellness visits, prenatal, physicals, prescription assistance, transportation assistance, insurance enrollment assistance and more.*

Glacier Family Medicine Clinic
11724 Seward Hwy. Suite #D
Seward, AK 99664
(907) 224-8733
glacierfamilymedicine.com

Services: *Prenatal Care, well child exams, immunizations, urgent care, xrays, minor surgical procedures, and more.*

PHYSICAL HEALTH

Central Peninsula

Medicenter Kenai
10543 Kenai Spur Hwy
Kenai, AK 99611
(907) 283-9118
www.kenaidoctor.com

Services: *Family practice, urgent care, occupational medicine, physical therapy and more.*

Dena'ina Wellness Center
508 Upland St.
Kenai, AK
(907) 335-7300
https://www.kenaitze.org
Services: *Medical, dental, behavioral health, wellness, physical therapy, traditional healing, labs and pharmacy.*

Southern Peninsula

Homer Medical Clinic
4136 Bartlett Street
Homer, AK
(907) 235-8586
http://www.homermedical.org

Services: *OB/GYN, midwifery, pediatrics, family medicine, behavioral health, occupational health, acute care, disease management and more.*

Kachemak Bay Medical Clinic
4201 Bartlett Street #202
Homer, AK
(907) 235-7000
http://www.kachemakbaymedical.com

Services: *Children's health, wellness and preventative exams, minor surgeries, occupational medicine.*

Seward

Harbor Medical Clinic
611 4th Avenue
Seward, AK
(907) 224-8901

Services: *General medical care*

Chugachmiut North Star Health Clinic
(907) 224-3490
www.chugachmiut.org

Services: *Serving Alaskan Native/ American Indian Beneficiaries. Primary Care Clinic, Behavioral Health Services, Diabetes Prevention, TobaccoPrevention & Control, Maternal/Child Health, Contract Health Services.*

ALASKAN HEALTH RESOURCES

State of Alaska Health & Social Services Directory
www.dhss.alaska.gov/pages/services.aspx

Alaska 2-1-1 or 800-478-2221
www.alaska211.org
Connects callers, at no cost, to information about critical health and human services available in communities around Alaska.

Alaska Department of Health and Social Services
Division of Health Care Services

Alaska Tobacco Quit Line
800-QUIT-NOW (784-8669)
www.alaskaquitline.com

Breast & Cervical Health Check
800-410-6266
www.dhss.alaska.gov/dph/wc /pages/bchc/default.aspx
A State of Alaska program providing free screening for eligible women.

Denali Kid Care
888-318-8890
www.dhss.alaska.gov/dhcs
A State of Alaska program designed to ensure that children/teens of working/non- working families can have the health insurance they need.

DENTAL

Central Peninsula

Peninsula Community Health Services of Alaska
230 E Marydale Ave
Soldotna, AK 99669
(907) 262-3119
www.pchsak.org

Services: *Medical, dental, behavioral health.*

Gentle Dental
104 S Binkley St. Suite A
Soldotna, AK
(907) 262-8834
http://www.gentledentalak.com

Soldotna Dental Arts
35657 Kenai Spur Hwy.
Soldotna, AK
(907) 420-3938
http://www.soldotnadentalarts.com

Legends Dental
Soldotna, AK
(907) 260-4700
http://legendsdentalak.com

Hu Family Dentistry
Soldotna, AK
(907) 262-6466
http://www.smilesofalaska.com

Peninsula Dental Center
Soldotna, AK
(907) 283-9125
peninsulafamilydentalcenter.com

Peninsula Pediatric Dentistry
Soldotna, AK
(907) 260-5439
http://www.kidztoof.com

Southern Peninsula

Homer Dental Center
(907) 235-7585
www.homerdentalcenter.com

Homer Dental Clinic
(907) 235-8909
www.homerdentalclinic.com

Preventive Dental Services
(907) 235-1286
www.preventivedentalservices.com

Ryan Abbot DDS
Anchor Point, AK
(907) 226-3700
www.ryanabbottdds.com

Ninilchik Family Dentist
66334 Aspen Ave
Ninilchik, AK
(907) 567-4444

Port Graham Clinic
(907) 284-2241
www.chugachmiut.org

Services: *Emergency care, pregnancy care, well child care, general health, dental, mental health services, and regularly scheduled visitation from specialists.*

Oral Surgery Associates
Anchorage • Kenai • Homer
(907) 283-7344
http://www.oralsurgeryalaska.com

Services: *Oral surgeons with offices in Anchorage, Kenai and Homer.*

Seward

Chugachmiut North Star Dental Clinic
201 Third Avenue Suite 115
Seward, AK
(907) 224-4925
www.chugachmiut.org/Services/Health/Northstar

Seward Family Dentistry
400 Fourth Avenue
Seward, AK
(907) 224-3071

Dr. Robert D. O'Connell
866-283-7575
Visits Seward Family Dentistry once a month.

DENTAL/VISION

Central Peninsula | Southern Peninsula | Seward

DENTAL, CONTINUED

Kenai Dental Clinic
Kenai, AK
(907) 283-4875
https://www.kenaiakdentalclinic.com

Dena'ina Wellness Center
508 Upland St.
Kenai, AK
(907) 335-7300
https://www.kenaitze.org

Cook Inlet Dental
Kenai, AK
(907) 283-0454
http://cookinletdental.com

Oral Surgery Associates
Anchorage • Kenai • Homer
(907) 283-7344
http://www.oralsurgeryalaska.com

Services: *Oral surgeons with offices in Anchorage, Kenai and Homer.*

VISION

Kenai Vision Center
Kenai, AK
(907) 283-7575
http://visionsource-kenaivision.com

Vista Optical
Soldotna, AKparph
(907) 260-3316
http://www.findvistaoptical.com

Eyewear Express
Peninsula Center Mall
(907) 260-9199
http://eyewearexpresssoldotna.com

Soldotna Optometry Clinic
Soldotna, AK
(907) 262-3168
http://visionsource-soldotna.com

VISION

Homer Eyecare
3726 Lake Street
Homer, AK
(907) 235-7745
http://www.homereyecare.com

Sitenga Eye Associates
4381 E Hill Road
Homer, AK
(907) 235-2358

VISION

Prism Optical
800-478-5510
Dr. Kosterman visits Providence once a month.

State of Alaska Fun Facts:

State Flower	Forget-Me-Not
State Gem	Jade
State Capitol	Juneau
State Bird	Willow Ptarmigan
State Insect	Dragonfly
Population	722,718
Square Miles	570,640
State Sport	Dog Mushing
State Motto	North to the Future!

PRESCRIPTIONS

Central Peninsula

Soldotna Professional Pharmacy
299 N. Binkley St
Soldotna, AK
(907) 262-3800

Geneva Woods Pharmacy
Soldotna, AK
(907) 262-2424
http://www.genevawoods.com/locations/#soldotna

Safeway Pharmacy
Soldotna and Kenai
(907) 714-5400

Walgreens Pharmacy
44001 Sterling Hwy
Soldotna, AK
(907) 260-6372

Fred Meyer Pharmacy
(907) 260-2233

Three Bears Pharmacy
10575 Kenai Spur Hwy
Kenai, AK
(907) 335-2061
http://threebearsalaska.com

Walmart Pharmacy
(907) 395-0871

Southern Peninsula

Safeway Pharmacy
Homer, AK
(907) 226-1000

Ulmer's Drug and Hardware
3858 Lake Street
Homer, AK
(907) 235-8594
www.ulmersdrugandhardware.com

Scott's Family Pharmacy
4014 Lake Street #101
Homer, AK
(907) 226-2580
http://scottsfamilyrx.com

Seward

Chugachmiut North Star Dental Clinic
201 Third Avenue Suite 115
Seward, AK
(907) 224-4925
www.chugachmiut.org/Services/Health/Northstar

Safeway Pharmacy
Seward, AK
(907) 224-6960

WOMEN'S CARE

Central Peninsula

The LeeShore Center
325 S. Spruce Street
Kenai, AK 99611
(907) 283-9479
24-Hr Crisis Line:
(907) 283-7257
www.leeshoreak.org

Services: *Advocacy for victims, 24 hr crisis intervention, support groups, assistance to abused/neglected elders and those with disabilities, transitional living center, child care assistance program.*

Friendship Mission
(907) 283-5277
kenaifriendshipmission.com/

ABC Crisis Pregnancy Center
508 S Willow Street Suite D
Kenai, AK
(907) 283-9062
www.cpcanchorage.com

Planned Parenthood
(907) 262-2622
www.plannedparenthood.org

ALASKA WIC

Southern Peninsula

South Peninsula Haven House
(Homer)
(907) 235-7712
havenhousealaska.org

Services: *Supporting and empowering people impacted by domestic violence and sexual assault and promoting healthy families.*

Kachemak Bay Family Planning Clinic
3959 Ben Walters Lane
Homer, AK 99603
(907) 235-3436
www.kbfpc.org

Services: *well-woman visits, mammogram, family planning and more.*

Women, Infants, and Children (WIC) Program
3446 Main Street
Homer, AK 99603
(907) 235-5495

Services: *Nutritional education for pregnant women, breastfeeding, vouchers for free food.*

Pregnancy Care Center of Homer
3896 Bartlett Street
Homer, AK
(907) 235-7899
http://pccofhomer.com

Planned Parenthood® Care. No matter what.

Seward

See Central Peninsula or Anchorage

Alaska Women's Health Program

ALASKA WOMEN'S HEALTH PROGRAM SUGGESTS THE FOLLOWING FOR GOOD HEALTH:

- Get at least 2.5 hours of moderate physical activity each week.
- Eat nutritious foods.
- Visit a doctor for regular checkups and get preventive screenings.
- Avoid risky behaviors like smoking and not wearing a seatbelt.
- Be conscious of mental health, which includes getting adequate sleep and managing stress.

Adult Health Services Unit & Family Planning Program

Women's, Children's & Family Health
Division of Public Health

Alaska Department of Health & Social Services

3601 C Street, Ste 322
Anchorage, AK 99503-5923

907-269-3400

SUBSTANCE ABUSE

Central Peninsula

Serenity House
Central Peninsula Hospital
245 N Binkley Street
Soldotna, AK 99669
(907) 714-4521
www.cpgh.org/serenityhouse

Services: *Chemical Dependency Treatment Center.*

Cook Inlet Council on Alcohol and Drug Abuse (CICADA)
(907) 283-3658

Services: *Out patient chemical dependency counseling for adults and adolescents.*

Al Anon
(907) 262-9231

Alcoholics Anonymous (AA)
(907) 262-2496

Narcotics Anonymous
(907) 335-9456

Southern Peninsula

South Peninsula Behavioral Health Services, Inc.
3948 Ben Walters Lane
Homer, AK 99603
(907) 235-7701
www.spbhs.org

Services: *mental health care, Journeys (adult rehab services), PRIDE (developmental disability services).*

Cook Inlet Council on Alcohol and Drug Abuse (CICADA)
(907) 235-8001

Services: *Out patient chemical dependency counseling for adults and adolescents.*

Al Anon
(907) 235-7210

Alcoholics Anonymous (AA)
(907) 235-6822

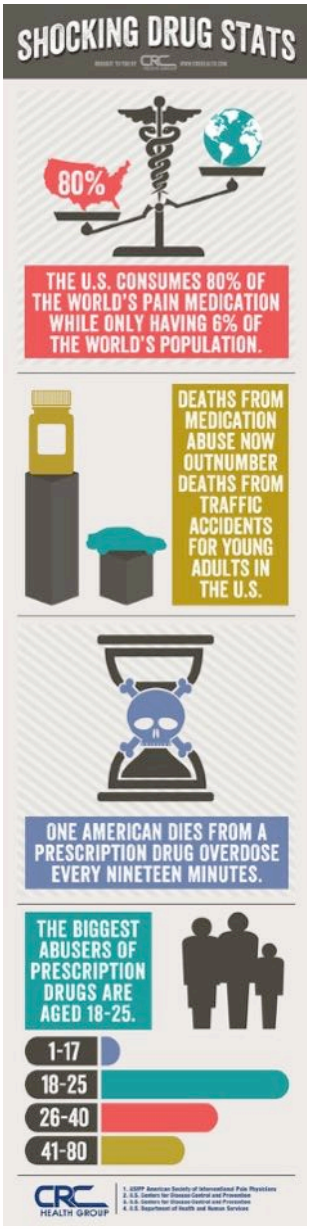
Ninilchik Traditional Council
PO Box 39368
Ninilchik, AK 99639
(907) 567-3370
www.ninilchiktribe-nsn.gov

Services: *Mental health, alcohol, and substance abuse outpatient treatment and counseling services.*

Seward

Alcoholics Anonymous
809 Fourth Ave
Seward, AK
(907) 224-3843

Narcotics Anonymous
866-258-6329
Third and Jefferson
Resurrection Lutheran Church
(Basement entrance)



MENTAL HEALTH

Central Peninsula

Serenity House
Central Peninsula Hospital
245 N Binkley Street
Soldotna, AK 99669
(907) 714-4521
www.cpgh.org/serenityhouse

Services: *Chemical Dependency Treatment Center.*

Peninsula Community Health Services of Alaska
230 E Marydale Ave
Soldotna, AK 99669
(907) 262-3119
www.pchsak.org

Services: *Medical, dental, behavioral health.*

AKEELA
10735 Kenai Spur Highway Set 2
Kenai, AK
(907) 283-6586
info@akeela.org
www.akeela.org

Services: *Integrated behavioral health prevention and clinical services throughout Alaska.*

Kenai Peninsula Community Care Center
320 S. Spruce Street
Kenai, AK
(907) 283-7635

Denai'ina Wellness Center
Sobriety Services
508 Upland St
Kenai, AK
(907) 335-7500
www.kenaitze.org

Services: *Mental Health*

Southern Peninsula

South Peninsula Behavioral Health Services, Inc.
3948 Ben Walters Lane
Homer, AK 99603
(907) 235-7701
www.spbhs.org

Services: *mental health care, Journeys (adult rehab services), PRIDE (developmental disability services).*

South Peninsula Hospital: The Annex Adult Rehab Services
966 Hillfair Court
Homer, AK 99603
(907) 235-7701

Services: *Transportation and other services available to eligible clients to promote recovery among adults who experience mental illness. Behavioral health, case management, housing support, skills training, counseling, and more.*

Ninilchik Traditional Council
PO Box 39368
Ninilchik, AK 99639
(907) 567-3370
www.ninilchiktribe-nsn.gov

Services: *Mental health, alcohol, and substance abuse outpatient treatment and counseling services.*

Seward

SeaView Community Services
302 Railway Avenue
P.O. Box 1045
Seward, Alaska 99664
(907)224-5257
CRISIS LINE: (907)224-3027

Services: *Infant learning program, disability services, behavioral health, community services, domestic violence, substance abuse recovery, and more.*

Alaska Department of Health and Social Services
Division of Behavioral Health

Partners in Prevention

central peninsula hospital

CARELINE
CRISIS INTERVENTION
HELP!
Call 1-877-266-HELP (4357)

CARELINE
877-266-HELP
www.carelinealaska.com

FAMILY NEEDS

DISABILITIES

TEEN ISSUES

EDUCATION

FAMILY & CHILDREN

FAMILY NEEDS

Family Needs

DISABILITIES

Central Peninsula

Frontier Community Services
43335 K Beach Road, #36
Soldotna, AK 99669
Phone: 907-262-6331
Fax: 907-262-6294
Email: work@fcsonline.org
www.fcsonline.org

Services: *Developmental disabilities, Alaskans Living Independently, Infants and Children, Mental Health Services, Fetal Alcohol Spectrum Disorder Program, Family Support Services.*

HOPE Community Resources
47272 Princeton Ave
Soldotna, AK 99669
(907) 260-9469
hopealaska.org

Services: *Assisted living homes, supports foster care providers, Hope Kenai Community Center offers recreational activities and classes.*

Independent Living Center
47255 Princeton Avenue Suite 8
Soldotna, AK
(907) 262-0453
www.peninsulailc.org

Vocational Rehab
(907) 283-3133

Southern Peninsula

South Peninsula Behavioral Health Services, Inc.
3948 Ben Walters Lane
Homer, AK 99603
(907) 235-7701
www.spbhs.org

Services: *mental health care, Journeys (adult rehab services), PRIDE (developmental disability services).*

The Independent Living Center
3953 Bartlett Street
PO Box 2474
Homer, AK 99603
(907) 235-7911
www.peninsulailc.org

Services: *Independent living services for a person of any age with any disability. Peer counseling and transportation assistance available.*

The Terrace Assisted Living
250 Herndon
Homer, AK 99603
(907) 235-6727

Services: *40 bed assisted living facility.*

Seward

The Independent Living Center
201 3rd Ave Suite 101B
Seward, AK
(907) 227-8711
www.peninsulailc.org

Services: *Independent living services for a person of any age with any disability. Peer counseling and transportation assistance available.*

SeaView Community Services
302 Railway Avenue
P.O. Box 1045
Seward, Alaska 99664
(907)224-5257
CRISIS LINE: (907)224-3027

Services: *Infant learning program, disability services, behavioral health, community services, domestic violence, substance abuse recovery, and more.*

Frontier Community Services

INDEPENDENT LIVING CENTER

DISABILITIES

Central Peninsula

ACCESS Alaska
33880 Community College Dr.
Soldotna, AK 99669
(907) 262-4955
info@accessalaska.org
www.accessalaska.org

Services: *Information and referral, independent living skills, peer counseling, advocacy, and nursing home transition.*

Consumer Direct Personal Care
412 Frontage Road #40
Kenai, AK 99611-7770
(907) 283-0809
www.consumerdirectak.com

Services: *Personal care assistance, chore & respite care.*

Frontier Community Services
43335 K Beach Road, #36
Soldotna, AK 99669
Phone: 907-262-6331
Fax: 907-262-6294
Email: work@fcsonline.org
www.fcsonline.org

Services: *Developmental disabilities, Alaskans Living Independently, Infants and Children, Mental Health Services, Fetal Alcohol Spectrum Disorder Program, Family Support Services*

HOPE Community Resources
47272 Princeton Ave
Soldotna, AK 99669
(907) 260-9469
hopealaska.org

Services: *Assisted living homes, supports foster care providers, Hope Kenai Community Center offers recreational activities and classes.*

Southern Peninsula

Consumer Direct Personal Care
126 W. Pioneer Avenue, #5
Homer, AK 99603-7564
907-226-1157
www.consumerdirectak.com

Services: *Personal care assistance, chore & respite care.*

South Peninsula Behavioral Health Services, Inc.
3948 Ben Walters Lane
Homer, AK 99603
(907) 235-7701
www.spbhs.org

Services: *mental health care, Journeys (adult rehab services), PRIDE (developmental disability services).*

The Independent Living Center
3953 Bartlett Street
PO Box 2474
Homer, AK 99603
(907) 235-7911
www.peninsulailc.org

Services: *Independent living services for a person of any age with any disability. Peer counseling and transportation assistance available.*

The Terrace Assisted Living
250 Herndon
Homer, AK 99603
(907) 235-6727

Services: *40 bed assisted living facility.*

ADRC
Aging & Disability Resource Centers

KENAI PENINSULA
Independent Living Center, Inc.
www.peninsulailc.org

Seward
201 Third Ave., Suite 102
P.O. Box 3523
Seward, AK 99664
907-224-8711

Central Peninsula
47255 Princeton Ave. Suite 8
Soldotna, Alaska 99669
907-262-6333

Homer
3953 Bartlett
P.O. Box 2474
Homer, AK 99603
907-235-7911

CONSUMER DIRECT CARE NETWORK ALASKA

H·O·P·E
Community Resources Inc.

YOUTH & TEENS

Central Peninsula

Boys and Girls Clubs of the Kenai Peninsula
705 Frontage Road Suite B
Kenai, AK
(907)283-2682
www.bgckp.com

Services: *Clubhouses and teen youth development programs in Kenai, Soldotna, Nikiski, Seward and Kasilof. Year round athletics programs.*

Community Schools
538 Arena Ave
Soldonta, AK
(907) 714-1211

http://www.ci.soldotna.ak.us/resident-services/community-schools

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Alaska 4-H Kenai Peninsula
43961 K Beach Road
Soldotna, AK
www.alaska4h.org/kenai-peninsula.html

BOYS & GIRLS CLUBS OF AMERICA

Southern Peninsula

Teens United for A Future
(907) 299-7578
teensunitedforafuture@ymail.com

Services: *Volunteers helping homeless teens and families obtain food, clothing, schooling, and more.*

Big Brothers Big Sisters of Alaska
PO Box 1034
Homer, AK 99603
(907) 235-8397
trish.herrmann@bbbsak.org
www.bbbsak.org

Services: *Community-based mentoring*

The R.E.C. Room
3957 Nielsen Circle
(907) 235-3436
http://homerrecroom.org

Services: *youth resource and enrichment co-op free to all teens age 12-18. Classes and peer educators.*

Homer Community Schools Parks and Recreation
www.cityofhomer-ak.gov/recreation

Services: *Classes, co-ed sports leagues, weight room, activity guide*

Seward

Teen Rec Room
City of Seward
336 3rd Ave
Seward, AK
(907) 224-4057

Teen and Youth Center
City of Seward
336 Jefferson
Seward, AK
(907) 224-5472

Boys & Girls Club
600 Sea Lion Drive
(907) 224-7001
www.bgckp.com

Boy Scouts
(907) 283-1699
Troop 568 meets at Elks Club
www.scoutingalaska.org

Civil Air Patrol Cadets
(907) 224-3000
www.gocivilairpatrol.com

Teen and Youth Center
(907) 224-5472
www.cityofseward.us

CHILDREN SERVICES

Alaska Parent Line
1-800-643-KIDS (5437)
www.rcpcfairbanks.org

Office of Children's Services
800-478-4444
www.dhss.alaska.gov/ocs

Alaska Youth and Family Network
(907) 770-4979
AYFN advocates for families and children with social/emotional/behavioral challenges and related disabilities.
www.ayfn.org

EDUCATION

Central Peninsula

Kenai Peninsula College
(907) 262-0300
www.kpc.alaska.edu/KPC

Kenai Learning Center (G.E.D)
(907) 262-0327
www.kpc.alaska.edu/KPC

New Frontier Vo-Tech (office)
(907) 262-9055
http://nfvtc.tripod.com/id13.html

UAF Cooperative Extension Services

Services: 4-H program for youth, agricultural education for all.

JOB Corp
(907) 562-6200

Vocational Rehabilitation Career Support and Training Services
(907) 335-3060

Cook Inlet Tribal Council Employment and Training
(907) 793-3300

Kenaitze Education and Career Development
(907) 335-7600

Southern Peninsula

Kachemak Bay Campus
Kenai Peninsula College (UAA)
533 E Pioneer Ave.
Homer, AK 99603
(907) 235-7743
www.kpc.alaska.edu/kbc

Services: *A.A., B.A., B.S. course work in several majors, GED program, career planning and more.*

Homer Public Library
500 Hazel Ave
Homer, AK 99603
(907) 235-3180
www.cityofhomer-ak.gov/library

Ninilchik Community Library
PO Box 39165
Ninilchik, AK 99639
(907) 567-3333

Seward

AVTEC Alaska's Institute of Technology
809 Second Avenue
Seward, AK
(907)224-3322
www.avtec.edu

Kenai Peninsula College – Resurrection Bay Extension Site
2001 Swetmann Avenue
Seward, AK
(907) 224-2285
www.kpc.alaska.edu/RBES

University of Alaska Fairbanks – Seward Marine Center
201 Railway Avenue
Seward, AK
(907) 224-5261
www.sfos.uaf.edu

Moose Pass Public Library
Depot Road Mile 30
Moose Pass, AK
(907) 288-3111

Seward Community Library
(907) 224-4082

Museum
239 6th Avenue
Seward, AK
(907) 224-3902
www.cityofseward.us/libraryweb

KENAI PENINSULA BOROUGH SCHOOL DISTRICT

148 North Binkley Street
Soldotna, Alaska 99669
(907) 714-8888
kpbsd.k12.ak.us

44 schools
One district, 25,600 square miles

FAMILY & CHILDREN

Central Peninsula

DAYCARES & PRESCHOOLS

Head Start (Sterling)
260-7446
sterling@ruralcap.com

Early Childhood Center
Kenaitze Indian Tribe
130 N. Willow St.
Kenai, AK 99611
907-335-7260
www.kenaitze.org/programs/early-childhood-center

Services: *Head start, after school, summer and daily early childhood programs. Open to Native and non-Native children.*

Boys and Girls Club
(907) 283-2682

Southern Peninsula

DAYCARES & PRESCHOOLS

Homer Early Childhood Coalition
195 East Bunnell Ave. Suite C
Homer, AK 99603
(907) 399-1567

Services: *various early childhood education projects and services.*

SPROUT
3691 Ben Walters Lane #4
Homer, AK 99603
(907) 235-6044
www.sproutalaska.org

Services: *Support, education and family strengthening for infants, toddlers, and families on the Southern Kenai Peninsula.*

Seward

DAYCARES & PRESCHOOLS

Child's Play Daycare
33175 Stoney Creek Ave.
Seward, AK
(907) 362-4082

Coast to Coast Kidcare
207-479-5804
33896 Tiehacker Road

Day Star Daycare & Preschool
224-8441
305 Coolidge Drive, P.O. Box 351

KPBSD Special Needs Preschool
224-3356
600 Sea Lion Drive

Lil' Kritters Daycare & Preschool
224-7184
213 Blue eld Drive

Robin's Nest Daycare
224-3262
13948 Collman Circle

KENAITZE INDIAN TRIBE

SPROUT

ALASKA CHILD CARE REFERRAL

Thread Alaska's Child Care Resource & Referral Network
800-278-3723
www.threadalaska.org
Thread's mission is to advance the quality of early education and child development by empowering parents, educating child care professionals, and collaborating with our communities.

Child Care Program Office
888-268-4632
www.hss.state.ak.us/dpa/programs/ccare Supporting families in accessing quality child care.
Community Care License 800-478-4444
www.cdss.ca.gov/cdssweb/PG105.htm

Day Care Assistance
283-4707
www.akafs.org/ca.html

DOMESTIC VIOLENCE/SEXUAL ASSAULT

Central Peninsula

The LeeShore Center
325 S. Spruce Street
Kenai, AK 99611
(907) 283-9479
24-Hr Crisis Line:
(907) 283-7257
www.leeshoreak.org

Services: *Advocacy for victims, 24 hr crisis intervention, support groups, assistance to abused/neglected elders and those with disabilities, transitional living center, child care assistance program.*

Friendship Mission
(907) 283-5277
kenaifriendshipmission.com/

ABC Crisis Pregnancy Center
508 S Willow Street Suite D
Kenai, AK
(907) 283-9062
www.cpcanchorage.com

Southern Peninsula

South Peninsula Haven House
(Homer)
(907) 235-7712
havenhousealaska.org

Services: *Supporting and empowering people impacted by domestic violence and sexual assault and promoting healthy families.*

Seward

SeaView Community Services
302 Railway Avenue
P.O. Box 1045
Seward, Alaska 99664
(907)224-5257
CRISIS LINE: (907)224-3027

Services: *Infant learning program, disability services, behavioral health, community services, domestic violence, substance abuse recovery, and more.*

GREEN DOT AK ALASKA

a green dot is any behavior, choice, word, or attitude that promotes safety for everyone and communicates utter intolerance for rape, partner violence and stalking. A green dot is intervening in a high risk situation – a green dot is talking to your friends about how you feel about violence – a green dot is hanging up a prevention poster – a green dot is putting a green dot statement on your social networking page - a green dot is wearing your green dot gear– a green dot is putting a link on your website to your local prevention program - a green dot is organizing a training for your organization. A green dot is simply your individual choice at any given moment to make our community safer.

Lee Shore

STATEWIDE SERVICES

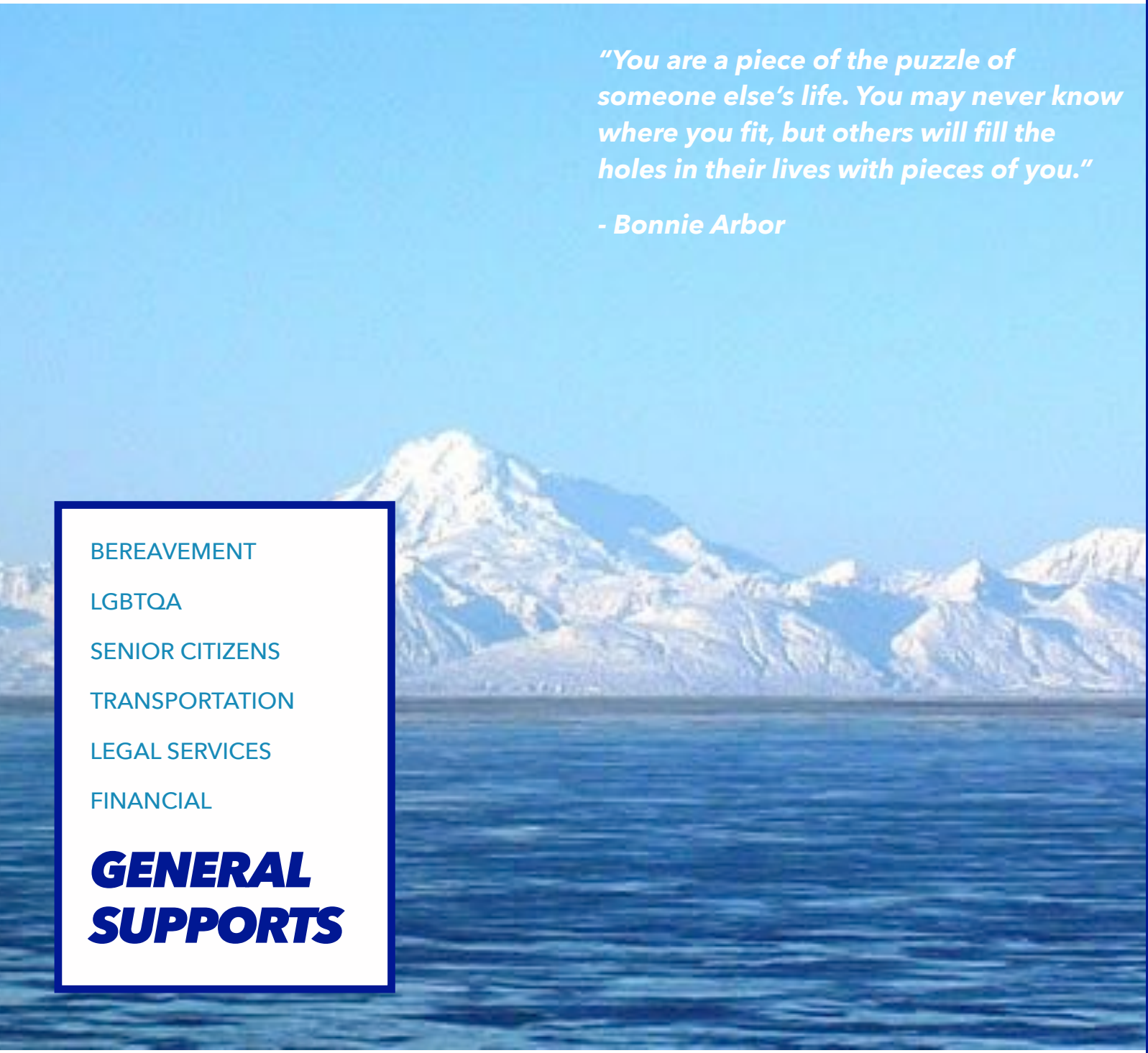
Alaska Women's Health Services
(907) 563-7228
akwomenshealth.com

Abused Women's Aid in Crisis (Anchorage)

ANDVSA
Alaska Network on Domestic Violence & Sexual Assault

FuturesWithoutViolence.org

GENERAL SUPPORTS



"You are a piece of the puzzle of someone else's life. You may never know where you fit, but others will fill the holes in their lives with pieces of you."

- Bonnie Arbor

BEREAVEMENT

LGBTQA

SENIOR CITIZENS

TRANSPORTATION

LEGAL SERVICES

FINANCIAL

GENERAL SUPPORTS

General Supports

BEREAVEMENT

Central Peninsula

Alaskan Funerals
5839 Kenai Spur Highway
Kenai, AK 99611
(907) 283-3333

35910 Jawle Street
Soldotna, AK 99669
(907) 260-3333

www.alaskanfuneral.com

Services:
Funeral services, celebrating life, memorialization, peaceful resting place.

Cemeteries
Spruce Grove Memorial Park
Russian Orthodox Cemetery
Soldotna Community Memorial Park
Kenai City Cemetery
McGahan Cemetery

Southern Peninsula

Alaskan Funerals
3522 Main Street
Homer, AK 99603
(907) 235-6861

www.alaskanfuneral.com

Services:
Funeral services, celebrating life, memorialization, peaceful resting place.

Cemeteries
Hickerson Cemetery
Anchor Point Cemetery
Ninilchik Russian Orthodox Cemetery
American Legion Cemetery

Seward

Peninsula Funeral Home & Cremation Service
Mile 5 1/2 Seward Why
Seward, AK 99664
(907) 224-5201

STATEWIDE SERVICES

State of Alaska Medical Examiner
5455 Dr. Martin Luther King Jr. Avenue
Anchorage, AK 99507
(907) 334-2200

State of Alaska Bureau of Vital Statistics
PO Box 110675
Juneau, AK 99811
(907) 465-3391

VETERANS

Central Peninsula

Veterans of Foreign Wars
Soldotna, AK
(907) 262-2722

Kenai Vet Center Outstation
Soldotna, AK
(877) 927-8387

Kenai VA
Kenai, AK
(907) 361-6370

American Veterans
Soldotna, AK
(907) 262-3540

American Legion
Sterling, AK
(907) 262-7265

Southern Peninsula

Veterans of Foreign Wars
Anchor Point, AK
(907) 235-5582

American Legion
Ninilchik, AK
(907) 567-3918

American Legion
Homer, AK
(907) 235-8864

Elk's Lodge
Homer, AK
(907) 235-2127

Seward

American Legion
402 5th Ave
Seward, AK
(907) 224-5440
www.americanlegionpost5.com/contact-us.html

Elk's Lodge
139 4th Ave
Seward, AK
(907) 224-3158

VFW
VETERANS OF FOREIGN WARS

B.P.O.E

AMERICAN LEGION

STATEWIDE SERVICES

Veteran's Clinic
(907) 395-4100
www2.va.gov/directory/guide/facility.asp?ID=472

Veteran's Center
(907) 260-7640
www.vetcenter.va.gov

OLDER ADULTS

Central Peninsula

ResCare HomeCare
44539 Sterling Hwy. #206
Soldotna, AK 99669
(907) 891-7622
www.rescare.com

Services: *A human services company that offers services to people of all ages and abilities to help make their lives more independent.*

Sterling Area Senior Citizens
34453 Sterling Highway
Sterling, AK 99672
(907) 262-6808
sterlingseniorcenter@alaska.net

Services: *Housing for older adults and adults with disabilities.*

Kenai Senior Center
(907) 283-4156
www.ci.kenai.ak.us/seniorcenter.html

Soldotna Senior Citizens Center & Friendship Terrace
197 W Park Ave
Soldotna, AK 99669
(907) 262-2322

Services: *Assisted living, community, and other support.*

Consumer Direct Personal Care
412 Frontage Road #40
Kenai, AK 99611-7770
(907) 283-0809
www.consumerdirectak.com

Services: *Personal care assistance, chore & respite care.*

Southern Peninsula

Homer Senior Citizens, Inc.
3935 Svedlund
Homer, AK 99603
(907) 235-7655
www.homerseniors.com

Services: *Friendship center Adult Day Services, independent housing, nutrition and transportation, meals on wheels.*

Anchor Point Senior Citizens
72750 Milo Fritz Ave
Anchor Point, AK 99556
(907) 235-7786

Ninilchik Senior Center
PO Box 39422
Ninilchik, AK 99639
(907) 567-3988
seniors@ptialaska.net
ninilchikseniors.org

Services: *Help, friendship and activities for seniors.*

Seldovia Senior Citizens
Mailing Address: Drawer L
Seldovia, AK 99663
(907) 234-7898 ext. 235

Consumer Direct Personal Care
126 W. Pioneer Avenue, #5
Homer, AK 99603-7564
907-226-1157
www.consumerdirectak.com

Services: *Personal care assistance, chore & respite care.*

Seward

Hope Community Resources
(907) 260-9469
www.hopealaska.org

Services: *Providing services and supports, designed by individuals and families who experience disabilities, that result in choice, control, family preservation and community inclusion.*

Independent Living Center
(907) 224-8711
www.peninsulailc.org

Meals on Wheels
(907) 224-5604
www.sewardsenior.org

Qutekcak Native Tribe
(907) 224-3118
Elder Care Programs
www.sewardaknatives.com
Services: *Designed to meet personal needs of Alaskan Native/American Indian elders.*

ResCare HomeCare
(907) 224-4424

Senior Center
336 Third Avenue
Seward, AK
(907) 224-5604
www.sewardsenior.org

Services: *Serving the nutritional, transportation, recreational and social needs of Seward seniors.*

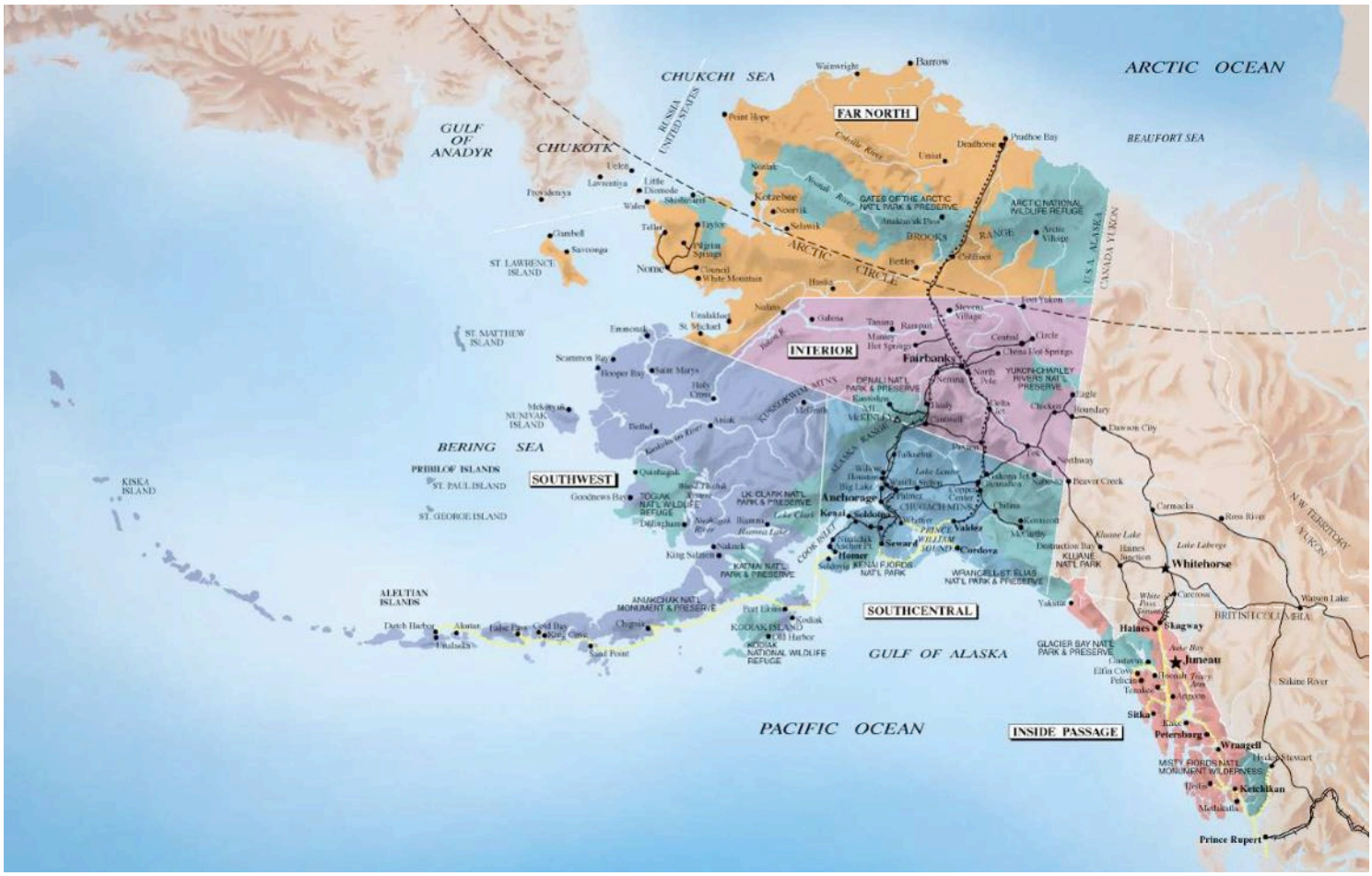
STATEWIDE SERVICES

ACLU of Alaska
www.acluak.org/en/issues/lgbt-rights

iknowmine
http://www.iknowmine.org/for-youth/lgbtq

ACLU
AMERICAN CIVIL LIBERTIES UNION

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM



TRANSPORTATION

Central Peninsula

Central Area Rural Transit System (CARTS)
43539 Kalifornsky Beach Road
Soldotna, AK 99669
(907) 262-8900
http://ridecartsak.org

Services: *Transportation in central peninsula area. Reservations required. Advance purchase of fare via website, mail or K-Beach office also required.*

SELDOVIA BAY FERRY alaska

SELDOVIA VILLAGE TRIBE
Tradition Integrated with Technology

Southern Peninsula

South Peninsula Hospital: The Annex Adult Rehab Services
966 Hillfair Court
Homer, AK 99603
(907) 235-7701

Services: *Transportation and other services available to eligible clients to promote recovery among adults who experience mental illness. Behavioral health, case management, housing support, skills training, counseling, and more.*

Seldovia Bay Ferry
(907) 435-3299
www.seldoviabayferry.com

Services: *boat transportation from Homer to Seldovia*

Seward

Seward Community Health Center
417 First Avenue
PO Box 2895
Seward, Alaska 99664
Phone 907-224-2273
(907) 224-CARE
www.sewardhealthcenter.org/transportation-assistance

Services: *SCHC Taxi Vouchers available to provide transportation to and from non-emergency medical appointments.*

Seward Chamber of Commerce
Free Summer Shuttle
(907) 224-3324
www.firststudentinc.com

Services: *Free summer shuttle*

Alaska Railroad
408 Port Avenue
(907) 224-2268 or 800-544-0552
www.alaskarailroad.com

Seward Bus Line
224-3608 or 888-420-7788
539 Third Avenue
www.sewardbuslines.net

STATEWIDE SERVICES

RAVN Air
(800) 866-8394
www.flyravn.com

Grant Aviation
(888) 359-4726
www.flygrant.com

Ravn ALASKA

GRANT AVIATION

LEGAL SERVICES

Central Peninsula

Alaska Legal Services
150 N. Willow Street
Kenai, AK
(907) 395-0352
888-478-2572
www.alsc-law.org

District Attorney
Scot H. Leaders
Trading Bay Professional Center
120 Trading Bay Road, Suite 200
Kenai, AK
(907) 283-3131

Kenai Public Defenders Offices
130 Trading Bay Road, Suite 390
Kenai, AK
(907) 283-3129

Wildwood Correctional
10 Chugach Ave
Soldotna, AK
(907) 260-7200

Southern Peninsula

Homer Police & Jail
4060 Heath Street
Homer, AK
(907) 235-3150

Court Clerk's Office
3670 Lake Street #400
Homer, AK
(907) 235-8171
http://www.courts.alaska.gov/courtdir/3ho.htm

Alaska Legal Services Corporation

Seward

Alaska Legislative Information Office
302 Railway Ave Suite 101
Seward, AK
(907) 224-5066
w3.legis.state.ak.us

Court and Corrections
Seward Court Magistrate
410 Adams Street, P.O. Box 1929
www.courts.alaska.gov

Seward Community Jail
410 Adams Street
(907) 224-3075
www.cityofseward.us

Visitors must be pre-approved for visitation. Approval forms are available online or at the dispatch window and must be submitted Monday thru Friday and at least one day prior to the day of visitation.

Spring Creek Correctional Center
(907) 224-8200
Mile 5 Nash Road, P.O. Box 2109
www.correct.state.ak.us/corrections/institutions/sccc

FINANCIAL

Central Peninsula

JOB SEARCH SERVICES

Kenai Public Assistance Office
(907) 283-2900
hss.state.ak.us/dpa/programs/apa/

Employment Services
(907) 283-2995
http://www.does.dc.gov/does/site/default.asp

Vocational Rehabilitation
(907) 283-3133

PUBLIC ASSISTANCE

Kenai Public Assistance Office
907-283-2900

Southern Peninsula

JOB SEARCH SERVICES

Homer Job Center and Public Assistance Division
270 W Pioneer Ave. #A
Homer, AK
(907) 226-3040

PUBLIC ASSISTANCE

Homer Public Assistance Office
(907) 226-3040
http://dhss.alaska.gov/dpa/pages/medicaid/default.aspx

Seward

JOB SEARCH SERVICES

Alaska Job Center
(907) 224-5276
www.jobs.state.ak.us

AVTEC Counseling and Job Placement Services
(907) 224-6170
www.avtec.edu/department/counseling-and-job-placement-services

Alaska Family Resource Center
(907) 224-9186

STATEWIDE SERVICES

Benefit / Food Stamps Hotline
888-804-6330
http://dhss.alaska.gov/dpa/Pages/fstamps/default.aspx

Workplace Alaska
800-587-0430
http://doa.alaska.gov/dop/workplace/

Division of Public Assistance
907-260-7633
http://dhss.alaska.gov/dpa/Pages/default.aspx

Unemployment Filing
888-252-2557 **VICTOR:** 888-222-9989
https://my.alaska.gov

Medicaid Recipient Helpline
800-780-9972
http://dhss.alaska.gov/dpa/pages/medicaid/default.aspx

Medicare Part D Helpline
800-633-4227

Primary Care Helpline
907-644-6842

Quest Program (EBT Card) Customer Service
888-997-8111

Senior Benefits Program
888-352-4150
http://dhss.alaska.gov/dpa/Pages/seniorbenefits/default.aspx

Vocational Rehabilitation
907-465-2814
http://labor.alaska.gov/dvr/

Alaska Benefits
https://www.benefits.gov/benefits/browse-by-state/state/143

PETS

Central Peninsula

Kenai Veterinary Hospital
(907) 283-4148

Soldotna Animal Hospital
(907) 260-7851

Twin Cities Veterinary Clinic
(907) 262-4581

Dr. Jerry Nybakken
(907) 260-5850

Kenai Animal Shelter
510 N Willow St.
Kenai, AK
(907) 283-7353
http://www.ci.kenai.ak.us

Soldotna Animal Shelter
205 S Kobuk St
Soldotna, AK
(907) 262-3969
http://www.soldotna.org/resident-services/animal-control

Southern Peninsula

Homer Animal Friends
(907) 235-7729
www.homeranimals.com

Services: *advocating for healthy animals. Vouchers for reduced spay/neuter.*

Homer Veterinary Clinic
326 Woodside Avenue
Homer, AK 99603
(907) 235-8960
www.homervet.com

Services: *small animal and equine care.*

Homer Animal Shelter
4060 Heath Street
Homer, AK
(907) 235-3141

Seward

SOS Save Our Seward Pets
(907) 224-7495
www.sospetsak.org
Services: *Reduced-cost spay and neuter program.*

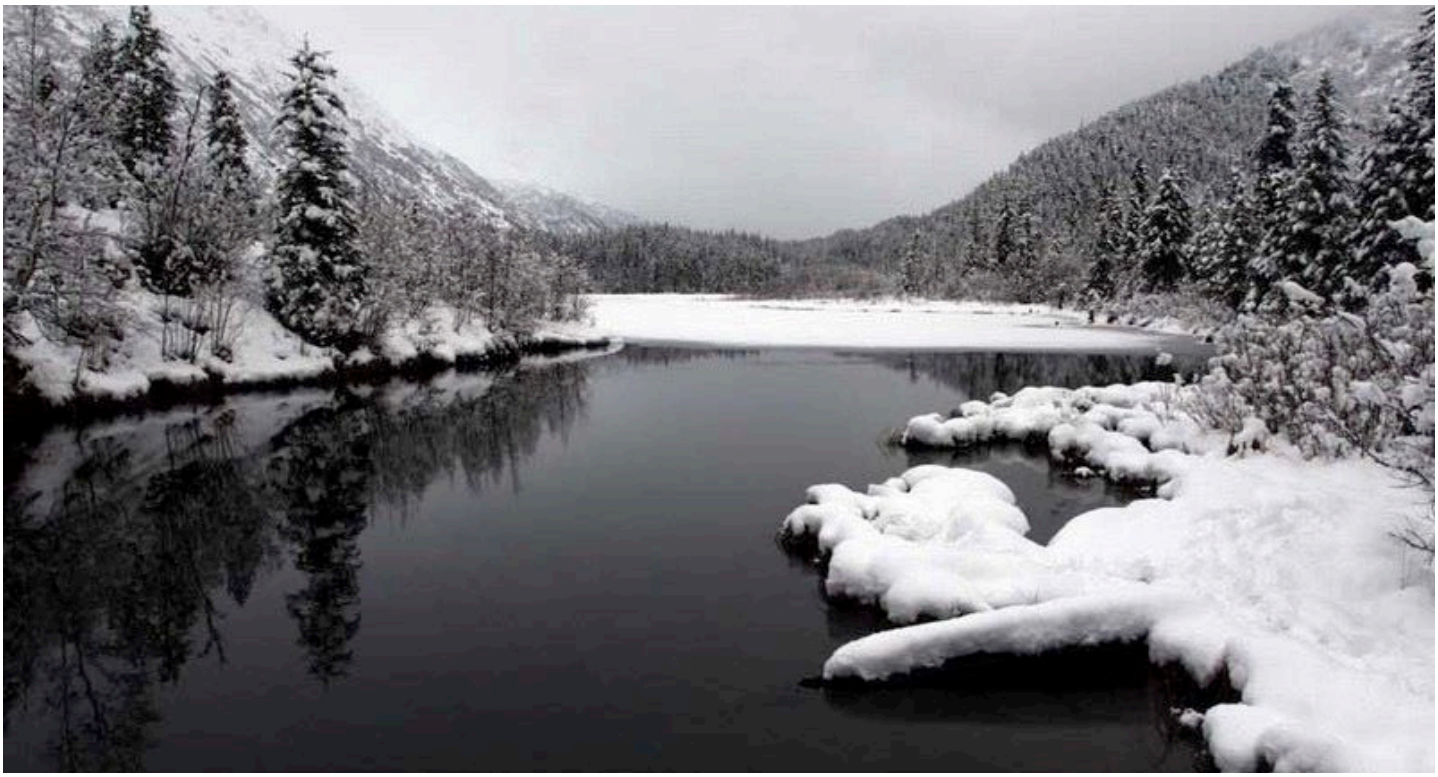
Alaska SeaLife Center
Rescue & Rehabilitation Hotline
888-774-7325
www.alaskasealife.org/
Services: *Report stranded marine mammals and birds.*

Pet Poison Helpline
855-764-7661
www.petpoisonhelpline.com

Seward Animal Shelter
(907) 224-7495
412 Sixth Avenue, P.O. Box 167
www.petfinder.com/shelters/AK10

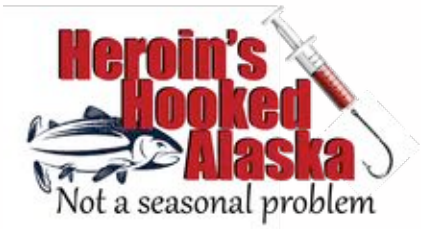
Seward Animal Clinic
(907) 224-5500

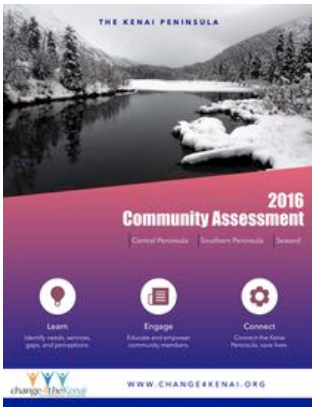
Soldotna Animal Hospital
(907) 260-7851 or 398-3838
42479 Sterling Hwy., Soldotna
www.soldotnaanimalhospital.com



Change 4 the Kenai is a coalition that is united to work toward connecting our community. C4K is currently dedicated to understanding the local increasing prevalence of injection drug use and the dire consequences. We plan to implement harm reduction programs and to break the stigma of addiction within the community through education.

Other C4K Community Projects & Task Forces:





This Directory is provided by the Change 4 The Kenai Prevention Coalition. For more information about the coalition and its activities, please visit www.change4kenai.org

change4theKenai
Connecting our Community

www.kenairesources.info

CONNECT COMM***UNITY,***

SAVE LIVES.