Fairbanks Wellness Coalition
Prescription Opioid Misuse and Heroin Use Prevention Needs Assessment

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Prepared for
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Executive Summary

Introduction
The Fairbanks Wellness Coalition formed in 2014 under the umbrella of a non-profit fiscal agent. The Coalition’s vision is a community where all generations experience wellness in mind, body, and spirit, and its purpose is to foster wellness in Fairbanks North Star Borough (FNSB) through primary prevention and advocacy.

In 2016, the Fairbanks Wellness Coalition was awarded funding through the Alaska Strategic Prevention Framework Partnerships for Success grant program to prevent the non-medical use of prescription opioids among 12- to 25-year-olds and heroin use among 18- to 25-year-olds in FNSB. This grant program uses the Strategic Prevention Framework, a planning model developed by the Federal Substance Abuse and Mental Health Services Administration (SAMHSA). This needs assessment represents the first step of the Strategic Prevention Framework process, and is intended to serve as a foundation for the Fairbanks Wellness Coalition to plan, implement, and evaluate prevention activities. As dictated by Strategic Prevention Framework Partnerships for Success program guidelines, prevention efforts will focus on three key factors that have a direct causal or contributory relationship to heroin and prescription opioid abuse on a community level: social availability, retail availability, and perceptions of risk for harm.

Methodology
Data collection was organized around four interrelated purposes of this needs assessment: 1) to identify the nature and extent of prescription opioid misuse and heroin use in FNSB; 2) to identify the consequences of prescription opioid misuse and heroin use; 3) to identify community factors that contribute to the social availability, retail availability, and perceived risk for harm of prescription opioid misuse and heroin use; and 4) to determine the level of readiness in the FNSB community to address prescription opioid misuse and heroin use and identify additional resources that may be needed to do so.

A combination of primary and secondary data sources and tools were used to compile and analyze both quantitative and qualitative data. Primary data collection included a retail availability survey of opioid prescribers and pharmacists, interviews with people in recovery, focus groups with youth, a community perceptions survey, and community readiness interviews.
Prescription Opioids and Heroin

Heroin and prescription opioids are part of the same opioid drug category and overlap in important ways. Prescription opioids are medications that reduce the intensity of pain signals reaching the brain and affect those brain areas controlling emotion, diminishing the effects of a painful stimulus.

Data from the National Survey on Drug Use and Health (NSDUH) indicate that pain relievers are the most commonly misused and abused type of prescription drug, far exceeding the misuse and abuse of stimulants, tranquilizers, and sedatives (as cited by State of Alaska Department of Health and Social Services, 2016).

Heroin is an opioid drug that is synthesized from morphine, and typically appears as a white or brown powder or as a black sticky substance. Heroin can be injected, inhaled by snorting or sniffing, or smoked – all of which deliver the drug to the brain very rapidly, where it is converted back into morphine and binds to opioid receptors, which are involved in the perception of pain and reward (National Institute on Drug Abuse, 2014).

Both prescription opioids and heroin are highly addictive drugs. According to the Centers for Disease Control (2017), anyone who takes prescription opioids can become addicted to them. In fact, as many as one in four patients receiving long-term opioid therapy in a primary care setting struggles with opioid addiction (as cited by CDC, Banta-Green et al., 2009; Boscario et al., 2010; Fleming et al., 2007). Heroin is also a highly addictive drug, with repeated heroin use changing the physical structure and physiology of the brain in ways that create long-term neuronal and hormonal system imbalances that are not easily reversed. Once addicted to either prescription opioids or heroin, it can be hard to stop.

Nature and Extent of Use

The exact number of individuals who have ever misused prescription opioids and/or used heroin in the FNSB is difficult to determine, but the available data indicate that as many as 1,019 high school students have ever used prescription drugs without a prescription and 82 have ever used heroin and as many as 1,400 individuals ages 18 to 27 have ever misused prescription opioids and 270 have ever used heroin.
Data indicate that 9.6% of 18- to 27-year-olds have ever misused prescription opioids (2.4% within the past 30 days), and 1.8% have ever used heroin in their lifetimes. (Hanson & Barnett, 2016).

Youth Risk Behavior Survey (YRBS) data indicate that 13.6% of high school students in FNSB have ever misused prescription drugs (not necessarily opioids) in their lifetimes (5.8% in the past 30 days), and just 1.1% have ever used heroin in their lifetime (YRBS, 2015).

In 2015, Fairbanks Memorial Hospital had a total of 218 Emergency Department discharges that were opioid-related, and 8 that were heroin-related (less than 1% of all discharges). Of the 218 opioid-related discharges, 54 (approximately one-quarter) were in the project’s focus 12- to 25-year-old age range (CBHRS at UAA).

Prescription opioid and heroin use appears to be higher among youth and young adults who are homeless or at risk of becoming homeless, as evidenced by data provided by Fairbanks Counseling and Adoption’s Street Outreach and Advocacy Program (SOAP), which showed 43.6% of youth served to be self-reported users of opioids, heroin, and methamphetamines. Of these users, 75% were ages 18 to 21 and 25% were ages 14 to 17.

At the end of 2016, there were 57 individuals enrolled in the methadone drug treatment program of the Interior AIDS Association (IAA), with an average age of 38. IAA’s needle exchange program provided approximately 58,500 syringes to 300 individuals in 2016, 84% of whom were self-reported heroin users. Of needle exchange program utilizers, 62% were ages 20 to 29 and 9% were ages 18 or 19.

Self-reported and treatment data strongly indicate that more women than men misuse prescription opioids and use heroin in the 18- to 25-year-old age group. However, available data for high school students indicates that more boys than girls are trying prescription drugs and heroin.

While statewide the percentage of individuals reporting ever misusing prescription opioids is higher for white individuals than for Alaska Natives, the reverse is true.
for heroin, where more Alaska Natives report ever using heroin than white individuals. Alaska Native individuals are also disproportionately represented in data for treatment of heroin use at Fairbanks Native Association (FNA), but not in data for the needle exchange program at Interior AIDS Association.

The extent to which prescription opioid misuse and heroin use are increasing or decreasing in FNSB is unclear. Although statewide data indicate that both prescription opioid misuse and heroin use are increasing, FNSB data do not show a clear pattern. For example, self-reported misuse of prescription drugs (not necessarily opioids) and heroin among high school students has decreased slightly (Youth Risk Behavior Survey 2013 and 2015). In addition, the actual number of individuals accessing treatment for prescription opioid or heroin addiction at FNA has decreased. This is not to say, however, that treatment by private providers has increased or decreased; this needs assessment does not include data from private treatment providers.

Interrelated Nature of Prescription Opioid and Heroin Use

The interrelated nature of opioid and heroin use should not be overlooked when addressing either issue:

- Statewide data indicate that 96% of the 18- to 27-year-olds who reported ever using heroin, also reported misusing prescription opioids (Hanson & Barnett, 2016).

- Seven of the 10 individuals who are in recovery from prescription opioid and/or heroin addiction who were interviewed for this needs assessment reported nonmedical use of prescription opioids prior to using heroin in much the same trajectory described in research (Compton et al., 2016). All seven of these respondents reported being given prescription opioids at a party or by a friend in their late teens. Within five years, all turned to heroin because it was less expensive than prescription opioids. Three specifically cited the introduction of the abuse-deterrent formulation of OxyContin as the catalyst for their move to heroin.

- More than half of the 15 key informants interviewed for the community readiness assessment specifically discussed the intertwined nature of heroin and prescription opioid abuse, stating that it is difficult to discuss them independently of each other, and that heroin is cheaper and/or easier to get than prescription opioids, contributing to a shift from opioids to heroin use in the community. Other key informants also referenced the contribution of the formulation change of opioids by pharmaceutical companies, that users may use opioids to mask heroin addiction.
and/or withdrawal symptoms, and that most users are poly-drug users.

Consequences of prescription opioid and heroin abuse are extremely severe and include addiction, overdose, and exposure to Hepatitis C Virus (HCV). Anecdotally, many key informants also referenced an increase in drug-related property crimes in FNSB; however, this evidence is difficult to corroborate with objective data sources.

Social Availability
There is strong evidence of broad social availability of prescription opioids in FNSB. Among those community perceptions survey respondents who reported misusing prescription opioids, most obtained them from friends or family or bought them “easily” on the streets. While many adults responding to the community perceptions survey reported they didn’t know how easy or difficult it is to access prescription opioids without a prescription, most respondents felt that young people would access prescription opioids through their friends or family members. In addition, while fewer than 30% of community perception survey respondents felt it was ok to dispose of unused medication in ways that risk social access to that medication, almost 50% stored unused prescription opioids in their homes. Furthermore, although most respondents (91%) felt that using an identified drug disposal site was an appropriate way to dispose of unused prescription opioids, fewer than 10% of respondents actually did so.

Retail Availability
There is some evidence of retail availability of prescription opioids in FNSB. One of the state’s primary tools to control the retail availability of prescription opioids is the Alaska Prescription Drug Monitoring Program (AKPDMP). While statewide the number of registered prescribers and dispensers has increased 24%, the Fairbanks Wellness Coalition retail availability survey data indicates the AKPDMP is not widely used by physicians or pharmacists, and very infrequently used by dentists in FNSB. While both physicians and dentists widely report that they have written policies related to prescribing opioids, pharmacies have implemented fewer policies and procedures to address the retail availability of prescription opioids. Survey data further suggests that a significant percent

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1 AS 17.30.200 requires that each dispenser shall submit, by electronic means, information regarding each prescription dispensed for a controlled substance. Each dispenser shall submit the required information to the central repository at least once each month unless the board waives this requirement for good cause shown by the dispensing vendor.
of physicians and dentists do not engage their patients in conversations about topics that reduce the likelihood of addiction to prescription opioids, nor do they take measures to reduce retail availability of prescription opioids, such as setting criteria for stopping or continuing opioids. Additionally, few Alaskan young adults ages 18 to 27 reported that their doctor or pharmacist had talked to them about risks related to prescription opioid use (Hanson & Barnett, 2016).

**Perception of Risk for Harm**
Data suggest that youth, young adults and adult community members are more aware of the risk for harm from heroin use than from prescription opioid misuse.

- Among 18- to 27-year-olds, there is a wide range of perceptions about how big of a problem prescription opioid misuse and heroin use are in the community, but overall, this age group perceives that heroin is a bigger problem than prescription opioid misuse. Similarly, this age group felt that people their age were at greater risk for harm from using heroin than from using prescription opioids. (Hanson & Barnett, 2016)
  - Data from interviews conducted with people in recovery corroborates this perception. Those who were interviewed did not see their friends suffer in any way from regularly using prescription opioids, reducing their perception of risk.
  - Youth focus group participants acknowledged that prescription medications can be dangerous when taken inappropriately, and in several instances attributed this knowledge to what they learned in school health classes. Younger participants did not exhibit specific knowledge about the dangers and side effects, and spoke more broadly overall about substance use, including alcohol, marijuana, and tobacco. Older participants had a more nuanced understanding of the side effects of prescription drug abuse.
  - Adult community members indicated a lower perception of risk for harm from occasionally taking prescription opioids to get high than they did for heroin.

**Community Readiness and Resources**
Community readiness to address the non-medical use of prescription opioids and heroin use in the community was evaluated using key informant interviews following the Tri-Ethnic Model of Community Readiness (Colorado State University, 2014). The overall community readiness score for prescription opioid misuse prevention was 2.8, and the overall
community readiness score for heroin use prevention was 2.6 (on a scale of 1 to 9). These scores indicate a level of community readiness that is above Stage 2: Denial and Resistance (belief that this issue is not a concern in the community, misperceptions about the issue, and lack of support to address the issues), but still somewhat below Stage 3: Vague Awareness (only vague knowledge about the issue, belief that the issue may be a concern but no immediate motivation to act, and only limited resources to address the issue).

Many of the challenges and barriers to addressing prescription opioid and heroin abuse that were described by key informants were the very reasons why community readiness scores were low (i.e., poor understanding of addiction, lack of awareness, misperceptions, stigma, etc.). However, a co-occurring theme that the community and leadership would be supportive of prevention efforts if they understood the problem points to the fact that there is a good opportunity to overcome these challenges. Key informants also described a wealth of community organizations and resources that could be utilized in prevention, as well as several community coalitions including the Fairbanks Opioid Workgroup.

**Prioritization of Community Factors**

Community factors related to social availability, retail availability, and perceptions of risk for harm that emerged as themes from the needs assessment include:

- Lack of community awareness about risks associated with use (perceptions of risk),
- Improper storage of prescription opioids (social availability),
- Improper disposal of prescription opioids (social availability),
- Low utilization of AKPDMP (retail availability), and
- Low use of best practices for prescribing/dispensing opioids among retail providers (retail availability).

These community factors were scored based on objective data and subjective community criteria using a scale of 1-5, with 5 being the highest priority and 1 being the lowest priority. The community factor receiving the highest priority was lack of community awareness about risks associated with use (score of 4.7), followed by improper storage of prescription opioids (score of 4.0), improper disposal of prescription opioids (score of 3.7), low utilization of AKPDMP (score of 3.4), and low use of best practices for prescribing/dispensing opioids among retail providers (doctors, dentists, pharmacists) (score of 2.6).
Introduction

The Fairbanks Wellness Coalition is a non-profit coalition formed in 2014 which operates under the umbrella of a 501(c)(3) fiscal agent and is comprised of individuals who represent or are a part of various coalitions, organizations and/or sectors in the Fairbanks North Star Borough (FNSB). The Fairbanks Wellness Coalition’s vision is a community where all generations experience wellness in mind, body and spirit. The coalition fulfills this vision by fostering wellness in FNSB through primary prevention and advocacy, and strives to always have representatives from youth or youth serving sectors of the community; parents; business; media; schools; law enforcement; religious or fraternal organizations; civic or volunteer groups; healthcare professionals; state local or tribal agencies; and the military.

FNSB Community Characteristics

FNSB, comprised of 7,338 square miles, is a 2nd class borough in the Interior region of Alaska, with a population of 98,645 people (Alaska DCCED, 2017). Fairbanks is the largest city in the borough and serves as a hub for the Interior Region of Alaska, with a full spectrum of shopping needs, medical services, and an international airport. Fairbanks is 45 minutes by air, or 6 hours by car via the Parks and Glenn Highways, from the state’s largest city of Anchorage. At an elevation of 436 feet above sea level, Fairbanks is located within the Tanana Valley, which rises to the southeast to an elevation of approximately 2,000 feet at the Canadian border. Fairbanks has views of the Alaska Range (including Denali) to the south, and views of the White Mountains to the north (FNSB Economic Development Division, 2014).

Population Size and Growth

The population of FNSB has grown significantly since 1990, increasing from 77,720 in 1990 to 82,840 in 2000 and 97,581 in 2010 according to U.S. Census figures. The State of Alaska Department of Commerce, Community, and Economic Development (DCCED) provides a commissioner-certified figure of 98,645 for the borough’s population in 2015 (Alaska DCCED, 2017) (Figure 1).
Fairbanks Wellness Coalition, 17

Figure 1. FNSB total population 1990 – 2015 (Data Source: Alaska DCCED, 2017)

U.S. Census estimates placed the population of FNSB in 2015 slightly higher at 99,631. While the population has been steadily increasing in FNSB, U.S. Census figures indicate the population of FNSB grew by just 2.1% from 2010-2015, barely more than half the 4.0% overall population growth rate for the entire State of Alaska during the same time period (United States Census Bureau, 2017).

**Age**

A comparison of 2000 and 2010 U.S. Census data reveals a young median age in the borough, as well as a slightly aging population. The median age in FNSB rose from 30 to 31 between 2000 and 2010 (State of Alaska, 2017); however, the median age of 31 in 2010 was still nearly three years younger than the Alaska statewide median age of 33.8 the same year (State of Alaska, 2017).

Despite the young median age in FNSB, from 2000 to 2010 the percentage of residents over the age of 65 rose from 4.6% to 6.5% of the total population. There was also an increase in the population age 45-64, rising from 19.8% in 2000 to 25.0% in 2010.

In contrast, the percentage of the population that was under the age of 19 dropped from 33.3% to 28.7% from 2000-2010. Similarly, there was a slight decrease in the population age 25-44 (33.3% in 2000 and 29.4% in 2010) (Alaska DCCED, 2017).

**Gender**

More males live in FNSB than do females. An estimated 54.4% of the population was male and 45.6% was female in 2015, a difference of 8.8%. This is a greater difference than in
2010, when 52.8% of the population was male and 47.2% was female (United States Census Bureau, 2017). The difference is even greater when compared to 2000 Census figures, when 52.2% were male and 47.8% were female (Alaska Department of Labor and Workforce Development, 2017a).

There is a larger gap in the gender distribution in FNSB than in the State of Alaska. According to U.S. Census estimates for 2015, while only 45.6% of the population in FNSB is female (54.4% is male), a greater number – 47.3% – are female in Alaska (52.7% in the state are male) (United States Census Bureau, 2017).

**Race**

The race distribution in FNSB has remained relatively stable since 2000. Figures from the U.S. Census Bureau for 2015 indicate that an estimated 76.9% of the population in FNSB is white (77.0% was white in 2010, and 77.8% was white in 2000). An estimated 7.2% of the population in FNSB was American Indian or Alaska Native (AI/AN) in 2015 (7.1% was AI/AN in 2010, and 6.9% was AI/AN in 2000.) In 2015, an estimated 5.7% of the population was Black or African American (4.5% was in 2010, and 5.9% was in 2000) (Alaska DCCED, 2017, United States Census Bureau, 2017).

In contrast to Alaska, FNSB has a larger white population and a smaller American Indian and Alaska Native population. While 76.9% of the population of FNSB was estimated to be white in 2015, only 66.5% was for the entire state. In 2015, 7.2% of the population of FNSB was estimated to be American Indian or Alaska Native, while 14.8% of the entire state population were estimated to be American Indian or Alaska Native – more than double the figure for FNSB.

**Military and Veteran Population**

There were an estimated 8,259 active duty military in FNSB in July, 2015 (slight increase from 8,166 in 2010) and 10,055 military dependents (decrease from 11,734). The 8,259 active duty military represented 8.4% of the estimated population of FNSB, while their 10,055 dependents represented 10.2% of the estimated population of FNSB (Alaska Department of Labor and Workforce Development, 2016).

American Community Survey 5-year estimates for 2011-2015 indicate that there are 11,301 veterans residing in FNSB (11.3% of the total population of the borough). Almost one-quarter (24.9%) of these veterans are in the 18- to 34-year-old age group (compared to 42.4% of the non-veteran population in FNSB) (United States Census Bureau, 2017a).

**Income and Employment**

American Community Survey 5-year estimates for 2011-2015 showed a median household income of $71,068 for FNSB, only slightly lower than the median household income for Alaska of $72,515. Median worker earnings were $35,795 in FNSB and $36,157 for Alaska. For full-time employees, median earnings for males in FNSB were $55,589, while female full-time employees made less, with median earnings of $42,864 (United States Census
Employment levels in FNSB dropped by 1.9% in 2016, and are forecasted to drop by another 2.0% in 2017, with these drops attributed to the decline in oil prices, including the effects on those who are employed on the North Slope and the indirect effects on secondary industries in Fairbanks such as retail, leisure and hospitality, and utilities. Other job losses include those in the construction industry and the University of Alaska Fairbanks. At the same time, growth is expected for both Eielson Air Force Base and Fort Wainwright in 2017 and 2018, with the addition of two F-35 units at Eielson Air Force Base and a drone hangar at Fort Wainwright. An addition of 2,765 new active duty personnel, civilian workers, and their families at Eielson Air Force Base is expected to stimulate the Fairbanks economy (Alaska Department of Labor & Workforce Development, 2017).

The unemployment rate in FNSB in November, 2016 (not seasonally adjusted) was 5.7%, lower than the 6.6% unemployment rate for the state of Alaska (Alaska Department of Labor & Workforce Development, 2017a).

**Poverty**
American Community Survey 5-year Estimates for 2011-2015 showed that 8.1% of all residents of FNSB were below poverty level in the past 12 months, fewer than for the state of Alaska (10.2%).

The percentage below the poverty level in FNSB was higher for those within the project’s focus age groups (12 to 25 for prescription opioid abuse and 18 to 25 for heroin use): almost one in 10 under age 18 (9.9%), and more than one in 10 ages 18 to 34 (10.4%), were below the poverty level.

When looking at all age groups combined, more females were below the poverty level (9.3%) than were males (7.0%). A higher number of American Indians and Alaska Natives in FNSB were below the poverty level (19.2%) than were whites (6.2%) (United States Census Bureau, 2017a).

**Education**
Residents of FNSB are served by the FNSB School District. The FNSB School District includes 18 elementary schools, eight secondary schools, and seven schools of choice which enroll a total of 13,851 students in grades Pre-K to 12 throughout the borough (FNSB School District, 2017).

FNSB is also home to the University of Alaska Fairbanks (UAF), which is part of Alaska’s statewide university system. UAF offers both undergraduate and graduate programs, with nine colleges and schools which offer 146 degrees and 31 certificates in 117 disciplines. UAF had 9,870 enrolled students and 633 faculty in Fall of 2015 (University of Alaska Fairbanks, 2016).
American Community Survey 5-year Estimates for 2011-2015 in FNSB indicate that of the 18- to 24-year-old population in FNSB, more than one in 10 (10.5%) are not a high school graduate.

Alaska Strategic Prevention Framework Partnerships for Success Grant Program

In 2016, the Fairbanks Wellness Coalition received funding from the State of Alaska through the Strategic Prevention Framework Partnerships for Success grant program to prevent the non-medical use of prescription opioids among 12- to 17-year-olds and the non-medical use of prescription opioids and heroin use among 18- to 25-year-olds in FNSB. This grant program uses the Strategic Prevention Framework, a planning model developed by the Federal Substance Abuse and Mental Health Services Administration (SAMHSA) intended to help guide states, tribes, jurisdictions, and communities in the selection, implementation, and evaluation of effective, culturally appropriate, and sustainable prevention activities. The five steps of the Strategic Prevention Framework are 1) needs assessment, 2) capacity building, 3) strategic planning, 4) implementation, and 5) evaluation.

This needs assessment represents the first step of the Strategic Prevention Framework process. In using this process, the Fairbanks Wellness Coalition will be able to implement data driven prevention programming that is dynamic and addresses the constellation of risk and protective factors of substance use in the Fairbanks community to create an environment that supports population-level change and supports community members in healthy decision-making (SAMHSA, 2016d). Additionally, the coalition utilizes the complimentary Positive Culture Framework process from the Center for Health & Safety Culture under Montana State University.

Purpose of the Needs Assessment

The overall purpose of this needs assessment is to identify community aspects in FNSB that contribute to the three key factors that have a direct causal or contributory relationship to heroin and prescription opioid abuse on a community level: social availability, retail availability, and perceptions of risk for harm. This needs assessment also assesses how ready the community is to address prescription opioid misuse and heroin use and identifies additional resources that may be needed to do so. These data will help the Fairbanks Wellness Coalition plan appropriate prevention strategies.

This needs assessment further documents data about the nature and extent of prescription
Prescription opioids are prescribed pain relievers and include drugs such as hydrocodone (Vicodin), oxycodone (OxyContin, Percocet), morphine (Kadian, Avinza), and codeine.

Data from the National Survey on Drug Use and Health (NSDUH) indicate that pain relievers are the most commonly misused and abused type of prescription drug, far exceeding the misuse and abuse of stimulants, tranquilizers, and sedatives (as cited by State of Alaska Department of Health and Social Services, 2016).

Prescription Opioid Misuse and Heroin Use - Intertwined Problems

Heroin and prescription opioids are part of the same opioid drug category and overlap in important ways. Prescription opioids are medications that reduce the intensity of pain signals reaching the brain and affect those brain areas controlling emotion, diminishing the effects of a painful stimulus. Medications that fall within this class of drugs include hydrocodone (Vicodin), oxycodone (OxyContin, Percocet), morphine (Kadian, Avinza), codeine, and related drugs. In addition to their pain-relieving properties, some of these drugs such as codeine and diphenoxylate (Lomitil) may be prescribed to relieve coughing or severe diarrhea (National Institute on Drug Abuse, 2016a).

Heroin is an opioid drug that is synthesized from morphine, and typically appears as a white or brown powder or as a black sticky substance. Heroin can be injected, inhaled by snorting or sniffing, or smoked - all of which deliver the drug to the brain very rapidly, where it is converted back into morphine and binds to opioid receptors, which are involved in the perception of pain and reward (National Institute on Drug Abuse,
Both prescription opioids and heroin are highly addictive drugs. According to the Centers for Disease Control (2017), anyone who takes prescription opioids can become addicted to them. In fact, as many as one in four patients receiving long-term opioid therapy in a primary care setting struggles with opioid addiction (as cited by CDC, Banta-Green et al, 2009; Boscarino et al., 2010; Fleming et al., 2007). Once addicted, it can be hard to stop. In 2014, nearly two million Americans either abused or were dependent on prescription opioid pain relievers.

Heroin is also a highly addictive drug, with repeated heroin use changing the physical structure and physiology of the brain in ways that create long-term neuronal and hormonal system imbalances that are not easily reversed. Heroin also produces profound degrees of tolerance and dependence, with more and more of the drug required over time to achieve the same effects; symptoms of withdrawal that may include restlessness, muscle and bone pain, insomnia, diarrhea, vomiting, cold flashes, and leg movements. Once a person becomes addicted to heroin, seeking and using the drug becomes their primary purpose in life (National Institute on Drug Abuse, 2014a).

Currently available research summarized by the National Institute of Drug Abuse (2015) demonstrates:

- Prescription opioid use is a risk factor for heroin use and a subset of people who abuse prescription opioids may progress to heroin use; nonetheless, heroin use is rare in prescription drug users.
- Prescription opioids and heroin have similar effects, but different risk factors.
- Increased drug availability is associated with increased use and overdose.
- Heroin use is driven by its low cost and high availability.

Research has identified three key factors that have a direct causal or contributory relationship to heroin and prescription opioid abuse on a community level: social

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Nora D. Volkow, MD Senate Caucus on International Narcotics Control, 2014
availability, retail availability, and perceptions of risk for harm (Birckmayer et al., 2004; State of Alaska, 2016a). Research has further shown that altering these factors can influence the use patterns and problem manifestations at the community level (Birckmayer et al., 2004). The State of Alaska identified these as contributing factors in Alaska and thus have guided data collection for this needs assessment:

1. **Social availability:** Social availability refers to the procurement of drugs through social sources like family and friends (Birckmayer, et al, 2004). Many studies suggest that increased social availability is a contributing factor to the non-medical use of prescription opioid medications. This may include receiving prescription opioids for free from friends or relatives, stealing prescription opioids from friends or relatives, or purchasing prescription opioids from friends or relatives.

2. **Retail availability:** Retail availability is accessibility of prescription opioids or heroin from retail sources, including both formal (physicians, dentists, and pharmacists) and informal markets (illicit drug sales). Evidence suggests that when formal market retailers are taught best practices, they are more likely to safeguard against potential patient misuse (Birckmayer, et al., 2004).

3. **Perceptions of risk for harm:** An individual's perception of the risks associated with opioids and heroin is related to their use behaviors. If individuals do not think they are doing anything potentially dangerous when they misuse prescription opioids or use heroin, they are more likely to abuse them. Furthermore, because prescription drugs are safe and effective when used properly and are broadly marketed to the public, the notion that they are also harmful and addictive when abused can be a difficult one to convey (National Institute on Drug Abuse, 2016).

**Organization of Report**

The needs assessment is divided into the following sections:

**Section 1: Methodology:** This section of the report describes the purpose of the needs assessment including guiding questions, data collection methods and data sources used in the assessment, and a description of data analysis methods.

**Section 2: Nature and Extent of the Problem:** This section of the report describes quantitative and qualitative data collected and analyzed to assess the nature and extent of prescription opioid misuse and heroin use in FNSB. It uses secondary data from sources such as the Youth Risk Behavior Survey (YRBS), Young Adult Substance Use Survey (YASUS), NSDUH, Alaska Prescription Drug Monitoring Program (AKPDMP), treatment providers, and interviews with adults in recovery from prescription opioid and/or heroin addiction.

**Section 3: Consequences:** This section of the report describes the quantitative and qualitative data collected and analyzed to assess the consequences of prescription opioid misuse and heroin use. It uses secondary data sources, such as the Alaska Health Facilities
Section 4: Community Factors Related to Social Availability: This section of the report describes the quantitative and qualitative data collected and analyzed to assess the community factors that contribute to the social availability of prescription opioids. This section uses several primary data sources, including a community perceptions survey, a retail availability survey, focus groups with youth, and interviews with people in recovery from prescription opioid and/or heroin addiction.

Section 5: Community Factors Related to Retail Availability: This section of the report describes the quantitative and qualitative data collected and analyzed to assess the community factors that contribute to the retail availability of prescription opioids. This section uses several primary data sources, including a community perceptions survey, a retail availability survey, focus groups with youth, and interviews with people in recovery from prescription opioid and/or heroin addiction.

Section 6: Community Factors Related to Perceptions of Risk: This section of the report describes the quantitative and qualitative data collected and analyzed to assess the community factors that contribute to perceptions of risk. This section uses several primary data sources, including a community perceptions survey, a retail availability survey, focus groups with youth, and interviews with people in recovery from prescription opioid and/or heroin addiction.

Section 7: Readiness: This section of the report describes the quantitative and qualitative data collected and analyzed to assess the level of readiness in the Fairbanks community to address prescription opioid misuse and heroin use, and identify additional resources that may be needed to do so. This section uses primary data gathered through key informant interviews.

Section 8: Synthesis/Recommendations/Prioritization: In this section of the report key findings are summarized and synthesized to prioritize conclusions.
Section 1: Methods

Data collection was organized around the four interrelated purposes of this needs assessment: 1) to identify the nature and extent of prescription opioid misuse and heroin use in the community; 2) to identify the consequences of prescription opioid misuse and heroin use; 3) to identify community factors that contribute to the social availability, retail availability, and perceived risk for harm of prescription opioid misuse and heroin use; and 4) to determine the level of readiness in the Fairbanks community to address prescription opioid misuse and heroin use and identify additional resources that may be needed to do so.

The needs assessment used six data collection instruments and sources: secondary data, a retail availability survey of opioid prescribers and pharmacists, interviews with people in recovery, focus groups with youth, a community perceptions survey, and community readiness interviews. These data collection instruments and sources are summarized and described in detail below (Figure 2).

![Figure 2. Needs assessment data collection instruments and sources](image)

<table>
<thead>
<tr>
<th>Nature and extent of prescription opioid and heroin use</th>
<th>Community Readiness Interviews</th>
<th>Community Perception Survey</th>
<th>Retail Availability Survey</th>
<th>Interviews with People in Recovery</th>
<th>Youth Focus Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consequences of prescription opioid misuse and heroin use among different groups</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community factors that contribute to social availability, retail availability, and perceived risk for harm</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
</tr>
<tr>
<td>Community readiness to address prescription opioid and heroin use and what additional resources may be needed</td>
<td>✅</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1.1. Secondary Data

The needs assessment used numerous secondary data sources, including the YRBS and
data collected by the State of Alaska Partnerships for Success evaluators. Data was analyzed to illustrate trends across years, and differences between demographic factors (gender, age, and race) and – as appropriate – between indicators. Following is a summary of data sources and the types of data that were collected.

Young Adult Substance Use Survey (YASUS): Self-report survey conducted by the Center for Behavioral Health Research and Services at the University of Alaska Anchorage (CBHRS at UAA). UAA purchased a mailing list of 18- to 27-year-olds in the focus boroughs/communities from a reputable marketing company. From this list, a random sample of 1,838 FNSB individuals was invited to participate in the survey by mail. Of those, 226 responses were received, yielding a response rate of 12.46%. Of those responses received, 167 (72.9% of responses) were within the focus age range of 18 to 27 (Hanson & Barnett, 2016). Data used in the needs assessment included the following:

- Percent of survey respondents ages 18 to 27 who reported ever misusing prescription opioids (FNSB and Alaska)
- Percent of survey respondents ages 18 to 27 who reported ever using heroin (FNSB and Alaska)
- Percent of survey respondents ages 18 to 27 in Alaska who reported ever misusing prescription opioids and who reported ever using heroin, by gender and race

Youth Risk Behavior Survey (YRBS): Conducted every other year by the State of Alaska in high schools statewide. Types of data collected for high school students in FNSB School District and the State of Alaska from 2011, 2013, and 2015:

- High school student reported use of prescription drugs and heroin by gender (FNSB)
- High school student reported use of prescription drugs without a prescription in the past 30 days (FNSB and Alaska)
- High school student reported use of prescription drugs without a prescription, lifetime (FNSB and Alaska)
- High school student reported use of heroin, lifetime (FNSB and Alaska)
- High school student reported perception of risk related to using prescription drugs without a prescription, risk related to binge drinking, and risk related to marijuana use (FNSB)

Alaska Health Facilities Data Reporting Program (HFDR): Inpatient and outpatient discharge data from health facilities in Alaska requested by CBHRS at UAA and shared with the Fairbanks Wellness Coalition. Data used in the needs assessment included the following:

- Number of heroin-related Emergency Department discharges at Fairbanks Memorial Hospital in 2015
- Number of prescription opioid-related Emergency Department discharges from
Fairbanks Wellness Coalition, 27

• Age, gender, and race of prescription opioid-related Emergency Department discharges in 2015

Program Records from Fairbanks Counseling and Adoption’s Street Outreach and Advocacy Program (SOAP): Data collected from individuals served by SOAP from April – September of 2016. Drug use is self-reported by those individuals served.

• Percent of youth served ages 10 to 21 who reported using opioids, heroin, and methamphetamines
• Gender of youth served ages 10 to 21 who reported using opioids, heroin, and methamphetamines
• Age in years of youth served who reported using opioids, heroin, and methamphetamines

Program Records from Interior AIDS Association (IAA) Northern Exchange Syringe Program and Project Special Delivery: Data collected about individuals utilizing needle exchange program and individuals enrolled in methadone drug treatment program:

• Number of syringes provided (program records)
• Age and gender of representative sample of individuals utilizing needle exchange program (self-report)
• Drug of use for representative sample of those utilizing needle exchange program (self-report)
• Number of individuals utilizing methadone drug treatment program and average daily census by fiscal year (program records)
• Gender, age and race of individuals enrolled in methadone drug treatment program (program records)
• Percent of those enrolled in methadone drug treatment program who are injection drug users (program records)

Program Records from Fairbanks Native Association (FNA): Data on admissions and unduplicated individuals served who were users of opiates, heroin, and prescription opioids, including for specified focus age ranges (ages 18 to 25 for heroin and ages 12 to 25 for prescription opioids):

• Percent of all individuals admitted for drug and alcohol use that were heroin users or prescription opioid users (program records)
• Average age of individuals admitted for opiate, heroin, and prescription opioid use (program records)
• Total number of heroin users and prescription opioid users, and number of users in focus age ranges (ages 18 to 25 for heroin and ages 12 to 25 for prescription opioids) (program records)
• Percent of all heroin users ages 18 to 25 (program records)
• Percent of all prescription opioid users ages 12 to 25 (program records)

Alaska State Troopers Statewide Drug Enforcement Unit: Tracks charges and arrests for heroin and prescription drug use statewide:

• Charges and arrests for heroin and prescription drugs in Alaska (2013 to 2015)
• Percent of all charges and arrests that were for heroin and prescription drugs in Alaska (2013 to 2015)
• FNSB-specific data was not provided by the Statewide Drug Enforcement Unit.

Alaska Prescription Drug Monitoring Program (AKPDMP): Statewide database to which prescribers and dispensers of controlled substances are required to report. As of July 2017, physicians and pharmacists are required to check the status of patients’ prescription records prior to prescribing or dispensing prescription opioids. In July 2017, House Bill 159 was also signed into law requiring additional AKPDMP use.

• AKPDMP data was not provided.

Alaska Uniform Response Online Reporting Access Data: Statewide emergency medical service patient care report data.

• Number of ambulance runs in 2015 and 2016 for Interior Region and State of Alaska that administered Naloxone (Narcan) for opioid overdose.

Alaska Health Analytics and Vital Records: Alaska Health Analytics and Vital Records provided the number of overdose deaths with underlying causes of unintentional drug poisoning, suicide drug poisoning, homicide drug poisoning, or drug poisoning of undermined intent in the International Classification of Diseases, 10th Revision for opioid pain relievers, heroin, and all overdoses for the five urban areas of the state of Alaska: Anchorage Municipality, City and Borough of Juneau, Fairbanks North Star Borough, Kenai Peninsula Borough, and Matanuska-Susitna Borough.

1.2. Community Readiness Interviews
The Goldstream Group developed a key informant interview protocol to evaluate levels of community awareness and understanding of the issues of prescription opioid misuse and heroin use in FNSB, as well as to evaluate how prepared and willing the community is to begin addressing these issues. The protocol is based on the five dimensions of community readiness identified by the Tri-Ethnic Center Community Readiness Model (Colorado State University, 2014): 1) community knowledge about the issue (How much does the community know about the issue?); 2) community knowledge of efforts (How much does the community know about current prevention programs and activities?); 3) leadership (What is the leadership’s attitude toward addressing the issue?); 4) community climate (What is the community’s attitude toward addressing the issue?); and 5) resources (What are the
resources being used or that could be used to address the issue?). The community readiness interview protocol is attached in Appendix B.

A purposive sample was used to select community representatives to interview. Coalition members together with the Goldstream Group project team identified key informants to be interviewed who represented a broad cross-section of stakeholders in the community knowledgeable about the issues. A total of 15 key informants were interviewed representing the following sectors of the community: schools, law enforcement, university, legal system, social services, medical services, veterans’ services, local businesses, city leadership, faith community, state behavioral health services, and persons in recovery.

Interviews were conducted, transcribed, scored, and analyzed by the Goldstream Group. The interviews were analyzed for key themes related to social availability, retail availability, and perceptions of risk for harm. In addition, all interviews were individually scored using the Tri-Ethnic Center Community Readiness Model (Colorado State University, 2014) stages of community readiness scale (Figure 3).

**Figure 3. Stages of Community Readiness Scale (Colorado State University, 2014)**

<table>
<thead>
<tr>
<th>Stage of Readiness</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Awareness</td>
<td>1</td>
</tr>
<tr>
<td>Denial/Resistance</td>
<td>2</td>
</tr>
<tr>
<td>Vague Awareness</td>
<td>3</td>
</tr>
<tr>
<td>Preplanning</td>
<td>4</td>
</tr>
<tr>
<td>Preparation</td>
<td>5</td>
</tr>
<tr>
<td>Initiation</td>
<td>6</td>
</tr>
<tr>
<td>Stabilization</td>
<td>7</td>
</tr>
<tr>
<td>Confirmation/Expansion</td>
<td>8</td>
</tr>
<tr>
<td>High Level of Community Ownership</td>
<td>9</td>
</tr>
</tbody>
</table>

Separate scores were given to each interview for prescription opioid misuse and for heroin use. Once scored, the scores for all interviews were averaged for each dimension of readiness for each of the two issues (prescription opioid misuse and heroin use). These scores were then averaged to arrive at an overall community readiness score for each issue.

1.3. Community Perceptions Survey

The Goldstream Group developed a community perceptions survey to gather adult opinions and perceptions around five main topics: 1) perceptions of the extent of prescription opioid misuse and heroin use in FNSB, 2) perceptions of the social availability of prescription opioids and heroin, 3) self-reported behavior related to social availability of prescription opioids, 4) perceptions of the retail availability of prescription opioids, and 5) the risk of harm from prescription opioid misuse and heroin use. In developing the survey, Goldstream Group used and/or modified questions from several published opinion surveys (see Denisco et al., 2011; Kahan et al., 2011; Admassu et al., 2015). The community perception survey
results by question are included in Appendix C.

A random sample was used to select adults to survey. Goldstream Group purchased from Experian a randomly selected list of 4,000 residential addresses in FNSB (out of a possible 29,000 addresses). A postcard was mailed to the 4,000 addresses directing adults in the household to complete an online Survey Monkey survey (https://www.surveymonkey.com/) on December 12, 2016. A follow-up postcard was mailed December 27, 2016. The survey was advertised on Facebook, in the local newspaper (both in print and online) and with paper fliers on public bulletin boards to encourage those who received a postcard to respond. Respondents were entered into a drawing to win either a $500 Amazon gift card, $500 worth of heating fuel, $50 Visa gift card and $25 Visa gift card.

Of the 4,000 postcards mailed, 260 were returned as undeliverable (6.5%). From the remaining 3,740 surveys, 236 completed surveys were received. The sampling error is plus or minus 6.35%. More females (56.8%) than males (36.9%) completed the survey. More than 70% of respondents were between the ages of 26 and 64 (Figures 4 and 5).

<table>
<thead>
<tr>
<th></th>
<th>Female</th>
<th>Male</th>
<th>No Gender Response</th>
<th>Total</th>
<th>Percent of Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 18 to 25</td>
<td>10</td>
<td>5</td>
<td>0</td>
<td>15</td>
<td>6.4%</td>
</tr>
<tr>
<td>Age 26 to 44</td>
<td>55</td>
<td>32</td>
<td>0</td>
<td>87</td>
<td>36.9%</td>
</tr>
<tr>
<td>Age 45 to 64</td>
<td>50</td>
<td>37</td>
<td>0</td>
<td>87</td>
<td>36.9%</td>
</tr>
<tr>
<td>Age 65 and Older</td>
<td>15</td>
<td>13</td>
<td>0</td>
<td>28</td>
<td>11.9%</td>
</tr>
<tr>
<td>No Age Response</td>
<td>4</td>
<td>0</td>
<td>15</td>
<td>19</td>
<td>8.1%</td>
</tr>
<tr>
<td>Total</td>
<td>134</td>
<td>87</td>
<td>0</td>
<td>236</td>
<td></td>
</tr>
</tbody>
</table>

Figure 4. Survey response by age and gender

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2 A confidence interval is a range of values that describes the uncertainty surrounding an estimate. We indicate a confidence interval by its endpoints; for example, the 90% confidence interval for the number of people, of all ages, in poverty in the United States in 1995 (based on the March 1996 Current Population Survey) is "35,534,124 to 37,315,094." A confidence interval is also itself an estimate. It is made using a model of how sampling, interviewing, measuring, and modeling contribute to uncertainty about the relation between the true value of the quantity we are estimating and our estimate of that value (U.S. Census, 2017).
Figure 5. Survey response by race and ethnicity

<table>
<thead>
<tr>
<th>Race/Category</th>
<th>Percent of Response (n=236)</th>
<th>US Census Data projected to 2015 <a href="http://www.census.gov/">http://www.census.gov/</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>84.3%</td>
<td>76.6%</td>
</tr>
<tr>
<td>American Indian or Alaska Native</td>
<td>7.2%</td>
<td>6.3%</td>
</tr>
<tr>
<td>Black or African American</td>
<td>1.3%</td>
<td>4.4%</td>
</tr>
<tr>
<td>Asian</td>
<td>2.5%</td>
<td>2.6%</td>
</tr>
<tr>
<td>Native Hawaiian or other Pacific Islander</td>
<td>0.4%</td>
<td>0.6%</td>
</tr>
<tr>
<td>Two or more races</td>
<td>N/A</td>
<td>8.5%</td>
</tr>
<tr>
<td>Other</td>
<td>2.1%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>2.5%</td>
<td>7.4%</td>
</tr>
</tbody>
</table>

Data was analyzed using descriptive statistics. Complete data tables are included in Appendix C.

1.4. Retail Availability Survey

The Goldstream Group developed and disseminated a survey to prescription opioid prescribers, including physicians and dentists, as well as pharmacists. This retail availability survey focused on the key areas where prescribers and pharmacists can limit retail availability of prescription opioids (e.g., completing courses on safe prescribing for pain medication, screening patients to identify signs of prescription drug abuse or dependence, talking to patients about the negative effects of misusing prescription drugs, and using the AKPDMP). In developing the survey, Goldstream Group used and/or modified questions from several published opinion surveys (see Denisco et al., 2011; Kahan et al., 2011). The survey was uploaded into SurveyMonkey, an online survey tool for dissemination (https://www.surveymonkey.com/). The retail availability results by question are included in Appendix D.

Non-random methods were used to sample dentists, pharmacists, and physicians to survey and may not be representative of the population of dentists, pharmacists, and physicians. A list of 56 dentists in FNSB was compiled from an internet search of dentists in FNSB. A list of 14 pharmacies in FNSB was compiled from an internet search of pharmacies in the FNSB; based on the Alaska Occupational Forecast (http://live.laborstats.alaska.gov/ocfcst/index.cfm), approximately 56 pharmacists are currently employed in FNSB. A list of 192 physicians was compiled from the FMH website list of physicians with hospital privileges compared to the Alaska State Medical Association directory which was not as complete (Figure 6).

The retail survey link was disseminated in several ways:

- The Goldstream Group mailed an introductory letter with the survey link to physicians, dentists and pharmacies on December 15, 2016.
On December 19, 2016 an introductory email and the survey link was emailed to the Fairbanks Memorial Hospital medical staff by a member of the staff on behalf of the Fairbanks Wellness Coalition.

Reminder postcards were hand delivered to dentists and pharmacists between January 16 and January 27, 2017.

On February 7, 2017 an introductory email and the survey link was emailed to the clinical directors of five major medical clinics in FNSB; a reminder email was sent on February 24, 2017.

In addition, the survey link was shared among members of the Fairbanks Opioid Workgroup and the Fairbanks Wellness Coalition who disseminated the link to physicians, dentists, and pharmacists they know.

**Figure 6. Retail availability survey sample statistics**

<table>
<thead>
<tr>
<th>Surveyed Group</th>
<th>Population Estimate</th>
<th>Number of Completed Surveys</th>
<th>Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>192</td>
<td>44</td>
<td>22.9%</td>
</tr>
<tr>
<td>Dentists</td>
<td>56</td>
<td>7</td>
<td>12.5%</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>56</td>
<td>12</td>
<td>21.4%</td>
</tr>
</tbody>
</table>

1Dentists and pharmacists were estimated by searching the internet for dentists in the Fairbanks area; physicians were all those listed on the FMH website as having hospital privileges and this list was compared to the Alaska State Medical Association directory which was not as complete.

1.5. Interviews with People in Recovery

The Goldstream Group developed an interview protocol to gather the opinions and perceptions of adults in recovery from prescription opioid and/or heroin addiction. The questions focused on four main topic areas: 1) information about how addicts started misusing prescription opioids and/or heroin and how they became addicted; 2) information about the social and retail availability of prescription opioids and heroin in the FNSB; 3) information about how interviewees stopped using and how they accessed help; and 4) perceptions about prevention messages and what might have prevented them from using in the first place. The interview protocol, consent forms, and summary of the interviews are attached in Appendix E.

A snowball sampling method was used to select adults for interviews. Individuals were recruited through the Fairbanks Opioid Workgroup as well as IAA and those interviewed were asked to refer others.

Ten adults were interviewed. Of those interviewed, five were men and five were women. We did not specifically ask for the age of those interviewed, but did ask for the age at which those interviewed began using. Interviews also encompassed the number of years that an individual used and how many they had been clean, thus making it possible to estimate the age of the interviewees. Eight of those interviewed were in their early 30s, one of those interviewed was in his or her early 40s, and one of those interviewed was in his or her early
Those interviewed all phoned the Goldstream Group offices, gave their oral informed consent to participate, and received a $25 gift card as an incentive for participating (gift cards were mailed or picked up at the Goldstream Group offices). Those who were interviewed remained anonymous, unless they provided their name to receive a gift card by mail for participating in the interview. If the interviewee did not want to provide his or her name and address he or she picked the gift card up at the Goldstream Group offices. The card was left with the front desk receptionist who did not know what was in the envelope or why it was being picked up; the receptionist did not work for Goldstream Group.

Interviews were recorded and transcribed. Data were analyzed for themes.

1.6. Youth Focus Groups
The Goldstream Group developed a focus group protocol to gather youth (ages 14 to 17) opinions and perceptions around three main topics: 1) perceptions of the extent of prescription opioid misuse and heroin use in their school, 2) perceptions of the social availability of prescription opioids and heroin, and 3) the risk of harm from prescription opioid misuse and heroin use. The interview protocol, consent and assent forms, and summary of the focus groups are attached in Appendix F.

A convenience sample was used to select students for interviews (figure 7). Students ages 14 to 17 were recruited to participate in the focus groups by the Fairbanks Wellness Coalition staff and were offered a $25 gift card as an incentive. Three groups participated, totaling 16 students. The focus groups were a convenience sample and are not representative of the 14- to 17-year-old population, but provide rich data to illustrate perceptions among this age group.

<table>
<thead>
<tr>
<th>Group</th>
<th>Number and Grade Level (Boys)</th>
<th>Number and Grade Level (Girls)</th>
<th>Total Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Middle School Group</td>
<td>2</td>
<td>Grade 7</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Grade 8</td>
<td></td>
</tr>
<tr>
<td>High School Group</td>
<td>1</td>
<td>Grade 11</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Grade 12</td>
<td></td>
</tr>
<tr>
<td>Mixed Grade Group</td>
<td>1</td>
<td>Grade 7</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Grade 9</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Grade 6</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Grade 8</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Grade 9</td>
<td></td>
</tr>
</tbody>
</table>

All students who participated in focus groups gave their informed assent to participate and their parents/guardians either gave verbal or written consent for their child's participation. Data were analyzed for themes.
1.7. Limitations

The needs assessment has several important limitations. The community perceptions and retail availability surveys are both limited by non-response error (not knowing if those of similar opinion are more likely to respond to the survey). This error was mitigated by comparing response demographics to known population demographics. The community perceptions survey was also limited by possible skewed sampling resulting from new and changing addresses not being included in the post office lists from which the sample was drawn (particularly a problem on military bases). This error was mitigated by using post office lists of addresses updated monthly.

In addition, these surveys rely on self-reported data. Self-reported data is limited by the fact that it rarely can be independently verified. Self-reported data also contain several potential sources of bias that should be noted as limitations. These are: 1) selective memory (remembering or not remembering experiences or events that occurred at some point in the past), 2) telescoping (recalling events that occurred at one time as if they occurred at another time), 3) attribution (the act of attributing positive events and outcomes to one's own agency but attributing negative events and outcomes to external forces), and 4) exaggeration (the act of representing outcomes or embellishing events as more significant than is actually suggested from other data) (University of Southern California Libraries, 2017).

This being said, self-report data are a critical component of our needs assessment and we have mitigated the limitations posed by self-report surveys in the following ways: 1) Self-reported data are accurate when individuals understand the questions and when there is a strong sense of anonymity. The needs assessment surveys were all disseminated to ensure anonymity of the respondents, as were the YRBS and the YASUS. 2) The survey results were compared to one another. There were consistencies between the results that support the validity of the findings. 3) The surveys accounted for a margin of error, but overall provide us with an accurate indication of what is occurring in FNSB (Brenner et al., 2003, as quoted by Most of Us).

Data to describe prescription opioid misuse/abuse and heroin use among the designated focus populations in the community (ages 12 to 25 for prescription opioid misuse/abuse and ages 18 to 25 for heroin use) is also difficult to accurately interpret and analyze for several reasons. First, the misuse of prescription opioids and heroin use are closely intertwined; this was noted by 60% of the 15 key informants knowledgeable about the issues in the community that were interviewed as part of this assessment. In addition, agencies may not track the use of heroin or prescription opiates separately in their data, instead tracking data as “opiates” or as “drugs.” Data is also reliant on users who seek services accurately reporting their own drug use.

Consumption patterns and certain community factors are also difficult to portray due to the small number of respondents to surveys conducted as part of this assessment, including the
community perceptions and retail availability surveys conducted by the Goldstream Group, and the YASUS conducted by the CBHRS at UAA (Hanson & Barnett, 2016). These smaller numbers also result in more difficulty accurately examining demographics such as age, gender, or race of users, as the number of self-reported users must be high enough to analyze these demographics with certainty and reliability. In addition, answers to demographic questions are typically optional in surveys.

Finally, there are limitations in the way in which some agencies collect data. For example, the Statewide Drug Enforcement Unit was able to produce the type of drug charges and arrests, and the number of total charges and arrests by age, race, and gender, but the system is not able to separately provide these demographics by individual drug type. As another example, while numerous sources anecdotally cited a connection between property crimes in Fairbanks and drug use or drug-seeking behavior (a significant theme in key informant interviews conducted as part of this assessment), when an individual is charged with or arrested for a property crime, any drug-related activity does not get recorded in the state’s database unless they have drugs on them at the time of arrest.
Section 2: Nature and Extent of Prescription Opioid Misuse and Heroin Use among Focus Age Groups

This section of the report describes quantitative and qualitative data collected and analyzed to assess the nature and extent of prescription opioid misuse and heroin use in FNSB. While prescription opioids and heroin are highly addictive in nature and the problem is serious for those it affects, the data analyzed indicated that prescription opioid misuse and heroin use affect a relatively small number of individuals within the designated focus populations in FNSB. For example, only 9.6% of 18- to 27-year-olds reported ever misusing prescription opioids, and 1.8% reported ever using heroin. Similarly, 13.6% of high school students reported using prescription drugs (not necessarily opioids) without a prescription in their lifetime, and 1.1% reported ever using heroin in their lifetime. In 2015, there were 218 prescription opioid-related discharges and 8 heroin-related discharges from Fairbanks Memorial Hospital. This accounts for less than 1% of all Emergency Department discharges in 2015.

Consumption patterns for prescription opioids and heroin are described in detail below, including data from service and treatment providers in the community. Wherever possible within each data source, heroin use and prescription opioid misuse are described separately; however, the interrelatedness of the two – a theme found throughout this assessment – should be taken under consideration when interpreting the data. In addition, as data is available, comparisons are made by gender, age, and race between FNSB and the State of Alaska.

2.1. Self-Reported Prescription Opioid Misuse and Heroin Use among 18- to 27-Year-Olds

The YASUS was administered in 2016 by CBHRS at UAA to 18- to 27-year-olds in Alaska. There were a total of 167 respondents to this survey ages 18 to 27 in FNSB. A far greater percent of YASUS respondents in FNSB reported ever misusing prescription opioids (9.6% of all respondents) than reported ever using heroin (1.8% of all respondents) (Hanson & Barnett, 2016). Based on FNSB 2010 Census data, these survey results indicate that of the roughly 15,026 individuals ages 18 to 25 living in FNSB, an estimated 1,400 have ever misused prescription opioids and an estimated 270 have ever used heroin (Figure 8).

- Of the 16 respondents in FNSB (9.6% of all respondents) who reported ever misusing prescription opioids, including using them without a prescription of their own, using

---

3 The most recent data available by single age year from which to analyze age and gender specific to the focus population for this project (ages 12 to 25 for prescription opioid misuse and ages 18 to 25 for heroin use) is 2010 census data.
them in greater amounts or for longer than they were told to, or using them in any other way than how a doctor directed, only two (1.2% of all respondents) indicated they had misused prescription opioids in the past 30 days, four (2.4% of all respondents) indicated they had misused prescription opioids more than 30 days ago but within the past 12 months, and 12 (7.2% of all respondents) indicated they had misused prescription opioids more than 12 months ago.

- Of the 3 respondents (1.8% of all respondents) who reported ever using heroin, none reported having used heroin in the past 30 days, one (0.6% of all respondents) reported having used heroin more than 30 days ago but within the past year, and two (1.2% of all respondents) reported having used heroin more than 12 months ago.

*Figure 8. Percent of 18- to 27-year-olds in FNSB who reported misusing prescription opioids or using heroin (n=167) (Data Source: Hanson & Barnett, 2016)*
Use in FNSB Compared to Alaska
Rates of prescription opioid misuse and heroin use among 18- to 27-year-olds were slightly lower in FNSB than in Alaska,\textsuperscript{4} with a total of 80 of 779 respondents statewide (10.3\%) reporting ever having misused prescription opioids (compared to 9.6\% in FNSB), and a total of 25 of 779 respondents statewide (3.2\%) reporting ever having used heroin (compared to 1.8\% in FNSB) (Figure 9).

\textit{Figure 9. Percent of 18-27 Year-olds in FNSB and Alaska who reported ever misusing prescription opioids and ever using heroin (n=779) (Data Source: Hanson & Barnett, 2016)}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure9.png}
\end{figure}

\begin{itemize}
\item Ever Misused Prescription Opioids: FNSB - 9.6\%, Alaska - 10.3\%.
\item Ever Used Heroin: FNSB - 1.8\%, Alaska - 3.2\%.
\end{itemize}

\textsuperscript{4}These numbers are based on initial reports from Hanson and Barnett on 12/23/16; further analysis/weighting for state reports may correct for sampling weaknesses at a later date.
Use by Gender
Sample sizes in FNSB were too small to examine patterns of use by gender or race for either prescription opioids or heroin. However, statewide, a slightly higher percentage of females reported ever misusing prescription opioids (10.9%) than did males (8.7%). Similarly, a higher percentage of females (3.8%) statewide reported ever using heroin than did males (2.3%) (figure10).

Figure 10. Percent of 18-27 year-olds in Alaska who reported ever misusing prescription opioids or using heroin by gender (n=779) (Data Source: Hanson & Barnett, 2016)
Use by Race
Statewide, a higher percentage of those who are white alone and non-Hispanic reported ever misusing prescription opioids (11.2%) compared to those who are Alaska Native/American Indian alone or in combination with another race (7.5%). This pattern was reversed for heroin use, with 3.3% of those who are white alone and non-Hispanic reporting ever using heroin, and 4.7% who are Alaska Native/American Indian alone or in combination with another race reporting ever using heroin (Figure 11).

![Figure 11. Percent of 18-27 year-olds in Alaska who reported ever misusing prescription opioids or using heroin by race (n=779) (Data Source: Hanson & Barnett, 2016)](image)

2.2. Self-Reported Misuse of Prescription Opioids and Heroin Use among High School Students
The YRBS is conducted every other year by the State of Alaska in high schools statewide, and includes questions about prescription drug misuse, as well as heroin use. (The survey does not ask specifically about prescription opioid drugs; however, the 2017 YRBS will include questions specifically about prescription opioid misuse, and data will be available in 2018.) In 2015, more YRBS respondents in FNSB School District reported misusing prescription drugs than reported using heroin.

Prescription Drugs: In 2015, an estimated 13.6% of all high school students in FNSB School District had used prescription drugs (not necessarily opioid prescriptions) without a prescription in their lifetime. This is a reduction from 2013, when 19.6% reported they had ever used a prescription drug without a prescription from a doctor during their life. In 2015 an estimated 5.8% had done so in the past 30 days (YRBS, 2015), and in 2013 an estimated
8.5% had done so in the past 30 days (YRBS, 2013). Extrapolating from FNSB 2010 Census data, this indicates that of the roughly 7,496 high school age students living in FNSB, an estimated 1,019 have ever misused a prescription drug in their lifetime (not necessarily opioids).

**Heroin:** In 2015, an estimated 1.1% of all high school students in FNSB School District had used heroin in their lifetime in 2015 (YRBS, 2015) and 2.5% in 2013 (YRBS, 2013). Again extrapolating from FNSB 2010 Census data, this indicates that of the roughly 7,496 high school age students living in FNSB, an estimated 82 have ever used heroin.

**Use by Gender**
The estimated number of males using a prescription drug without a prescription was higher than for females in FNSB School District. In 2015, an estimated 15.3% of males had used prescription drugs without a prescription in their lifetime, while fewer females (11.7%) did. Similarly, an estimated 6.4% of males used prescription drugs without a prescription in the past 30 days, while only 5.2% of females did. Students who reported using heroin were all male (Figure 12).

*Figure 12. Estimated percent of high school students in FNSB School District who used prescription drugs without a prescription or used heroin in 2015 (Data Source: CBHRS, UAA based on Alaska YRBS)*

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5 The most recent data available by single age year from which to analyze age and gender specific to the focus population for this project (12-25 years for prescription opioid misuse and 18-25 years for heroin use) is 2010 census data.
**FNSB Compared to Alaska**

On both the 2011 and 2013 YRBS, FNSB School District high school students reported higher rates of lifetime prescription drug use without a prescription, 30-day prescription drug use without a prescription, and lifetime heroin use than students statewide. However, in 2015, FNSB students reported lower rates of lifetime prescription drug use without a prescription, 30-day prescription drug use without a prescription, and lifetime heroin use than students statewide (Figures 13, 14, and 15).

*Figure 13. Estimated percent of high school students in FNSB School District and in Alaska who used prescription drugs without a prescription in their lifetime (Data Source: CBHRS, UAA based on Alaska YRBS)*

![Graph showing the percentage of high school students in FNSB School District and in Alaska who used prescription drugs without a prescription in their lifetime. The graph shows a decrease in the percentage over the years for both FNSB and Alaska.]

*Figure 14. Estimated percent of high school students in FNSB School District and in Alaska who used prescription drugs without a prescription in the past 30 days (Data Source: CBHRS, UAA based on Alaska YRBS)*

![Graph showing the percentage of high school students in FNSB School District and in Alaska who used prescription drugs without a prescription in the past 30 days. The graph shows a decrease in the percentage over the years for both FNSB and Alaska.]*
2.3. Use among Homeless Youth and Youth at Risk of Being Homeless

Self-reported use of heroin and prescription opioids is high among youth who access SOAP, which provides outreach to 10- to 21-year-olds who are at high risk of becoming homeless, or who are currently homeless or have run away from home.

During the 6-month period from April to September 2016, SOAP served a total of 289 unduplicated individuals ages 10 to 21. Of these 289 individuals, 126 (43.6%) self-reported use of heroin, prescription opioids, and methamphetamines. All of these individuals had used all three drugs. Of the 126 self-reported users of heroin, prescription opioids, and methamphetamines who were served by SOAP during this 6-month time period, nearly two-thirds (65.9%) were male, and just over one-third (34.1%) were female (Figure 16). These users ranged in age from 14 to 21 years, with 75% between the ages of 18 and 21 (Figure 17).

---

6 Discussions with representatives from the Alaska State Troopers Statewide Drug Enforcement Unit revealed that it is anecdotally common for users of heroin and other opiates to also be users of methamphetamines. These users may use methamphetamines to combat the drowsiness caused by heroin/opiates, and conversely use heroin/opiates to combat the high caused by methamphetamines. Data specifically linking heroin/opiate and methamphetamine use in FNSB is generally not available.
2.4. Number of Individuals Receiving Treatment for Prescription Opioid and Heroin Addiction

Several public agencies in FNSB provide treatment for prescription opioid and heroin addiction, including Interior AIDS Association (IAA), which offers a needle exchange program and a methadone drug treatment program; and FNA, which provides substance abuse treatment services.
**Interior AIDS Association (IAA)**

At the end of 2016, IAA served approximately 300 individuals through its Northern Exchange Syringe Program, a needle exchange program, and 57 individuals through Project Special Delivery, a methadone drug treatment program.

**Northern Exchange Syringe Program**

IAA estimates that for the 11-month period from January through November 2016, 300 individuals accessed its Northern Exchange Syringe Program. These 300 individuals exchanged approximately 58,500 syringes—an average of approximately 175 syringes per day. These individuals completed IAA’s data request form asking for demographic and drug use information a total of 364 times. The majority of users were ages 20 to 29 (Figure 18) and were white (Figure 19).

*Figure 18. Northern Exchange Syringe Program participants by age (n=364) (Data Source: IAA)*

---

7 The goals of Northern Exchange Syringe Program are to provide injection drug users with new, sterile injection equipment as a means of reducing the spread of blood-borne viruses and/or injection-related infections, as well as to remove used injection equipment from circulation through exchanging old syringes for new ones.

8 The Northern Exchange Syringe Program collects voluntary information from individuals who come into IAA to exchange needles. Some individuals may complete the program’s data request form numerous times and others may never complete the data request form. In addition, individuals may exchange needles for others who are not represented in the data. Nonetheless, even with these caveats, the IAA data provides a descriptive picture of who is using the Northern Exchange Syringe Program.
Of the data request forms completed by users of the Northern Exchange Syringe Program during the same time period in 2016, 251 indicated which drug(s) the needle exchange service user used. The majority (83.7%) indicated they were heroin users, with the remainder using cocaine, methamphetamines, or suboxone (Figure 20).

Of the data request forms completed, 364 indicated the needle exchange service user’s gender and age. The majority (224, or 61.5%) were female, while 140 (38.5%) were male (Figure 21).
**Project Special Delivery**

Project Special Delivery, IAA’s methadone treatment program, is one of just four methadone treatment programs in Alaska (SAMHSA, 2016c), and has served a total of 230 unduplicated individuals since it opened in Fairbanks at the end of 1999. As of December 2016, 57 individuals were actively enrolled in the program.

The number of individuals served by Project Special Delivery has steadily increased from 2003 to 2016, with a low of 31 in FY 2004 and a high of 63 in FY 2016. The average daily census for individuals enrolled in the program has also seen a steady increase since 2003, with a low of 23.6 individuals in FY 2003 and a high of 44.0 individuals in FY 2016 (Figure 22).

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Figure 21. Gender of individuals utilizing Northern Exchange Syringe Program from January to November 2016 (n=364 duplicated individuals) (Data Source: IAA)

<table>
<thead>
<tr>
<th>Gender</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>38%</td>
</tr>
<tr>
<td>Females</td>
<td>62%</td>
</tr>
</tbody>
</table>

---

9 Methadone is a medication used in medication-assisted treatment (MAT) to help people reduce or quit their use of heroin or other opioids, including prescription opioids. Methadone has been used for decades to treat people who are addicted to heroin and prescription opioids. When taken as prescribed, it is safe and effective. It allows people to recover from their addiction and to reclaim active and meaningful lives. Methadone works by changing how the brain and nervous system respond to pain. It lessens the painful symptoms of opiate withdrawal and blocks the euphoric effects of opiate drugs such as heroin, morphine, and codeine, as well as semi-synthetic opioids like oxycodone and hydrocodone. Patients taking methadone to treat opioid addiction must receive the medication under the supervision of a physician. By law, methadone can only be dispensed through an opioid treatment program (OTP) certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) (SAMHSA, 2015).
More women than men have been enrolled in the methadone treatment program (Figure 23).

The average age of those served by the program ranges from a low of 35 in 2011 to a high of 42 in 2004. In 2016, the average age was 38, with a range of 21 to 67 years. When examining the average age of those served by the program for trends, it appears that overall age has shown a slight downward trend over time (Figure 24).
The percentage of those served by Project Special Delivery from 2003 to 2016 who were Alaska Native range from a low of 13% in 2013 to a high of 38% in 2005 (Figure 25). This represents a disproportionate percentage of the population of FNSB as a whole – just 7% of the population of the Borough was American Indian or Alaska Native in 2010, according to U.S. Census figures.
Since 2003, the percentage of those served by Project Special Delivery who were injection drug users has varied from a low of 41% to a high of 64%, with no apparent trend or pattern. In FY 2016, 62% of those served by Project Special Delivery were injection drug users.

**Fairbanks Native Association (FNA)**

FNA provides outpatient and residential alcohol and drug treatment services to adolescents and adults, regardless of race.

In 2013, FNA treated 59 individuals for heroin addiction (12.5% of all unique individuals served in 2013), and 55 individuals for prescription opioid addiction (11.7% of all individuals served in 2013). By 2016, these numbers had decreased: in 2016 FNA treated 49 individuals for heroin addiction (11.1% of all unique individuals served in 2016) and a total of 24 unique individuals (5.4% of all unique individuals served in 2016) for prescription opioid addiction (Figure 26).

*Figure 26. Number of unique individuals served by drug and alcohol programs at FNA who were heroin and prescription opioid users (Data Source: FNA)*
More females than males were admitted for both heroin and prescription opioid use in 2016. The percentage of females admitted was higher for heroin and for prescription opioids than it was for all drug and alcohol admissions combined (Figure 27).

Figure 27. Unique admissions for heroin and prescription opioids by gender in 2016 at FNA (Data Source: FNA)

Those who received treatment from FNA for heroin and prescription opioids were younger than those who received treatment of other addictions. The average age of prescription opioid users from 2013 to 2016 was 36, and the average age of heroin users from 2013 to 2016 was 29; the average age of those who received treatment of other addictions was 40 (Figure 28).

Figure 28. Average age in years for unique individuals served by FNA for alcohol and drug treatment (Data Source: FNA)

FNA saw an overall decline in the number of heroin and prescription opioid users treated from 2013 to 2016 (Figure 29), as well as a decline in the percentage of individuals served...
that were in the focus age ranges (18-25 for heroin and 12-25 for prescription opioids) (Figure 30).

**Figure 29. Heroin and prescription opioid users served by Fairbanks Native Association (Data Source: Fairbanks Native Association)**

**Figure 30. Percent of heroin and prescription opioid users served by FNA who were within the focus age ranges (Data Source: FNA)**
2.5. Charges and Arrests Related to Prescription Opioid Misuse and Heroin Use

According to the Alaska State Troopers 2015 Annual Drug Report, Alaska has continued to see an increase in the abuse of heroin and other opiates, including a variety of prescription opiate medications. This increase in heroin and opiate use has primarily been seen in urban areas (Alaska State Troopers, 2016). The Alaska Statewide Drug Enforcement Unit made 233 heroin-related charges and arrests statewide in 2015, an increase from 209 in 2014 and 151 in 2013. During the same time period, there was a slight decrease in the number of charges and arrests for prescription drugs (may include non-opiates as well as opiates). There were 59 charges and arrests statewide for prescription drugs in 2015, which was a decrease from 96 in 2014 and 126 in 2013. Of all alcohol or drug-related charges and arrests made by the Statewide Drug Enforcement Unit in Alaska in 2015, 23.0% were for heroin and 6.0% were for prescription drugs (Figure 31).

Data was requested from the Alaska Statewide Drug Enforcement Unit for heroin and prescription drug-related charges and arrests specific to FNSB during the same time period. Several factors were discovered impacting the ability to accurately assess trends over time include challenges of consistency in reporting and documenting data related to charges and arrests, as well as a shift in focus over the past several years from a larger number of smaller cases to a smaller number of larger cases. For these reasons, conclusions specific to FNSB could not be drawn.
Section 3: Consequences of Opioid Misuse and Heroin Use

This section of the report describes the quantitative and qualitative data collected and analyzed to assess the consequences of prescription opioid misuse and heroin use. It uses secondary data sources, such as the Alaska HFDR, as well as primary data and anecdotal evidence collected through the community perceptions survey, community readiness interviews, and interviews with people in recovery.

Major consequences identified include overdose, addiction, exposure to Hepatitis C and HIV infections, and property crime. Of 218 prescription opioid-related Emergency Department discharges at Fairbanks Memorial Hospital in 2015, 54 (nearly one-quarter) were in the focus population of 12- to 25-year-olds.

3.1. Overdose and Death

Overdoses and death are serious consequences for both prescription opioid misuse and heroin use. Nationally and in Alaska, prescription opioid-related overdose deaths now outnumber overdose deaths involving all illicit drugs such as heroin and cocaine combined (Behavioral Health Coordinating Committee, 2016). According to 2015 data recently released by the Centers for Disease Control and Prevention (CDC), deaths from prescription opioid overdose, heroin, and fentanyl all have continued to rise in the United States. From 2014 to 2015, deaths related to synthetic opiates such as fentanyl increased by nearly 75%. While as recently as 2007 gun homicides outnumbered heroin deaths by more than 5 to 1, in 2015 more people died from heroin related causes than from gun homicides (Ingraham, C., 2016).

Prescription Opioid and Heroin Deaths

Heroin and prescription opioid-associated deaths in the State of Alaska more than tripled from 2009 to 2015, with 402 people dying from prescription opioids as the primary or a contributing cause of death during that time period and 127 people dying from heroin use as the primary or a contributing cause of death during that time period (State of Alaska Epidemiology Bulletin, 2016). Although the pattern of heroin and prescription opioid-associated deaths in FNSB has followed a similar trend to the other four major urban areas in Alaska (Anchorage Municipality, City and Borough of Juneau, Mat-Su Borough, and Kenai Peninsula Borough), FNSB has the lowest rate of heroin and prescription opioid-associated deaths (FNSB prescription opioid overdose deaths are represented by the yellow
dashed line and FNSB heroin overdose deaths are represented by the yellow solid point) (Figure 32 and Figure 33).

*Figure 32. Heroin and opioid pain reliever overdose mortality by year(s), deaths occurring in Alaska urban centers, 2001 to 2016 (Data Source: Alaska Health Analytics and Vital Records, 2017)*

**Figure 32.** Heroin and opioid pain reliever overdose mortality by year(s), deaths occurring in Alaska urban centers, 2001 to 2016 (Data Source: Alaska Health Analytics and Vital Records, 2017)

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10 Alaska Health Analytics and Vital Records provided the number of overdose deaths with underlying causes of unintentional drug poisoning, suicide drug poisoning, homicide drug poisoning, or drug poisoning of undermined intent in the International Classification of Diseases, 10th Revision for opioid pain relievers, heroin, and all overdoses for the five urban areas of the state of Alaska: Anchorage Municipality, City and Borough of Juneau, Fairbanks North Star Borough, Kenai Peninsula Borough, and Matanuska-Susitna Borough. Deaths per 100,000 were reported for overlapping time periods (e.g., 2001 to 2003 and 2002 to 2004) because the number of deaths per year is small.
Prescription Opioid and Heroin Overdoses

Several indicators provide an estimate of the number of overdoses that occur in Fairbanks from prescription opioids and/or heroin. For instance, in 2015, there were eight heroin-related discharges and 218 prescription opioid-related discharges out of a total of 28,954 Emergency Department discharges at Fairbanks Memorial Hospital (Health Facilities Data Reporting Program, 2016).

Of the 218 prescription opioid-related Emergency Room discharges (0.8% of all Emergency Room discharges), 54 (nearly one-quarter) were for individuals in the focus age group of 12- to 25-year-olds. Slightly more than one-third (39.0%) of all 218 prescription opioid-related discharges were males, while slightly less than two-thirds (61.0%) were females. Two-thirds (67.0%) of all 218 prescription opioid-related discharges were white, and 29.4% were Alaska Native (Health Facilities Data Reporting Program, 2016).

---

11 Alaska Health Analytics and Vital Records provided the number of overdose deaths with underlying causes of unintentional drug poisoning, suicide drug poisoning, homicide drug poisoning, or drug poisoning of undermined intent in the International Classification of Diseases, 10th Revision for opioid pain relievers, heroin, and all overdoses for Fairbanks North Star Borough. Number of deaths were reported for overlapping time periods (e.g., 2001 to 2003 and 2002 to 2004) because the number of deaths per year is small.

12 The Alaska Health Facilities Data Reporting Program (HFDR) collects inpatient and outpatient discharge data from healthcare facilities in AK, which shows utilization of health services and provides evidence of conditions for which people receive treatment. ‘15 FMH discharge data obtained by CBHRS at UAA in Dec ‘16.
Naloxone is an opioid analgesic that is designed to rapidly reverse an opioid overdose and can quickly restore normal respiration to a person whose breathing has slowed or stopped as a result of heroin or prescription opioid overdose (National Institute on Drug Abuse, 2016c). In 2015, there were 62 ambulance runs in the Interior region of Alaska where Naloxone was administered for overdose. This number represents 50.4% of the 123 administrations of Naloxone statewide. In 2016, there were 56 ambulance runs in the Interior where Naloxone was administered. This number represents 39.2% of the 143 administrations of Naloxone statewide (Figure 34).

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Ambulance Runs with Naloxone in Alaska</th>
<th>Ambulance Runs with Naloxone in Interior Region</th>
<th>Percent of State Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>123</td>
<td>62</td>
<td>50.4%</td>
</tr>
<tr>
<td>2016</td>
<td>143</td>
<td>56</td>
<td>39.2%</td>
</tr>
</tbody>
</table>

Key informants interviewed as part of this needs assessment expressed concern that the development of toxic knock-off drugs to replace more expensive prescription opioids and/or heroin will lead to more overdose emergencies and deaths because people won’t understand what they are taking or what the dangers are.

“...And then what’s happening too is you’re having OxyContin, oxycodone, fentanyl knockoff drugs that are basically toxic knockoffs of these drugs that, used in combination, wind up killing people as well...what they were doing is they were just slightly altering the chemical makeup of the drug, and so they were producing a new compound...People are inventive, and they’re entrepreneurial, so they’re tweaking the recipe so to speak, and they’re creating these new compounds. And no one knows how they’re gonna affect people...It’s like Russian Roulette: I’ll try this, try that, mix them together and see what happens.” (Key Informant 8, December, 2016)
3.2. Hepatitis C Virus and HIV

**Hepatitis C Virus**

The Hepatitis C Virus is most often spread by sharing needles or other equipment to inject drugs (Centers for Disease Control and Prevention, 2016b). Several indicators provide an estimate of the number of people in Fairbanks who have contracted the Hepatitis C Virus from sharing needles or other equipment to inject drugs.

- The number of reported Hepatitis C Virus cases in the Interior Region of the state increased by 23% from 105 new cases in 2014 to 129 new cases in 2015. This represents 8.5% of the 1,511 newly reported cases of Hepatitis C in Alaska in 2015 (Alaska Department of Health and Social Services, 2016a).

- From 2011 to 2015, individuals ages 18 to 29 accounted for the largest increase by age group of Hepatitis C Virus cases reported to the State of Alaska Section of Epidemiology.

- From 2011 to 2015 there was a 75% increase in the rate of reported Hepatitis C Virus cases among 18-29 year olds in the Interior Region of the state (Alaska Department of Health and Social Services, 2016b). In 2011, the rate of Hepatitis C Virus cases reported for 18- to 29-year-olds in the Interior of Alaska was 87 per 100,000. That rate increased dramatically to 152 per 100,000 in 2015 (Hanlon, T., 2016). Because diagnoses of Hepatitis C Virus often occur years after patients’ initial acquisition of infection (Alaska Department of Health and Social Services, 2016b), many of the reported cases for persons ages 18 to 29 may have actually occurred at a much younger age.

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13 Hepatitis C Virus is a contagious liver disease that ranges in severity from a mild illness lasting a few weeks to a serious, lifelong illness that attacks the liver. It results from infection with the Hepatitis C virus (HCV), which is spread primarily through contact with the blood of an infected person. Hepatitis C is usually spread when blood from a person infected with the Hepatitis C virus enters the body of someone who is not infected.
**HIV**

On average, one in ten new HIV infections\(^{14}\) are caused by the sharing of needles. (International HIV/AIDS Alliance, 2016). While most people know that intravenous drug use and needle-sharing can transmit HIV, fewer are aware of the role that drug abuse in general plays. A person under the influence of certain drugs is more likely to engage in risky behaviors such as having unsafe sex with an infected partner, including “transactional” sex—trading sex for drugs or money. Drug abuse and addiction can also worsen HIV symptoms for those who already carry the virus, causing greater neuronal injury and cognitive impairment, for example (National Institute on Drug Abuse, 2012).

Several indicators provide an estimate of the number of people in Fairbanks who have contracted HIV from sharing needles or other equipment to inject drugs.

- In 2015, 64 cases of HIV were reported to the Alaska Section of Epidemiology, 22 (34%) of which were newly diagnosed in Alaska, yielding a statewide incidence rate for HIV of 3 cases per 100,000 persons.
- Twelve of 21 people interviewed with newly diagnosed HIV in Alaska in 2015 (57%) reported a history of drug and alcohol abuse (Alaska Department of Health and Social Services, 2016c).

### 3.3. Addiction

Both prescription opioids and heroin are highly addictive drugs. According to the Centers for Disease Control (2017), anyone who takes prescription opioids can become addicted to them. In fact, as many as one in four patients receiving long-term opioid therapy in a primary care setting struggles with opioid addiction (as cited by CDC, Banta-Green et al., 2009; Boscarino et al., 2010; Fleming et al., 2007). Once addicted, it can be hard to stop. In 2014, nearly two million Americans either abused or were dependent on prescription opioid pain relievers.

\(^{14}\) 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. Untreated, HIV reduces the number of CD4 cells in the body. This damage to the immune system makes it harder and harder for the body to fight off infections and some other diseases. (Centers for Disease Control and Prevention, 2016c).
Repeated heroin use changes the physical structure and physiology of the brain in ways that create long-term neuronal and hormonal system imbalances that are not easily reversed. Heroin also produces profound degrees of tolerance and dependence, with more and more of the drug required over time to achieve the same effects, and symptoms of withdrawal that may include restlessness, muscle and bone pain, insomnia, diarrhea, vomiting, cold flashes, and leg movements. Once a person becomes addicted to heroin, seeking and using the drug becomes their primary purpose in life (National Institute on Drug Abuse, 2014a).

More than half of key informants interviewed for this assessment (60.0%) spoke specifically about the highly addictive nature of heroin and opioids as compared to other drugs. In addition, 40.0% of those interviewed felt that members of the community do not understand the nature of addiction and believe that people make a personal choice to continue using these drugs.

“Enslavement. Just thinking of the destructive nature of addiction and the progressive nature….I truly believe that it hijacks a person and changes them into someone else, and they do things they never would have done before, and they start living in ways that are contrary to their personal values…” (Key Informant 1, December, 2016)

3.4. Property Crimes

According to the Alaska State Troopers, as the demand for prescription drugs has increased and the available supply has decreased, many who abuse prescription drugs may no longer be able to pay for their addictions and resort to property and violent crimes to support their addiction. Prescription drugs have been linked to the following crimes: homicide, assault, prescription fraud, home invasion thefts, property thefts, and pharmacy robberies. There is particular concern for the well-being of vulnerable populations, such as the elderly, and those with severe long-term illnesses, such as cancer (Alaska State Troopers, 2016).

In community readiness interviews conducted as part of this assessment, nearly half of the 15 key informants interviewed (47.0%) specifically spoke about the high number of property crimes in Fairbanks that are drug related.

“But everybody knows that we’ve got to lock our cars and our windows for the first time in decades here in Fairbanks because somebody’s likely to break into your house because they need drug money. I believe that the concern is high as it relates to protection of personal self and property.” (Key Informant 10, December, 2016)

According to the Statewide Drug Enforcement Unit, the street values of heroin and opiates in Fairbanks are high. In 2016, one gram of heroin – approximately equivalent to the amount of sugar in a single sugar packet – sold for anywhere from $450 to $500 in
Fairbanks. An 80 mg pill of Oxycodone/OxyContin sold for $150 in 2016, a 9 mg pill of hydrocodone sold for $40, and a $100mg pill of morphine sold for $90. The financial implications for those who are addicted creates a strong case for a resulting correlation with property crimes.

While a significant number of property crimes are anecdotally attributable to drug-seeking behavior, discussion with the Alaska State Troopers Statewide Drug Enforcement Unit revealed that this is very difficult to demonstrate in the data because a person must be charged with both a property crime and a drug offense at the same time in order to link the two.

Data provided by the Alaska Court System show the number of felony and misdemeanor property crime filings in FNSB have increased slightly from 2007 to 2016, with a spike in misdemeanor property crime filings in 2014. However, there is no increasing or decreasing linear trend for either felonies ($P=0.56$) or misdemeanors ($P=0.19$) (Figure 35).

**Figure 35. Number of misdemeanor and felony property crime filings in FNSB for FY2007 – FY2016**
*(Data Source: Alaska Court System)*

3.5. Other Crimes

Six out of 10 recovery interview participants sold drugs at some point to help fund their own drug habit. Three of the interviewees were arrested and charged with a felony. Two spent time in prison. The quotations below are representative of those participants who spoke about dealing drugs to support their own habit:

“Where there’s a will, there’s a way. There’s all sorts of different ways you can do extraction to get stuff, and like I said, we were kind of into chemistry.”
So, one thing we did do was we started actually ordering on-line, and I think they've gotten a bit stricter now. But we turned to the Internet, and we were ordering things, and places will send it here...” (Recovery Interview 3, December 2016)

“...more and more people started doing OxyContin that I knew, and then I ended up getting ahold of a friend down south that was able to get 'em for, you know, like I said, a quarter of the price of what they were going for up here, and that's kinda where I started doing that. He started shooting shipments up to me and I started selling 'em.” (Recovery Interview 7, December 2016)

3.6. Community Perceptions of Consequences

In the community perceptions survey adults were asked in an open-ended question to list what they felt were the most significant consequences of young people misusing prescription opioid medications (Figure 36). In response to this question, 42.1% cited elements of lost jobs, homelessness, or school drop-out; 38.3% cited addiction or dependence, and 29.9% cited crime or theft to support the habit. When asked the same question about consequences of heroin use, 40.9% of respondents cited addiction or dependence, 39.9% cited death, and 32.5% cited crime or theft to support the habit. Interestingly, only 17.8% of survey respondent listed death as a consequence for prescription opioid misuse when far more people in Alaska have died from causes associated with prescription opioids in the last ten years than from causes associated with heroin. Respondents did not list Hepatitis C Virus or HIV either, even though both diseases are closely associated with sharing needles.

Figure 36. Perceptions of consequences from misuse of prescription opioids and heroin among FNSB adults (Data Source: Community Perceptions Survey)

<table>
<thead>
<tr>
<th>Prescription Opioids (n=214)</th>
<th>Heroin (n=203)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lost jobs, quit school, homelessness (42.1%)</td>
<td>Addiction or dependence (40.9%)</td>
</tr>
<tr>
<td>Addiction or dependence (38.3%)</td>
<td>Death (39.9%)</td>
</tr>
<tr>
<td>Crime or theft to support habit (29.9%)</td>
<td>Crime or theft to support habit (32.5%)</td>
</tr>
<tr>
<td>Physical effects (22.0%)</td>
<td>Physical effects (30.0%)</td>
</tr>
<tr>
<td>Impaired judgement, altered behavior (19.6%)</td>
<td>Unemployment, quit school (27.6%)</td>
</tr>
<tr>
<td>Death (17.8%)</td>
<td>Social isolation, break with family (21.2%)</td>
</tr>
</tbody>
</table>
Section 4: Community Factors that Contribute to Social Availability

This section of the report describes the quantitative and qualitative data collected and analyzed to assess the community factors that contribute to the social availability. This section uses several primary data sources, including a community perceptions survey, a retail availability survey, focus groups with youth, and interviews with people in recovery from prescription opioid and/or heroin addiction.

Social availability refers to the procurement of drugs through social sources, such as family and friends (Birckmayer et al., 2004). Many studies suggest that increased social availability is a contributing factor to the non-medical use of prescription opioid medications. This may include receiving prescription opioids for free from friends or relatives, stealing prescription opioids from friends or relatives, or purchasing prescription opioids from friends or relatives.

SAMHSA’s 2009 NSDUH found that more than seventy percent of people who used prescription pain relievers non-medically got them from friends or relatives, while approximately five percent got them from a drug dealer or from the Internet. (SAMHSA, 2009).

Analysis of data sources revealed that young people get started using drugs most often through their peers or family, and that prescription opioids and heroin are relatively easy to obtain in the community. Data also show that few people utilize proper drug storage and/or disposal methods in the community.

4.1. Initiation of Drug Use

A community perceptions survey of adults in FNSB indicated that adults are aware of how young people who misuse prescription opioids get started. A total of 42.1% of adults who responded to the survey felt that young people who misuse prescription opioids get started by “borrowing” a family or friend’s prescription, and 38.0% felt that they get started as a result of their peers (peer pressure, their peers are doing it, etc.). Just more than 15% felt that young people get started

“The most common story I hear is I started in high school using OxyContin, and then they switched the chemical makeup and I switched to heroin. That is really common in my age group.” -- (Recovery Interview 4, December 2016)

In general, those in recovery from prescription opioid or heroin abuse interviewed as part of this needs assessment started because they were hanging out with people and going to parties where substances were available. They went to parties where opioid pills were part of what was passed around, in addition to pot, alcohol, mushrooms, or ecstasy. Many tried Vicodin or other pills once or twice before trying OxyContin, but once they tried OxyContin, many said the addiction was quick and fierce. This first Oxy high, without fail, was an experience that they remembered and tried to recreate through the coming years of their addiction struggle.
by using legitimate prescriptions, as well as that they get started in the context of having fun or experimenting (Figure 37).

Figure 37. Perceptions of how young people get started misusing prescription opioids: top three ways among FNSB adults (n=216) (Data Source: Community Perception Survey, 2016)

<table>
<thead>
<tr>
<th>Concept</th>
<th>Count</th>
<th>Percent of Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>From family or friend’s prescription, “borrowing”</td>
<td>91</td>
<td>42.1%</td>
</tr>
<tr>
<td>Peers</td>
<td>82</td>
<td>38.0%</td>
</tr>
<tr>
<td>Injury, legitimate prescription leads to addiction</td>
<td>33</td>
<td>15.3%</td>
</tr>
</tbody>
</table>

Similarly, almost half of respondents (44.9%) felt that young adults who use heroin started as a result of their peers (peer pressure, their friends are doing it, etc.) A total of 17.6% of respondents felt that young adults get started using heroin as a result of progressing from prescription opioid medications, and 15.3% felt that they get started for fun and/or experimentation (Figure 38).

Figure 38. Perceptions of how young people get started using heroin: top three ways among FNSB adults (n=206) (Data Source: Community Perception Survey, 2016)

<table>
<thead>
<tr>
<th>Concept</th>
<th>Count</th>
<th>Percent of Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peers</td>
<td>97</td>
<td>44.9%</td>
</tr>
<tr>
<td>Progression from prescription</td>
<td>37</td>
<td>17.6%</td>
</tr>
<tr>
<td>Fun, experimenting, partying</td>
<td>33</td>
<td>15.3%</td>
</tr>
</tbody>
</table>

4.2. Sources of Access
More than half of community perception survey respondents felt it was very likely that young people would access prescription opioids through their friends (65.6%), by stealing (57.8%), from drug dealers (56.5%), or from family members (52.9%) (Figure 39).

Figure 39. Perceptions of how likely young people are to access prescription opioids through various sources among FNSB adults (Data Source: Community Perception Survey, 2016)

<table>
<thead>
<tr>
<th>Source</th>
<th>n</th>
<th>Very unlikely</th>
<th>Unlikely</th>
<th>Likely</th>
<th>Very likely</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friends</td>
<td>224</td>
<td>3.1%</td>
<td>0.4%</td>
<td>28.1%</td>
<td>65.6%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Stealing</td>
<td>225</td>
<td>2.7%</td>
<td>4.9%</td>
<td>32.0%</td>
<td>57.8%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Drug dealers</td>
<td>223</td>
<td>2.7%</td>
<td>4.9%</td>
<td>30.5%</td>
<td>56.5%</td>
<td>5.4%</td>
</tr>
<tr>
<td>Family members</td>
<td>225</td>
<td>4.0%</td>
<td>8.0%</td>
<td>32.9%</td>
<td>52.9%</td>
<td>2.2%</td>
</tr>
<tr>
<td>Doctors</td>
<td>223</td>
<td>13.0%</td>
<td>28.7%</td>
<td>35.9%</td>
<td>18.4%</td>
<td>4.0%</td>
</tr>
<tr>
<td>Emergency room visits</td>
<td>224</td>
<td>10.7%</td>
<td>25.4%</td>
<td>32.1%</td>
<td>17.4%</td>
<td>14.3%</td>
</tr>
<tr>
<td>Online</td>
<td>222</td>
<td>8.6%</td>
<td>25.2%</td>
<td>22.1%</td>
<td>13.1%</td>
<td>31.1%</td>
</tr>
<tr>
<td>Forged prescriptions</td>
<td>225</td>
<td>12.9%</td>
<td>32.0%</td>
<td>32.4%</td>
<td>10.2%</td>
<td>12.4%</td>
</tr>
<tr>
<td>Dentists</td>
<td>225</td>
<td>18.2%</td>
<td>40.0%</td>
<td>24.4%</td>
<td>8.0%</td>
<td>8.9%</td>
</tr>
<tr>
<td>Veterinarians</td>
<td>225</td>
<td>22.2%</td>
<td>40.0%</td>
<td>11.1%</td>
<td>2.2%</td>
<td>24.4%</td>
</tr>
</tbody>
</table>

More than three-quarters of community perception survey respondents (77.8%) felt that it
was very likely young people would access heroin from drug dealers while over half (55.4%) felt it was very likely young people would access heroin from friends (Figure 40).

Figure 40. Perceptions of how likely young people are to access heroin through various sources among FNSB adults (Data Source: Community Perception Survey, 2016)

<table>
<thead>
<tr>
<th>Source</th>
<th>n</th>
<th>Very unlikely</th>
<th>Unlikely</th>
<th>Likely</th>
<th>Very Likely</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug dealers</td>
<td>221</td>
<td>2.3%</td>
<td>1.4%</td>
<td>16.7%</td>
<td>77.8%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Friends</td>
<td>222</td>
<td>2.7%</td>
<td>5.0%</td>
<td>33.3%</td>
<td>55.4%</td>
<td>3.6%</td>
</tr>
<tr>
<td>Stealing</td>
<td>219</td>
<td>5.0%</td>
<td>16.0%</td>
<td>31.5%</td>
<td>39.3%</td>
<td>8.2%</td>
</tr>
<tr>
<td>Family members</td>
<td>221</td>
<td>12.2%</td>
<td>33.0%</td>
<td>29.0%</td>
<td>14.9%</td>
<td>10.9%</td>
</tr>
<tr>
<td>Online</td>
<td>221</td>
<td>20.8%</td>
<td>26.2%</td>
<td>12.7%</td>
<td>3.6%</td>
<td>36.7%</td>
</tr>
</tbody>
</table>

4.3. Social Acceptability

Only 9.9% of community perception survey respondents felt that heroin use is socially acceptable among young adults in Fairbanks. However, more than one-third of respondents (35.1%) indicated they were unsure (Figure 41).

Figure 41. Perceptions of social acceptance of heroin: percent who reported heroin is and isn’t socially acceptable among young adults (ages 18 to 25) in FNSB (n=222) among FNSB adults (Data Source: Community Perception Survey, 2016)

<table>
<thead>
<tr>
<th>Response</th>
<th>Count</th>
<th>Percent of Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>122</td>
<td>55.0%</td>
</tr>
<tr>
<td>Yes</td>
<td>22</td>
<td>9.9%</td>
</tr>
<tr>
<td>Unsure</td>
<td>78</td>
<td>35.1%</td>
</tr>
</tbody>
</table>

4.4. Ease of Access

A significant percent of community perception survey respondents felt it was either somewhat easy or very easy to access prescription opioids (45.2%) as well as heroin (44.9%) in the community (Figure 42). Very few felt access was very difficult (3.5% for prescription opioids and just 0.9% for heroin). However, many respondents reported that they didn’t know how difficult or easy these drugs are to access (32.6% for prescription opioids and 38.1% for heroin).
While the YASUS (Hanson & Barnett, 2016) asked respondents who had reported misusing prescription opioids or using heroin to rate how easy or difficult it was to get these drugs, response rates for FNSB and for Alaska were too low to be able to draw conclusions.

Individuals in recovery from opioid and/or heroin addiction who were interviewed for this assessment unanimously reported that prescription opioids were “easy” to access. Seven of the ten interviewed specifically reported that they were given prescription opioids for the first time by a friend or at a party. Two of those interviewed received a legitimate prescription and then began misusing them, reporting that there were numerous places to buy prescription opioids in the community.

After being prescribed drugs by their doctors for medical reasons, and then becoming addicted, two individuals noted either shifting to purchasing additional pills on the street to supplement their prescriptions, or taking advantage of multiple pharmacies by using insurance at one and cash at other(s) to get refills. Pills purchased on the street were often secured through recognition of others who use:

“when you’re taking that kind of stuff a lot of times you can just spot somebody else who is also an opioid user...the more you use the more people you meet that also use and sell, and then it just kind of becomes easy” (Recovery Interview 1, December 2016).

4.5. Drug Disposal

Although fewer than 30% of community perceptions survey respondents felt it was ok to dispose of unused medication in ways that risk social access to unused medication, such as by storing them in the house (28.1%) or throwing them in the garbage (14.5%), a higher
percentage reported actually disposing of their unused medications in only these ways (Figure 43). Close to half (46.0%) of respondents reported having disposed of unused prescription medications by storing them in the house, and 22.0% reported throwing them in the garbage.

Figure 43. Self-reported methods of disposing unused prescription medication compared to perceptions of appropriate disposal methods among FNSB adults (Data Source: Community Perceptions Survey, 2016)

While community perception respondents overwhelmingly felt that returning unused prescriptions to a pharmacy, health care provider, drug take-back day, or drug disposal site were appropriate disposal methods, far fewer respondents (5.0% to 12.1%) reported actually using these methods to dispose of unused prescription medications (Figure 44).
In comparison, more than half of the young adults surveyed in the YASUS reported that they still have unused prescription medications. Of 167 respondents ages 18 to 27 in FNSB, 49 (29.3% of survey respondents in the borough) indicated they had been prescribed prescription opioids in the past 3 years. When asked what they did with any leftover, unused prescription opioids, less than one-third of these 49 individuals (32.7%) said they did not have any leftover medications, and more than half (55.1%) indicated that they still had them. However, none of these survey respondents indicated they had given any leftover, unused prescription opioids to a friend or family member, sold them to a friend or family member, or sold them on the street. Just three of the 49 individuals (6.1%) said they disposed of unused medications at a drug “take back” program, three (6.1%) said they flushed them down the toilet or sink, two (4.1%) said they brought them to a pharmacy, and two (4.1%) said they threw them in the trash (Figure 45).
Figure 45. Self-reported disposal of unused prescription opioid medications among 18- to 27-year-olds in FNSB (n=49)

(Data Source: Hanson & Barnett, 2016)

Very few respondents to the community perceptions survey (just 9.8%) indicated they had been given advice on medication disposal by a medical provider or pharmacist in the past 12 months (Figure 46).

Figure 46. Percent of FNSB adults who reported being given advice on medication disposal by a medical provider or pharmacist in the past 12 months (n=224) (Data Source: Community Perception Survey, 2016)
Section 5: Retail Availability of Prescription Opioids

Retail availability refers to the accessibility of prescription opioids or heroin from retail sources, including both formal (physicians, dentists, and pharmacists) and informal markets (illicit drug sales). Evidence suggests that when formal market retailers are taught best practices, they are more likely to safeguard against potential patient misuse (Birckmayer et al., 2004).

While the majority of physicians and dentists who responded to the Retail Availability Survey reported having formal policies and procedures for prescribing opioids, fewer pharmacists reported specific policies regarding the dispensing of prescription opioid medications. The use of best practices for prescribing opioids among physicians and dentists varied in frequency, with the highest number of providers reporting discussing benefits, risk factors and side effects with the patient, as well as setting realistic goals with the patient for pain and function. A relatively low number of physicians reported utilizing the AKPDMP to monitor their own prescribing practices or individual patients.

5.1. Physician and Dentist Policies and Procedures Related to Prescribing Opioids

A Retail Availability Survey of physicians, dentists, and pharmacists in FNSB was conducted from December, 2016 to January, 2017. Eighty percent of physicians and dentists who responded to this survey indicated they have formal policies and procedures in place for prescribing prescription opioids.

5.2. Pharmacist Policies and Procedures Related to Dispensing Opioids

Approximately half of the twelve pharmacists in FNSB responding to the Retail Availability Survey reported using practices that reduce retail availability of prescription opioids (Figure 47).
5.3. Utilization of Prescribing Best Practices

Data suggests that a significant percent of physicians and dentists do not regularly engage their patients in conversations about topics that reduce the likelihood of addiction to prescription opioids as well as reduce retail availability of prescription opioids, such as setting criteria for stopping or continuing opioids (Figure 48).
**Figure 48.** Percent of physicians and dentists who reported most of the time or always initiating conversations with their patients around topics related to prescription opioid use (Data Source: Retail Availability Survey, 2016)

<table>
<thead>
<tr>
<th>Activity</th>
<th>n</th>
<th>Never</th>
<th>Sometimes</th>
<th>Most of the time</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Set realistic goals with the patient for pain and function based on diagnosis.</td>
<td>32</td>
<td>6.3%</td>
<td>3.1%</td>
<td>31.3%</td>
<td>59.4%</td>
</tr>
<tr>
<td>Check that non-opioid therapies have been tried and optimized (i.e. non-opioid medications, physical therapy, weight loss, behavioral treatment, intra-articular corticosteroids, etc.).</td>
<td>26</td>
<td>0.0%</td>
<td>3.8%</td>
<td>26.9%</td>
<td>69.2%</td>
</tr>
<tr>
<td>Discuss benefits, risk factors, and side effects with the patient.</td>
<td>32</td>
<td>3.1%</td>
<td>0.0%</td>
<td>37.5%</td>
<td>59.4%</td>
</tr>
<tr>
<td>Conduct a urine drug screen to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.</td>
<td>31</td>
<td>32.3%</td>
<td>29.0%</td>
<td>19.4%</td>
<td>19.4%</td>
</tr>
<tr>
<td>Set criteria for stopping or continuing the opioids.</td>
<td>31</td>
<td>9.7%</td>
<td>25.8%</td>
<td>16.1%</td>
<td>48.4%</td>
</tr>
<tr>
<td>Assess baseline pain and function (i.e. PEG scale).</td>
<td>26</td>
<td>34.6%</td>
<td>15.4%</td>
<td>23.1%</td>
<td>26.9%</td>
</tr>
<tr>
<td>Schedule an initial re-assessment in 1-4 weeks.</td>
<td>26</td>
<td>19.2%</td>
<td>7.7%</td>
<td>26.9%</td>
<td>46.2%</td>
</tr>
<tr>
<td>Initially prescribe short-acting opioids using a low dosage until the scheduled re-assessment.</td>
<td>26</td>
<td>3.8%</td>
<td>3.8%</td>
<td>30.8%</td>
<td>61.5%</td>
</tr>
<tr>
<td>Use a written agreement with the patient that outlines such things as patient responsibilities, number and frequency of refills, urine or serum medication levels screening, and reasons for which the drug therapy may be discontinued.</td>
<td>31</td>
<td>38.7%</td>
<td>6.5%</td>
<td>12.9%</td>
<td>41.9%</td>
</tr>
</tbody>
</table>

Data from the YASUS further suggests that physicians and dentists do not regularly engage their patients in conversations about topics that reduce the likelihood of addiction to prescription opioids (Figure 49).
Figure 49. Percent of those age 18-27 in FNSB who received a prescription for opioids in the past 3 years who reported their doctor or pharmacist talked to them about topics that reduce the likelihood of addiction to prescription opioids (n=49) (Data Source: Hanson & Barnett, 2016)

For those individuals in recovery who were interviewed as part of this needs assessment, and whose addictions began through prescribed medications, neither person cited having an accurate sense of the danger of using opioids before they became addicted. The following quote is representative:

“Not really, no. They kinda just say, you know, "Well, I'm gonna give you some pain medicine. That should help you be able to do the things that you need to do." That’s kind of how they push it off to you, I think, is that, you know, just that basically you’ll be able to do what you need to do. And so, and because it’s coming from a doctor I think you kind of just feel safe doing it. You know?” (Interview 2, December 2016)

5.4. Alaska Prescription Drug Monitoring Program (AKPDMP)
The AKPDMP is the State of Alaska system for monitoring Schedule II-V controlled substances dispensed in the state. Providers enter data on medications prescribed for individual patients into the system, are able to retrieve reports on individual patients, and are able to monitor their own prescribing or dispensing practices using this system.

Use of AKPDMP to Monitor Own Prescribing Practices
Results of the retail availability survey indicate that the AKPDMP is not widely used by
individual physicians, dentists or pharmacists to monitor their own prescribing and/or dispensing practices. Only 10 medical providers (25.0%) reported monitoring their own prescribing practices using the AKPDMP. Almost a third (33.3%) of pharmacists reported using the AKPDMP to monitor opioid dispensing at their pharmacy (Figure 50).

*Figure 50. Percent of physicians, pharmacists, and dentists who reported monitoring their own controlled substance prescribing or dispensing using the AKPDMP (Data Source: Retail Availability Survey, 2016)*

![Figure 50](image.png)

**Use of AKPDMP to Monitor Individual Patients**

Physicians responding to the retail availability survey reported a wide range of frequency with which they request AKPDMP reports for individual patients when they prescribe and/or refill opioid medications. Responses ranged from never to always, with no clear patterns (Figure 51).

*Figure 51. Percent of physicians who reported requesting an AKPDMP report when writing a new opioid prescription (n=34) and refilling an opioid prescription (n=34) (Data Source: Retail Availability Survey, 2016)*

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Count</th>
<th>When Writing a New Prescription (n=40)</th>
<th>When Writing a Refill (n=33)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>5</td>
<td>22.5%</td>
<td>15.2%</td>
</tr>
<tr>
<td>Sometimes</td>
<td>11</td>
<td>27.5%</td>
<td>33.3%</td>
</tr>
<tr>
<td>Most of the time</td>
<td>6</td>
<td>17.5%</td>
<td>18.2%</td>
</tr>
<tr>
<td>Always</td>
<td>7</td>
<td>15.0%</td>
<td>21.2%</td>
</tr>
<tr>
<td>Only if I have a specific concern</td>
<td>4</td>
<td>17.5%</td>
<td>12.1%</td>
</tr>
</tbody>
</table>
Section 6: Perceptions of Risk for Harm

An individual’s perception of the risks associated with the misuse of opioids and heroin use impacts their use behaviors; if individuals do not think they are doing anything potentially dangerous when they misuse prescription opioids or use heroin, they are more likely to abuse them. Furthermore, because prescription drugs are safe and effective when used properly and are broadly marketed to the public, the notion that they are harmful and addictive when abused can be a difficult one to convey (National Institute on Drug Abuse, 2016).

Analysis of data sources related to perception of risk for harm revealed varied perceptions. Among 18- to 27-year-olds, there was a higher perception of risk for harm from regular use than occasional use for both prescription opioids and heroin, as well as a higher perception of risk for harm from heroin than for prescription opioids. High school youth showed a higher perception of risk for harm from prescription drug misuse than from either binge drinking or from smoking marijuana. Community adults also showed a higher perception of risk for harm from regular use of both prescription opioids and heroin than from occasional use, as well as a higher perception of risk for heroin than for opioids. Less than one-third of 18- to 27-year-olds reported seeing messaging in the community about risks associated with prescription opioid misuse, or the safe storage and disposal of opioid medications.

Many key informants interviewed for the community readiness assessment indicated that the amount that people know about the risks from opioid misuse and heroin use is directly correlated to whether they have personal experience with the problem – either themselves or by a friend or family member. People in recovery who were interviewed also reported that they did not understand how addictive these drugs could be.

6.1. Perceptions among people ages 18 to 27

In the YASUS conducted by CBHRS at UAA (Hanson & Barnett, 2016), respondents ages 18 to 27 in FNSB were asked to rate, on a scale of 1 to 6, how much of a problem they felt prescription opioid misuse and heroin use is in the community, with 1 being not a problem at all and 6 being a very large problem (figure 52).
A higher percentage of respondents rated heroin as either not a problem or a very small problem than did for prescription opioids, with 34.2% of respondents giving heroin a score of 1 or 2, compared to 30.0% for prescription opioid misuse.

Interestingly, a higher percentage of respondents also rated heroin as a very large problem, with 31.8% giving it a score of 5 or 6, compared to 26.4% of respondents giving prescription opioids a score of 5 or 6.

*Figure 52. Perceptions among 18- to 27-year-olds in FNSB of prescription opioid misuse and heroin use as a problem (n=167) (Data Source: Hanson & Barnett, 2016)*

Themes from key informant interviews conducted as part of this assessment indicate that people see the issue as more of a problem if it has affected them personally. In addition, one key informant expressed that while fewer people in the community are affected by heroin than prescription opioids, those who have been affected by heroin are much more passionate about the issue. Key informants also discussed a higher acceptability of prescription opioids because they are provided by a doctor, which provides the message that they are safer:

*The prescription pills can be prescribed and so people are more – have a hard time distinguishing when people shouldn’t be using them, but everybody knows not to use heroin. And so some people think I’m taking this because of this, but if it’s not prescribed, it’s not okay.’ So I think that’s one
of the reasons people are more aware of heroin than they are of prescription pain meds. (Key Informant 14, December, 2016)

Respondents to the YASUS (Hanson & Barnett, 2016) were also asked to rate how much they felt people risk harming themselves physically or in other ways when they try misusing prescription opioids (using without a prescription or in ways other than prescribed) once or twice, as well as when they regularly misuse prescription opioids once or twice per week. Respondents were asked to rate the risk of harm on a scale of 1 to 6, with 1 being no risk and 6 being great risk. A higher percentage of individuals (56.9%) saw great risk in misusing prescription opioids regularly once or twice per week than did in misusing prescription opioids only once or twice (32.9%) (Figure 53).

Figure 53. Perceived risk of harm among 18- to 27-year-olds in FNSB from prescription opioid misuse (Data Source: Hanson & Barnett, 2016)

When asked about perceived risk of harm from heroin use, a higher number of respondents indicated that they perceive great risk from using heroin than did for prescription opioids, with 62.9% indicating great risk when trying heroin only once or twice, and 80.8% indicating great risk from regularly using heroin once or twice per week (Figure 54).
6.2. Perceptions among Youth (12 to 17)

In the 2015 YRBS, an estimated 57.7% of high school students in FNSB School District indicated they felt there is a great risk of harm from using prescription drugs without a doctor’s prescription, and an estimated 84.1% felt the risk of harm was moderate or greater (Figure 55). This is higher than for both binge drinking 1 or 2 times per week and for smoking marijuana 1 or 2 times a week (CBHRS at UAA).
To better understand the perceptions of youth related to prescription opioid use, three focus groups were conducted by the Goldstream Group. These focus groups included a total of 16 youth in grades 7 to 12. Overall, students exhibited a lack of knowledge about what prescription opioids are. Vicodin was mentioned by just one focus group participant who had been prescribed the drug following surgery. One other youth recognized the name of the drug Vicodin upon hearing it, and was able to connect that knowledge to a relative’s dental surgery. Other youth mentioned such things as dental numbing agents, the raspberry toothpaste used with a spin brush when getting your teeth cleaned, Tylenol 3 (a stronger version of over-the-counter Tylenol that contains codeine and requires a prescription), and Xanax.

Overall, younger youth indicated a higher perception of prescription opioid misuse among their peers than did older youth. Younger youth provided such responses as “I think it’s more than we know,” and “60%”; however, this could be related to their conflating of prescription opioids with other prescriptions and over-the-counter drugs. Older youth responded with statements such as “I don’t think it’s that common” and “friends will share ADHD medication – that’s super common... (but) prescription stuff, no.”

Youth focus group participants were asked to describe side effects and dangers of opioid misuse. Participants acknowledged that prescription medications can be dangerous when taken inappropriately, and in several instances attributed this knowledge to what they learned in school health classes. Younger participants did not exhibit specific knowledge about the dangers and side effects, and overall spoke more broadly about substance use, including alcohol, marijuana and tobacco. Older participants had a more nuanced understanding of the side effects of prescription drug abuse, including descriptions of
different kinds of highs (i.e. good v. bad highs), and that some people may abuse drugs but be affected differently (i.e. some may experience a drop in grades and others may not).

6.3. Adult Perceptions of Prescription Opioid Misuse by Young People

While the overwhelming majority of adults responding to the community perceptions survey felt that young people would significantly harm themselves if they take prescription opioids regularly to get high (90.1%), only 50% of respondents felt they would significantly harm themselves if they took prescription opioids occasionally to get high (Figure 56). Two-thirds of respondents (66.5%) felt that young people would significantly harm themselves if they took more than the recommended dosage of a prescription if they were feeling more pain than usual.

*Figure 56. Percent of adults in FNSB who felt that young people would harm themselves if they take prescription opioids to varying degrees (Data Source: Community Perception Survey, 2016)*
The majority of community perception survey respondents recognized many of the risks of prescription opioid misuse (Figure 57). For example, more than three-quarters of respondents strongly disagreed with the statements that it is okay to mix prescription opioids with sedatives, that it is okay to mix prescription opioids with alcohol, or that taking prescription opioids using a method that is different than prescribed is okay.

Figure 57. Percent of adults in FNSB who recognized risks associated with prescription opioids (Data Source: Community Perception Survey, 2016)

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>It is okay to mix prescription opioids with sedatives</td>
<td>224</td>
<td>84.8%</td>
<td>10.3%</td>
<td>0.4%</td>
<td>0.9%</td>
<td>3.6%</td>
</tr>
<tr>
<td>It is okay to mix prescription opioids with alcohol</td>
<td>224</td>
<td>84.4%</td>
<td>12.5%</td>
<td>0.0%</td>
<td>0.9%</td>
<td>2.2%</td>
</tr>
<tr>
<td>Taking prescription opioids using a method that is different than prescribed (i.e. crushing, chewing or injecting) is okay</td>
<td>224</td>
<td>75.9%</td>
<td>16.1%</td>
<td>1.8%</td>
<td>0.9%</td>
<td>5.4%</td>
</tr>
<tr>
<td>Prescription opioids are not as addictive as other drugs</td>
<td>221</td>
<td>73.8%</td>
<td>19.5%</td>
<td>1.8%</td>
<td>0.9%</td>
<td>4.1%</td>
</tr>
<tr>
<td>Prescription opioids provide a “safe high.”</td>
<td>224</td>
<td>69.6%</td>
<td>23.7%</td>
<td>2.7%</td>
<td>0.4%</td>
<td>3.6%</td>
</tr>
<tr>
<td>Prescription opioids are safer than street drugs</td>
<td>224</td>
<td>52.2%</td>
<td>21.9%</td>
<td>15.2%</td>
<td>2.7%</td>
<td>8.0%</td>
</tr>
<tr>
<td>It is likely that the non-medical use of prescription opioids will lead to heroin use</td>
<td>224</td>
<td>4.9%</td>
<td>12.1%</td>
<td>34.8%</td>
<td>13.8%</td>
<td>34.4%</td>
</tr>
<tr>
<td>It is likely that someone taking prescription opioids that were not prescribed to them would get caught by law enforcement</td>
<td>224</td>
<td>23.7%</td>
<td>48.2%</td>
<td>11.2%</td>
<td>3.6%</td>
<td>13.4%</td>
</tr>
</tbody>
</table>

6.4. Adult Perceptions of Heroin Use by Young Adults

Similarly, the majority of community perception survey respondents recognized many of the risks of heroin use (Figure 58).
Figure 58. Percent of adults in FNSB who recognized risks associated with heroin use (Data Source: Community Perception Survey, 2016)

<table>
<thead>
<tr>
<th>Statement</th>
<th>n</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin provides a “safe high”</td>
<td>222</td>
<td>89.2%</td>
<td>7.7%</td>
<td>0.0%</td>
<td>0.5%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Heroin is not as addictive as other drugs</td>
<td>221</td>
<td>88.7%</td>
<td>6.8%</td>
<td>1.4%</td>
<td>0.0%</td>
<td>3.2%</td>
</tr>
<tr>
<td>Heroin is safer to use than other street drugs</td>
<td>222</td>
<td>86.0%</td>
<td>8.6%</td>
<td>1.4%</td>
<td>0.0%</td>
<td>4.1%</td>
</tr>
<tr>
<td>It is okay to mix heroin with sedatives</td>
<td>222</td>
<td>84.2%</td>
<td>9.5%</td>
<td>0.9%</td>
<td>0.0%</td>
<td>5.4%</td>
</tr>
<tr>
<td>It is okay to mix heroin with alcohol</td>
<td>222</td>
<td>83.8%</td>
<td>10.4%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>5.9%</td>
</tr>
<tr>
<td>It is likely that someone using heroin would be caught by law enforcement</td>
<td>221</td>
<td>9.0%</td>
<td>31.2%</td>
<td>38.0%</td>
<td>8.1%</td>
<td>13.6%</td>
</tr>
<tr>
<td>It is likely that someone who uses heroin occasionally will become addicted</td>
<td>222</td>
<td>9.0%</td>
<td>3.6%</td>
<td>20.7%</td>
<td>63.5%</td>
<td>3.2%</td>
</tr>
<tr>
<td>People don’t know or understand the risks associated with heroin use</td>
<td>222</td>
<td>4.1%</td>
<td>15.8%</td>
<td>40.1%</td>
<td>35.6%</td>
<td>4.5%</td>
</tr>
</tbody>
</table>

The majority of respondents also felt that young adults significantly harm themselves when using heroin, with 94.1% of respondents indicating they strongly agree that young adults harm themselves when using heroin regularly to get high, and 63.8% indicating they strongly agree that young adults harm themselves when they use heroin only occasionally to get high (Figure 59).
Very few community perceptions survey respondents felt that young adults understand the various risks they face when using heroin (Figure 60).

### Figure 60. Percent of adult in FNSB who think young adults understand the various risks from using heroin (Data Source: Community Perception Survey, 2016)

<table>
<thead>
<tr>
<th>Risk</th>
<th>n</th>
<th>Not at all</th>
<th>A little bit</th>
<th>Moderately well</th>
<th>Very well</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart and lung infections or complications</td>
<td>221</td>
<td>67.4%</td>
<td>17.6%</td>
<td>4.1%</td>
<td>1.8%</td>
<td>9.0%</td>
</tr>
<tr>
<td>Liver or kidney disease</td>
<td>219</td>
<td>64.8%</td>
<td>18.7%</td>
<td>4.6%</td>
<td>1.8%</td>
<td>10.0%</td>
</tr>
<tr>
<td>Hepatitis, HIV or other infections from sharing needles</td>
<td>221</td>
<td>24.4%</td>
<td>38.0%</td>
<td>24.9%</td>
<td>5.0%</td>
<td>7.7%</td>
</tr>
<tr>
<td>Overdose</td>
<td>221</td>
<td>22.6%</td>
<td>41.2%</td>
<td>22.6%</td>
<td>6.8%</td>
<td>6.8%</td>
</tr>
<tr>
<td>Addiction</td>
<td>221</td>
<td>17.6%</td>
<td>42.1%</td>
<td>28.1%</td>
<td>4.1%</td>
<td>8.1%</td>
</tr>
</tbody>
</table>
6.5. Perceptions of those in Recovery

Those participants who were prescribed opioids stated that they did not perceive any real dangers from using medication they were prescribed. As one of these participants puts it:

*They (doctors) kinda just say, you know, “Well, I’m gonna give you some pain medicine. That should help you be able to do the things that you need to do.” That’s kind of how they push it off to you, … just that basically you’ll be able to do what you need to do. And so, because it’s coming from a doctor I think you kind of just feel safe doing it. You know? (Recovery Interview 2, December 2016).*

After previously doing other drugs casually and also using ADD medication in the past, a third participant who had opioids prescribed didn’t really think anything of experimenting with yet another substance, especially since it was prescribed by a doctor:

*I didn’t really know at the time how addictive prescription pain killers were.* (Recovery Interview 7, December 2016).

Those participants who were not prescribed opioids varied in their responses. About half of these participants noted that, while they may have been aware of the addictive nature of opioids, they did not necessarily take them to heart due to the urge to mask emotional trauma, a sense of “it won’t happen to me,” or the lack of immediate evidence in the experiences of those around them that the drug was dangerous. The following are representative:

*I always feel like I’m smarter than, I’m one step ahead… Like, “Oh, I know. I know. I just won’t do it.” Like, “I just won’t do it that way. I just won’t shoot up or I won’t do the same thing this many days.” (Recovery Interview 3, December 2016)*

*I wouldn’t say that I was stupid growing up, so I kinda knew that there was a risk involved. I understand the concept of take medication as prescribed and medication serves a purpose, but I’ve seen a lot of people around me doing it, and I wasn’t seeing any effects at the time, and so I figured I might as well give it a shot, you know?… I didn’t care… I just didn’t wanna feel.* (Recovery Interview 5, December 2016)

*I guess a few months after I started using OxyContin… I knew it wasn’t something I wanted to do my whole life because I wouldn’t live very long.*
But it didn’t really deter me… No, I wouldn’t say I thought of any dangers at all when I was using. (Recovery Interview 8, December 2016)

“I know I have heard over and over from other people that they’re totally surprised that we have a heroin problem at all.”

Key Informant 5, December, 2016

But it didn’t really deter me… No, I wouldn’t say I thought of any dangers at all when I was using. (Recovery Interview 8, December 2016)

I was emotionally battered very, very bad and [heroin use] was an answer to that. I think that’s one of the greatest problems is people don’t think it all the way through… It’s an immediate gratification and that is one of the greatest issues. (Recovery Interview 9, December 2016)

I remember pukin’ my brains out the first time I took it for about all day and thinking I’m never gonna do this again and then as soon as that went away, it was, like, okay, let’s do that again. [I wanted to do it again, honestly, I think it was just because of the high. I like that kinda high, I guess. (Recovery Interview 10, December 2016)

6.6. Lack of Community Knowledge and Understanding

Many key informants interviewed for this assessment highlighted stigma, misperceptions, and a general lack of knowledge in the community about both prescription opioid misuse and heroin use. For example, 80% of those interviewed spoke about misperceptions of who users may be (i.e. street people, junkies, etc.) and a lack of awareness that the problem exists in Fairbanks.

Nearly half of key informants (47%) indicated that the level of knowledge about the issues in the community is very low unless someone has been personally affected by it. Many (40%) also spoke about a misperception in the community that people are making a choice to use heroin and opioids and that the community does not understand the nature of addiction:

[What people know does depend on their personal experience and people around them. (Key Informant 6, December, 2016)

I think maybe there’s a lack of awareness of the insidious nature of the opioids and there’s a widespread belief that addiction is a moral failing and a weakness or a choice.] (Key Informant 1, December, 2016)

In the YASUS conducted by the CBHRS at UAA (Hanson & Barnett, 2016) survey respondents were asked to indicate whether they had seen a variety of messaging related to
prescription opioids on radio, TV, or in printed materials such as posters and pamphlets. Of the 167 respondents to this question in FNSB, 43.7% indicated they had not seen any messaging. A little over one-third of respondents (36.5%) indicated they had seen messaging on the safe use of prescription opioids as prescribed by a doctor, and just under one-quarter (23.4%) indicated they had seen messaging on the risks of sharing prescription opioids with others (Figure 61).

*Figure 61. Percent of 18- to 27-year-olds in FNSB who indicated seeing messaging related to prescription opioids on the radio, TV or printed materials (n=167) (Data Source: Hanson & Barnett, 2016)*
Section 7: Community Readiness for Change

This section of the report describes the data collected and analyzed to assess the level of readiness in FNSB community to address prescription opioid misuse and heroin use and identify additional resources that may be needed to do so.

Key informant interviews were conducted to evaluate the levels of community awareness and understanding of the issues of prescription opioid misuse and heroin use in FNSB, as well as to evaluate how prepared and willing the community is to begin addressing these issues. A total of 15 individuals were interviewed representing the following sectors of the community: schools, law enforcement, university, legal system, social services, medical services, veterans’ services, local businesses, city leadership, faith community, state behavioral health services, and persons in recovery.

All interviews were individually scored using the Community Readiness Model from the Tri-Ethnic Center at Colorado State University (Colorado State University, 2014), which is based on the premise that prevention efforts must match a community’s level of readiness in order to be successful. The model measures five different dimensions of community readiness that are intended to help successfully identify prevention strategies appropriate to the community’s level of readiness to support prevention efforts. These five dimensions are 1) community knowledge about the issue (how much does the community know about the issue), 2) community knowledge of efforts (how much does the community know about current prevention programs and activities), 3) leadership (what is the leadership’s attitude toward addressing the issue), 4) community climate (what is the community’s attitude toward addressing the issue), and 5) resources (what are the resources being used or that could be used to address the issue).

Scores were given to each of the five dimensions of readiness for each interview, and separately for prescription opioid misuse and for heroin use. Once scored, the scores for all interviews were averaged for each dimension of readiness for each of the two issues (prescription opioid misuse and heroin use). These scores were then averaged to arrive at an “overall” community readiness score for each issue. A summary of the community readiness scale is in Figure 62 below.
The overall community readiness score for opioids was 2.8, and the overall community readiness score for heroin was 2.6. Scores across the five dimensions of readiness showed a consistent pattern between prescription opioid misuse and heroin use, with heroin use receiving slightly lower scores than opioids across all five dimensions. The highest score received for both substances was for leadership, (3.3 for opioids and 3.2 for heroin) while the lowest score received for both substances was for community knowledge of prevention efforts (2.1 for opioids and 1.6 for heroin). In most cases, the score for community knowledge of efforts was very low because key informants were able to describe very little to no prevention efforts that currently exist in the community (80% of interviews). Scores are presented in Figure 63 below.
There was some range in scores across key informants for both substances. Ranges dipped as low as 1 in some instances, and went as high as 4.5 in other instances (Figure 64 and Figure 65).
The overall community readiness scores of 2.8 and 2.6 for opioids and heroin respectively indicate a level of community readiness that is above Stage 2: denial and resistance (belief that this issue is not a concern in the community, misperceptions about the issue, and lack of support to address the issues), but still somewhat below stage 3: vague awareness (only vague knowledge about the issue, belief that the issue may be a concern but no immediate motivation to act, and only limited resources to address the issue).

While community readiness scores were low, every key informant interviewed (100% of interviews) indicated that they felt the leadership in the community would be supportive of prevention efforts in the community if they understood the problem. In addition, 87% of those interviewed felt that the community would be supportive of prevention efforts if they understood the problem:

*If they knew how serious we believe it is [...] I think they would be – they would be aligned, they would be fearful, they’d look at the statistics of use and the vulnerability and access and how [...] it’s traveling. And I’m sure that once they had educated information, not fear tactics so much but the logical steps that referred to [...] where it comes from, how it develops in a community and then how it takes hold, I think they would be very interested in the education.* (Key Informant 15, December, 2016)

Key informants cited numerous misperceptions in the community, which contributed to a lower readiness score. For example, 80% of those interviewed expressed that there are misperceptions in the community of who users are, including perceptions that these problems aren’t happening in Fairbanks, that drug users are all junkies or street people,
that this only happens to other people, that these are urban/inner city problems, or that these are problems from the 60’s:

*I*in the movie sense, which is track marks and somebody strung out. So I think that in general most people wouldn’t know if they were standing next to a heroin user until that person runs out of drugs, so they’re sick, [they’ve] run out of money, which means they’ve run out of drugs. So your classic movie picture of a heroin addict. I think most people who use heroin don’t fit that profile at all and you wouldn’t know. (Key Informant 6, December, 2016)

Nearly half of those interviewed (47%) expressed that the level of knowledge about the issues is very low in the community unless someone has been affected by it personally (i.e. a family member). Nearly half also discussed the stigma that exists in talking about these issues in the community. In one-third of interviews (33%) key informants described that people may know the signs of someone being under the influence, but they are unable to tell what substance it is (i.e. alcohol, heroin, other drugs):

*But to a person, a lay person, I don’t think they would really – they could probably sense maybe something’s wrong, but I don’t think they would truly know what’s going on.* (Key Informant 12, December, 2016)

While most of those interviewed (80%) were able to describe little to no prevention efforts that currently exist in the community, almost half (47%) did reference what they described as prevention efforts “once someone is already a user.” These included methadone, suboxone, naloxone, and needle exchange programs. These key informants described that while these programs are not primary prevention, they do prevent user overdose as well as theft and other crimes in the community driven by the highly addictive nature of opioids and heroin (60% of those interviewed spoke specifically to the highly addictive nature of opiates and heroin as compared to other drugs, and 47% spoke to the high number of property crimes in Fairbanks that are drug related):

*Speaking regarding methadone maintenance:* But the bottom line is, for a lot of these folks, it was preventive in nature because it took away their craving for the opiate. They really got stabilized. It took away their drug seeking behavior. And so the tie in prevention-wise in terms of the community was these people weren’t going out committing crimes. They weren’t breaking into houses. They weren’t doing stuff like that because they didn’t need to. So, from that perspective, you were preventing a lot of personal and I would say community problems by having a program like that. (Key Informant 8, December, 2016)

Also important to note are themes surrounding the interrelatedness of prescription opioid and heroin use. Almost two-thirds of key informants (60%) noted that that heroin and
opioid abuse are intertwined and it is difficult to speak about one without including the other. More than half of key informants (53%) also specifically commented that heroin is cheaper and easier to get than prescription opioids on the street, and noted the contribution this has made to heroin use in the community:

I guess I’d lump them all together. I think there certainly is a distinction, but at the same time they’re an intertwined problem. (Key Informant 13, December, 2016)

When we first started to see the shift in this coming back around again, I think people knew very little. They couldn’t even believe heroin came back. And they didn’t understand the reason why heroin is becoming popular again. And with the tightening constraints put on opioids, the prescription medication [...] and why someone that has an opioid addiction or someone that has heard that opioids are the best thing since sliced bread are willing to even - especially our young folks who are impressionable - are willing to give this a shot. [...] they’re risk takers and believe that they can control the substance and don’t realize how addictive it is. And it’s less expensive and easier to get access to. (Key Informant 9, December, 2016)

Also worth highlighting is a comment made by one key informant that heroin users often use prescription opioids to mask heroin withdrawal symptoms and/or hide their heroin addiction. In addition, another key informant discussed prescription opioid formulation changes by pharmaceutical companies to slow-release formulas intended to prevent the abuse of these medications; this informant cited the reformulation as a factor contributing to a shift to increased heroin use.

A complete summary of interview themes is included in Appendix B.
Section 8: Resources Assessment

8.1. Current and Past Prevention Activities in the Community

Very few prevention efforts currently exist in the community that are focused on heroin or prescription opioid use; 80% of key informants interviewed for this assessment were able to describe few to no prevention efforts in the community. However, all key informants felt that the leadership in the community would be supportive of prevention efforts in the community if they understood the problem, and 87% of those interviewed felt that the community in general would be supportive of efforts if they understood the problem.

Specific efforts that were described in the community were Red Ribbon Week in the FNSB School District, and viewings of the film “Chasing the Dragon.” Key informants did not describe any prescription drug disposal programs in the community unless prompted, and when prompted those that did, described them as very limited. These individuals were also uncertain how much of a deterrent these programs actually provide, noting that drug seekers may steal from elderly or very ill relatives who have known medications at home, or may go to events such as yard sales or open houses that provide access to spaces where prescription opioids may be kept.

Several key informants alluded to varying levels of prevention when asked specifically about prevention and prevention resources in the community; they noted that, while not primary prevention, community programs such as the methadone treatment program can be seen as prevention in that they prevent both overdose and drug seeking behavior that correlates with the high rate of property crimes in Fairbanks. Furthermore, correlating with the highly addictive properties of heroin and prescription opioids, many spoke to the need for increased treatment services for those who already experience substance addiction in addition to heroin and opioid-specific prevention programs.

The Fairbanks Wellness Coalition identified several additional prevention efforts occurring in the community:

- The State Drug Enforcement Unit conducts periodic drug awareness classes for law enforcement, social workers, school teachers, and students in the area.
- FNSB School District’s Alcohol, Tobacco, & Other Drugs Program provides substance use, misuse, and abuse education in secondary schools in health classes and through the Office of Safe & Healthy Students.
- National Drug Take Back Days led by the DEA are held in April and October of each year. In the past, local Alaska State Troopers, North Pole and Fairbanks Police Departments, and Ft. Wainwright have taken part to varying degrees. However, no local agency has coordinated efforts and there has been little advertising across the borough for these events.
- The North Pole Police Department takes back drugs year around, but there has been
Fairbanks Wellness Coalition, 94

little known advertising.

- FNA has a Future Foundations grant that focuses on multiple substance abuse issues among Alaska Native teens and young adults and includes prevention activities. FNA facilitates two councils (ages 14 to 18 and 19 to 25) who develop and carry out the activities.

8.2. Community Strengths and Opportunities to Support Prevention

Key informants were asked in interviews to describe strengths and cultural norms in the community that may support prevention efforts. Many of these strengths centered around the size and characteristics of the community. Key informants described Fairbanks as a close-knit community with a hometown feel where neighbors care about each other, that the community has the ability to come together, that people in the community rally for each other, and that people are friendly and have a “help your neighbor” attitude. Key informants also described Fairbanks as a community that is small and contained enough to have the potential for an impact when the right mechanism is found to get the message out; informants also noted that Fairbanks’s small size means that that you can get the support needed, and that there are ways to access the entire community and it is easy to get the word out. The following quote is representative:

_I think a lot of some of the cultural norms are [...] the friendliness or the atmosphere of Fairbanks, you know, help your neighbor attitude is something that can benefit this effort._ (Key Informant 14, December, 2016)

Other community strengths cited by key informants included that law enforcement is doing increased outreach, the community has a strong spirit, and the community has many resources that can be utilized:

_I think the greatest resource is actually just the energy and the commitment of really a whole wide spectrum from the community that they’re willing to pitch in._ (Key Informant 13, December, 2016)

Key informants also cited several community factors that may be viewed as opportunities in that they can provide catalysts for addressing the problem. For example, one key informant stated that the timing is right to address these problems in that they are currently regularly in the media. Other key informants described that the problem of theft and property crimes in Fairbanks affects everyone and while this is a problem, it also will help raise awareness in the community of the drug problem and the need for efforts to address it. Finally, key informants described that although people are generally unaware of the problem unless it has affected them personally, there are not too many degrees of separation in the community:

_But a lot of people, [...] if they don’t have direct knowledge it’s not too many degrees of separation before you get to someone that they know that’s been_
Key informants also felt that there are some engaged leaders in the community and with proper education the leadership would be very supportive of prevention efforts. One key informant also described that people in the community see the value in access to prescription pain medications for those who need it, and would therefore be very inclined to support abuse prevention efforts to protect their own access to these medications.

8.3. Challenges and Barriers to Prevention

Key informants were also asked in interviews to describe challenges or barriers to the prevention of heroin and prescription opioid abuse in the community. Challenges and barriers cited roughly fell into several categories including a sense of independence, denial and/or lack of awareness of the problem and the issues that surround it in the community, stigma and misperceptions about drug use and addiction, economics and funding, and issues related to treatment services for those who experience drug addiction.

Several key informants described a general sense of independence and desire for privacy as a characteristic of people in Fairbanks as well as Alaska that could negatively impact prevention. These key informants also described a sector of the population that does not like rules or regulations. Key informants also described Fairbanks as a community that has a high tolerance for self-medicating behavior:

> Alaskans are very independent, and they're very – let's see, what am I trying to say? They like their privacy, and they don't like legislation and taxes and rules and regulations. [...] I don't know if that has any bearing or relevance, but that's what comes to mind for me is people don't want to be told what to do or legislated. They want to be left alone to do their own thing. (Key Informant 1, December, 2016)

Many key informants discussed stigmas related to drug use as well as misperceptions of addiction. These misperceptions include that drug abuse is a choice (along with a lack of understanding of addiction).

> A lot of folks still see addiction as something that somebody's done to themselves, right? It's self-administered. It's a willful thing that they have actually done. And they may see – especially when you're talking about the so-called harder drugs – heroin and meth and that sort of thing – that those folks still need to be punished. (Key Informant 8, December, 2016)

Many key informants indicated that the community is unaware of the problem unless it has personally affected someone close to them, with several key informants noting a “head in the sand” attitude and that a crisis will have to occur to gain people’s attention.

> In my conversations with people, I find that there's a lot of head in the sand
attitude about it that even if people do know something about it from commercials that are trying to create public awareness, they still think that that’s happening to “somebody else” or in another area of town or, you know, not in the golden heart city of Fairbanks and all that sort of thing. So there’s a lot of denial about where it’s happening and to whom. (Key Informant 5, December, 2016)

Many noted that people don’t believe this issue is happening in Fairbanks. Some also noted denial on the part of parents that this could happen to their own child – especially at the younger ages, as well as misperceptions of drug users as junkies, prostitutes, or street people and/or that this is only an inner-city problem. Several noted that what people know about heroin use is related to what they have seen in the movies or on television, also noting that while there are PSAs on a national level, there is very little if any information available about heroin and prescription opioid abuse at the local level. The following quote is representative:

It’s considered a native problem, drunk people, prostitutes, but the middle class is getting hit with it and it’s because we don’t, I don’t know. I think they’re ashamed, or they think they’re going to be stigmatized [...]. It doesn’t matter if you’re black, white, yellow, green, rich, poor, it happens. It’s just that with more money you have the better chance you can hide it. (Key Informant 7, December, 2106)

Key informants described numerous aspects of the economy and funding as a challenge to overcome when implementing prevention programming, with several speaking to the current economic climate in Alaska as well as in FNSB, indicating that people at the current time are more focused on jobs and other economic issues. In addition, many noted that while the leadership would be supportive of prevention efforts, securing funding to support prevention efforts could pose a significant challenge, especially in uncertain economic times.

I just think right now we’re in competition with our economy. So if you talk about what’s important to people right now it’s jobs or even being able to stay here [...] what I’m seeing is that our economics is just kind of the thing that people are really more concerned about right now, and they don’t have a lot of time to worry about other people’s problems. (Key Informant 11, December, 2016)

The thing that’s going to be your biggest kicker is because you have new administration everywhere, new mayors and not only that but I believe that the state is in a crisis already. And so I think your biggest thing is who’s going to fund this? (Key Informant 7, December, 2016)

Several key informants noted that a challenge in preventing the misuse of prescription
opioids lies in the fact that people don’t readily see abuse as a problem because these drugs are legally prescribed by doctors and therefore presumed to be safe.

Key informants also discussed that while school and school district involvement as well as the structure provided are important to prevention efforts, school resources are limited, especially in regards to the many demands of time on students. Several felt that the school district was not as involved as it could be, and that schools could be doing more.

Key informants also discussed several underlying issues that may affect the success of prevention efforts, noting that it is important to take these into consideration when addressing the prevention of heroin and opioid abuse. These included such things as a need to deal with addiction and not just the drugs themselves (i.e., people will just move to another drug if the addiction issue is not dealt with), that drug use is a symptom of other problems, that childhood trauma needs to be addressed, and that as drug supply becomes limited, other toxic knock-off drugs are developed that pose other dangers to users. In addition, many key informants discussed the need for more treatment services in the community for those people who already experience addiction, and that the community must have the resources and solutions ready to address treatment is primary prevention is to be effective. Within this theme, key informants also discussed that a “siloing” effect (the tendency for efforts to focus on only one aspect related to a given issue) makes it difficult for efforts to be sustainable; the problem needs to be addressed as a community problem in order to blanket the whole community and be successful rather than addressing the problem in a piecemeal manner:

"I think that’s one of the first things I was made aware by attending these meetings is how one organization comes up to this point and stops. Another one starts over here, another one starts over here, and there are all these gaps in between, and so I think that those efforts are there but they’re not necessarily blanketing enough. So we still have a lot of people falling through the cracks." (Key Informant 5, December, 2016)

8.4. Prevention Resources
While participants were only able to name a very few prevention activities in the community, they did name many resources. In addition to the Fairbanks Wellness Coalition, informants named the Fairbanks Opioid Workgroup and the State Opioid Taskforce as groups that are working to address these issues in the community as well as statewide. Other coalitions mentioned include the Fairbanks Housing and Homeless Coalition and Community Action Planning meetings.

Many local organizations were also named, including IAA, FNA, Tanana Chiefs Conference, Love Inc., Big Brothers Big Sisters, the local food bank, the WIC office, and the women’s shelter. Key informants also listed Fairbanks Memorial Hospital, Tanana Valley Clinic, and physicians and pharmacists as local resources. Also mentioned were churches and the
faith community, FNSB School District, the University of Alaska Fairbanks, Fairbanks Police Department, the library, local media sources, SOAP, rotary clubs, PTSAs, unions, and tribal groups. A variety of programs for those with substance use issues were also mentioned, including AA and NA, Turning Point, and treatment programs in general.

Other resources identified by key informants include 4H, local rotary clubs, 211, AKPDMP, CDC medical guidelines for providers, the crisis line, the film Chasing the Dragon, Red Ribbon Week, and the Office of Children’s Services.
Section 9: Prioritization of Community Factors

In February 2017, the Fairbanks Wellness Coalition brought together the Assessment & Evaluation Workgroup for a three-meeting process to discuss data collected and prioritize community factors identified in the initial draft of this needs assessment. The group consisted of six coalition or community members familiar with the coalition’s processes or with local opioid problems, two coalition staff members, and a Goldstream Group project team member. The first meeting focused on reviewing and discussing the data collected (summary tables provided at this meeting are included in Appendix A). During the second meeting the team reviewed the three intervening variables (social availability, retail availability, and perceptions of risk for harm), as well as related community factors identified through the needs assessment including data confirming the focus population identified by the State of Alaska for this project. After the second meeting, workgroup members individually reviewed objective and subjective factors related to each community factor, and then reconvened for a final meeting to discuss their findings and prioritize these community factors through an established process. The final prioritization was then approved by the coalition.

The community factors that were identified for prioritization based on themes identified from the initial draft of the needs assessment included: improper storage of prescription opioids (social availability), improper disposal of prescription opioids (social availability), low utilization of AKPDMP (retail availability), low use of best practices for prescribing/dispensing opioids among retail providers (retail availability), and lack of community awareness about risks associated with misuse of prescription opioids (perceptions of risk for harm).

Objective factors considered in the prioritization process included reliability of the data, validity of the data, completeness of the data, and trends shown by the data. Subjective factors considered include magnitude and severity of the problem, coalition and community capacity to address each community factor, preventability of each community factor, relevant cultural factors, existing community services related to each community factor, other efforts in the community, political will to address each community factor, and whether an impact can be made in the community during the project period for each community factor.

Discussion of these factors included the following:

- Changing attitudes and beliefs based on values first will result in effectively changing behavior under the Positive Culture Framework.
- Best practices of retail professionals (physicians, dentists, and pharmacists) regarding prescription opioids vary by type of professional and may not be well-defined.
- People who use prescription opioids for medical reasons will need to be able to store them properly.
- Due to the independent nature of the community, convincing people to properly store prescription opioids may be easier than convincing people to properly dispose of unneeded prescription opioids.
- AKPDMP reporting requirements have recently changed and may evolve in the future.
- Prevention strategies of adopting best practices and increasing AKPDMP use for prescription opioids will need to involve local retail availability professionals in the planning and implementation.
- Prioritization may mean that strategies aren’t developed for all five of the community factors during strategic planning.
- Prioritization doesn’t preclude strategies from being developed for all five community factors during strategic planning but may mean strategies for one is started before strategies of other factors.

Following satisfactory discussion of community factors, the seven prioritization subcommittee members (two coalition staff members, four knowledgeable coalition or community members, and one Goldstream Group team member) scored each community factor identified on a scale of 1 to 5 as follows: 1 = not a priority at this time, 2 = low priority, 3 = moderate priority, 4 = high priority, and 5 = highest priority. To weight prioritization scores, each member was allowed to give only one score of 5 (highest priority). A summary of scores for each community factor and the average score received for each community factor is below.

<table>
<thead>
<tr>
<th>Intervening Variable</th>
<th>Community Factor</th>
<th>Individual Prioritization Scores of Subcommittee Members</th>
<th>Average Score</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
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<tr>
<td>Perception of Risk for Harm</td>
<td>Lack of community awareness about risks associated with use</td>
<td></td>
<td></td>
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<tr>
<td>Social Availability</td>
<td>Improper storage of prescription opioids</td>
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<tr>
<td>Social Availability</td>
<td>Improper disposal of prescription opioids</td>
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<tr>
<td>Retail Availability</td>
<td>Low utilization of AKPDMP</td>
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<tr>
<td>Retail Availability</td>
<td>Low use of best practices for prescribing or dispensing opioids among retail providers</td>
<td>√√√</td>
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Section 10: Discussion

Heroin and opioids are highly addictive drugs and the impacts to those who are addicted are significant. It is critical when addressing these issues in FNSB to frame the issue in the context of local data that is specific to the nature and extent of the problem in FNSB.

Nature and Extent of Use

- Data indicate that 9.6% of 18- to 27-year-olds have ever misused prescription opioids (2.4% within the past 30 days), and 1.8% have ever used heroin in their lifetimes. YRBS data indicate that 13.6% of high school students in FNSB have ever misused prescription drugs (not necessarily opioids) in their lifetimes (5.8% in the past 30 days), and just 1.1% of high school students have ever used heroin in their lifetime.
- In 2015, Fairbanks Memorial Hospital had a total of 218 Emergency Department discharges that were opioid-related, and 8 that were heroin-related (less than 1% of all discharges). Of the 218 opioid-related discharges, 54 (approximately one-quarter) were in the project’s focus 12 to 25 age range.
- Opioid and heroin use appears to be higher among youth and young adults who are homeless or at risk of becoming homeless, as evidenced by data provided by SOAP, which showed 43.6% of youth served to be self-reported users of opioids, heroin, and methamphetamines. Of these users, 75% were ages 18 to 21 and 25% were ages 14 to 17.
- At the end of 2016, there were 57 individuals enrolled in Project Special Delivery, IAA’s methadone drug treatment program, with an average age of 38 years. Northern Exchange Syringe Program, IAA’s needle exchange program, provided a total of approximately 58,500 syringes in 2016 to an estimated 300 individuals, 84% of whom were self-reported heroin users. Of those individuals utilizing the needle exchange program, 62% were ages 20 to 29 and 9% were ages 18 to 19.
- Self-reported and treatment data strongly indicate that more women than men misuse prescription opioids and use heroin among the age group of 18- to 25-year-olds. However, available data for the younger age group of 12- to 17-year-olds indicates that more boys than girls are trying prescription opioids and heroin.
- While statewide the percentage of individuals reporting ever misusing prescription opioids is higher for white individuals than for Alaska Native individuals, the reverse is true for heroin, where more Alaska Native individuals report ever using heroin than white individuals. Alaska Native individuals are also disproportionately represented in data for treatment of heroin use at FNA, but not data for the needle exchange program at IAA.

It is unclear from the data the extent to which prescription opioid misuse and heroin use are increasing or decreasing in FNSB. Although statewide data indicate that both prescription opioid misuse and heroin use are increasing, FNSB data does not paint a clear picture. For example, self-reported use among those ages 12 to 17 has slightly decreased as
shown by YRBS data. In addition, the actual number of individuals accessing treatment for prescription opioid or heroin addiction at FNA has decreased. This is not to say however that treatment by private providers has increased or decreased; this needs assessment does not include data from private treatment providers.

The interrelated nature of opioid and heroin use should not be overlooked when addressing either issue:

- Seven of the ten individuals who are in recovery from prescription opioid and/or heroin addiction that were interviewed for this needs assessment reported nonmedical use of prescription opioids prior to using heroin in much the same trajectory described in research (Compton et al., 2016). All four respondents reported being given prescription opioids at a party or by a friend in their late teens. Three then moved to smoking OxyContin. Within five years, all seven turned to heroin because it was more cost-effective than prescription opioids. Three specifically cited the introduction of the abuse-deterrent formulation of OxyContin as the catalyst for their move to heroin.

- More than half of the 15 key informants interviewed for the community readiness assessment specifically discussed the intertwined nature of heroin and prescription opioid abuse, stating that it is difficult to discuss them independently of each other, as well as that heroin is cheaper and/or easier to get than prescription opioids, contributing to a shift from opioids to heroin use in the community. Other key informants also referenced the contribution of the formulation change of opioids by pharmaceutical companies, that users may use opioids to mask heroin addiction and/or withdrawal symptoms, and that most users are poly-drug users.

In addition to the highly addictive nature of opioids and heroin, some consequences of prescription opioid and heroin use appear to be increasing, particularly the reported cases of Hepatitis C Virus. Anecdotally many key informants also referenced an increase in drug-related property crimes in FNSB; however, this evidence is difficult to corroborate with objective data sources.

Social Availability

There is strong evidence of broad social availability of prescription opioids in FNSB. Among those who reported misusing prescription opioids, most obtained them from friends or family or bought them “easily” on the streets. While many adults responding to the community perceptions survey reported they didn’t know how easy or difficult it is to access prescription opioids without a prescription, most respondents felt that young people would access prescription opioids through their friends or family members. In addition, while fewer than 30% of community perception survey respondents felt it was ok to dispose of unused medication in ways that risk social access to unused medication, almost 50% stored unused prescription opioids in their homes. Furthermore, although most community members felt that using an identified drug disposal method, such as a drug take-back
program was called for, fewer than 12% of respondents actually did so.

**Retail Availability**

One of the state’s primary tools to control the retail availability of prescription opioids is the AKPDMP. However, needs assessment data suggests the AKPDMP is not widely used by physician or pharmacists, and very infrequently used by dentists. While both physicians and dentists widely report that they have written policies related to prescribing opioids, pharmacies have implemented fewer policies and procedures to address the retail availability of prescription opioids. Data further suggests that a significant percent of physicians and dentists do not regularly engage their patients in conversations about topics that reduce the likelihood of addition to prescription opioids as well as reduce retail availability of prescription opioids, such as setting criteria for stopping or continuing opioids. Additionally, few Alaskan young adults ages 18 to 27 reported that their doctor or pharmacist had talked to them about risks related to prescription opioid use.

**Perception of Risk for Harm**

Data suggest that youth, young adults and adult community members are more aware of the risk for harm from heroin use than from prescription opioid misuse.

- Among 18- to 27-year-olds there is a wide range of perceptions about how big of a problem prescription opioid misuse and heroin use are in the community, but overall, this age group perceives that heroin is a bigger problem than prescription opioid misuse. Similarly, this age group felt that people their age were at greater risk for harm from using heroin than from using prescription opioids.
- Data from interviews conducted with people in recovery confirms this perception. Those who were interviewed did not see their friends suffer in any way from regularly using prescription opioids, reducing their perception of risk.
- Youth focus group participants acknowledged that prescription medications can be dangerous when taken inappropriately, and in several instances attributed this knowledge to what they learned in school health classes. Younger participants did not exhibit specific knowledge about the dangers and side effects, and spoke more broadly overall about substance use, including alcohol, marijuana and tobacco. Older participants had a more nuanced understanding of the side effects of prescription drug abuse, including descriptions of different kinds of highs (i.e., good vs. bad highs), and that some people may abuse drugs but be affected differently (i.e., some may experience a drop in grades and others may not).
- Adult community members indicated a lower perception of risk for harm from occasionally taking prescription opioids to get high than they did for heroin.

**Community Readiness and Resources**

The overall community readiness score for opioids was 2.8, and the overall community readiness score for heroin was 2.6. These scores indicate a level of community readiness
that is above Stage 2: Denial and Resistance (belief that this issue is not a concern in the community, misperceptions about the issue, and lack of support to address the issues), but still somewhat below Stage 3: Vague Awareness (only vague knowledge about the issue, belief that the issue may be a concern but no immediate motivation to act, and only limited resources to address the issue).

Scores across the five dimensions of readiness showed a consistent pattern between prescription opioid misuse and heroin use, with heroin use receiving slightly lower scores than opioids across all dimensions. In most cases, the score for community knowledge of efforts was very low because key informants were able to describe very little to no prevention efforts that currently exist in the community (80% of interviews).

Many of the challenges and barriers to addressing prescription opioid and heroin abuse that were described by key informants were the very reasons why the community readiness scores were low (i.e., poor understanding of addiction, lack of awareness, misperceptions, stigma, etc.). However, a co-occurring theme that the community and leadership would be supportive of prevention efforts if they understood the problem points to the fact that there is a good opportunity to overcome these challenges. Key informants also described a wealth of community organizations and resources that could be utilized in prevention, as well as several community coalitions including the Fairbanks Opioid Workgroup.

Prioritization of Community Factors

Community factors related to the intermediate variables of social availability, retail availability, and perceptions of risk for harm that emerged as themes from the needs assessment include improper storage of prescription opioids (social availability), improper disposal of prescription opioids (social availability), low utilization of AKPDMP (retail availability), low use of best practices for prescribing/dispensing opioids among retail providers (retail availability), and lack of community awareness about risks associated with use (perceptions of risk for harm).

These community factors were scored and prioritized based on objective and subjective data and using a scale of 1 to 5, with 1 indicating a community factor is not a priority at this time, and 5 indicating a community factor is the highest priority. Scores for community factors are shown in the table below. It should be noted that while a lower score indicates that a community factor is a lower priority to address, it doesn’t indicate that a community factor is not important and should not be addressed.
<table>
<thead>
<tr>
<th>Intervening Variable</th>
<th>Community Factor</th>
<th>Score</th>
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<tr>
<td>Perception of Risk for Harm</td>
<td>Lack of community awareness about risks associated with use</td>
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<tr>
<td>Social Availability</td>
<td>Improper storage of prescription opioids</td>
<td>4.0</td>
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<tr>
<td>Social Availability</td>
<td>Improper disposal of prescription opioids</td>
<td>3.7</td>
</tr>
<tr>
<td>Retail Availability</td>
<td>Low utilization of AKPDM</td>
<td>3.4</td>
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<tr>
<td>Retail Availability</td>
<td>Low use of best practices for prescribing/dispensing opioids among retail providers (doctors, dentists, pharmacists)</td>
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Citations


Appendix A: Summary of Needs Assessment Data

Data Sources

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>YASUS = Young Adult Substance Use Survey</td>
<td>YFG = Youth Focus Groups</td>
</tr>
<tr>
<td>CPS = Community Perceptions Survey</td>
<td>RI = Interviews with People in Recovery</td>
</tr>
<tr>
<td>YRBS = Youth Risk Behavior Survey</td>
<td>RAS = Retail Availability Survey</td>
</tr>
<tr>
<td>CRA = Community Readiness Assessment</td>
<td>SDS = Other Secondary</td>
</tr>
</tbody>
</table>

Improper storage of prescription opioid medications (social availability)

- YASUS – 55.1% of 18-27 year olds who have been prescribed Rx opioids in past 3 years still have unused Rx opioids
- YASUS – only 30.6% of 18-27 year olds reported their doctor or pharmacist talked to them about not sharing pills with others
- YASUS – only 26.5% of 18-27 year olds reported their doctor or pharmacist talked to them about safe and secure storage of pills
- YASUS – only 19.2% of 18-27 year olds have seen messaging about the safe and secure storage of Rx opioids
- CPS – 93.7% of adults feel young people are likely or very likely to obtain Rx opioids from friends
- CPS – 89.8% of adults feel young people are likely or very likely to obtain Rx opioids by stealing
- CPS – 85.8% of adults feel young people are likely or very likely to obtain Rx opioids from family members
- CPS – 46.0% of adults reported storing unused Rx opioids in their house
- CPS – 45.2% of adults feel Rx opioids are either somewhat easy or very easy to access in Fairbanks
- RI – 7 of 10 people in recovery who were interviewed (and all who went on to use heroin) got their first Rx opioids from friends

Improper disposal of prescription opioid medications

- YASUS – 55.1% of 18-27 year olds who have been prescribed Rx opioids in past 3 years still have unused Rx opioids
- YASUS – only 30.6% of 18-27 year olds reported their doctor or pharmacist talked to them about not sharing pills with others
- YASUS – only 6.1% of 18-27 year olds had disposed of unused Rx opioids at a drug take. Lack of community awareness about risks of use (prescription opioids) back program and only 4.1% had brought them to a pharmacy
- YASUS – only 16.8% of 18-27 year olds have seen messaging about the safe disposal of leftover Rx opioids
- CPS – 93.7% of adults feel young people are likely or very likely to obtain Rx opioids from friends
- CPS – 89.8% of adults feel young people are likely or very likely to obtain Rx opioids by stealing
✓ CPS – 85.8% of adults feel young people are likely or very likely to obtain Rx opioids from family members
✓ CPS – 46.0% of adults reported storing unused Rx opioids in their house
✓ CPS – Only 12.1% of adults reported bringing unused Rx medications to a drug disposal site, 10.8% to a pharmacy, 10.4% to a drug take back day, and 5.0% to a healthcare provider
✓ CPS – only 10% of adults were given advice on medication disposal by a medical provider or pharmacist in the past 12 months
✓ CPS – 45.2% of adults feel Rx opioids are either somewhat easy or very easy to access in Fairbanks
✓ RI – 6 of 8 people in recovery who were interviewed (and all who went on to use heroin) got their first Rx opioids from friends

Low utilization of Alaska Prescription Drug Monitoring Program (AKPDMP)
✓ RAS - Only 27% of physicians reported they use the AKPDMP to monitor their own prescribing practices
✓ RAS – 0% of dentists reported they use the AKPDMP to monitor their own prescribing practices
✓ RAS – only 46% of pharmacists reported they use the AKPDMP to monitor their own dispensing practices
✓ RAS – Only 36.3% of physicians report they request a patient report from AKPDMP when writing a new opioid prescription either always or most of the time
✓ RAS – Only 38.0% of physicians report they request a patient report from AKPDMP when refilling opioid prescription either always or most of the time
✓ RAS – 18.2% of physicians report they never request a patient report from AKPDMP when writing a new opioid prescription
✓ RAS – 19.0% of physicians report they never request a patient report from AKPDMP when refilling an opioid prescription

Low use of best practices for prescribing/dispensing opioids among retail providers (doctors, dentists, pharmacists)
✓ RAS – 77% of physicians and 83% of dentists report having formal policies and procedures in place for prescribing opioids
✓ RAS – 64.7% of physicians and 60.0% of dentists report they discuss benefits, risk factors, and side effects of Rx opioids with the patient
✓ RAS – 64.7% of physicians reported checking that non-opioid therapies had been tried and optimized first
✓ RAS - 62.5% of physicians report they initially prescribe short-acting opioids using a low dosage until a scheduled re-assessment
✓ RAS – 58.8% of physicians and 60.0% of dentists report setting goals with the patient for pain and function
✓ RAS – 50% of physicians and 40% of dentists report they set criteria for stopping or continuing the opioids
✓ RAS - 50.0% of physicians report they schedule an initial reassessment in 1-4 weeks
✓ RAS - 37.5% of physicians and 0% of dentists report using a written agreement with patients
✓ RAS – 31.3% of physicians report assessing baseline pain and function using a PEG scale
✓ RAS – 12.5% of physicians and 0% of dentists reported conducting a urine drug screen to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use
✓ RAS - 54.5% of pharmacists report they have a system in place to flag patients who have exhibited possible signs of opioid abuse
✓ RAS – 45.5% of pharmacists report they have a system in place to flag patients at risk for overdose due to high dosages or multiple providers
✓ RAS – 18.2% of pharmacists report they always require a picture ID to pick up an opioid prescription
✓ YASUS – 69.4% of 18-27 year olds report their doctor or pharmacist talked to them about side effects or problems from use
✓ YASUS - 65.3% of 18-27 year olds report their doctor or pharmacist talked to them about using pills as prescribed and not more
✓ YASUS – only 32.7% of 18-27 year olds report their doctor or pharmacist talked to them about a specific treatment plan including a plan for stopping use
✓ YASUS – Fewer than one-quarter (24.5%) of 18-27 year olds report their doctor or pharmacist talked to them about expected benefits, about the risk of developing an opioid use disorder or addiction, or about alternatives to prescription opioids
✓ RI – Two people who first became addicted to Rx opioids that were prescribed for pain reported they did not receive any patient education (their prescriptions were first provided approximately 10 years ago)

**Lack of community awareness about risks of use (prescription opioids)**

✓ YASUS – 32.9% of 18-27 year olds felt there is great risk from misusing Rx opioids once or twice and 56.9% felt there is great risk from misusing Rx opioids once or twice per week.
✓ YRBS – 57.7% of FNSB high school students indicated their perceived risk of harm from Rx drug misuse is great and 84.1% indicated it is moderate or greater
✓ YRBS – FNSB high school students perceive a greater risk of harm from Rx drug use than from binge drinking 1-2 times a week or smoking marijuana 1-2 times a week
✓ YFG – Youth indicated they perceive marijuana as less risky than Rx opioids
✓ CPS – 93.7% of adults feel young people are likely or very likely to obtain Rx opioids from friends
✓ CPS – 90.1% of adults feel young people risk significant harm if they take Rx opioids regularly to get high
✓ CPS – 85.8% of adults feel young people are likely or very likely to obtain Rx opioids from family members
✓ CPS – 66.5% of adults feel young people risk harm if they take more than a recommended dosage of an opioid
✓ CPS – 50.0% of adults feel young people risk significant harm if they take Rx opioids occasionally to get high
✓ CPS – 42.9% of adults feel young people risk significant harm if they take Rx opioids that were prescribed to someone else
✓ CPS – More than three-quarters of adults strongly disagree with the statements that it is ok to mix Rx opioids with sedatives (84.8%), that it is ok to mix Rx opioids with alcohol (84.4%), or that taking Rx opioids using a method other than prescribed is ok (75.9%)
✓ CPS – Between one-half and three-quarters of adults strongly disagree with the statements that that Rx opioids are not as addictive as other drugs (73.8%), that Rx opioids provide a safe high (69.6%), or that Rx opioids are safer than street drugs (52.2%)

✓ CPS – 48.6% of adults strongly disagree with the statement that it is likely the misuse of Rx opioids will lead to heroin use

✓ YASUS – 43.7% of 18-27 year olds have not seen any messaging about Rx opioids

✓ YASUS – only 36.5% of 18-27 year olds have seen messaging about the safe use of Rx opioids as prescribed by a doctor and fewer than one-quarter (23.4%) have seen messaging about the risks of sharing Rx opioids with others

✓ YASUS – fewer than one-third (30.6%) of 18-27 year olds reported their doctor or pharmacist talked to them about not sharing pills with others

✓ RI – 7 of 10 people in recovery who were interviewed (and all who went on to use heroin) got their first Rx opioids from friends

Lack of community awareness about risks of use (heroin)

✓ YASUS – 62.9% of 18-27 year olds feel there is great risk from using heroin once or twice and 80.8% feel there is great risk from using heroin once or twice per week

✓ CPS – 94.1% of adults feel young adults risk significant harm if they use heroin regularly to get high

✓ CPS – 75.7% of adults agree or strongly agree that people don’t know or understand the risks associated with heroin use

✓ CPS – 63.3% of adults feel young adults risk significant harm if they use heroin only occasionally to get high

✓ CPS – More than 80% of adults strongly disagree with the statements that heroin provides a safe high (89.2%), that heroin is not as addictive as other drugs (88.7%), that heroin is safer to use than other street drugs (86.0%), that it is ok to mix heroin with other sedatives (84.2%), or that it is ok to mix heroin with alcohol (83.8%)

✓ CPS – 63.5% adults strongly agree with the statement that it is likely someone who uses heroin occasionally will become addicted

✓ CPS – Between one-quarter and one-third of adults think that young people understand the risk of addiction from using heroin moderately or very well (32.2%), that young people understand the risk of overdose from using heroin moderately or very well (29.4%), or that young people understand the risk of hepatitis, HIV or other infections from using heroin moderately or very well (29.9%)

✓ CPS – Fewer than 10% of adults feel that young people understand the risk of kidney or liver disease from using heroin moderately or very well (6.4%) and that young people understand the risks of heart and lung infections or complications from using heroin moderately or very well (5.9%)
Appendix B: Community Readiness Assessment

Fairbanks Wellness Coalition
Community Readiness Assessment (Prescription Opioids and Heroin)

**Purpose:** The purpose of the Community Readiness Assessment is to better understand the level of readiness in the community for prevention programming around the non-medical use of prescription opioids and heroin use in the target populations.

The Tri-Ethnic Center model for Community Readiness Assessment uses key informant interviews with stakeholders representing a variety of community sectors who are knowledgeable about the issue, the community, and community resources. Questions are asked that are intended to evaluate 1) community knowledge about the issue, 2) existing prevention efforts in the community, 3) attitudes of community leadership, 4) attitudes of community members (community climate), and 5) prevention resources to address the issue. Interviews are then scored and averaged to arrive at a community readiness score of 0-9.

This document will serve as an interview guide for key informant interviews conducted as part of the Community Readiness Assessment. Interviews will be conducted and scored by the Goldstream Group. Additional questions are included in blue boxes that are not part of the community readiness assessment itself. These questions have been added to help better understand community perceptions, contributing factors, and consequences of prescription opioid misuse and abuse and heroin use in Fairbanks. Answers to these questions will be used in combination with other data collected during the needs assessment.

**Introduction:** The Fairbanks Wellness Coalition recently received funding from the State of Alaska to prevent and reduce the non-medical use of prescription opioids among 12-25 year olds, and heroin use among 18-25 year olds. The first step required as part of this grant is to conduct a thorough needs assessment of these issues in Fairbanks North Star Borough.

As part of this needs assessment, we are conducting interviews with a variety of people in the community to better understand the level of community readiness and
resources to prevent prescription opioid abuse and heroin use. Do you have any questions before we begin?

### Introductory Questions

#### Opioids

Opioids are a class of drugs that are prescribed to reduce pain and include drugs such as Vicodin, Oxycodone, hydrocodone, OxyContin, Percocet and morphine. They are often prescribed for injury-related, post-surgical, and dental pain. They work by reducing the intensity of pain signals to the brain and affect the areas of the brain that control emotion.¹ Opioids are currently among the most commonly abused drugs in the U.S.

1. On a scale of 1 to 10, with 10 being the highest, how much of a concern do you think the misuse and abuse of prescription opioids is in Fairbanks North Star Borough?

#### Heroin

Heroin is an opioid drug that is synthesized from morphine, a naturally occurring substance extracted from the seed pod of the Asian opium poppy plant. It usually appears as a white or brown powder or as a black sticky substance known as “black tar heroin.” Heroin can be injected, inhaled by snorting or sniffing, or smoked. When heroin enters the brain, it is converted back into morphine which binds to opioid receptors. Heroin has a high risk for addiction.¹

2. How about heroin? How much of a concern would say heroin use is in Fairbanks North Star Borough on a scale of 1 to 10?

### Dimension A. Community Knowledge about the Issue

#### Opioids

3. How much do you think people in the community know about the misuse and abuse of prescription opioids in Fairbanks North Star Borough?

   - Would you say none, a little, some, or a lot?
   - Can you tell me more about how you came to that answer?

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¹ National Institute on Drug Abuse
4. Do you think people in the community understand factors that may contribute to the misuse and abuse of prescription opioids?

- Can you tell me more about how you came to that answer?
- Factors may include such things as social availability of prescription opioids, acceptability of their use, the ability to get prescriptions from prescribers (retail availability), etc.

5. Do you think people in the community know how to tell if someone is misusing or abusing prescription opioids?

- Can you tell me more about how you came to that answer?
- Physical signs may include not feeling pain at normal levels, constricted pupils, drowsiness and confusion, nausea, constipation. Other signs may include doctor or pharmacy shopping, increasing tolerance, early requests for refills, etc.
6. How well do you think people in the community understand the risks of using prescription opioids in ways that aren’t prescribed, or in using someone else’s prescription?

   - Can you tell me more about how you came to that answer?
   - May be the physical impacts to an individual, overdose risk, addiction, etc.

7. Do you think people in the community understand how and where people who misuse and abuse prescription opioids get their drugs?

**ADD IF NOT COVERED YET:**

   - What factors do you think contribute to the abuse of prescription opioids in Fairbanks North Star Borough? *(Prompt: Individual factors and community factors)*
   - How do you think people in Fairbanks gain access to prescription opioids?
   - What do you think are the major consequences of prescription opioid abuse in Fairbanks?
   - How do you think people who misuse opioids got started abusing prescription drugs?

**Heroin**

8. How much do you think people in the community know about the use of heroin in Fairbanks North Star Borough?

   - Would you say none, a little, some, or a lot?
   - Can you tell me more about how you came to that answer?

9. Do you think people in the community understand factors that may contribute to the use of heroin?

   - Can you tell me more about how you came to that answer?
   - Factors may include ease of access, that it’s cheap, addiction, etc.

10. Do you think people in the community know about the signs and symptoms of heroin use?

    - Can you tell me more about how you came to that answer?
    - Physical signs may include fading in and out of wakefulness, nodding off suddenly, constricted pupils, poor decision making or self-control, memory loss, itching, nausea, vomiting. Other signs may include remnants of the drug or paraphernalia
11. How well do you think people in the community understand the risks of heroin use?

- Can you tell me more about how you came to that answer?
- Deterioration of white matter affecting decision making and ability to regulate behavior, addiction, uncontrollable drug-seeking

12. Do you think people in the community know or understand how and where heroin users get their drugs?

ADD IF NOT COVERED YET:
- What factors do you think contribute to heroin use in Fairbanks North Star Borough? *(Prompt: Individual factors and community factors)*
- What do you think are the major consequences of heroin use in Fairbanks?
- Where or from whom do you think people in Fairbanks gain access to heroin?

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**Dimension B. Prevention Efforts and Knowledge of Efforts**

**Opioids**

13. Can you describe any efforts that currently exist in Fairbanks North Star Borough focused on preventing the misuse and abuse of prescription opioids?

- Efforts of medical providers, health and social service organizations, community groups, churches, schools, etc.
- To the best of your knowledge, how long have these prevention efforts been going on?

14. What do you think are the strengths of these efforts?

15. What do you think are the weaknesses?

16. How many people in the community do you think know about these efforts?

- Would you say a few, some, or most?
- Which populations would say are more or less aware of these efforts?
17. Do you think people in the community understand the purpose of these efforts? Why or why not?

18. Do you know of any efforts in the community to plan for additional opioid abuse prevention programming?

- *Can you tell me more about them?*

**ADD IF NOT COVERED YET:**

- How about prescription drug disposal programs? What currently exists in Fairbanks? Do you think a lack of disposal programs contributes to the problem of opioid misuse and abuse? Why or why not?

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**Heroin**

19. Can you describe any efforts that currently exist in Fairbanks North Star Borough focused on preventing the use of heroin?

- *Efforts of medical providers, health and social service organizations, community groups, churches, schools, etc.*
- *To the best of your knowledge, how long have these prevention efforts been going on?*

20. What do you think are the strengths of these efforts?

21. What do you think are the weaknesses?

22. How many people in the community do you think know about these efforts?

- *Would you say a few, some, or most?*
- *Which populations would say are more or less aware of these efforts?*

23. Do you think people in the community understand the purpose of these efforts? Why or why not?
24. Do you know of any efforts in the community to plan for additional programs to prevent the use of heroin?

  • *Can you tell me more about them?*

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**Dimension C. Leadership**

**Opioids**

25. On a scale of 1-10, with 1 being no concern, and 10 being great concern, how much of a concern would you say the abuse of prescription opioids is to the leadership of the city and borough, such as the mayor, council members, or others who are elected to office and leadership positions such as local state house and senate legislators?

  • *Can you tell me how you came to that answer?*

26. Do you feel they would support efforts to prevent and reduce the abuse of prescription opioids in Fairbanks?

  • *Do you think they would be willing to actively participate in planning efforts?*
  • *Do you think they would be willing to contribute resources to prevention efforts (time, space, financial resources, etc.)*

27. How about the leadership of organizations such as schools, spiritual groups, or health and social service organizations? On a scale of 1-10, with 1 being no concern and 10 being great concern, how much of a concern would you say the abuse of prescription opioids is to the leadership of these groups and organizations?

  • *Can you tell me how you came to that answer?*

28. Do you feel they would support efforts to prevent and reduce the abuse of prescription opioids in the community?

  • *Do you think they would be willing to actively participate in planning efforts?*
  • *Do you think they would be willing to contribute resources to prevention efforts (time, space, financial resources, etc.)*
Heroin

29. On a scale of 1-10, with 1 being no concern, and 10 being great concern, how much of a concern would you say the use of heroin is to the leadership of the city and borough, such as the mayor, council members, or others who are elected to office and leadership positions such as local state house and senate legislators?

- *Can you tell me how you came to that answer?*

30. Do you feel they would support efforts to prevent heroin use in Fairbanks?

- *Do you think they would be willing to actively participate in planning efforts?*
- *Do you think they would be willing to contribute resources to prevention efforts (time, space, financial resources, etc.)*?

31. How about the leadership of organizations such as schools, spiritual groups, or health and social service organizations? On a scale of 1-10, with 1 being no concern and 10 being great concern, how much of a concern would you say that heroin use is to the leadership of these groups and organizations?

- *Can you tell me how you came to that answer?*

32. Do you feel they would support efforts to prevent and reduce the use of heroin in Fairbanks?

- *Do you think they would be willing to actively participate in planning efforts?*
- *Do you think they would be willing to contribute resources to prevention efforts (time, space, financial resources, etc.)*?

Dimension D. Community Climate

Opioids

33. On a scale of 1-10, with 1 being none and 10 being a lot, how much of a concern do you think the abuse of prescription opioids is to residents of Fairbanks?

- *How did you come to that answer?*
34. Do you think the community would support efforts to prevent and reduce the abuse of prescription opioids?

- Can you tell me how you came to that answer?

35. Do you think community members would be willing to actively participate in efforts to prevent and reduce the abuse of prescription opioids?

- Ways they might participate could be attending educational sessions, attending planning meetings, helping to implement prevention strategies in the community, sharing their own experiences, financial donations, etc.

36. What potential obstacles do you think exist in the community that could be barriers to prevent prescription opioid misuse and abuse?

37. What strengths currently exist in the community that you think could help efforts to prevent prescription opioid misuse and abuse?

38. Are there any cultural norms in Fairbanks that you think may impact efforts to prevent the abuse of prescription opioids, either positively or negatively?

**Heroin**

39. On a scale of 1-10, with 1 being none and 10 being a lot, how much of a concern do you think that heroin use is to residents of Fairbanks?

- How did you come to that answer?

40. Do you think the community would support efforts to prevent heroin use?

- Can you tell me how you came to that answer?

41. Do you think community members would be willing to actively participate in efforts to prevent heroin use?

- Ways they might participate could be attending educational sessions, attending planning meetings, helping to implement prevention strategies in the community, sharing their own experiences, financial donations, etc.

42. What potential obstacles do you think exist in the community that could be barriers to efforts to prevent heroin use?
43. What strengths currently exist in the community that you think could help efforts to prevent heroin use?

44. Are there any cultural norms in Fairbanks that you think may impact efforts to prevent heroin use, either positively or negatively?

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### Dimension E. Resources for Prevention

#### Opioids

45. What type of information is available in Fairbanks about the abuse of prescription opioids?

- Data, statistics, pamphlets, notices, information provided at meetings, etc.

46. Where do you think people in the community get their information about prescription opioid use?

- Newspaper, radio, doctors, friends, relatives, teachers, etc.

47. If someone in Fairbanks was at risk for abusing prescription opioids, can you think of any resources that might be available in the community to help them?

48. Are there organizations or specific individuals in the community that you think would be willing to provide resources in-kind such as staff time or meeting space to support the development programs to prevent prescription opioid abuse?

49. Do you know whether there are any groups in the community that are currently seeking other sources of financial support for the prevention of prescription opioid abuse?

50. Are there any infrastructural groups in Fairbanks other than the Fairbanks Wellness Coalition that you think could be resources for the prevention of prescription opioid use (i.e. coalitions, workgroups, etc.)?

#### Heroin

51. What type of information is available in Fairbanks about heroin use?

- Data, statistics, pamphlets, notices, information provided at meetings, etc.
52. Where do you think people in the community get their information about heroin use?
   
   - Newspaper, radio, doctors, friends, relatives, teachers, etc.

53. If someone in Fairbanks was at risk for using heroin, can you think of any resources that might be available in the community to help them?

54. Are there organizations or specific individuals in the community that you think would be willing to provide resources in-kind such as staff time or meeting space to support the development of programs to prevent heroin use?

55. Do you know whether there are any groups in the community that are currently seeking other sources of financial support for the prevention of heroin?

56. Are there any infrastructural groups in Fairbanks other than the Fairbanks Wellness Coalition that you think could be resources for heroin prevention (i.e. coalitions, workgroups, etc.)?

**Closing Question**

57. Do you have any additional comments about either prescription opioid use or heroin use that you would like to make?
Appendix B: Community Readiness Assessment

Summary of Themes from Key Informant Interviews Conducted as Part of Community Readiness Assessment

<table>
<thead>
<tr>
<th>Interconnectedness of Opioids and Heroin</th>
<th>Count (n=15)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicated that heroin and opioid abuse are intertwined - it is difficult to talk about them independently of each other</td>
<td>9</td>
<td>60%</td>
</tr>
<tr>
<td>Stated that heroin is cheaper and/or easier to get than opioids - this has contributed to a shift from opioids to heroin use in the community</td>
<td>8</td>
<td>53%</td>
</tr>
<tr>
<td>Spoke of poly drug users (including combination of meth and heroin)</td>
<td>2</td>
<td>13%</td>
</tr>
<tr>
<td>Discussed that people use opioids to &quot;cover&quot; heroin use (mask the withdrawal symptoms and/or hide the heroin addiction)</td>
<td>1</td>
<td>7%</td>
</tr>
<tr>
<td>Explained that pharmaceutical companies have recently changed the formulation of opioids to make them slow release and require digestion in the stomach - this has contributed to increased heroin use</td>
<td>1</td>
<td>7%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Community Knowledge, Stigma and Misperceptions</th>
<th>Count (n=15)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discussed misperceptions in the community of who users are (they are junkies or street people, this is an urban/inner city problem, it only happens to &quot;other people&quot;, it's not happening in Fairbanks, it'll never happen to me, this is a problem from the 60's)</td>
<td>12</td>
<td>80%</td>
</tr>
<tr>
<td>Indicated the level of knowledge is low in the community unless it's affected you or someone you know</td>
<td>7</td>
<td>47%</td>
</tr>
<tr>
<td>Discussed the stigma associated with drug use, including the impact this stigma has on open discussion</td>
<td>7</td>
<td>47%</td>
</tr>
<tr>
<td>Discussed misperception in the community that people are making a choice to use and/or that drug use is a moral failing - the community does not understand addiction</td>
<td>6</td>
<td>40%</td>
</tr>
<tr>
<td>Indicated that people can tell when others are &quot;on something&quot; but they don't know how to distinguish what it is (i.e. alcohol, specific drug, etc.)</td>
<td>5</td>
<td>33%</td>
</tr>
<tr>
<td>Indicated that people's knowledge is based on what they see in TV</td>
<td>3</td>
<td>20%</td>
</tr>
<tr>
<td>Prevention</td>
<td>Count</td>
<td>Percent</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>-------</td>
<td>---------</td>
</tr>
<tr>
<td>Felt that the leadership of the community would be supportive of prevention efforts if they understood the problem(s)</td>
<td>15</td>
<td>100%</td>
</tr>
<tr>
<td>Felt that the community would be supportive of prevention efforts if they understood the problem(s)</td>
<td>13</td>
<td>87%</td>
</tr>
<tr>
<td>Were able to describe little to no prevention efforts in the community</td>
<td>12</td>
<td>80%</td>
</tr>
<tr>
<td>Mentioned there are competing and/or higher priority issues for the community such as economics/jobs, limited amounts of time, limited funding</td>
<td>7</td>
<td>47%</td>
</tr>
<tr>
<td>Referenced available prevention once someone is already a user and the positive impacts, including prevention of overdose, and the prevention of theft and other crime for the entire community (e.g. methadone, suboxone, naloxone, needle exchange program)</td>
<td>6</td>
<td>40%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Themes</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spoke specifically of the highly addictive nature of opiates/heroin as compared to other drugs</td>
<td>9</td>
<td>60%</td>
</tr>
<tr>
<td>Discussed the high number of property crimes in Fairbanks that are drug related</td>
<td>7</td>
<td>47%</td>
</tr>
<tr>
<td>Stated that youth are starting at younger ages, and that prevention needs to begin earlier</td>
<td>5</td>
<td>33%</td>
</tr>
<tr>
<td>Referenced the contribution of poorly managed pain to opioid and heroin use</td>
<td>3</td>
<td>20%</td>
</tr>
<tr>
<td>Discussed that the data that is available is slow to reflect what's happening in the community</td>
<td>1</td>
<td>7%</td>
</tr>
</tbody>
</table>
Appendix C: Community Perception Survey Results

Distribution
A mailing list of 4000 randomly selected addresses within the borough was purchased through Experian (http://www.experian.com/small-business/mailing-lists.jsp).

Postcards advertising the on-line survey with a web address and a scanable QR code were sent to the list on Dec 12, 2016 and Dec 27, 2016. About 260 of the original postcards were returned as undeliverable. The survey was advertised on Facebook, in the local newspaper (both in print and online) and with paper fliers on public bulletin boards.

Survey Response Demographics
The survey was closed on January 17, 2017 with 236 responses. More females (57%) than males (37%) completed the survey. More than 70% of respondents were between the ages of 26 and 64.

Survey Response by Age and Gender

<table>
<thead>
<tr>
<th>Age</th>
<th>Female</th>
<th>Male</th>
<th>No Gender Response</th>
<th>Total</th>
<th>Percent of Response (n=236)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 18 to 25</td>
<td>10</td>
<td>5</td>
<td></td>
<td>15</td>
<td>6.4%</td>
</tr>
<tr>
<td>Age 26 to 44</td>
<td>55</td>
<td>32</td>
<td></td>
<td>87</td>
<td>36.9%</td>
</tr>
<tr>
<td>Age 45 to 64</td>
<td>50</td>
<td>37</td>
<td></td>
<td>87</td>
<td>36.9%</td>
</tr>
<tr>
<td>Age 65 and Older</td>
<td>15</td>
<td>13</td>
<td></td>
<td>28</td>
<td>11.9%</td>
</tr>
<tr>
<td>No Age Response</td>
<td>4</td>
<td>0</td>
<td></td>
<td>15</td>
<td>8.1%</td>
</tr>
<tr>
<td>Total</td>
<td>134</td>
<td>87</td>
<td></td>
<td>236</td>
<td></td>
</tr>
<tr>
<td>Percent of Response (n=236)</td>
<td>56.8%</td>
<td>36.9%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Overall response rate was just over 5%. Some Zip Codes had a better response than others, especially West Fairbanks, 99709 and East Fairbanks, 99712.
## Survey Response by Zip Code

<table>
<thead>
<tr>
<th>Zip Codes</th>
<th>Count in Mailing List</th>
<th>Count in Response</th>
<th>Percent Response by zipcode</th>
</tr>
</thead>
<tbody>
<tr>
<td>99701</td>
<td>725</td>
<td>37</td>
<td>5.1%</td>
</tr>
<tr>
<td>99702</td>
<td>69</td>
<td>1</td>
<td>1.4%</td>
</tr>
<tr>
<td>99703</td>
<td>195</td>
<td>1</td>
<td>0.5%</td>
</tr>
<tr>
<td>99705</td>
<td>892</td>
<td>49</td>
<td>5.5%</td>
</tr>
<tr>
<td>99706</td>
<td>68</td>
<td>2</td>
<td>2.9%</td>
</tr>
<tr>
<td>99707</td>
<td>176</td>
<td>1</td>
<td>0.6%</td>
</tr>
<tr>
<td>99708</td>
<td>214</td>
<td>8</td>
<td>3.7%</td>
</tr>
<tr>
<td>99709</td>
<td>1031</td>
<td>77</td>
<td>7.5%</td>
</tr>
<tr>
<td>99710</td>
<td>58</td>
<td>1</td>
<td>1.7%</td>
</tr>
<tr>
<td>99711</td>
<td>49</td>
<td>3</td>
<td>6.1%</td>
</tr>
<tr>
<td>99712</td>
<td>414</td>
<td>33</td>
<td>8.0%</td>
</tr>
<tr>
<td>99714</td>
<td>57</td>
<td>2</td>
<td>3.5%</td>
</tr>
<tr>
<td>99716</td>
<td>18</td>
<td></td>
<td>0.0%</td>
</tr>
<tr>
<td>99725</td>
<td>34</td>
<td>2</td>
<td>5.9%</td>
</tr>
<tr>
<td>No response</td>
<td></td>
<td>19</td>
<td>5.9%</td>
</tr>
<tr>
<td>Total</td>
<td>4000</td>
<td>236</td>
<td>5.9%</td>
</tr>
</tbody>
</table>

Survey response was not as racially diverse as the actual population of Fairbanks is expected to be, but did have more than 13% response from non-white community members.

## Survey Response by Race and Ethnicity

(Respondents could choose more than one response and 18 respondents, or 7.6%, did not answer at all.)

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Percent of Response (n=236)</th>
<th>US Census Data projected to 2016 <a href="http://www.census.gov/">http://www.census.gov/</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>84.3%</td>
<td>76.90%</td>
</tr>
<tr>
<td>American Indian or Alaska Native</td>
<td>7.2%</td>
<td>7.20%</td>
</tr>
<tr>
<td>Black or African American</td>
<td>1.3%</td>
<td>5.70%</td>
</tr>
<tr>
<td>Asian</td>
<td>2.5%</td>
<td>3.20%</td>
</tr>
<tr>
<td>Native Hawaiian or other Pacific Islander</td>
<td>0.4%</td>
<td>0.60%</td>
</tr>
<tr>
<td>Other</td>
<td>2.1%</td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>2.5%</td>
<td></td>
</tr>
</tbody>
</table>
Question Responses
Survey Questions 1-9 In your opinion, what are the top three substance abuse issues in Fairbanks North Star Borough? The question was asked for three age groups: under 18 years, 18 to 25 years, and adults over 25 years.

Survey Question 1, 4 and 7.Number one substance abuse issue by age

<table>
<thead>
<tr>
<th></th>
<th>Under the age of 18</th>
<th>18-25 years</th>
<th>Over 25 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>59.6%</td>
<td>54.3%</td>
<td>67.2%</td>
</tr>
<tr>
<td>Marijuana</td>
<td>17.9%</td>
<td>8.2%</td>
<td>3.9%</td>
</tr>
<tr>
<td>Methamphetamines (meth)</td>
<td>8.5%</td>
<td>19.4%</td>
<td>11.6%</td>
</tr>
<tr>
<td>Prescription opioids</td>
<td>7.7%</td>
<td>6.5%</td>
<td>9.1%</td>
</tr>
<tr>
<td>Heroin</td>
<td>5.5%</td>
<td>10.3%</td>
<td>6.9%</td>
</tr>
<tr>
<td>Cocaine</td>
<td>0.4%</td>
<td>0.9%</td>
<td>0.9%</td>
</tr>
</tbody>
</table>

Figure 1. Number One Substance Abuse Issue by Age

Top Three Substance Abuse Issues by Age

<table>
<thead>
<tr>
<th></th>
<th>Under the age of 18</th>
<th>18-25 years</th>
<th>Over 25 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>30.2%</td>
<td>28.3%</td>
<td>31.0%</td>
</tr>
<tr>
<td>Marijuana</td>
<td>20.7%</td>
<td>14.5%</td>
<td>9.8%</td>
</tr>
<tr>
<td>Prescription opioids</td>
<td>18.1%</td>
<td>15.6%</td>
<td>19.4%</td>
</tr>
<tr>
<td>Methamphetamines (meth)</td>
<td>16.7%</td>
<td>23.1%</td>
<td>20.8%</td>
</tr>
<tr>
<td>Heroin</td>
<td>8.6%</td>
<td>12.9%</td>
<td>13.3%</td>
</tr>
<tr>
<td>Cocaine</td>
<td>3.1%</td>
<td>4.8%</td>
<td>4.9%</td>
</tr>
</tbody>
</table>
Survey Question 10: How small or big of a problem do you think the non-medical use of prescription opioids is in the Fairbanks North Star Borough?

<table>
<thead>
<tr>
<th>Count</th>
<th>Percent of Response (n=231)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not a problem at all</td>
<td>2</td>
</tr>
<tr>
<td>Small problem</td>
<td>23</td>
</tr>
<tr>
<td>Moderate problem</td>
<td>100</td>
</tr>
<tr>
<td>Big problem</td>
<td>78</td>
</tr>
<tr>
<td>Don’t know</td>
<td>28</td>
</tr>
</tbody>
</table>

Survey Question 11. Which of the following age groups do you think are most likely to misuse prescription opioids in the Fairbanks North Star Borough?

Note: Respondents could choose more than one age range so that percent response totals to more than 100%.

<table>
<thead>
<tr>
<th>Count</th>
<th>Percent of Response (n=229)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number that answered more than one range</td>
<td>75</td>
</tr>
<tr>
<td>Youth ages 12-17</td>
<td>30</td>
</tr>
<tr>
<td>Young adults ages 18 to 25</td>
<td>97</td>
</tr>
<tr>
<td>Adults ages 26 to 44</td>
<td>143</td>
</tr>
<tr>
<td>Adults ages 45 to 64</td>
<td>56</td>
</tr>
<tr>
<td>Adults age 65 and older</td>
<td>24</td>
</tr>
</tbody>
</table>
Survey Question 12. How difficult or easy would you say it is for people to get prescription opioids without a prescription in the Fairbanks North Star Borough?

<table>
<thead>
<tr>
<th>Count</th>
<th>Percent Response (n=230)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Difficult</td>
<td>8</td>
</tr>
<tr>
<td>A little bit difficult</td>
<td>43</td>
</tr>
<tr>
<td>Somewhat easy</td>
<td>67</td>
</tr>
<tr>
<td>Very easy</td>
<td>37</td>
</tr>
<tr>
<td>I don’t know</td>
<td>75</td>
</tr>
</tbody>
</table>

Survey Question 13. Have you ever known someone who has misused or abused prescription opioid medications?

<table>
<thead>
<tr>
<th>Count</th>
<th>Percent Response (n=231)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>147</td>
</tr>
<tr>
<td>Unsure</td>
<td>32</td>
</tr>
<tr>
<td>No</td>
<td>52</td>
</tr>
</tbody>
</table>

Survey Question 14. In your opinion, what are the three most significant consequences from young people (ages 12-25) in Fairbanks misusing prescription opioids?

Respondents were requested to list three consequences and many listed even more than that so the sum of percent response is much greater than 100%.

<table>
<thead>
<tr>
<th>Concept</th>
<th>Count</th>
<th>Percent Response (n=214)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unemployment, quit school, wage loss, homelessness</td>
<td>90</td>
<td>42.1%</td>
</tr>
<tr>
<td>Addiction, dependence</td>
<td>82</td>
<td>38.3%</td>
</tr>
<tr>
<td>Crime, Stealing to support the habit</td>
<td>64</td>
<td>29.9%</td>
</tr>
<tr>
<td>Physical effects such as nausea and vomiting, constipation, liver damage, impaired immune system</td>
<td>47</td>
<td>22.0%</td>
</tr>
<tr>
<td>Impaired judgement, brain damage, altered behavior</td>
<td>42</td>
<td>19.6%</td>
</tr>
<tr>
<td>Death</td>
<td>38</td>
<td>17.8%</td>
</tr>
<tr>
<td>Social isolation, break with family</td>
<td>31</td>
<td>14.5%</td>
</tr>
<tr>
<td>Overdose</td>
<td>26</td>
<td>12.1%</td>
</tr>
<tr>
<td>Ruined life, loss of direction</td>
<td>26</td>
<td>12.1%</td>
</tr>
<tr>
<td>Advancing to other drugs such as heroin</td>
<td>24</td>
<td>11.2%</td>
</tr>
<tr>
<td>Legal consequences of improper use, jail</td>
<td>21</td>
<td>9.8%</td>
</tr>
<tr>
<td>Harming others, abuse, violence</td>
<td>20</td>
<td>9.3%</td>
</tr>
<tr>
<td>Increased risk of major depression, suicide</td>
<td>11</td>
<td>5.1%</td>
</tr>
<tr>
<td>Accidents</td>
<td>8</td>
<td>3.7%</td>
</tr>
<tr>
<td>Impaired driving, car wrecks</td>
<td>6</td>
<td>2.8%</td>
</tr>
<tr>
<td>Loss of independence, ability to be self sufficient</td>
<td>5</td>
<td>2.3%</td>
</tr>
</tbody>
</table>
Survey Question 15: How do you think young people in Fairbanks get started misusing prescription opioids? Responses may be coded as more than one idea and so will not sum to 100%.

<table>
<thead>
<tr>
<th>Concept</th>
<th>Count</th>
<th>Percent of Response (n=216)</th>
</tr>
</thead>
<tbody>
<tr>
<td>From family or friend prescription, &quot;borrowing&quot;</td>
<td>91</td>
<td>42.1%</td>
</tr>
<tr>
<td>Peers</td>
<td>82</td>
<td>38.0%</td>
</tr>
<tr>
<td>Injury, legitimate prescription leads to hooked</td>
<td>33</td>
<td>15.3%</td>
</tr>
<tr>
<td>Fun, experimenting</td>
<td>33</td>
<td>15.3%</td>
</tr>
<tr>
<td>Bad role models, parenting</td>
<td>19</td>
<td>8.8%</td>
</tr>
<tr>
<td>Theft</td>
<td>17</td>
<td>7.9%</td>
</tr>
<tr>
<td>Boredom, lack of better activities</td>
<td>11</td>
<td>5.1%</td>
</tr>
<tr>
<td>Depression, lack of hope, isolation</td>
<td>7</td>
<td>3.2%</td>
</tr>
<tr>
<td>From other drugs</td>
<td>7</td>
<td>3.2%</td>
</tr>
<tr>
<td>Availability</td>
<td>6</td>
<td>2.8%</td>
</tr>
<tr>
<td>Don't Know</td>
<td>5</td>
<td>2.3%</td>
</tr>
<tr>
<td>Drug dealers. off the streets</td>
<td>5</td>
<td>2.3%</td>
</tr>
<tr>
<td>Think prescription drugs aren't dangerous</td>
<td>4</td>
<td>1.9%</td>
</tr>
<tr>
<td>Self-medicating</td>
<td>3</td>
<td>1.4%</td>
</tr>
</tbody>
</table>

Survey Question 16. How unlikely or likely do you think it is that someone who misuses prescription opioids would obtain them from:

<table>
<thead>
<tr>
<th>Source</th>
<th>n</th>
<th>Very unlikely</th>
<th>Unlikely</th>
<th>Likely</th>
<th>Very likely</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friends</td>
<td>224</td>
<td>3.1%</td>
<td>0.4%</td>
<td>28.1%</td>
<td>65.6%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Family members</td>
<td>225</td>
<td>4.0%</td>
<td>8.0%</td>
<td>32.9%</td>
<td>52.9%</td>
<td>2.2%</td>
</tr>
<tr>
<td>Doctors</td>
<td>223</td>
<td>13.0%</td>
<td>28.7%</td>
<td>35.9%</td>
<td>18.4%</td>
<td>4.0%</td>
</tr>
<tr>
<td>Drug dealers</td>
<td>223</td>
<td>2.7%</td>
<td>4.9%</td>
<td>30.5%</td>
<td>56.5%</td>
<td>5.4%</td>
</tr>
<tr>
<td>Dentists</td>
<td>225</td>
<td>18.2%</td>
<td>40.0%</td>
<td>24.4%</td>
<td>8.4%</td>
<td>8.9%</td>
</tr>
<tr>
<td>Forged prescriptions</td>
<td>225</td>
<td>12.9%</td>
<td>32.0%</td>
<td>32.4%</td>
<td>10.2%</td>
<td>12.4%</td>
</tr>
<tr>
<td>Stealing</td>
<td>225</td>
<td>2.7%</td>
<td>4.9%</td>
<td>32.0%</td>
<td>57.8%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Emergency room visits</td>
<td>224</td>
<td>10.7%</td>
<td>25.4%</td>
<td>32.1%</td>
<td>17.4%</td>
<td>14.3%</td>
</tr>
<tr>
<td>Online</td>
<td>222</td>
<td>8.6%</td>
<td>25.2%</td>
<td>22.1%</td>
<td>13.1%</td>
<td>31.1%</td>
</tr>
<tr>
<td>Veterinarians</td>
<td>225</td>
<td>22.2%</td>
<td>40.0%</td>
<td>11.1%</td>
<td>2.2%</td>
<td>24.4%</td>
</tr>
</tbody>
</table>
Survey Question 17. Within the past 12 months, have you disposed of unused prescription medications by:

<table>
<thead>
<tr>
<th>Disposal Method</th>
<th>Count (n)</th>
<th>No</th>
<th>Yes</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rinsing them down the sink</td>
<td>223</td>
<td>96.0%</td>
<td>4.0%</td>
<td></td>
</tr>
<tr>
<td>Storing them in the house</td>
<td>224</td>
<td>54.0%</td>
<td>46.0%</td>
<td></td>
</tr>
<tr>
<td>Returning them to a pharmacy</td>
<td>223</td>
<td>89.2%</td>
<td>10.8%</td>
<td></td>
</tr>
<tr>
<td>Flushing them down the toilet</td>
<td>223</td>
<td>84.8%</td>
<td>15.2%</td>
<td></td>
</tr>
<tr>
<td>Giving them to friends or family</td>
<td>223</td>
<td>97.3%</td>
<td>2.7%</td>
<td></td>
</tr>
<tr>
<td>Returning them to a health care provider</td>
<td>221</td>
<td>95.0%</td>
<td>5.0%</td>
<td></td>
</tr>
<tr>
<td>Putting them in cat litter or coffee grounds</td>
<td>223</td>
<td>97.8%</td>
<td>2.2%</td>
<td></td>
</tr>
<tr>
<td>Throwing them in the garbage</td>
<td>223</td>
<td>78.0%</td>
<td>22.0%</td>
<td></td>
</tr>
<tr>
<td>Bringing them to a drug disposal site</td>
<td>223</td>
<td>87.9%</td>
<td>12.1%</td>
<td></td>
</tr>
<tr>
<td>Bringing them to a drug take-back day</td>
<td>221</td>
<td>89.6%</td>
<td>10.4%</td>
<td></td>
</tr>
</tbody>
</table>

Survey Question 18. Do you believe it is okay to dispose of unused medications by:

<table>
<thead>
<tr>
<th>Disposal Method</th>
<th>Count (n)</th>
<th>No</th>
<th>Yes</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rinsing them down the sink</td>
<td>222</td>
<td>71.6%</td>
<td>18.9%</td>
<td>9.5%</td>
</tr>
<tr>
<td>Storing them in the house</td>
<td>221</td>
<td>58.8%</td>
<td>28.1%</td>
<td>13.1%</td>
</tr>
<tr>
<td>Returning them to a pharmacy</td>
<td>222</td>
<td>9.5%</td>
<td>73.0%</td>
<td>17.6%</td>
</tr>
<tr>
<td>Flushing them down the toilet</td>
<td>223</td>
<td>61.9%</td>
<td>30.0%</td>
<td>8.1%</td>
</tr>
<tr>
<td>Giving them to friends or family</td>
<td>220</td>
<td>95.0%</td>
<td>3.6%</td>
<td>1.4%</td>
</tr>
<tr>
<td>Returning them to a health care provider</td>
<td>222</td>
<td>22.5%</td>
<td>59.5%</td>
<td>18.0%</td>
</tr>
<tr>
<td>Putting them in cat litter or coffee grounds</td>
<td>222</td>
<td>69.4%</td>
<td>16.7%</td>
<td>14.0%</td>
</tr>
<tr>
<td>Throwing them in the garbage</td>
<td>221</td>
<td>76.0%</td>
<td>14.5%</td>
<td>9.5%</td>
</tr>
<tr>
<td>Bringing them to a drug disposal site</td>
<td>222</td>
<td>3.6%</td>
<td>91.0%</td>
<td>5.4%</td>
</tr>
<tr>
<td>Bringing them to a drug take-back day</td>
<td>221</td>
<td>4.1%</td>
<td>86.0%</td>
<td>10.0%</td>
</tr>
</tbody>
</table>

Survey Question 19. Within the past 12 months, have you been given advice on medication disposal by a medical provider or pharmacist?

<table>
<thead>
<tr>
<th>Response</th>
<th>Count</th>
<th>Percent Response (n=224)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>197</td>
<td>87.9%</td>
</tr>
<tr>
<td>Yes</td>
<td>22</td>
<td>9.8%</td>
</tr>
<tr>
<td>Unsure</td>
<td>5</td>
<td>2.2%</td>
</tr>
</tbody>
</table>
Survey Question 20. In your opinion, how much will young people (ages 12-25) harm themselves if they

<table>
<thead>
<tr>
<th>Activity</th>
<th>n</th>
<th>No Harm</th>
<th>Minimal Harm</th>
<th>Moderate Harm</th>
<th>Significant Harm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Take prescription opioids that were prescribed to someone else for pain?</td>
<td>224</td>
<td>1.8%</td>
<td>16.5%</td>
<td>38.8%</td>
<td>42.9%</td>
</tr>
<tr>
<td>Take prescription opioids occasionally to get high?</td>
<td>224</td>
<td>1.3%</td>
<td>8.5%</td>
<td>40.2%</td>
<td>50.0%</td>
</tr>
<tr>
<td>Take prescription opioids regularly to get high?</td>
<td>222</td>
<td>0.5%</td>
<td>1.8%</td>
<td>7.7%</td>
<td>90.1%</td>
</tr>
<tr>
<td>Take more than the recommended dosage of a prescribed opioid if they are feeling more pain than usual?</td>
<td>224</td>
<td>1.3%</td>
<td>8.0%</td>
<td>24.1%</td>
<td>66.5%</td>
</tr>
</tbody>
</table>

Survey Question 21. How much do you disagree or agree with the following statements?

<table>
<thead>
<tr>
<th>Statement</th>
<th>n</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription opioids provide a “safe high.”</td>
<td>224</td>
<td>69.6%</td>
<td>23.7%</td>
<td>2.7%</td>
<td>0.4%</td>
<td>3.6%</td>
</tr>
<tr>
<td>Prescription opioids are safer than street drugs</td>
<td>224</td>
<td>52.2%</td>
<td>21.9%</td>
<td>15.2%</td>
<td>2.7%</td>
<td>8.0%</td>
</tr>
<tr>
<td>Prescription opioids are not as addictive as other drugs</td>
<td>221</td>
<td>73.8%</td>
<td>19.5%</td>
<td>1.8%</td>
<td>0.9%</td>
<td>4.1%</td>
</tr>
<tr>
<td>It is likely that someone taking prescription opioids that were not prescribed to them would get caught by law enforcement</td>
<td>224</td>
<td>23.7%</td>
<td>48.2%</td>
<td>11.2%</td>
<td>3.6%</td>
<td>13.4%</td>
</tr>
<tr>
<td>It is okay to mix prescription opioids with alcohol</td>
<td>224</td>
<td>84.4%</td>
<td>12.5%</td>
<td>0.0%</td>
<td>0.9%</td>
<td>2.2%</td>
</tr>
<tr>
<td>It is okay to mix prescription opioids with sedatives</td>
<td>224</td>
<td>84.8%</td>
<td>10.3%</td>
<td>0.4%</td>
<td>0.9%</td>
<td>3.6%</td>
</tr>
<tr>
<td>It is likely that the non-medical use of prescription opioids will lead to heroin use</td>
<td>224</td>
<td>4.9%</td>
<td>12.1%</td>
<td>34.8%</td>
<td>13.8%</td>
<td>34.4%</td>
</tr>
<tr>
<td>Taking prescription opioids using a method that is different than prescribed (i.e. crushing, chewing or injecting) is okay</td>
<td>224</td>
<td>75.9%</td>
<td>16.1%</td>
<td>1.8%</td>
<td>0.9%</td>
<td>5.4%</td>
</tr>
</tbody>
</table>

Survey Question 22: How small or big of a problem do you think heroin use is in the Fairbanks North Star Borough?

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
<th>Percent of Response (n=224)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not a problem at all</td>
<td>1</td>
<td>0.4%</td>
</tr>
<tr>
<td>Small problem</td>
<td>14</td>
<td>6.3%</td>
</tr>
<tr>
<td>Moderate problem</td>
<td>60</td>
<td>26.8%</td>
</tr>
<tr>
<td>Big problem</td>
<td>85</td>
<td>37.9%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>64</td>
<td>28.6%</td>
</tr>
</tbody>
</table>
Survey Question 23. Which of the following age groups do you think are most likely to use heroin in the Fairbanks North Star Borough?

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Count</th>
<th>Percent of Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of respondents</td>
<td>222</td>
<td>100%</td>
</tr>
<tr>
<td>Number that answered more than one range</td>
<td>123</td>
<td>100%</td>
</tr>
<tr>
<td>Youth ages 12-17</td>
<td>26</td>
<td>11.7%</td>
</tr>
<tr>
<td>Young adults ages 18 to 25</td>
<td>159</td>
<td>71.6%</td>
</tr>
<tr>
<td>Adults ages 26 to 44</td>
<td>166</td>
<td>74.8%</td>
</tr>
<tr>
<td>Adults ages 45 to 64</td>
<td>57</td>
<td>25.7%</td>
</tr>
<tr>
<td>Adults age 65 and older</td>
<td>14</td>
<td>6.3%</td>
</tr>
</tbody>
</table>

Survey Question 24. How difficult or easy would you say it is for people to get heroin in the Fairbanks North Star Borough?

<table>
<thead>
<tr>
<th>Difficulty Level</th>
<th>Count</th>
<th>Percent Response (n=223)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Difficult</td>
<td>2</td>
<td>0.9%</td>
</tr>
<tr>
<td>A little bit difficult</td>
<td>36</td>
<td>16.1%</td>
</tr>
<tr>
<td>Somewhat easy</td>
<td>70</td>
<td>31.4%</td>
</tr>
<tr>
<td>Very easy</td>
<td>30</td>
<td>13.5%</td>
</tr>
<tr>
<td>I don't know</td>
<td>85</td>
<td>38.1%</td>
</tr>
</tbody>
</table>

Survey Question 25. Have you ever known someone who has used or abused heroin?

<table>
<thead>
<tr>
<th>Response</th>
<th>Count</th>
<th>Percent Response (n=223)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>102</td>
<td>45.7%</td>
</tr>
<tr>
<td>Unsure</td>
<td>33</td>
<td>14.8%</td>
</tr>
<tr>
<td>No</td>
<td>88</td>
<td>39.5%</td>
</tr>
</tbody>
</table>

Survey Question 26. In your opinion, is using heroin socially acceptable among young adults (ages 18 to 25) in Fairbanks?

<table>
<thead>
<tr>
<th>Response</th>
<th>Count</th>
<th>Percent Response (n=222)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>122</td>
<td>55.0%</td>
</tr>
<tr>
<td>Yes</td>
<td>22</td>
<td>9.9%</td>
</tr>
<tr>
<td>Unsure</td>
<td>78</td>
<td>35.1%</td>
</tr>
</tbody>
</table>
Survey Question 27. In your opinion, what are the three most significant consequences of young adults (ages 18-25) in Fairbanks using heroin? Respondents were requested to list three consequences and many listed even more than that so the sum of percent response is much greater than 100%.

<table>
<thead>
<tr>
<th>Concept</th>
<th>Count</th>
<th>Percent of Response (n=203)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addiction, dependence</td>
<td>83</td>
<td>40.9%</td>
</tr>
<tr>
<td>Death</td>
<td>81</td>
<td>39.9%</td>
</tr>
<tr>
<td>Crime, stealing to support the habit</td>
<td>66</td>
<td>32.5%</td>
</tr>
<tr>
<td>Physical effects such as nausea and vomiting, constipation, liver damage, impaired immune system</td>
<td>61</td>
<td>30.0%</td>
</tr>
<tr>
<td>Unemployment, quit school, wage loss</td>
<td>56</td>
<td>27.6%</td>
</tr>
<tr>
<td>Social isolation, break with family</td>
<td>43</td>
<td>21.2%</td>
</tr>
<tr>
<td>Overdose</td>
<td>33</td>
<td>16.3%</td>
</tr>
<tr>
<td>Legal consequences of improper use, jail</td>
<td>33</td>
<td>16.3%</td>
</tr>
<tr>
<td>Ruined life, loss of direction, homelessness</td>
<td>28</td>
<td>13.8%</td>
</tr>
<tr>
<td>Impaired judgement, brain damage, altered behavior</td>
<td>24</td>
<td>11.8%</td>
</tr>
<tr>
<td>Loss of independence, ability to be self-sufficient, not responsible</td>
<td>16</td>
<td>7.9%</td>
</tr>
<tr>
<td>Harming others, abuse, violence</td>
<td>16</td>
<td>7.9%</td>
</tr>
<tr>
<td>Accidents</td>
<td>5</td>
<td>2.5%</td>
</tr>
<tr>
<td>Impaired driving, car wrecks</td>
<td>3</td>
<td>1.5%</td>
</tr>
<tr>
<td>Advancing to other drugs</td>
<td>3</td>
<td>1.5%</td>
</tr>
</tbody>
</table>

Survey Question 28. How do you think people get started using heroin? Responses may be coded as more than one idea and so will not sum to 100%.

<table>
<thead>
<tr>
<th>Concept</th>
<th>Count</th>
<th>Percent of Response (n=206)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peers</td>
<td>97</td>
<td>44.9%</td>
</tr>
<tr>
<td>Progression from prescriptions</td>
<td>38</td>
<td>17.6%</td>
</tr>
<tr>
<td>Fun, experimenting, partying</td>
<td>33</td>
<td>15.3%</td>
</tr>
<tr>
<td>From other drugs</td>
<td>31</td>
<td>14.4%</td>
</tr>
<tr>
<td>In search of a stronger high, desperate to get high</td>
<td>17</td>
<td>7.9%</td>
</tr>
<tr>
<td>Self-medicating, coping</td>
<td>14</td>
<td>6.5%</td>
</tr>
<tr>
<td>Availability</td>
<td>13</td>
<td>6.0%</td>
</tr>
<tr>
<td>Depression, lack of hope, isolation</td>
<td>10</td>
<td>4.6%</td>
</tr>
<tr>
<td>Can no longer get other opioids</td>
<td>6</td>
<td>2.8%</td>
</tr>
<tr>
<td>Boredom, lack of better activities</td>
<td>5</td>
<td>2.3%</td>
</tr>
<tr>
<td>Bad role models, parenting</td>
<td>4</td>
<td>1.9%</td>
</tr>
<tr>
<td>Bad choices</td>
<td>4</td>
<td>1.9%</td>
</tr>
<tr>
<td>Drug dealers, off the streets</td>
<td>3</td>
<td>1.4%</td>
</tr>
<tr>
<td>Socially acceptable, media</td>
<td>3</td>
<td>1.4%</td>
</tr>
</tbody>
</table>
Survey Question 29. How unlikely or likely do you think it is that someone who uses heroin would obtain it from:

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>Very unlikely</th>
<th>Unlikely</th>
<th>Likely</th>
<th>Very Likely</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friends</td>
<td>222</td>
<td>2.7%</td>
<td>5.0%</td>
<td>33.3%</td>
<td>55.4%</td>
<td>3.6%</td>
</tr>
<tr>
<td>Family members</td>
<td>221</td>
<td>12.2%</td>
<td>33.0%</td>
<td>29.0%</td>
<td>14.9%</td>
<td>10.9%</td>
</tr>
<tr>
<td>Drug dealers</td>
<td>221</td>
<td>2.3%</td>
<td>1.4%</td>
<td>16.7%</td>
<td>77.8%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Stealing</td>
<td>219</td>
<td>5.0%</td>
<td>16.0%</td>
<td>31.5%</td>
<td>39.3%</td>
<td>8.2%</td>
</tr>
<tr>
<td>Online</td>
<td>221</td>
<td>20.8%</td>
<td>26.2%</td>
<td>12.7%</td>
<td>3.6%</td>
<td>36.7%</td>
</tr>
</tbody>
</table>

Survey Question 30. How much do you disagree or agree with the following statements?

<table>
<thead>
<tr>
<th>Statement</th>
<th>n</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin provides a “safe high”</td>
<td>222</td>
<td>89.2%</td>
<td>7.7%</td>
<td>0.0%</td>
<td>0.5%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Heroin is safer to use than other street drugs</td>
<td>222</td>
<td>86.0%</td>
<td>8.6%</td>
<td>1.4%</td>
<td>0.0%</td>
<td>4.1%</td>
</tr>
<tr>
<td>Heroin is not as addictive as other drugs</td>
<td>221</td>
<td>88.7%</td>
<td>6.8%</td>
<td>1.4%</td>
<td>0.0%</td>
<td>3.2%</td>
</tr>
<tr>
<td>It is likely that someone using heroin would be caught by law enforcement</td>
<td>221</td>
<td>9.0%</td>
<td>31.2%</td>
<td>38.0%</td>
<td>8.1%</td>
<td>13.6%</td>
</tr>
<tr>
<td>It is likely that someone who uses heroin occasionally will become addicted</td>
<td>222</td>
<td>9.0%</td>
<td>3.6%</td>
<td>20.7%</td>
<td>63.5%</td>
<td>3.2%</td>
</tr>
<tr>
<td>People don’t know or understand the risks associated with heroin use</td>
<td>222</td>
<td>4.1%</td>
<td>15.8%</td>
<td>40.1%</td>
<td>35.6%</td>
<td>4.5%</td>
</tr>
<tr>
<td>It is okay to mix heroin with alcohol</td>
<td>222</td>
<td>83.8%</td>
<td>10.4%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>5.9%</td>
</tr>
<tr>
<td>It is okay to mix heroin with sedatives</td>
<td>222</td>
<td>84.2%</td>
<td>9.5%</td>
<td>0.9%</td>
<td>0.0%</td>
<td>5.4%</td>
</tr>
</tbody>
</table>

Survey Question 31. In your opinion, how much will young adults (ages 18-25) harm themselves (physically, mentally, or in

<table>
<thead>
<tr>
<th>Use heroin only occasionally to get high</th>
<th>n</th>
<th>No Harm</th>
<th>Minimal Harm</th>
<th>Moderate Harm</th>
<th>Significant Harm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use heroin regularly to get high</td>
<td>222</td>
<td>0.0%</td>
<td>0.9%</td>
<td>5.0%</td>
<td>94.1%</td>
</tr>
</tbody>
</table>

Survey Question 32. How well do you think young adults (ages 18-25) in Fairbanks understand the following risks from using heroin?

<table>
<thead>
<tr>
<th>Risk</th>
<th>n</th>
<th>Not at all</th>
<th>A little bit</th>
<th>Moderately well</th>
<th>Very well</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addiction</td>
<td>221</td>
<td>17.6%</td>
<td>42.1%</td>
<td>28.1%</td>
<td>4.1%</td>
<td>8.1%</td>
</tr>
<tr>
<td>Overdose</td>
<td>221</td>
<td>22.6%</td>
<td>41.2%</td>
<td>22.6%</td>
<td>6.8%</td>
<td>6.8%</td>
</tr>
<tr>
<td>Hepatitis, HIV or other infections from sharing needles</td>
<td>221</td>
<td>24.4%</td>
<td>38.0%</td>
<td>24.9%</td>
<td>5.0%</td>
<td>7.7%</td>
</tr>
<tr>
<td>Liver or kidney disease</td>
<td>219</td>
<td>64.8%</td>
<td>18.7%</td>
<td>4.6%</td>
<td>1.8%</td>
<td>10.0%</td>
</tr>
<tr>
<td>Heart and lung infections or complications</td>
<td>221</td>
<td>67.4%</td>
<td>17.6%</td>
<td>4.1%</td>
<td>1.8%</td>
<td>9.0%</td>
</tr>
</tbody>
</table>
Survey Question 33. In the last 12 months have you seen...

<table>
<thead>
<tr>
<th>Information</th>
<th>n</th>
<th>No</th>
<th>Yes</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information about preventing the non-medical use of prescription opioids</td>
<td>222</td>
<td>53.6%</td>
<td>39.6%</td>
<td>6.8%</td>
</tr>
<tr>
<td>Information about preventing heroin use</td>
<td>221</td>
<td>73.8%</td>
<td>19.9%</td>
<td>6.3%</td>
</tr>
<tr>
<td>Information about the risks from non-medical use of prescription opioids</td>
<td>220</td>
<td>52.7%</td>
<td>40.9%</td>
<td>6.4%</td>
</tr>
<tr>
<td>Information about the risks from using heroin</td>
<td>222</td>
<td>65.3%</td>
<td>29.3%</td>
<td>5.4%</td>
</tr>
<tr>
<td>Information about disposing unused medications, particularly prescription opioids</td>
<td>222</td>
<td>64.0%</td>
<td>29.3%</td>
<td>6.8%</td>
</tr>
</tbody>
</table>
Appendix D: Fairbanks Wellness Coalition Retail Availability Survey Results

Pharmacist Survey

Survey Response

Twelve pharmacists completed our survey. They ranged in experience from 4 months to 39 years of being a pharmacist, with an average of 18 years.

Survey Question: When you dispense a prescription opioid at your pharmacy, about how often do you request a report on the patient through the Alaska Prescription Drug Monitoring Program (AKPDMP)?

<table>
<thead>
<tr>
<th>Count</th>
<th>Percent Response (n=12)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>0</td>
</tr>
<tr>
<td>Sometimes</td>
<td>4</td>
</tr>
<tr>
<td>Most of the time</td>
<td>4</td>
</tr>
<tr>
<td>Always</td>
<td>2</td>
</tr>
<tr>
<td>Only if I have a specific concern</td>
<td>2</td>
</tr>
</tbody>
</table>

Survey Question: Do you utilize the AKPDMP Prescriber/Dispenser reports to monitor opioid dispensing at your pharmacy?

<table>
<thead>
<tr>
<th>Count</th>
<th>Percent Response (n=12)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>6</td>
</tr>
<tr>
<td>Yes</td>
<td>4</td>
</tr>
<tr>
<td>Unsure</td>
<td>2</td>
</tr>
</tbody>
</table>

Survey Question: Do you have a system in place at your pharmacy to flag patients who are at increased risk of overdose due to high dosages of opioids or opioids prescribed by multiple providers?

<table>
<thead>
<tr>
<th>Count</th>
<th>Percent Response (n=12)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>6</td>
</tr>
<tr>
<td>Yes</td>
<td>5</td>
</tr>
<tr>
<td>Unsure</td>
<td>1</td>
</tr>
</tbody>
</table>

Survey Question: Do you have a system in place at your pharmacy to flag patients who have exhibited possible signs of opioid abuse such as aberrant behavior, requesting early refills, cash transactions, requests for partial dispensing of prescriptions, etc?

<table>
<thead>
<tr>
<th>Count</th>
<th>Percent Response (n=12)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>7</td>
</tr>
<tr>
<td>Yes</td>
<td>4</td>
</tr>
<tr>
<td>Unsure</td>
<td>1</td>
</tr>
</tbody>
</table>
Survey Question: Do you require a photo identification to pick up prescriptions for opioids?

<table>
<thead>
<tr>
<th>Count</th>
<th>Percent Response (n=12)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>1</td>
</tr>
<tr>
<td>Sometimes</td>
<td>5</td>
</tr>
<tr>
<td>Usually</td>
<td>1</td>
</tr>
<tr>
<td>Always</td>
<td>2</td>
</tr>
<tr>
<td>Only if I have a specific concern about the patient</td>
<td>3</td>
</tr>
</tbody>
</table>

Survey Question: When a patient picks up a prescription for opioids at your pharmacy, how often do you discuss each of the following with the patient?

<table>
<thead>
<tr>
<th>n</th>
<th>Never</th>
<th>Sometimes</th>
<th>Most of the time</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>How to take the medications exactly as prescribed.</td>
<td>11</td>
<td>0.0%</td>
<td>18.2%</td>
<td>36.4%</td>
</tr>
<tr>
<td>Risks of using the medications inappropriately.</td>
<td>11</td>
<td>0.0%</td>
<td>27.3%</td>
<td>36.4%</td>
</tr>
<tr>
<td>Risk of dependence and addiction.</td>
<td>11</td>
<td>9.1%</td>
<td>36.4%</td>
<td>45.5%</td>
</tr>
<tr>
<td>Whether they are taking any other medications.</td>
<td>11</td>
<td>0.0%</td>
<td>27.3%</td>
<td>36.4%</td>
</tr>
<tr>
<td>Which medications they should avoid while taking opioids.</td>
<td>11</td>
<td>0.0%</td>
<td>27.3%</td>
<td>36.4%</td>
</tr>
<tr>
<td>Most common side effects from opioids.</td>
<td>11</td>
<td>0.0%</td>
<td>9.1%</td>
<td>27.3%</td>
</tr>
<tr>
<td>Importance of reporting side effects to their doctor or pharmacist.</td>
<td>11</td>
<td>0.0%</td>
<td>27.3%</td>
<td>36.4%</td>
</tr>
<tr>
<td>Expectations regarding refills and refill requirements.</td>
<td>11</td>
<td>0.0%</td>
<td>27.3%</td>
<td>45.5%</td>
</tr>
<tr>
<td>Importance of using one pharmacy for all medications.</td>
<td>11</td>
<td>27.3%</td>
<td>9.1%</td>
<td>36.4%</td>
</tr>
<tr>
<td>Dangers of saving unused medications.</td>
<td>11</td>
<td>36.4%</td>
<td>27.3%</td>
<td>27.3%</td>
</tr>
<tr>
<td>How to safely store and dispose of any unused medications to prevent diversion or misuse.</td>
<td>11</td>
<td>27.3%</td>
<td>18.2%</td>
<td>36.4%</td>
</tr>
<tr>
<td>Ask whether they have any additional questions.</td>
<td>11</td>
<td>0.0%</td>
<td>9.1%</td>
<td>9.1%</td>
</tr>
</tbody>
</table>

Open Response Survey Question: Please describe drug-shopping behaviors you see in your pharmacy, if any.

- Early refill requests. New Patients with large quantities or High Doses, out of town prescribers. Use of hydrocodone cough syrups as an alternative.
- I work at an inpatient pharmacy, so we do not fill prescriptions for patients normally. In past years I have seen patients seeking specific medications or claiming allergy or intolerances to steer prescriber toward certain narcotics.
- Multiple ED visits, excuses to get early refills (ie leaving on trips, out of town/village) Stolen prescriptions, patients talk to much at the counter and always have a story.
Multiple providers and pharmacies
patients from different pharmacy come over, or call us if we have certain CII in stock.
People claiming pills are lost, stolen, dropped in the sink, etc. thus requesting early refills. Patients going to multiple pharmacies for opioids and benzodiazepines-paying cash at some and using their insurance at others.
sometimes we will have a phone call from someone who wants to know cash price of an opioid. We have seen some who use more than directed.
Use of a discount/coupon cards for opioid prescriptions or cash pay to avoid the insurance informing us of fills at other pharmacies; short term opioid scripts from multiple doctors/dentists

Open Response Survey Question: Is there anything else you like to add about the non-medical use of prescription opioids in the Fairbanks North Star Borough?

A lot of the opioid overuse falls to providers who overprescribe opioids or prescribe opioids inappropriately (i.e. Migraines, nerve pain, "chronic pain syndrome," etc). Providers need to be more discerning when writing opioid prescriptions and they also need to be more willing to try non-opioid medications - opioids are not first line medications for non-cancer pain nor are they the answer for every medical condition.

As a hospital pharmacist I do not directly see this problem outside of endocarditis patients and just as part of their medical history

I certainly would like to see less diversion

Suboxone is absolutely being abused, diverted, sold, traded, etc. in Fairbanks. It is readily available without a prescriptions to basically anyone who wants it. Also, there are a ton of patients in Fairbanks who are combining prescribed opioids with prescribed benzodiazepines despite this being a dangerous combination that is not recommended by the FDA or CDC.

Use of insulin and other syringes, does everyone know that syringes require prescriptions except insulin syringes, does everyone check to see if they have a "Sharps container" and where in town is it to be disposed of. I know, do you? Use of codeine and Hydrocodone cough syrups and pain medications as an alternative source.

We have seen medication stolen or missing within family situations.
## Physician Survey

### Survey Response

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Female</th>
<th>Male</th>
<th>No Response</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentistry</td>
<td></td>
<td>1</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>2</td>
<td>5</td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>Family Medicine</td>
<td>9</td>
<td>12</td>
<td></td>
<td>21</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>3</td>
<td>2</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Neurology</td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Orthopedics</td>
<td></td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>4</td>
<td></td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Surgery</td>
<td></td>
<td>2</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>No Response</td>
<td></td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>18</td>
<td>24</td>
<td>7</td>
<td>49</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Less than 10 years</th>
<th>10 to 20 Years</th>
<th>More than 20 Years</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentistry</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>2</td>
<td>5</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Family Medicine</td>
<td>4</td>
<td>8</td>
<td>9</td>
<td>21</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Neurology</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Orthopedics</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Surgery</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>No Response</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>12</td>
<td>22</td>
<td>15</td>
<td>49</td>
</tr>
</tbody>
</table>

**Survey Question:** Does your practice have formal policies and procedures in place for the prescribing of prescription opioids?

<table>
<thead>
<tr>
<th></th>
<th>Count</th>
<th>Percent Response (n=40)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>7</td>
<td>17.5%</td>
</tr>
<tr>
<td>Yes</td>
<td>32</td>
<td>80.0%</td>
</tr>
<tr>
<td>Unsure</td>
<td>1</td>
<td>2.5%</td>
</tr>
</tbody>
</table>
Survey Question: When you write a new opioid prescription for a patient, how often do you request a Patient Report from the AKPDMP to check for possible drug interactions, high opioid dosage, or obtaining opioids from multiple providers?

<table>
<thead>
<tr>
<th>Count</th>
<th>Percent Response (n=40)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>9</td>
</tr>
<tr>
<td>Sometimes</td>
<td>11</td>
</tr>
<tr>
<td>Most of the time</td>
<td>7</td>
</tr>
<tr>
<td>Always</td>
<td>6</td>
</tr>
<tr>
<td>Only if I have a specific concern</td>
<td>7</td>
</tr>
</tbody>
</table>

Survey Question: When you write a refill opioid prescription for a patient, how often do you request a Patient Report from the AKPDMP prior to writing the prescription?

<table>
<thead>
<tr>
<th>Count</th>
<th>Percent Response (n=33)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>5</td>
</tr>
<tr>
<td>Sometimes</td>
<td>11</td>
</tr>
<tr>
<td>Most of the time</td>
<td>6</td>
</tr>
<tr>
<td>Always</td>
<td>7</td>
</tr>
<tr>
<td>Only if I have a specific concern</td>
<td>4</td>
</tr>
</tbody>
</table>

Survey Question: Do you utilize AKPDMP Prescriber/Dispenser Reports to monitor your own controlled substance prescribing?

<table>
<thead>
<tr>
<th>Count</th>
<th>Percent Response (n=40)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>27</td>
</tr>
<tr>
<td>Yes</td>
<td>10</td>
</tr>
<tr>
<td>Unsure</td>
<td>3</td>
</tr>
</tbody>
</table>
Survey Question: When you prescribe opioids for long-term pain management, how often do you do each of the following (given to physicians only, one dentist replied):

<table>
<thead>
<tr>
<th>Activity</th>
<th>n</th>
<th>Never</th>
<th>Sometimes</th>
<th>Most of the time</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Set realistic goals with the patient for pain and function based on diagnosis.</td>
<td>32</td>
<td>6.3%</td>
<td>3.1%</td>
<td>31.3%</td>
<td>59.4%</td>
</tr>
<tr>
<td>Check that non-opioid therapies have been tried and optimized (i.e. non-opioid medications, physical therapy, weight loss, behavioral treatment, intra-articular corticosteroids, etc.).</td>
<td>26</td>
<td>0.0%</td>
<td>3.8%</td>
<td>26.9%</td>
<td>69.2%</td>
</tr>
<tr>
<td>Discuss benefits, risk factors, and side effects with the patient.</td>
<td>32</td>
<td>3.1%</td>
<td>0.0%</td>
<td>37.5%</td>
<td>59.4%</td>
</tr>
<tr>
<td>Conduct a urine drug screen to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.</td>
<td>31</td>
<td>32.3%</td>
<td>29.0%</td>
<td>19.4%</td>
<td>19.4%</td>
</tr>
<tr>
<td>Set criteria for stopping or continuing the opioids.</td>
<td>31</td>
<td>9.7%</td>
<td>25.8%</td>
<td>16.1%</td>
<td>48.4%</td>
</tr>
<tr>
<td>Assess baseline pain and function (i.e. PEG scale).</td>
<td>26</td>
<td>34.6%</td>
<td>15.4%</td>
<td>23.1%</td>
<td>26.9%</td>
</tr>
<tr>
<td>Schedule an initial re-assessment in 1-4 weeks.</td>
<td>26</td>
<td>19.2%</td>
<td>7.7%</td>
<td>26.9%</td>
<td>46.2%</td>
</tr>
<tr>
<td>Initially prescribe short-acting opioids using a low dosage until the scheduled re-assessment.</td>
<td>26</td>
<td>3.8%</td>
<td>3.8%</td>
<td>30.8%</td>
<td>61.5%</td>
</tr>
<tr>
<td>Use a written agreement with the patient that outlines such things as patient responsibilities, number and frequency of refills, urine or serum medication levels screening, and reasons for which the drug therapy may be discontinued.</td>
<td>31</td>
<td>38.7%</td>
<td>6.5%</td>
<td>12.9%</td>
<td>41.9%</td>
</tr>
</tbody>
</table>
Survey Question (given to dentists only): When you prescribe opioids for pain management, how often do you do each of the following:

<table>
<thead>
<tr>
<th>Action</th>
<th>Count</th>
<th>Never</th>
<th>Sometimes</th>
<th>Most of the time</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Set realistic goals with the patient for pain and function based on diagnosis.</td>
<td>5</td>
<td>40.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>60.0%</td>
</tr>
<tr>
<td>Discuss benefits, risk factors, and side effects with the patient.</td>
<td>5</td>
<td>20.0%</td>
<td>0.0%</td>
<td>20.0%</td>
<td>60.0%</td>
</tr>
<tr>
<td>Conduct a urine drug screen to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.</td>
<td>5</td>
<td>100.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Set criteria for stopping or continuing the opioids.</td>
<td>5</td>
<td>60.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>40.0%</td>
</tr>
<tr>
<td>Use a written agreement with the patient that outlines such things as patient responsibilities, number and frequency of refills, urine or serum medication levels screening, and reasons for which the drug therapy may be discontinued.</td>
<td>5</td>
<td>100.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

Survey Question: When a patient of yours is on long-term prescription opioid medications, how frequently do you require them to schedule a follow-up visit?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Count</th>
<th>Percent Response (n=28)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Once per Month</td>
<td>9</td>
<td>32.1%</td>
</tr>
<tr>
<td>Every three months</td>
<td>10</td>
<td>35.7%</td>
</tr>
<tr>
<td>Every six months</td>
<td>1</td>
<td>3.6%</td>
</tr>
<tr>
<td>Annually</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
<td>28.6%</td>
</tr>
</tbody>
</table>

Open Response Survey Question: Please describe drug-shopping behaviors you see in your practice, if any.
(All responses listed in alphabetical order)

- "losing" scripts; dental complaints; complaints of resistance to multiple meds except oxy, methadone, etc
- At the conclusion of a visit a patient might ask for a refill knowing that I am ready to move on to the next patient. I might sense that the patient does this on purpose, hoping that I will take the quick/easy way out and simply renew their prescription
- claims of lost medications multiple allergies listed
- early refills The other doctors just don't understand me. You are the best doctor I know you will always treat me well.
- Hypnotics abuse is common-- as common as opioid abuse. Frequent Dr. Shopping in Fairbnaks.
• I am pretty conservative about beginning new long term use of opioids. I have noticed some patient will come to the clinic to "feel" out my prescribing practices. Then when I tell them everything I will require them to do to work towards non-narcotic means of treatment and requirements of my pain contract, most do not come back to the clinic.
• making requests from more than one doc (even if unsuccessful) Going to the ER frequently with pain of different types or reporting inadequate control to ER
• multiple providers
• Multiple providers Not revealing recent prescriptions
• Multiple providers from different specialities
• n/a
• New patient, just moved or visiting. Lost RX, acute injury but patient is adamant that nothing will work but hydrocodone or dilaudid, for example. Patient admits to using their "friends " narcotics and requests more, and angry when I try to discuss alternatives. Patient is seeing another Dr or waiting for a procedure and is requesting rx of specific narcotic to "get them through". Red flags: agitation when I suggest other options for pain management, admission of sharing narcotics or buying on the street, admission of hx of ETOH, any drugs, or other substances abuse, pain clinics, or long-term narcotic use in past, depression/anxiety anxiety current problem.
• New patients requesting drugs. Prior physicians supplying drugs no longer available.
• occasionally a parent will ask a pediatric provider who is seeing the child to fill and Rx for the parent
• Our practice (UAF clinic) sees very few patients for narcotic prescriptions
• Patients who state the only medication that works is...; patients who state their meds have been taken; patients who jump from one provider to another with multiple nonspecific injuries
• Phone calls from patients seeking to establish with a new provider for controlled drug management. This practice is not accepting any new patients on chronic narcotics - exception family member of existing patient might be considered.
• Post surgical follow up for extended periods of time
• pt's frequently lose or gets rx's stolen
• Pts trying to manipulate system and providers
• RArelly seen in this peds practice
• We see many patients who doctor shop in the emergency department. This is apparent when the PDMP is referenced on many patients.

Open Response Survey Question: When prescribing long-term opioid therapy, what risk factors do you assess patients for?
(All responses listed in alphabetical order)

• An SBRT is done with all patients
• Combination of benzodiazepines with opioids/opiates. Diversion.
• comorbidities, OSA, Obesity, ETOH, BZD’s
• Compliance with Rxs as prescribed, divergence of prescribed medications, possibility of inadvertent OD especially if concomitant benzodiazepines used, AKPDMP review to ensure no violation of pain contract or consistent with patient reported encounters with other providers prescribing controlled drugs.
• Depression, past substance/alcohol abuse, FH of substance abuse, past history of physical/sexual abuse.
drug and alcohol use, previous pain med use, psychiatric evaluation
Hx of substance abuse  Hx of opioid use
I do not have any long term opioid users
I do not prescribe long term opioids
I don't prescribe long term opiates
I don't prescribe long term tx
n/a
n/a - no long-term opioid treatment is provided. Patients are referred to pain clinics if necessary
No new ongoing patients are accepted
ORF for initial visits  COMM for follow up visits
Other at risk drugs, ETOH abuse, prior suicide attempts, social/personal situation
Pain, realistic expectations, honesty, compliance, and I verify determine other physicians involved in their care who might be prescribing
parental use
Prior substance abuse, family history of substance abuse, mood disorders, degree of alcohol use, use of other medications (i.e. hypnotics, muscle relaxents..). Also screen for cardiopulmonary disorders which could be made worse with opiates.
response, drug seeking, asking for other or more meds
Safety and history of abuse and alcohol history. Screening for symptoms of sleep apnea
See above. I rarely do this unless patient is palliative.

Open Response Survey Question: When following-up with a patient who is taking prescription opioids, what side effects do you ask the patient if they are experiencing? (All responses listed in alphabetical order)

- Breakthrough pain, i.e. efficacy. Nausea/vomiting/constipation/mental status changes and open question on any problems to report.
- Change in mood; daytime sleepiness; ineffective pain control; constipation; difficulty voiding.
- constipation energy/somnolence overall functionality
- constipation nausea, vomiting
- Constipation, apnea at night, altered mental status.
- Constipation, drowsiness, confusion, difficulty sleeping
- constipation, drowsy, tolerance
- constipation, sedation, if they are driving while on meds,
- Constipations, rebound pain, need for larger quantities to have the same result.
- Dizziness, blurred vision, nausea
- Drowsiness, constipation
- Fatigue, confusion, weakness... I focus on function and realistic goals. If patient reports abundance of sleep or decrease in function I seriously scale back. I also check for depression.
- I don’t follow up
- itching, difficulty concentrating, moody, nervous/anxiety when they stop. Irritability. depression. tiredness.
- N/A
- n/a since we only prescribe for very short-term periods
- na
n/a
nausea, increasing pain, constipation, neuropathy
Sedation, constipation

Open Response Survey Question: When following-up with a patient who is on opioid medications what early warning signs for overdose risk do you look for?
(All responses listed in alphabetical order)

- Admission of ETOH or sedatives despite my telling them not to. Depression or anxiety worsening, life stressors
- Alcohol or poly substance use, sleepy, shallow respiration, clammy, depressed pulse
- Altered mental status, early request for refills, claims of lost or stolen medication. Higher risk if also on benzodiazepines. Overall gestalt of patient behaviors both at clinic visits and staff encounters between visits.
- any increase in use
- behaviors to stock pile opiates, excuses for lost medications, request for opiates that can be melted and injected (opiates that don't contain other compounds such as tylemol, ibuprofen, etc)
- confusion
- Daytime sleepiness; change in menatation.
- Escalating requests Combination with benzos or sleep aids
- Falling asleep in day, seeing other providers, taking other meds, ETOH abuse
- falls in last month, early refills.
- frequent visits for pain related complaints, inconsistent history, lying regarding what pain medications have been prescribed in the past, patient being on a pain contract and asking for additional medications or running out of chronic pain medications too soon, history of or current drug/alcohol abuse,
- multiple medications cognitive impairment
- multiple refill requests, complaints/symptoms inconsistent with exam
- n/a
- n/a
- NA
- Patient running out of medication prior to planned time frame. Patient reporting that the medication did not work and they need a stronger one. Lost Rx's.
- requests for more even though functionality is unchanged. increased somnolence increased resp issues in pt’s with underlying resp dz
- Sleepy, dizzy, slow breathing.
- Usage pattern issues with focusing. Also if there was a dose increased how pt is doing

Open Response Survey Question: Is there anything else you like to add about the non-medical use of prescription opioids in the Fairbanks North Star Borough?
(All responses listed in alphabetical order)

- 10 dollarsper mg on street
- Foundation Health, local and hopefully caring entity taking over management of FMH/TVC/DC from BannerHealth, could benefit our community tremendously by establishing a true multidisciplinary pain medical management clinic. One not offering procedures 1st but true management. Accessible to those without adequate insurance. I do the best I can for the 25 or so patients I prescribe chronic narcotics
to, but acknowledge I am not a pain specialist. Have considered many times no longer doing this, but these patients simply have no place to go in our town.

- I rarely prescribe opioids
- I wish pharmacy plans were more involve in notifying us about interaction with opioids and sleep aides as they are about statins or proton pump inhibitors. I think some pharmacy monitoring system focus on cost vs long term safety
- Impediments to better managing opioid mis-use in this community (I avoid the term "non-medical", since I think most people in this community mis-using opioids are actually trying to treat conditions that just will not be managed with opioids): -near total lack of psychiatry services, and a general lack of counseling services, for Medicaid patients--huge impediment for getting needed care. -limited to no pain management specialists with whom to consult or co-manage patients. -ongoing lack of primary care appointments for new and existing patients--currently this shortage is at severe levels, with virtually no clinic in Fairbanks accepting new patients at this time for primary care, and no clinic (other than Interior Community Clinic) accepting new patients with chronic pain or significant psychiatric illnesses. Most people engaged in non-medical use of opioids/opiates locally either have a mental health condition inadequately managed (depression, anxiety, ADHD, PTSD), or inadequately managed somatic pain (i.e., chronic pain). In comparison, very few are truly "recreational users".
- It is a problem everywhere.
- it's a problem! but it is everywhere...
- None
- Physicians and providers need to set firm boundaries; yet, pay attention to pain and address it humanistically and compassionately.
- pregnant women and neonatal abstinence syndrome
- Should also include hypnotics in your program.
- This survey is good, but there needs to be a n/a choice for some of the question. I would like to see more reaching out to teenagers about the danger of opiates. Direct contact with schools, staff, students, and parents.
- we need a plan
- We need more (affordable) detox and long-term rehab treatment options
Appendix E: Interviews with People in Recovery

Fairbanks Wellness Coalition
Non-Medical Use of Prescription Opioids (NMUPO) and Heroin Use
Persons in Recovery Interview Guide

Introduction

Thank you for participating in this interview. I am going to ask you about prescription opioids and heroin. By prescription opioids I mean medications that are prescribed most often for pain, such as Vicodin, Oxycodeone, Percocet, Oxycontin, Fentanyl and Morphine.

Everything you say will be kept confidential, and you may stop the interview at any time. If you want to skip any of the questions, please just let me know. Do you have any questions before we get started?

1. How much of a problem do you think opioid and heroin use is in the community?

2. How did you get started using either heroin or prescription opioids?
   a. How old were you?
   b. What did you start with...what did you progress to next...next?

3. Why do you think you started using drugs?

4. Were the drugs easy to access?

5. Did you perceive any dangers from using [heroin or opioids]?

6. Where did you get the drugs when you started using?
   a. Did the source of your drugs change at all over time? If so, how?

7. How did you stop using?
a. How did you learn about the program [i.e. methadone program, needle exchange program, etc.]?
8. Did you ever see or hear any messages about the risks of taking [opioids or heroin]?
   a. [If yes] What did you hear? Can you describe the message?
   b. [If yes] Why didn’t that message keep you from taking drugs?

9. Can you think of anything that would have helped prevent you from using?
Consent to Participate in Interview

This interview is part of a project by the Fairbanks Wellness Coalition to learn about factors in the Fairbanks North Star Borough that may cause or contribute to prescription opioid misuse and heroin use. Results will be used to develop prevention efforts that will improve the wellness of our community.

The interview is expected to take no longer than one hour.

I agree to participate in this interview conducted by the Goldstream Group and understand all of the following:

- I may stop participating at any time. There is no penalty if I choose to withdraw.
- My participation in this interview will in no way affect my current or future relations with the Fairbanks Wellness Coalition, the Goldstream Group, or other related institutions.
- Any information that I provide during the interview will be kept confidential, and my name will not be connected to this interview in any way.
- Any information I provide will be used only for the purposes of this project.
- The interview will be audio recorded.

If I have questions or concerns, I may contact:

Karen Taber, Fairbanks Wellness Coalition Coordinator
(907) 328-2614.

I have read and understood the information contained in this consent form. I freely and voluntarily consent to take part in the project described above.

__________________________________________  __________________________
Name (please print)                        (Date)

__________________________________________
Signature
Appendix E: Interviews with People in Recover Results

Methods
From December 2016 through February 2017, phone interviews were conducted with 10 individuals who self-identified as in recovery from opiate addiction. A 9-question interview tool was used to guide confidential semi-structured interviews ranging from 20 to 60 minutes in duration. Participants were offered a $25 Amazon gift card for participation, and could pick it up at a location that would preserve confidentiality, or have it mailed to a convenient address. One participant declined the certificate.

Analysis
The following section discusses participant responses to each interview question, with representative quotations where appropriate.

1. How much of a problem do you think opioid and heroin use is in the community?
When asked how much of a problem they thought opioid and heroin use is in the Fairbanks community, all participants felt the matter to be a significant problem that has been increasing in severity. Several provided their opinion on what factors contribute to the problem’s severity; one cited doctor behavior around prescribing as the source of the problem (lack of alternative methods for dealing with physical pain, and lack of resources provided to deal with addictiveness of drug), while two cited rising crime rates as the largest indicator. Other participants noted simply that they know it’s a big problem in town because they saw it everywhere; one person noted, “from [living] that lifestyle I kind of know what to look for” (P8). One person notes their line of work has them encountering people in recovery daily and it “probably influences my perception” (P4), while four others cite their engagement with the recovery community (through activities such as 12-step groups) as why they have a clearer perception of the severity of the problem in Fairbanks than the average person who does not have such involvement. One person who has been in recovery for roughly six years noted, “and from what I hear, it’s gotten a hell of a lot worse, especially with…the influx of heroin” (P7); another noted, “I’m a 25-year opiate addict…I’m well familiar with the use that goes on” (P9).

2. How did you get started using either heroin or prescription opioids? (what did you do next, etc.)
Participants cited two main paths by which they became addicted to either heroin or prescription opioids. Three out of 10 participants became addicted to prescription opioids as a result of being prescribed opioid pain medication by a doctor, and six out of 10 cited becoming addicted to prescription opioids because of its availability at parties or gatherings of friends and its misuse being normalized. Seven of these nine participants who first became addicted to prescription opioids then shifted to heroin use; two – both of whom developed addiction due to prescriptions from their doctors – did not shift to using heroin.
One participant was an outlier and was addicted to heroin before misusing prescription opioids.

**Perceptions of Low Risk, Prevalence**

Several participants either described on their own a perception that most people their age were misusing prescription opioids, or were asked if they had this sense when they were first beginning to use. All participants articulated a sense that everyone in their friend group was using, and at least three articulated a sense that the majority of the broader school population on the whole had at least tried prescription opioids recreationally. Five of the six participants who started using because of prescription opioid availability at parties or gatherings noted that, at the beginning of their addition, they justified trying prescription opioids because everyone seemed to be doing it with no serious negative effects. The following quotes are representative:

- I hung out with a pretty rough crowd so, but even then it seemed like [prescription opioid use] wasn't affecting them and their bodies a whole lot, besides like their bodies and the actual affect the drug has, you know? (P5)
- You might think of those sort of like keggers, the end of high school, early college days. That's kind of like the culture of that age. And opioid addiction was the culture. It just seemed so normal... I was watching so many people, I'd been to countless parties, countless gatherings where I was watching people do this, and it became almost like a curiosity for me. And at that time I didn't really know anybody who I would consider heavily addicted. I didn't know anybody that was having horrible consequences about it or I wasn't hearing about it. I wasn't exposed to that yet. And so, to me it seemed like there wasn't a lot of risk involved. It was just sort of the thing to do. (P4)

The following comment, while not about opioids, reflects the sense among participants that substance use was normalized:

- I mean, pretty much the large majority – I'd probably say about 90 percent of the kids that were in my class at school smoked weed. I mean, or at least had tried it... even kids that, you know, were always bookworms growing up .... You know, drinking too. People drank on the weekends and partied and stuff like that, but it just wasn't really that big of a deal at the time, I guess. Mostly it just seemed like everybody did it. (P7)

A few participants contrasted the socially acceptable and prevalent nature of prescription opioids to the socially unacceptable nature of other substances such as heroin and meth:

- [Heroin is] so socially unacceptable to talk about. You have this problem that completely cripples you that you can't really turn to anyone for help, and if you do it's just so shamed. Using heroin especially is one of, to me and my friends, it's one of those things it's like, "Holy cow. Heroin. It doesn't get much worse than that unless
you're smoking crack." It's this very, ahh, lots of judgement thinking about it or whatever. (P3)

- I never touched meth because of – I don't know if you remember these pictures, they used to be all over when I was in high school. It would show people's mug shots pre- and post-meth use. And that worked for me. I was like, "Oh, man. Meth's a horrible drug. I'll never do meth." (P4)

**Drugs Used**

The three participants who started their addiction through opioid prescriptions prescribed to them started with Percocet, Vicodin, and Ultram, and worked up to higher dosages either via prescription or via gaming the pharmacies or buying on the streets. They progressed to use other drugs, and between them these included Dilaudid, morphine, and (where not originally prescribed) Vicodin and Percocet. As noted above, only one of these individuals went on to use heroin, citing the rising cost of illegally-procured prescription opioids.

For those participants who began with opioids procured through friends, addiction typically began with use of OxyContin 80. In all cases, this was the drug of choice until it became too expensive or too difficult to procure, at which point participants shifted to heroin use.

In most of these cases, these participants were already drinking and/or smoking pot, and had sometimes tried a Vicodin or Percocet once or twice before developing an addiction in earnest sometimes two years after the first time trying. The following quote is representative:

- It was very rarely before the OxyContin. It was maybe every couple weeks I would say. It wasn't really an issue. It didn't even cross my mind I didn't see it as an addictive drug at that time. I didn't really like doing it I was just doing it 'cause friends were doing it and I was like oh, I'll try it. Yeah, it really started once OxyContin got introduced. (P8)

**Age of Onset of Active Addiction**

For those who started by abusing their own prescriptions, the average age was 22 or 23. For those who started through access to opioids through friends, participants report starting slightly younger, at the end of high school or right after graduating, ages 17-19. One outlier participant started using cocaine in her early 20’s, shifting then to heroin, and to prescription opioids only after sustaining a back injury.

**3. Why do you think you started using drugs?**

Those participants who began abusing drugs after being prescribed opioids cited lack of knowledge of the degree of addictiveness of the pills. The following quote is representative:

- I got started after I had a surgery. I was unable to stop taking the pills, and so it turned into an addiction. (P2)
- I mean I knew you could get addicted, but I guess I kind of just thought that – I don't know. I kind of just didn't even really think about that or think that it would happen to me, I guess. And it's really weird. It's a slippery slope and it happens really fast and it happens like before you even know. I mean I don't know how to explain it except that like one day I'm taking them and I'm feeling better and I can
function, and then the next it's like it's out of control and you don't even know how you got this way. It's crazy. (P1)

Those who started using due to availability from friends most commonly cited using drugs as a way to avoid negative emotions, curiosity about and enjoyment of being high, and a byproduct of hanging out with the wrong crowd in high school. In addition, the outlier participant who began their opioid addiction with heroin rather than prescription opioids also noted past trauma and drug-using friends as part of what led to addiction.

Avoidance of Negative Emotions
Five participants referenced drug use as helping them mask unwanted feelings, whether they were larger traumas or smaller-scale insecurities. The following quotes are representative:

- I went through a lot of very hard to handle emotional things right at the end of high school and wasn't prepared enough, wasn't given the tools to express myself appropriately or how to handle hardship or I didn't know what to do. So, I did what I – I just tried to snuff out any feeling. You know what I mean? It's like I don't know how to process these emotions, so I'm just going to try and pretend I don't have them kind of thing. (P3)
- I always struggled with my weight. I think I was insecure, and it made me feel like the funniest, smartest woman in the room. So, I think that that fed into it, but I didn't have this big ...I didn't have depression, anxiety, trauma, nothing. I was an honor student, and I ended up a heroin addict. (P4)
- I was really sad growing up...drugs kind of filled a hole, if that makes sense. (P6)

Enjoy and Intrigued by the High
Four cited either liking the way it felt to be high, or were intrigued by the risk. The following comments are representative:

- I liked the way that I felt...I mean I knew heroin was incredibly addictive, and it was cut with horrible things and you never know what the quality of it, and that smoking things is dangerous to your lungs. At that point, at the point of starting heroin I just didn't care, I just wanted to get high. I just wanted to chase that feeling and relive that euphoria that I felt when I first smoked an 80. (P5)
- It was like an adrenalin rush. A lot of people that I used with were the same people that I would go riding in the mountains or snowboarding with. You know, do all these crazy things with because we like adrenalin and so the risk was kind of an adrenalin rush at the same time. (P8)
- I tried it once and just kind of fell in love with it, for lack of better words. (P6)
- liked the lifestyle s/he saw neighbors’ siblings had, seemed lavish/fun (P7)

Several people cited outright that the crowd they spent time with was part of the problem, providing proximity to drugs:

- I got in with the wrong crowd (P9)
- it was the people I knew. (P10)
4. Were the drugs easy to access?

All participants articulated having a relatively easy time procuring opioids. Notably, when OxyContin design shifted to make that drug much more difficult to use in the manner may addicts were using it, the price of the drug roughly tripled (one user cited the price went from $80 for a pill to over $300), and the local supply dried up, those participants who were using oxy during this time cited that heroin became more easily accessed, and was cheaper, so they proceeded to switch to using heroin. In addition, several participants noted they became involved in dealing oxy or heroin to help fund their own addictions.

Ease of Access

All participants cited having a fairly easy time locating either opioids or, when that became less prevalent, heroin. Two participants even note their places of employment provided opportunity to connect with other users. The following quotes are representative:

- A lot of times you can just spot somebody else who is also an opioid user and just kind of talk to them about it or – you know what I mean? And just like make a connection. At least that's how I did it...And I worked in a restaurant, so a lot of people that I knew from there, I would just ask them. And then, you know, the more you use the more you, more people you meet that also use and sell, and then it just kind of becomes easy. (P1)
- It seems like there was a lot of that (OxyContin) around this town. (P2)
- I could find oxycontin easier than I could find a bag of pot... it was everywhere. It was just everywhere. It wasn't hard. (P4)
- they were incredibly easy to access... [Oxycontins] flooded the streets. (P5)
- I think the last couple years [oxy’s] dropped off and there's, like – there's nothing but heroin around. (P10)

Dealing

Six out of 10 participants dealt drugs at some point to help fund their own drug habit. Only one out of three of those who started due to personal opioid prescription misuse ended up dealing, while four out of six of those who started due to friends/proximity ended up dealing, the quotations below are representative of those participants who spoke about dealing drugs to support their own habit:

- Where there’s a will, there’s a way. There's all sorts of different ways you can do extraction to get stuff, and like I said, we were kind of into chemistry. So, one thing we did do was we started actually ordering off line, and I think they've gotten a bit stricter now. But we turned to the Internet, and we were ordering things, and places will send it here... (P3)
- more and more people started doing OxyContin that I knew, and then I ended up getting a hold of a friend down south that was able to get 'em for, you know, like I said, a quarter of the price of what they were going for up here, and that's kinda where I started doing that. He started shooting shipments up to me and I started selling 'em. (P7)
I was pretty deep into the drug culture and so I knew a lot of people and people know people and so it was easy to find that way. When I first started using OxyContin, I didn't even think that there was heroin in Fairbanks. (P8)

5. Did you perceive any dangers from using [heroin or opioids]?

Those participants who were prescribed opioids stated that they did not perceive any real dangers from using medication they were prescribed. As one of these participants puts it:

- They (doctors) kinda just say, you know, "Well, I'm gonna give you some pain medicine. That should help you be able to do the things that you need to do." That's kind of how they push it off to you, ... just that basically you'll be able to do what you need to do. And so, because it's coming from a doctor I think you kind of just feel safe doing it. You know?

After previously doing other drugs casually and also using ADD medication in the past, a third participant who had opioids prescribed didn't really think anything of experimenting with yet another substance, especially since it was prescribed by a doctor:

- I didn't really know at the time how addictive prescription pain killers were. (P7)

Those participants who were not prescribed opioids varied in their responses. About half of these participants noted that, while they may have been aware of the addictive nature of opioids, they did not necessarily take them to heart due to the urge to mask emotional trauma, a sense of “it won't happen to me,” or the lack of immediate evidence in the experiences of those around them that the drug was dangerous. The following are representative:

- I always feel like I'm smarter than, I'm one step ahead... Like, "Oh, I know. I know. I just won't do it." Like, "I just won't do it that way. I just won't shoot up or I won't do the same thing this many days." (P3)
- I wouldn't say that I was stupid growing up, so I kinda knew that there was a risk involved. I understand the concept of take medication as prescribed and medication serves a purpose, but I seen a lot of people around me doing it, and I wasn't seeing any effects at the time, and so I figured I might as well give it a shot, you know?... I didn't care... I just didn't wanna feel. (P5)
- I guess a few months after I started using OxyContin...I knew it wasn't something I wanted to do my whole life because I wouldn't live very long. But it didn't really deter me... No, I wouldn't say I thought of any dangers at all when I was using. (P8)
- I was emotionally battered very, very bad and [opioid abuse] was an answer to that. I think that's one of the greatest problems is people don't think it all the way through... It's an immediate gratification and that is one of the greatest issues. (P9)
- I remember pukin' my brains out the first time I took it for about all day and thinking I'm never gonna do this again and then as soon as that went away, it was, like, okay, let's do that again. [I wanted to do it again] Honestly I think it was just because of the high. I like that kinda high, I guess. (P10)
6. Where did you get the drugs when you started using?
In general, those who started with prescriptions from doctors shifted to buying them off the street or in one case, gaming different pharmacies. The other participants bought them from friends or off the street, stole them from medicine cabinets, and became dealers. Participants noted often purchasing from out of state or moving there wholesale, in one case utilizing the internet, and in one case using home chemistry methods as part of dealing.

7. How did you stop using?
Catalyst for Seeking Recovery
Participants most commonly cited arrest and/or incarceration, feeling out of control, and intervention by family or a friend as catalysts for deciding to become sober/enter into recovery. The following quotes are representative:

- So basically once I got to a point where I owed somebody a lot of money, and I was out of pills and out of money and just, I was just sinking, and so a friend of mine told me, “Hey, you should really get into the methadone clinic. You won't have to worry about this every day.” ‘Cause I was literally, my day would consist literally of just making sure that I had enough medicine to get through the day. (P1)
- I never looked at it like I was addicted to them until (the doctor) mentioned it that way. I mean, when I was taking the things when I wasn't in pain anyway that’s when I kind of realized I had an addiction. (P2)
- I just was getting kind of curious about IV use when I got arrested, and that was kind of what set me on a trajectory of recovery (P4)
- I was pretty fortunate. My parents, they kinda saw the problem coming from a distance and started planning for it, and then confronted me. They were able to financially support me through inpatient treatment and outpatient treatment (P5)
- And I had other friends that were in recovery that I knew that I'd used with for a long time and I saw them like happy and thriving and I was like I kind of wanted it...[and] I wanted to make my mom happy. I kind of got tired of her. ...She paid my phone bill throughout this whole time I was using just so she could see if I was alive. I kind of got tired of...feeling guilty about [that]... My mom was a big major role in me doing that. (P8)

Method that Led to Success
Several participants describe a series of attempts at sobriety, and a common theme among participants is that they finally found success when they weren’t treating just the physical but also the psychological underpinnings of their addictive behavior. In addition, five participants noted benefitting from the use of either suboxone or vivitrol. Two representative quotes follow:

- A miracle, I guess. It was a lot of different things at the same time...I went to Turning Point and I got education on the disease of addiction, and that really helped ‘cause then all of a sudden I understood what was really happening in my brain. (P6)
• When I was in jail [the last time, two years ago,] I literally got down on my knees...I've always been a strong believer and have a strong faith...I was in there for a little over six weeks and during that time...I got spiritually connected and into my faith. [with that and]... the Suboxone program I have been successfully clean for two years now. (P9)

8. Did you ever see or hear any messages about the risks of taking [opioids or heroin]?

In general, most but not all participants who addressed this messaging question in relation to prescription opioids had a general knowledge that prescription opioids could be addictive if misused, and had little to no awareness of messaging beyond “may cause drowsiness” on the sides of bottles, and inconsistent warnings from doctors if prescribed.

• I kind of just didn’t even really think about that or think that it would happen to me, I guess...[But] it’s a slippery slope and it happens really fast and it happens like before you even know...One day I’m taking them and I’m feeling better and I can function, and the next it’s like it’s out of control and you don’t even know how you got this way. It’s crazy. (P1)
• I mean, right on the bottle it says “don’t mix with alcohol,” it may cause drowsiness. I think I was pretty aware of that. (P2)
• No. Not really. Not even anything about overdose. [saw the eggs in a frying pan thing, but] When you’re in an emotional trauma state, I-need-a-drink kind of state and you’re just going to take anything to...not feel the pain ... you don’t care. Like, eggs in a frying pan is better than whatever it is you’re feeling. Or it seems that way. (P3)
• I’d seen some [messaging] with meth...I know that meth was always...the untouchable, you don’t do that, you don’t touch that. But with OxyContin, I didn’t even really know that it was an opiate. (P6)

Participants who addressed messaging about the dangers of heroin cited hearing more about meth, and when they had received messaging about IV drug use it missed the mark and did not have a prohibitive affect:

• People didn’t really talk about the risks of heroin at that time. What everyone talked about was the methamphetamine...that was where a lot of the advertisements were...It would show people’s mug shots pre- and post-meth use. And that worked for me. [never did meth.] (P4)
• [regarding a school video viewed at 10 years old, detailing the dangers of drug use] Like how would putting a bottle to my mouth make a needle go into my arm?” (P5)
• Sadly, I didn’t have any information or knowledge to the ramifications that would come from extended use of heroin and before I knew it, I was addicted. (P9)
9. Can you think of anything that would have helped prevent you from using?

Better Awareness by Doctors

When asked what might have served as a preventative measure, those who started addictions due to doctor prescriptions understandably cited wanting increased discretion with prescribing and more counseling when prescribed. In addition, participants recommended having some sort of step-down system to help patients stop taking the medication in a way that avoids withdrawal.

- Maybe just more information from the doctors, and I think maybe a little bit more discretion when it comes to like prescribing them, because a lot of doctors will just give them to you and just not even think twice about it. (P1)
- Maybe teaching [those with family history of addiction] the dangers of it, and maybe the doctors need to be a little...stricter [with] prescribing [opioids]...[and] I think you've got to inform people about the problems. Maybe show them some examples of people, such as myself...[make the doctors] be a little more aware of who they're prescribing to to ensure that something like diversion is not happening. (P2)
- I think about 30 percent of the people in the methadone clinic had become addicted through prescriptions from a doctor and were never informed about the dangers of being addicted afterwards. What are you going to do? So, that's important. I can't believe doctors will hand out – I feel like they shouldn't ever prescribe it without having a detox program in place. I feel like they should – everyone should be weaned off and, I don't know. It still bothers me today that doctors do that. That they'll just cold turkey someone after giving them a prescription for months. Even now I had a bunch of teeth pulled way back when I was in treatment, and I told her I didn't want to go home with a prescription and she gave it to me anyway. I couldn't believe that. I was like – I'm very open and honest with my doctors about what it is 'cause that's part of relapse prevention is, I'm a recovering addict and I don't want to be prescribed any narcotics unless my leg fell off or something. Seriously, don't give them to me. (P3)
- I know a lot of people that have been addicted and really badly because doctors just feed 'em tons of drugs, tons of opiates, and for a lot longer than what they should have or a lot stronger than what they need. They don't do any follow-up, they don't check and see, like, well how's this patient doing. Are they getting dependent on it? (P7)

Mental Health Support

For other participants, the resounding theme was a desire for better mental health and general support for kids before they start using, as well as those seeking treatment or continuing in their recovery journey.

- I think another part of it when it comes to prevention is giving kiddos a place. So, I think that adolescents just want to fit in, and I just wanted to fit in, and I think that's part of it. I'm at this party, and maybe they're drinking beer, but in the back room there was these cooler kids doing Oxy, and I want to be a part of that. I want to
be in the cool group. And so, I think with prevention it's a bit part of helping kiddos find a spot in the world that doesn't involve drugs and alcohol. (P4)

- Maybe have it be more normalized to talk to a counselor when [traumatic] things happen...I really feel like learning how to process things and get it expressed in a healthy way is so important ... 'Cause life will be tough, and you're going to want to not feel the way you feel, and you need to find a way to make yourself feel better. And that's going to happen. Let's not do it with these things. Let's do it with these things instead. (P3)

- I mean, I don't know how to explain it. You know, life hurt and I found something that made it not hurt anymore.... I think probably better access to mental health care [would have helped]... I didn't have any healthy outlet... You know, maybe there's this mental health issue that needs to get addressed and maybe that's why you're using. (P6)

- I think having more access for people that are going through life, you know, more groups, more counseling, more – I just felt like I was all alone. I just felt like there was nobody that I could turn to. We live in a society that tells you just suck it up, grab the bull, and keep pushing forward. And that nobody has life's problems and that's not how it is. Life is a struggle... People feel like they fall short, they feel like they don't live up to. There's not positive affirmation being given to young people to say hey, you know what, okay, so you're screwing up there, but you're doing great here. Push on, push on, you're doing good. (P9)

However, therapy may not have been helpful at the time this person was beginning to become a serious user:

- I could say that therapy might have helped me 'cause I did have some not super big trauma but minor trauma in my childhood. My parents split up when I was five and so therapy might have helped but honestly, I don’t know if I was willing at that time to accept therapy. When I started using, I didn't realize that I had this issue in my life and so not recognizing an issue, I can't do anything about it. I don't' really know what would have helped. (P8)

**Education**

Education was a major theme in what recovering addicts saw as useful for prevention. This includes education about what terrible effects opioids can have on a body, as well as better awareness of cultural norms – i.e., NOT all kids are doing drugs.

- I think that if I would've known how dangerous it was then that could've been – like I said, the thing that really kept me away from methamphetamines were those pictures. And in my head it was like, being a teen it was like vanity. It was like, "Oh, well, I don't want to look like that. I don't want to have scabs all over my face." And so, I think that was impactful to me, that campaign against meth was so impactful that even in my 20s I was not willing to do that. (P4)

- When I was doing OxyContin it was like, "This is prescribed by a doctor. This is a medication." It wasn't – I remember the first time I heard someone call it hillbilly
heroin, and I was confused. Like, why would you call it – use the word heroin to even describe it? It's different. I thought it was a different thing... So, I think the education about it would've been really important for me. (P4)

- [do you think that knowing most kids don't take pills, would that have made a difference?] I think so. Yeah. If it didn't seem like it was such a cultural norm. Yeah. I think it would've (P4)

- I guess just more education. In the school setting I feel like there's a lot of classes in school that are pointless, and I'll never use ever again in my life, and maybe some kind of substance abuse education courses, requirements, might've helped. If someone would've told me 5 of my friends would've died in the first year of my recovery, I don't know if I ever would've started using drugs in the first place. (P5)

For some, however, increased exposure to drugs and their affects might promote increased fascination with drugs and drug culture, as this participant experienced:

- I don't really know, honestly, because the way my thinking was is like when my friend, like I talked about when my friend was like you don't want to do this, it's terrible like just please don't do it...I don't think that would have really helped 'cause it would have just intrigued me earlier, really. (P8)

Recovery Resource Access

Access to resources is lacking – recovery when it’s needed, and also housing:

- There's waiting lists to get into the Suboxone program. There's waiting lists, you have to go through hoops. There's nothing that's immediately readily available for people. And so what happens is they go right back to solving the problem to get rid of that pain. And then, there's no housing. I'm going through some legal stuff right now because of the behaviors of two years ago and my hope and my prayer is to start a foundation for especially women. It's a faith based recovery program for them to come out to where it's housing that it's safe that they are involved in spiritual guidance as well as meetings and recovery. And just getting re-entry into the community that's what we need desperately. (P9)

Other?

Examples of resiliency:

I mean, it was kind of a tough road getting to where I'm at now, but I'm incredibly grateful for the fact that I went through what I did. I mean, I don't think I would have had the determination and the drive to go for an engineering degree if I hadn't gone through all this stuff and gotten clean. (P7)

and my hope and my prayer is to start a foundation for especially women. It's a faith based recovery program for them to come out to where it's housing that it's safe that they are involved in spiritual guidance as well as meetings and recovery. (P9)
Appendix F: Youth Focus Group Protocol and Results

Fairbanks Wellness Coalition
Non-Medical Use of Prescription Opioids (NMUPO)
Youth Focus Group (Ages 12-14) Discussion Guide

Introduction

Thank you for participating in our focus group. There are a couple of rules that we like to follow when we are having a focus group. I wrote these on the white sheet:

- All opinions are important -- we want to hear your ideas and thoughts even if they are negative
- Be respectful of other opinions
- Listen to what others have to say
- Ask each other questions if you don’t understand a response or want more information
- Ask me questions if you don’t understand a question
- Everything said in this room stays confidential

We are going to record the conversation so please only use your first name when you tell me who you are and when you ask someone else a question.

Warm-up Question

What is your favorite video game?

1. Which prescription drugs are you familiar with? [Write out list]

2. Which of these drugs do you think are prescription opioids?
   a. What is a prescription opioid? What is it used for?
   b. What are some common names that doctors would call a prescription opioid?
   c. What are some common names that kids your age might call these drugs?
3. What are some of the reasons a person would get a prescription for _____ [use the name of one of the drugs the kids brought up]?

4. If a person was taking one of these drugs for _____ [use the example provided by the kid] what do you think would be the side effects? What are some reasons that you might not want to take these types of drugs?

5. Have you had a health class at school?
   a. During health class did you ever talk about the risks [or dangers] of taking prescription opioids without a prescription? What did you talk about?
   b. Did you ever talk about taking prescription opioids in a way that wasn’t prescribed? What did you talk about? Or what did your teacher talk about?

6. How common do you think it is for others your age to take prescription opioids without a prescription from their doctor?

7. Where do you think others your age might get prescription opioids if they didn’t have a prescription?

8. Describe what might happen if people your age took prescription opioids without a prescription. [prompts]
   - Would they get in trouble with the law?
   - Would they get in trouble at school?
   - Would they get sick?
   - Would they get addicted?

9. Have you ever heard any messages about why people shouldn’t take prescription opioids without a prescription?
   a. What did the messages say?
   b. [if they saw any messages] What did you like about the messages? What didn’t you like?
   c. Do you think this was an effective message for teens?
10. Have you seen any other types of messages about why people shouldn’t take drugs or drink alcohol?
   a. What did the messages say?
   b. [if they saw any messages] What did you like about the messages? What didn’t you like?
   c. Do you think this was an effective message for teens?
Participant Assent to Participate in Focus Group

This focus group is part of a project by the Fairbanks Wellness Coalition to learn about factors in the Fairbanks North Star Borough community that cause or contribute to prescription opioid misuse and heroin use. Results will be used for prevention efforts that will improve wellness in our community.

The purpose of this focus group is to better understand what teens think about the misuse of prescription opioids. Teens will not be asked about their own use or non-use of prescription opioids.

The focus group is expected to last no longer than 1.5 hour in duration, and it will take place outside of school hours.

I agree to participate in this focus group conducted by the Fairbanks Wellness Coalition and Goldstream Group and understand all of the following:

● I may stop participating at any time. There is no penalty if I choose to withdraw.
● My participation in this focus group will in no way affect my grades in school, or current or future relations with the Fairbanks Wellness Coalition or other related institutions.
● Any information that I provide during the focus group will be kept confidential, and that my name will not be connected to this interview in any way.
● Any information I provide will be used only for the purposes of the research.
● Focus groups will be audio recorded.

If I have questions or concerns, I may contact:

Karen Taber, Coordinator of the Fairbanks Wellness Coalition: (907) 328-2614.

I have read and understood the information contained in this consent form. I freely and voluntarily consent to take part in the research project described above.

__________________________________      ___
Teen’s name (please print)        (Date)

__________________________________
Teen’s signature
Dear Parent or Guardian,

Your child has been selected to participate in one of two teen focus groups with a total of 6 to 8 youth. One group will consist of 12-14 year olds and the other group will consist of 15-17 year olds. The purpose of this focus group is to understand what Fairbanks North Star Borough teens think about the misuse of prescription opioids. We will not ask any questions directly related to personal use or other actions taken in relation to prescription opioids. This focus group is part of a project by the Fairbanks Wellness Coalition to learn about factors in the Fairbanks North Star Borough community that cause or contribute to prescription opioid misuse and heroin use. Results will be used for prevention efforts to improve wellness in our community. The focus group is expected to last no longer than 1.5 hours and it will take place outside of school hours.

Your child can stop participating in the focus group at any time that she or he wishes, and will be told that it is OK to do so. Focus groups will be audio recorded. The focus group transcripts will be confidential. Participants will not be identified by name. Your decision whether or not to participate will not affect your current or future relations with the Fairbanks Wellness Coalition or other related institutions. The Fairbanks Wellness Coalition Coordinator is Karen Taber; please feel free to contact her with any questions or concerns at (907) 328-2614.

My child ___________________________ has my permission to participate in this focus group.

(Parent’s printed name) ___________________________ (Date) __________________

_____________________________
(Parent’s signature)
Appendix F: Youth Focus Group Results

Focus Group Ages 12-14
Two separate focus groups were conducted with participants ages 12-14. The first focus group consisted of two 7th graders and an 8th grader from two different Fairbanks North Star Borough School District middle schools; the second focus group consisted of four 9th-graders from Fairbanks North Star Borough School District High Schools. The analysis below applies to both focus groups where no distinction is outlined.

Confusion About What an Opioid Is
Participants exhibited lack of knowledge about what an opioid is throughout the focus groups. In the first focus group, when participants were asked “Do you think any of those drugs that you named are prescription opioids?”, the first participant response was “what’s an opioid?” Moderator clarifies by stating an opioid is a form of painkiller, and responses included “like Vicodin?” but also “that numbing stuff” you get at the dentist. Vicodin was provided as an answer by a participant who had been prescribed it after a surgery, and another participant later exhibited knowledge of the name and connected that knowledge to their relative’s dental surgery experience.

Dental numbing agents; the raspberry toothpaste used with the spin brush when getting your teeth cleaned; somewhat-controlled OTC substances such as Tylenol 3.

Misperceptions of how many kids use opioids
- For 12-14 year olds, estimates range high – “60%” “I think it’s more than we know” (paraphrased from field notes), etc. – but that could be related to their conflating prescription opioids with other abused prescription and OTC drugs

Knowledge of Effects/Dangers of Opioids
Kids at first seemed to know some of the side effects: “it makes them numb to actual pain and mental pain like emotions.” But it became clear that participants were blurring the distinction between prescription opioids and regular OTC substances that kids sometimes abuse (Tylenol 3, etc.).

Students take health in 7th, 8th, and 9th grade, though classes are mixed grade in 7th and 8th, and a broad range of topics are covered (mental/physical/social health). While participants often struggled to remember the exact details of class content, they exhibited an awareness that legal drugs – or “medicine” as they called it when asked to provide “common names that kids your age might call these (prescription) drugs” – could be dangerous or lethal when taken inappropriately, and attributed this knowledge to their health class in several instances.
However, participants in general did not discern between prescription opioids and OTC “medicines” such as Tylenol 3 that, as participants described, are relatively easy to access in comparison. One participant described that, while in a pharmacy “you usually need like an ID or something” to access sensitive over the counter substances, in regular stores “they’ve got that section with the medicine, and they [other kids] just get it and just buy it, and nobody asks questions.”

When asked to describe the physical consequences of abusing/misusing prescription opioids, participants again conflated prescription opioids with other substances – in this case, marijuana, tobacco, and alcohol use. One participant, perhaps sensing the moderator’s recasting of the question to garner responses specific to opioids, reasoned that “I think the reason we keep channeling off to like tobacco and marijuana and drinking is because that’s really what we’ve learned. [...] We didn’t even know what [opioids] were.”

Desire for Strong. Informative messaging
This age group valued the “gross-out” factor when discussing what type of messaging would be most likely to alter their behavior and prevent them from misusing opioids or other substances. Participants in the first group made reference to a commercial in which someone removes their skin to reveal wrinkled/damaged skin underneath, and removes healthy teeth to reveal missing or yellow/badly stained teeth underneath. The January focus group referenced several times a peer-to-peer experience in which older kids bring pig lungs to an assembly in upper elementary school; kids touch and look at the healthy vs. the unhealthy lung, watch how the two different lungs inflate differently, etc. Gross-out factor as well as peer-to-peer were valued.

Preferences about Mode of Messaging
Social Media, TV
Some participants did not hold Instagram in high regard, while one did (“I love Instagram, personally”). A few had accounts, but the consensus was that, in one participant’s words, “it’s like the most lamest social media thing you can even get these days.” A majority of participants articulated some level of frustration with social media in general, citing ads as the big drawback. Facebook was unequivocally for adults, though Facebook Live has some redeeming values and might be part of a comeback of sorts of Facebook onto the teen radar. Participants resented the technical bugs of Kik (an app they said was used as a method of texting by kids who only had iPods, not phones and thus no phone number), and recognized that Musical.ly is great but “mostly for girls,” noting that “when boys use it, they just ruin it” (this sentiment was articulated by a boy). Participants were frustrated with ads on Pandora.

While participants didn’t discuss at length TV ads as a way in which they prefer to receive messaging, participants did refer to seeing memorable messages about substance abuse
while watching TV. In the January focus group, two 14-year-olds co-constructed a description of a TV ad they could remember. One noted the ad “was just comparing [...] prescribed drugs to illegal drugs such as marijuana and everything and they were saying how – they were comparing how each one is just as dangerous and harmful.” The second male stated “Yeah, on TV, it was showing how teens, like our age, were addicted to drugs and it was showing like a company that can help you get off of it.” When the moderator asked what he liked about the ad, he replied “So I liked how they were like getting kids off of the streets of doing drugs and everything.” Another stated: “it was kind of interesting. So I got to learn how some of the things that doctors give us, […]now that you see the facts, […] it’s kind of a little mind boggling.”

Health Class
The December 12-14 focus group also suggested health class might be a place to spend more time providing kids their age with information on the topic of opioids misuse, specifically if opioid misuse prevention is a serious concern. In one participant’s words, “I'm not blaming the health teacher ‘cause I know she only has like one quarter to teach us all this stuff, but we never really learn about [opioid misuse]. If that really is like something really important, then […] it would be cool if she could work that in as well, rather than just […] cigarettes, tobacco, and drinking.”

Parents, Peers, Personal Messaging
In the January 11 focus group, participants mentioned hearing messages about the dangers of opioid and other drug abuse from their parents. One participant said “I heard my mom talking about it [opioid use] to my dad,” while another stated “My mom was talking about it to me, how people in Anchorage, like, they're like getting in trouble at school and everything about, like, Xanax, drugs and just pills and everything.” Another participant cited his parents will use everyday encounters as teachable moments, and liked the casual way they handled it: “And usually in my family it's very casual, just like you see someone on the street […] and my dad's, like, yeah, and we'll talk about it for a couple of minutes or something like that. Or if it comes up, like, we see a sign or something like that, just it's real casual. It's nothing he has to sit me down and he has to like break me with it […] It just happens every day speaking.”

Parents were also cited as a potential prevention strategy. One participant described his teacher’s young-adult son’s visit to his classroom in 5th grade to share a strategy he and his mom (the teacher) devised. It was “a way that he could like get out of doing drugs or drinking alcohol from his friends. […] he'll like text his mom on the side, tell her, say, do the call. They planned a call saying his mom called and said did you do your chores, he'll be like no and then she'll start yelling, telling him to get home. So they planned a call. […] And so he wouldn’t seem like the bad one.”
Focus Group Ages 15-17

Four 10th graders and two seniors, from two different public high schools (one senior had recently switched from a third school) and one home-schooled (the other senior).

Confusion about What an Opioid Is

As with the younger participants, 15-17-year-olds were confused about what medications counted as opioids. While several seemed to become clear on what was meant by opioid, others still provided examples of Xanax or other abused prescription drugs when asked about prescription opioids.

Misperceptions of how many kids use opioids

- For older kids, estimates are lower – “I don’t think it’s that common” “friends will share ADHD medication – that’s super common...(but) prescription stuff, no.” If they're doing it it’s by themselves, it’s not a bunch of people together. No one says “hey I’m doing this, I’m cool.” (paraphrased from field notes)

Knowledge of Effects/Dangers of Opioids

While younger kids seemed to have a blanket understanding of all drugs are bad, don’t do them, opioid or no, the older participants had more nuanced understanding. One participant, when describing reasons why it might be bad to abuse prescription opioids, stated “not only does it hurt you physically, it like, it's just like I don't get why people would want to do it because it's not like a good high, I guess you would call it.” In other words, if you were going to do drugs, opioids, in this person’s understanding, weren’t worth the trouble and it’s implied that more desirable drug experience could be had with other substances.

Some older kids expressed knowing some individuals who used drugs but, as they described, functioned fine, kept up their grades, and weren’t addicted. One participant noted: “a lot of people are like, "Oh, if you do drugs your GPA is going to go down." But a lot of people's theirs don't and a lot of people focus on the, if you do drugs you're going to have bad grades. But, then people do drugs and then they don't have bad GPAs. So, since they have good GPAs no one thinks that they do drugs.” In addition to being an indicator of out-of-touch messaging, this quote is an example of participant understanding that not all drugs affect all people the same way; some people may be able to do drugs without visible detrimental consequences.

Desire for Strong, Informative Messaging

Older kids especially prefer/crave information about opioids – not just scare tactics. Don’t want a lecture. Want information that they can use to make informed decisions. In particular, they state desire for messaging about short-term effects of drug use, specifically in cases where kids might be using but keeping up their grades and physical appearance
and so think everything is fine. Lots of messaging about drug use in general is about long-term effects; but kids use in the short term and don’t see negative changes, think “oh I’m fine”

However, even though they stated they didn’t want scare tactics or gross-out factor stuff, one participant did describe a gross commercial when asked to describe effective messaging:

- think the one with the lady who has to have her throat cleaned. She has a hole that she has to breathe through and has to have it cleaned. I think that one just disgusted me and probably was the only one that ever affected me at all because I wanted to vomit. ‘Cause it was gross dude. They were sticking a tube down there to scrub out her neck.

One participant has a relative who works with opioid recovery, and thus was aware of the opioid issue. When her health class didn’t cover opioid use, she became curious, and on her own googled health class-comparable facts about opioid use/misuse.

Participants did not think highly of the Truth ads, citing essentially that they try too hard to be meme-like and hip:

- I think the least effective add I've seen for any drug stuff over the truth ads because they're so – they try and connect to the kids, but then they go in such a bad way that it just becomes a big joke and annoying because then it'll pop up on your social media all the time, and they're just like – like they take all these Internet culture things and put it in it for no reason, and at the end it says, "Don't smoke."

When asked point-blank what kind of messaging the Wellness Coalition could provide that this group would find useful, a representative reply was: “I think if you guys said something along the lines of, "This is the drug. These are the names. Here's the short-term effects. Here's the long-term effects. This is how you get help." Then that probably, like, be a lot of information that kids our age need.”

**Nonjudgmental messaging**

Important to provide info and not just yell at kids/use scare tactics, tell them that if they do something once they're addicted for life, since it might have a self-fulfilling prophecy effect. One participant described:

- if you go into a conversation already thinking, that person does this, that person does this, and you tell them, like, "I don't want you to be afraid, but you're going to probably do this. Like, you're at risk for doing this." I don't think that that really helps the person. Because then – like, I know a situation where the parents told the kid multiple times, like, "You're just going to be a runaway. You're no hope. You're no this – you're just going to end up a druggie on the side of the road." And he basically was like, "Well, my parents already have that expectation of me." Blah, blah, blah, blah. "Why am I even trying with school? Why am I even doing this if my parents don't think I can do it, why do I think that I can do it?"
Later in the discussion, this theme comes up again, and another participant describes: “I think a lot of people who do prescription opioids, like what I see a lot is they're depressed. So, they don't really care at the time. And then maybe later they're not depressed and they're like, "Oh well, I've already done it." So, they do it more.”

Preferred Mode of Messaging
While the older kids were also lukewarm about facebook, they were more receptive to it, one participant even stating it was maybe the easiest way to access messaging:

- For me it's simple. I just go on the Internet. I just go on Facebook or something and have it be right there. If there's something on the news about it on Facebook and there's news channels and stuff that will post stuff and just find out about it like that.

Additional social media-related suggestions followed:

- I think the best way if you're wanting to do an ad-like video or something like that is get a good amount of video, like a good – at least a couple-minutes long video that you can share on Facebook, put on YouTube and then ask a bunch of teachers to show in their class. And I think that would probably be the best way to get it to kids. Or have it on Facebook where someone can find it sort of thing.

Both ages suggest health class could be a place to talk about opioids abuse – participants state that they don’t really cover it at all right now.

One suggested method for doing this effectively was the following:

- I think those – like, probably the best health class strategy that I've seen is the teacher closes the door, he doesn't make – he doesn't make – the teacher doesn't make it so people can't see in. You can still see in. He lets everyone just get comfortable. And then he talked to the class, like as a group discussion. I think that's probably the most effective way to talk to kids about – because people are emotional. They're – like I think showing fact-based stuff helps a lot of people, but I also think that having a conversation with people helps a lot as well.