Growing Up Anchorage

2015

Anchorage youth and young adult behavioral health and wellness assessment

Anchorage Collaborative Coalitions

UAA University of Alaska Anchorage

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Executive Summary

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

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

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

Phase I Key Findings:

Existing data on Anchorage youth and young adults

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

Substance Use

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

Mental Health

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

Suicide

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

Intermediate Variables

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

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

Environmental Factors.

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

Interpersonal Factors.

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

Intrapersonal Factors.

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

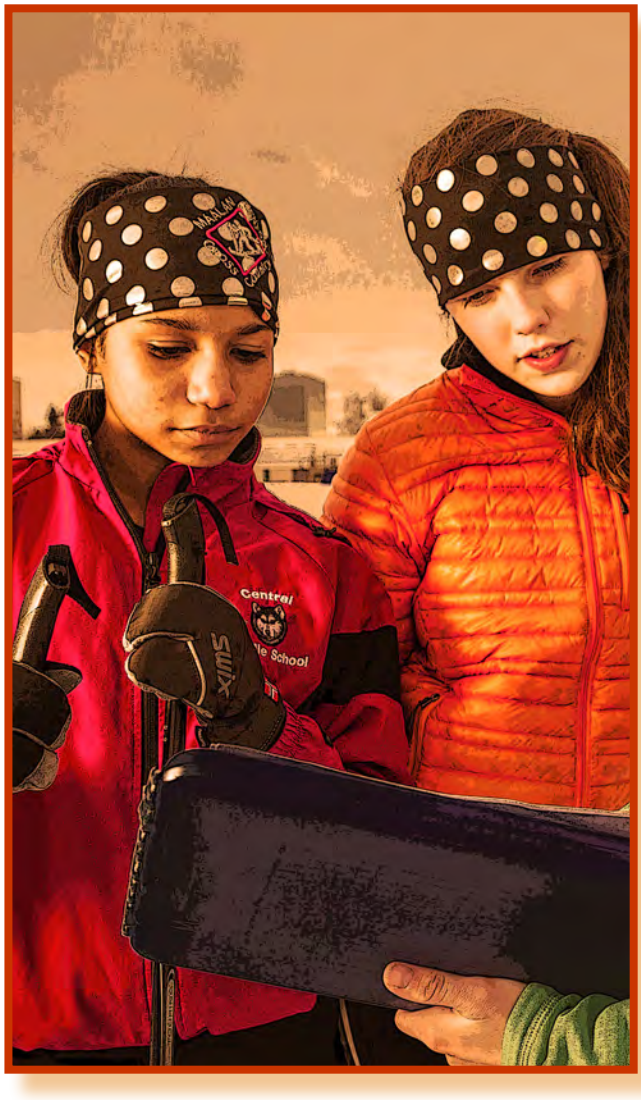
Risk and Protective Factors. Additional analyses were conducted to identify which specific intrapersonal, interpersonal, or environmental factors protected youth from engaging in risk behaviors and conditions. The following table displays some of the strongest protective factors that decreased the likelihood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

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

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

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

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



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

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

Outcome of Phase I

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

Summary of Priority Areas

Bullying

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

Feeling Alone

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

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

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

Adult Perceptions of Anchorage Youth (APAY)

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

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

Young Adult Survey (YAS)

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

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

Focus Groups

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

Bullying.

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

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

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

Mental Health.

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

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

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

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

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

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

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

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

Solutions were focused at the youth level and community level.

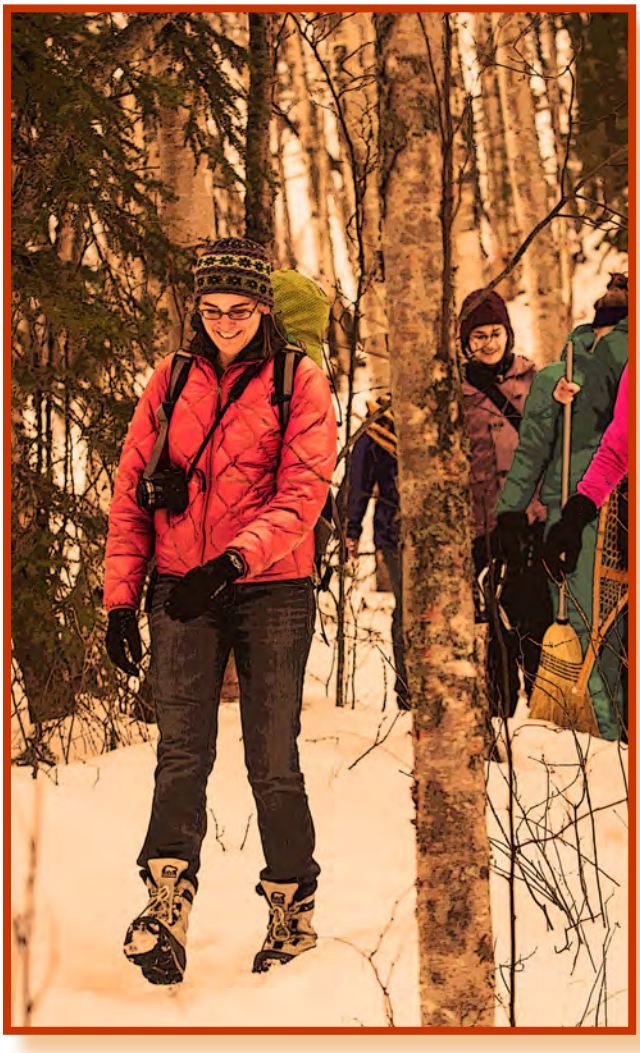
Youth Level Soultions	*Community Level Solutions*
Asking the youth to help with something important so they feel they are making a contribution. Validating the youth's feelings, rather than encouraging their concealment or denying the importance of those feelings. Expressing an interest in the youth's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

Synthesis and Recommendations

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

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

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



Giving Helping Growing

Introduction

Purpose

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

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

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

Background

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

Substance Use

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

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

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

Mental Health

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

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

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

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

Suicide

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

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

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

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

Priority Areas of Focus

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

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

Bullying

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

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

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

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

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

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

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

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

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

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

Feeling Alone

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

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

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

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

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

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

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

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

There is some debate regarding gender disparities

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

Community Profile

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

History of Anchorage

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

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

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

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

Demographics

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

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

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

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

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

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

Anchorage Youth Population by Age

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

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

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

1 State of Alaska Department of Labor, Anchorage Neighborhoods: Great Diversity Within Alaska's Largest City, by Eddie Hunsinger and Eric Sandberg (September, 2013); accessed 4/7/15; http://labor.alaska.gov/research/trends/sep13art1.pdf

2 State of Alaska Department of Labor, Anchorage Neighborhoods: Great Diversity Within Alaska's Largest City, Eddie Hunsinger and Eric Sandberg, 2013; http://labor.alaska.gov/research/trends/sep13art1.pdf

3 State of Alaska Department of Labor, Anchorage Migration: The Movement Between Alaska's Major Native Areas and Anchorage, by J. Gregory Williams, State Demographer, 2010, http://labor.alaska.gov/research/trends/feb10art1.pdf

4 Joint Base Elmendorf-Richardson; accessed 4/7/15; http://www.jber.af.mil/main/welcome.asp

5 Department if Commerce, Community, and Economic Development: Community and Regional Affairs, "Community: Anchorage"; "Income 2009-2013 ACS 5-Year Estimates"; accessed 4/9/15; http://commerce.state.ak.us/cra/DCRAExternal/community/Details/2d5ef9f0-9855-4b68-9350-bc9d20e81807

6 Department if Commerce, Community, and Economic Development: Community and Regional Affairs, "Community: Anchorage"; "Poverty 2009-2013 ACS 5 Year Estimates"; accessed 4/9/15; http://commerce.state.ak.us/cra/DCRAExternal/community/Details/2d5ef9f0-9855-4b68-9350-bc9d20e81807

7 Department if Commerce, Community, and Economic Development: Community and Regional Affairs, "Community: Anchorage"; "Population by Gender"; accessed 4/9/15; http://commerce.state.ak.us/cra/DCRAExternal/community/Details/2d5ef9f0-9855-4b68-9350-bc9d20e81807

8 US Census Bureau, "Anchorage Municipality, Alaska"; last revised March 31, 2015; accessed 4/9/15; http://quickfacts.census.gov/qfd/states/02/02020.html

9 Department if Commerce, Community, and Economic Development: Community and Regional Affairs, "Community: Anchorage", Population by Age; accessed 4/9/15; http://commerce.state.ak.us/cra/DCRAExternal/community/Details/2d5ef9f0-9855-4b68-9350-bc9d20e81807

10 Sheltered Homeless Persons in Anchorage 10/1/2013-9/30/2014, from the Homeless Management Information System; "Exhibit 1.1 Estimated Homeless Counts during a One-Year Period", p. 11; accessed 4/9/15; http://www.alaskahousing-homeless.org/sites/default/files/AHAR 2014 Anchorage.pdf

11 Sheltered Homeless Persons in Anchorage 10/1/2013-9/30/2014, from the Homeless Management Information System; "Exhibit 3.1 Demographic Characteristics of Sheltered Homeless Persons", p. 3; accessed 4/9/15; http://www.alaskahousing-homeless.org/sites/default/files/AHAR 2014 Anchorage.pdf

12 PowerPoint, "RespectAbility: Alaska and Jobs for PWDs" by Jennifer Laszlo Mizrahi, Slide 4; accessed 4/10/15; http://respectabilityusa.com/Resources/By State/Alaska and Jobs for PwDs.pdf

13 Disability Statistics: "Find U.S. disability statistics in 3 easy steps"; Current Population Survey; accessed 4/10/15; http://www.disabilitystatistics.org/reports/cps.cfm?statistic=prevalence

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

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

Anchorage Schools

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

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

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

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

Economy & Cost of Living

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

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

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

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

2012 Top Anchorage Employment Sectors[1]

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

2012 Top Anchorage Occupations[2]

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

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

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

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

Transportation

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

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

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

Health Services

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

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

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

Parks & Green Spaces

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

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

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

Recreational Opportunities

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

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

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

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

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

Religious Organizations

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

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

Government

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

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

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

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

Public Safety, Crime & Legal System

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

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

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

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

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

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

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

Family Dynamics

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Community Engagement

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

Data Decisions

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

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

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

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

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

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

2 See References Cited secion of report.

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

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

Priority Issue: Mental Health

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

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

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

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

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

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

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

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

Achievers)
45. YWCA

ACC Member Trainings

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

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

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

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

Recruitment & Co-Facilitation

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

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

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

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

Data Analysis

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

Caring
Mentoring
Sharing

Assessment Methodology

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

Secondary Data

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

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

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

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

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

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

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

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

Primary Data

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

Adult Perceptions of Anchorage Youth: 2015 Survey

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

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

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

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

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

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

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

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

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

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

Young Adult Survey

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

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

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

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

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

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

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

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

YAS Participant Demographics

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

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

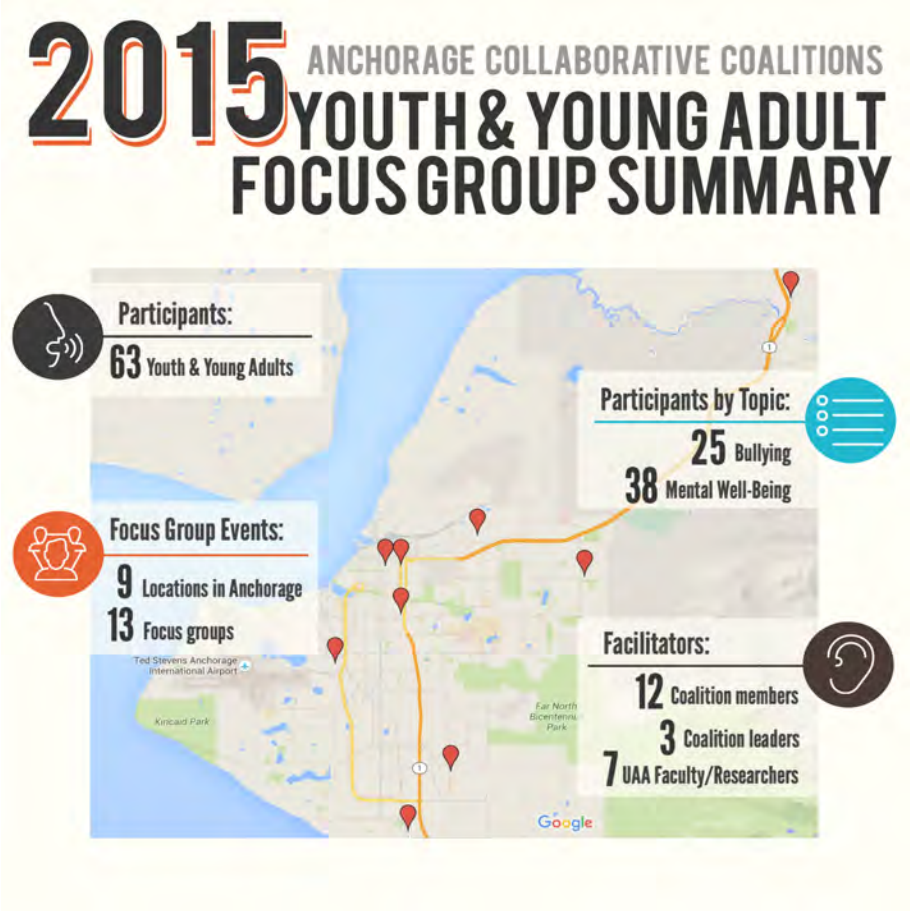
Focus Groups

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

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

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

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



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

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

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

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

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

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

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

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

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

form and signup for the focus group event.

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

Focus Group Events

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

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

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

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

Overall Participant Demographics (*N* = 68)

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

School Age Youth Demographics (*n* - 44)

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

Young Adult Demographics (*n* - 24)

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

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

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

Learning
Belonging
Engaging

Key Findings

Secondary Data

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

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

Substance Use

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

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

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

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

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

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

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

Mental Health

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

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

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

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

Suicide

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

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

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

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

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

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

Intermediate Variables

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

1 NSDUH - Suicide
2 YRBS - Suicide

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

Environmental Level Factors

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

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

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

Also asked on YRBS is whether youth have been

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

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

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

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

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

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

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

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

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

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

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

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

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

Interpersonal Level Factors

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

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

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

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

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

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

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

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

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

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

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

Intrapersonal or Individual Level Factors

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

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

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

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

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

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

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

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

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

Factors that Protect Youth from Risk Behaviors and Conditions

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

Associated Factors with Bullying, Mental Health, and Suicidal Ideation

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

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

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

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

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

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

There were two risk factors considered in the regression model:

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

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

4 YRBS - Regression Protect & Risk Factors

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

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

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

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

Limitations of Secondary Data

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

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

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

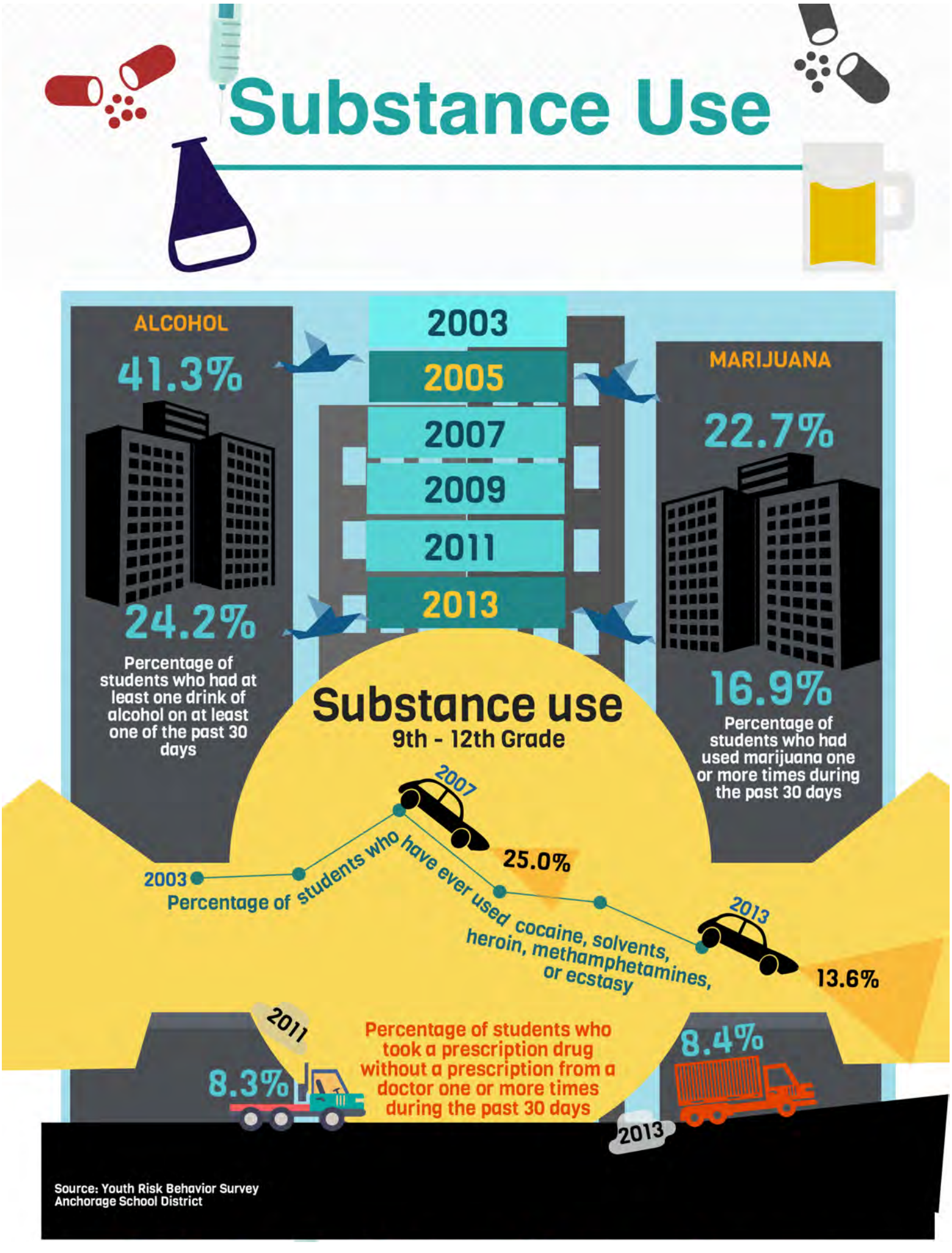
Moreover, trends over time cannot be examined as a result of added or modified questions or changes in operational definitions that impact results or interpretations of them (e.g., changing the reporting of poisoning in suicide attempts; changing the way the reason for school suspensions and expulsions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

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

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

Infographics of Secondary Data Findings

Substance Use



Substance Use and Dependence

Ages 12 to 17 years
2010 to 2012

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

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

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

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

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

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

Percentage of use/ dependence in the past year

0 10 20 30 40

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

Ages 18 to 25 years
2010 to 2012

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

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

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

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

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

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

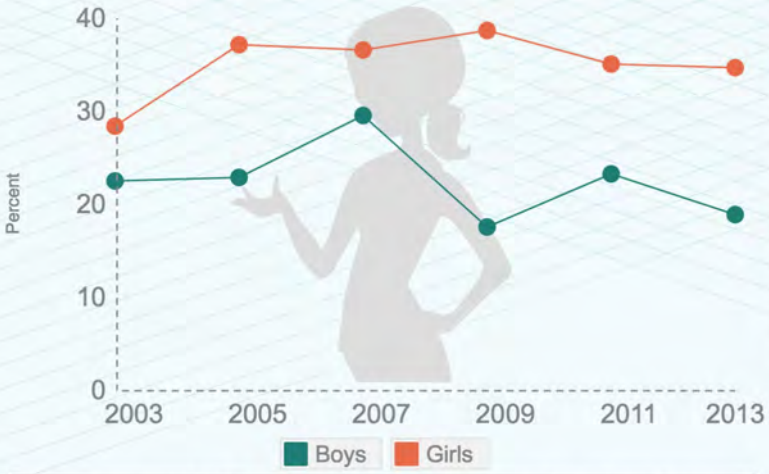
DEPENDENCE
- alcohol dependence (7.26%)
- illicit drug dependence (4.77%)

Percentage of use/ dependence in the past year

0 10 20 30 40

Youth Mental Health

Feelings of sadness, hopelessness, and stress



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

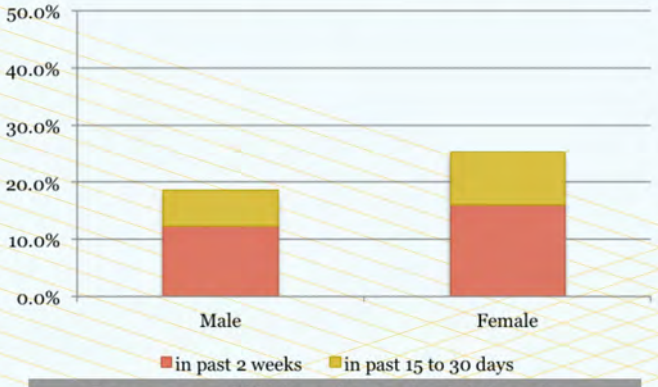
Acronyms

ASD - Anchorage School District
UAA -University of Alaska Anchorage

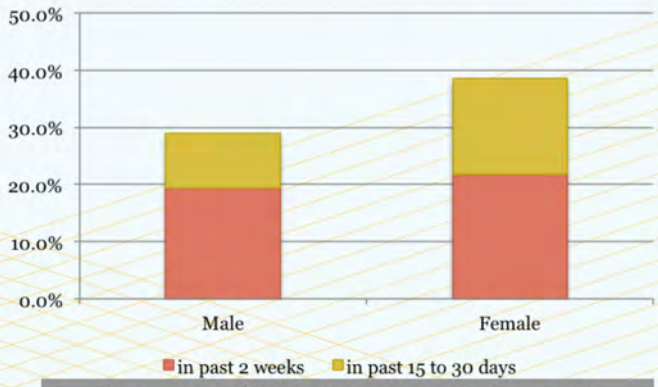
Data Sources

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

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

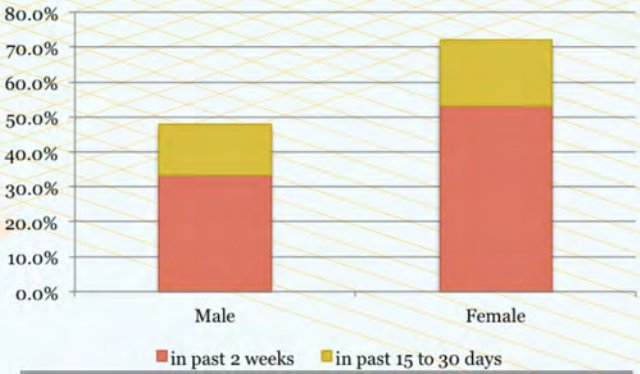


Percentage of UAA students who felt hopeless



Percentage of UAA students who felt very sad

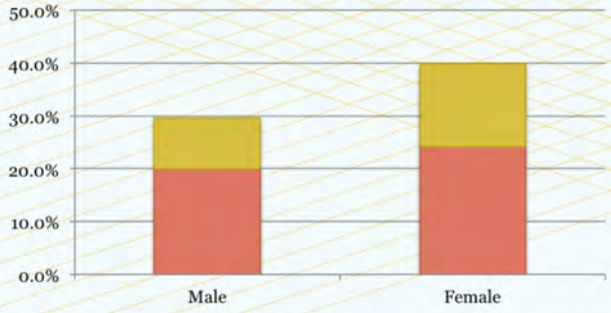
52.1% of female students at UAA reported high stress over the past 12 months.



Percentage of UAA students who felt overwhelmed

Feelings of Loneliness

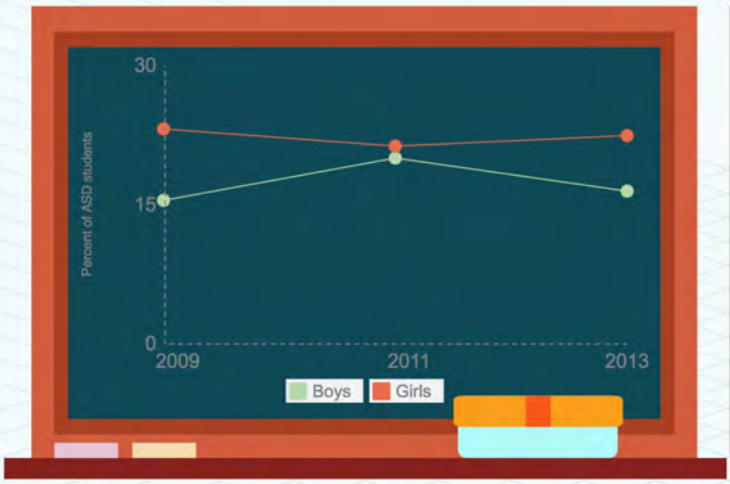
Percentage of ASD students who agree or strongly agree to feeling alone

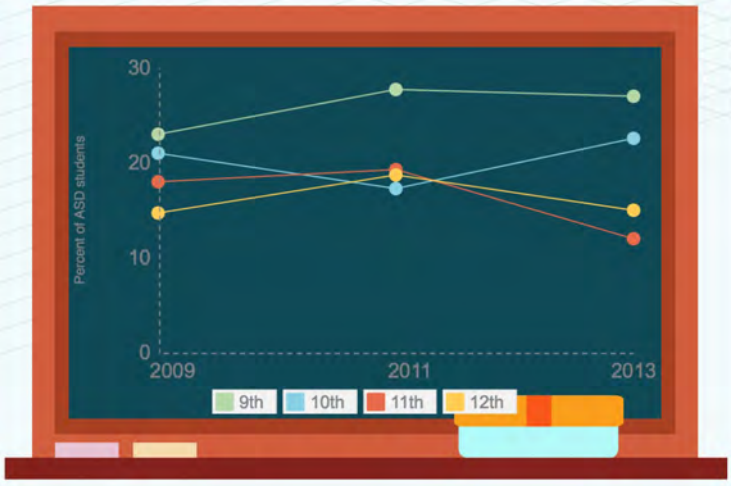


Percentage of UAA students who felt very lonely

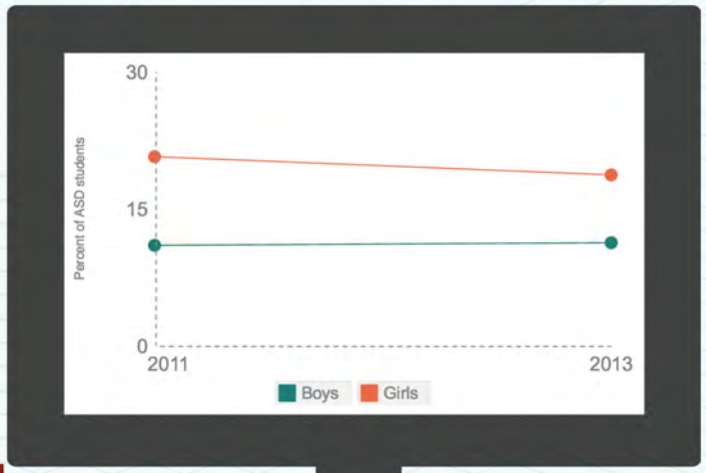
Feelings of being alone have been increasing among ASD students.

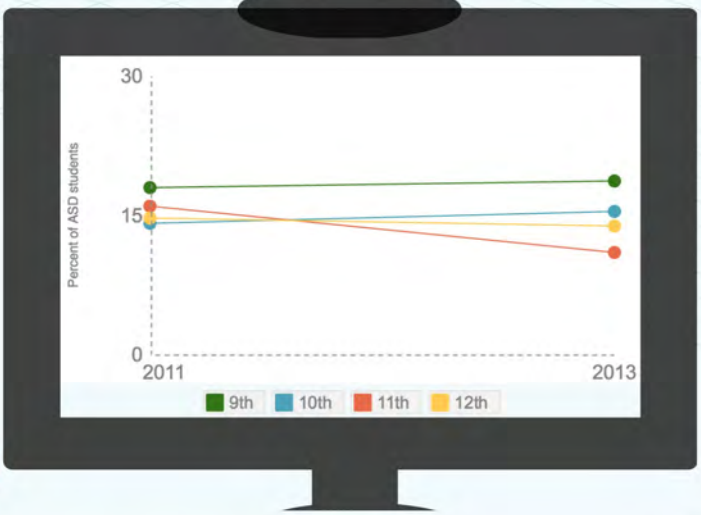
Bullied at School





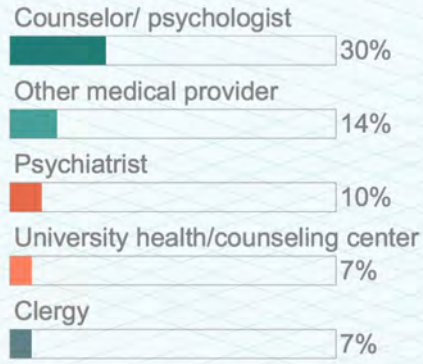
Bullied Electronically





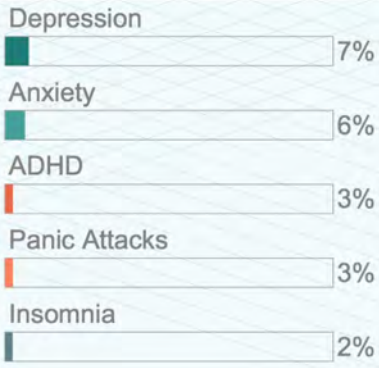
Mental Health Diagnosis and Treatment

Ever received mental health services

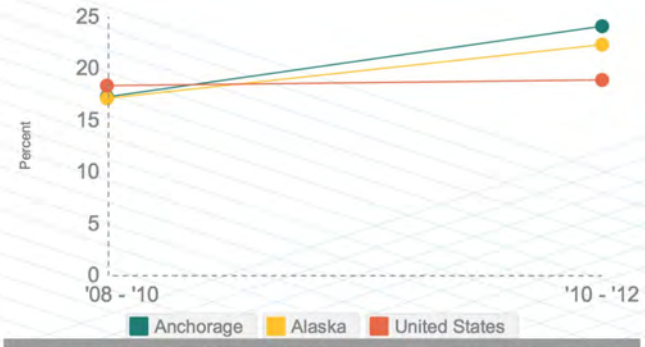


62.1% of students would consider seeking help from a mental health professional in the future.

Current mental health diagnosis in past 12 months

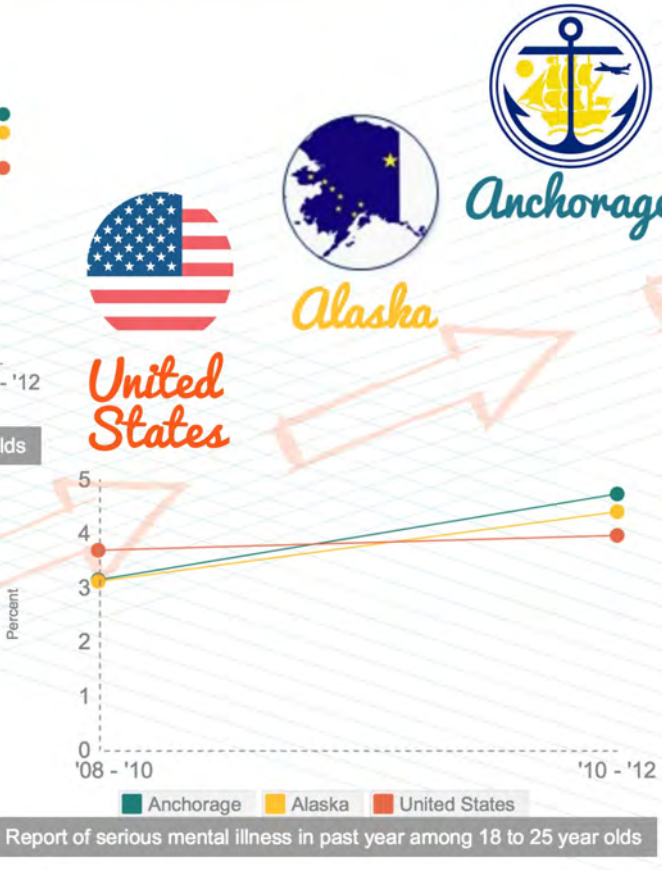


Source: National College Health Assessment, 2009



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

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



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

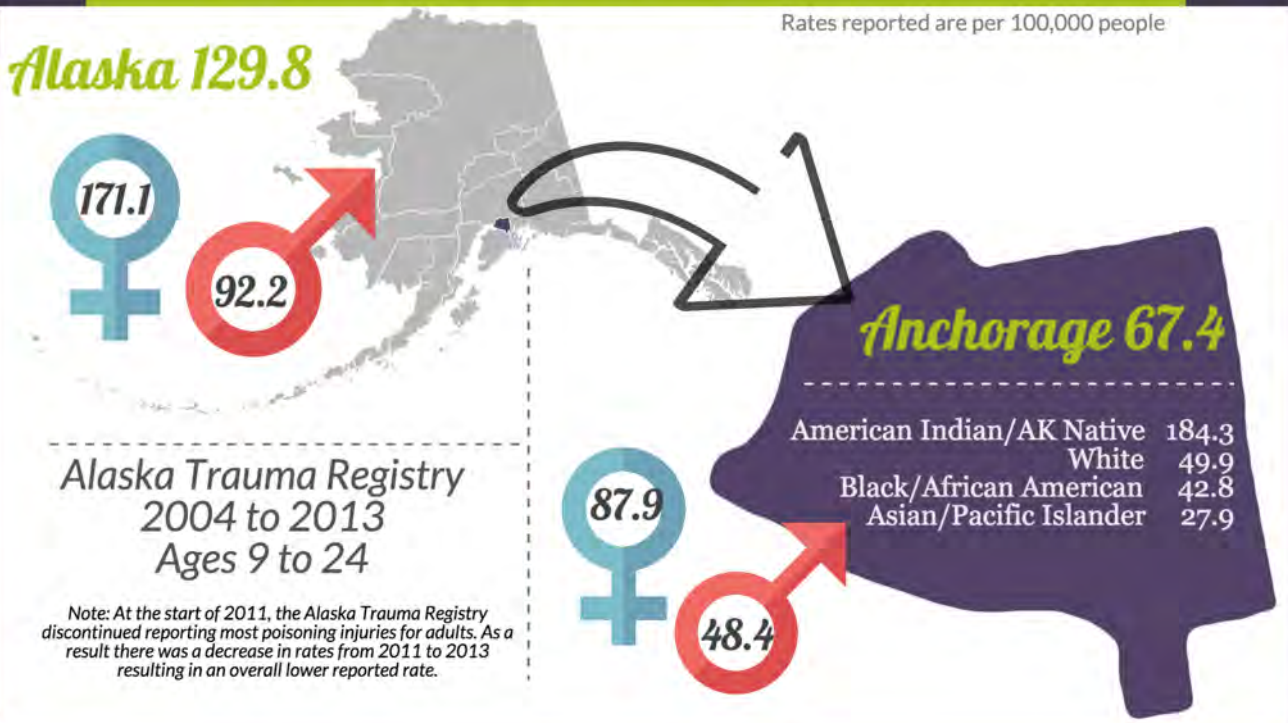
Source: National Survey on Drug Use and Health (NSDUH)

Suicide Prevalence

Alaska and Anchorage

Rates of suicide attempt and self-harm

Rates reported are per 100,000 people



Alaska Trauma Registry
2004 to 2013
Ages 9 to 24

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

Rates of death

Rates reported are per 100,000 people

Anchorage 15.0

6.4

23.0

Most Common Means

	Alaska	Anchorage
Firearm	14.5	9.0

9.0

37.0

Alaska 23.6

Bureau of Vital Statistics
2004 to 2013
Ages 9 to 24

Age

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

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

Substance Use

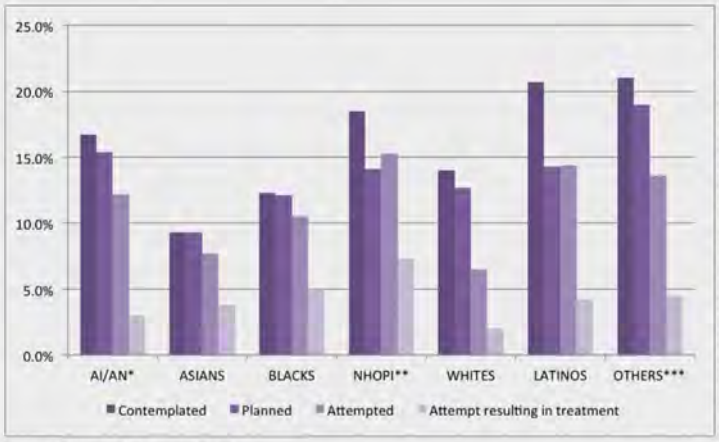
Reported involvement as percent of all cases of intentional self-harm

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

** Number not provided

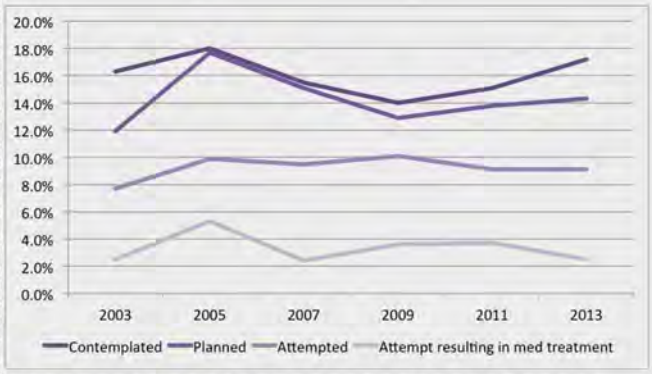
Anchorage School District

By Ethnicity 2009 to 2013



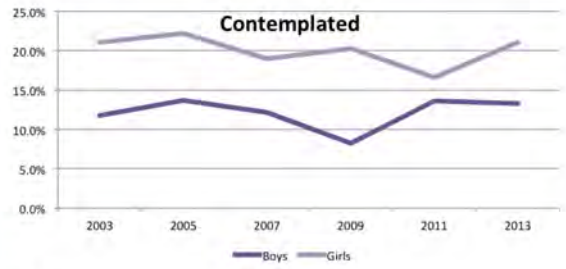
*American Indian/Alaska Native
**Native Hawaiian and Other Pacific Islanders
***Includes mixed race and unidentified race

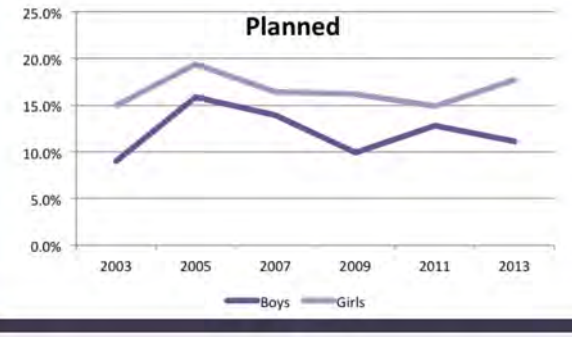
Percent of Anchorage Students



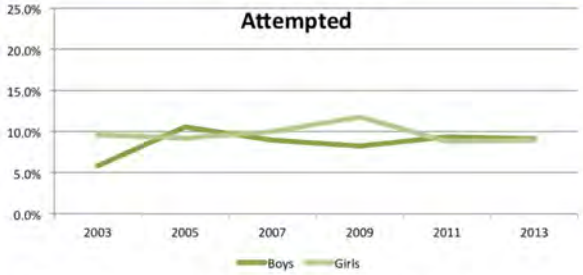
Youth Risk Behavior Survey
2003 to 2013
Anchorage School District
9th through 12th grade

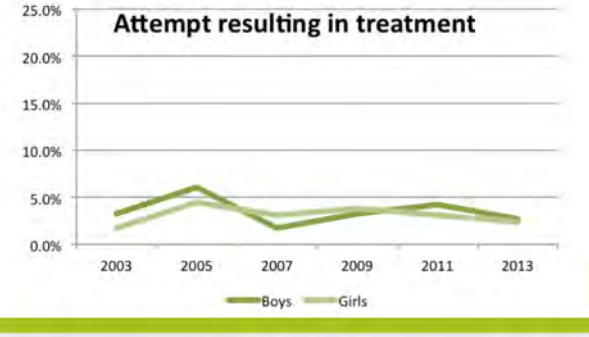
Suicide Ideation





Suicide Attempt





Intermediate Variables

YRBS Protective Factors

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

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

Ever bullied at school

Ever bullied electronically

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

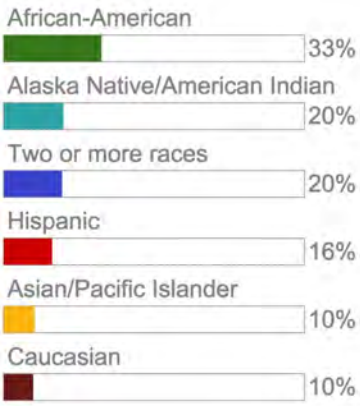
Source: YRBS collected in 2003-2013 from 9th through 12th grade students in the Anchorage School District

SCHOOL SUSPENSIONS

2010-2014

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

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



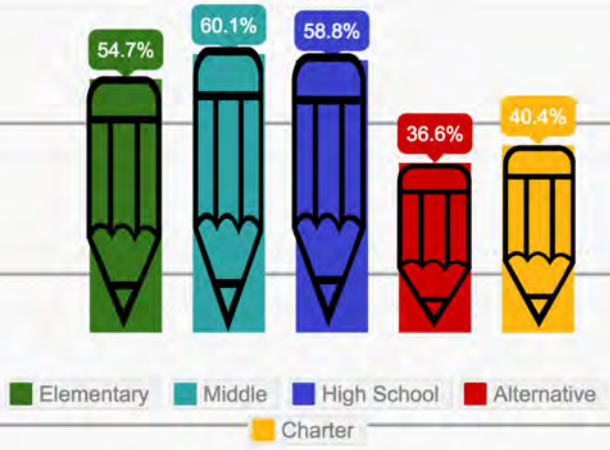
Suspensions within ethnicity

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

Source: Alaska Department of Education and Early Development

Bullying at school

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



Source: SCCS, averages for 2008-2014

Graduation Rates

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

Lowest five graduation rates within categories are represented.

4-Year Cohort

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

5-Year Cohort

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

Source: Alaska Department of Education and Early Development

Dropout Rates

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

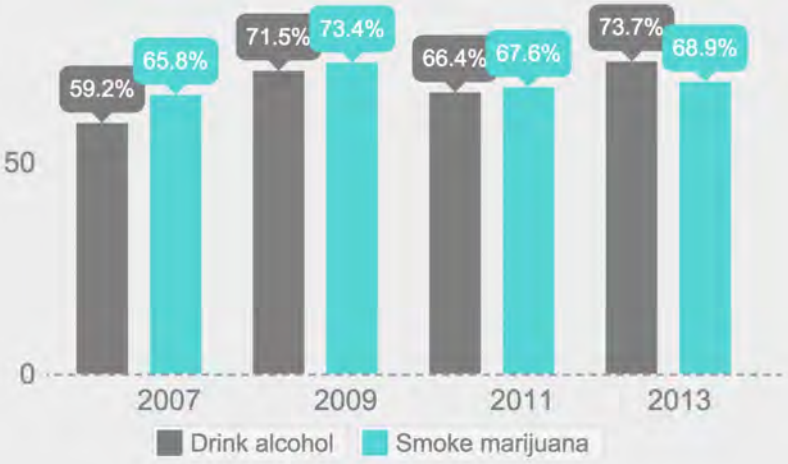
Highest five dropout rates within categories are represented.

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

Source: Alaska Department of Education and Early Development

How (un)cool is alcohol and marijuana?

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



Source: YRBS

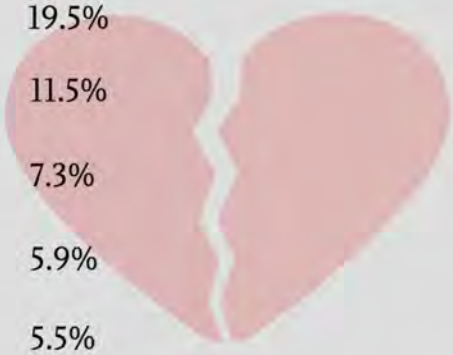
As a consequence of drinking, UAA students who drink reported they:

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

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

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

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



Source: National College Health Assessment, 2009

Primary Data

Adult Perceptions of Anchorage Youth (APAY): Preliminary Results

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

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

Knowledge of Youth Behavioral Health Issues

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

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

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

Concern Regarding Youth Behavioral Health Issues

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

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

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

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

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

Degree of Effort to Address Youth Behavioral Health Issues

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

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

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

Adult Engagement in Youth's Lives

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

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

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

Perceptions of School Environment

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

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

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

Young Adult Survey (YAS)

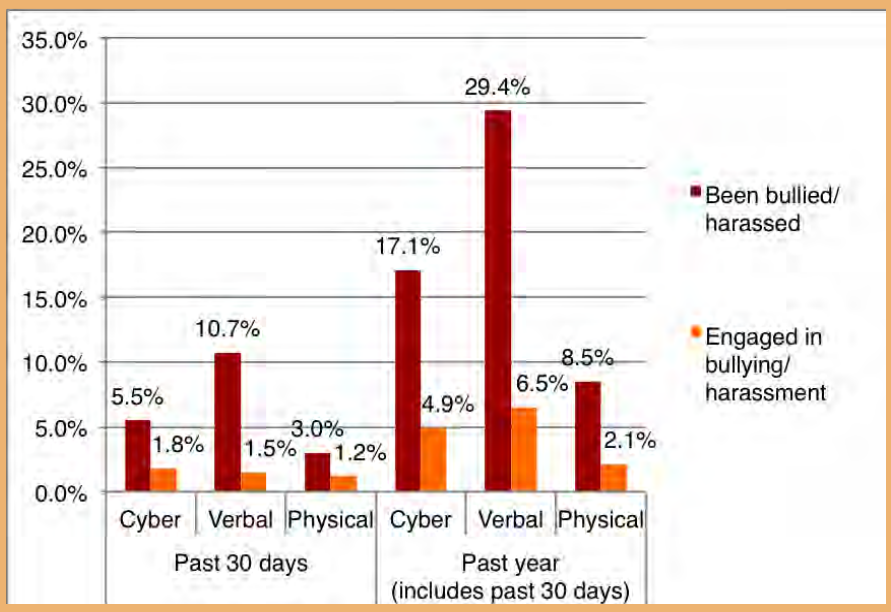
The YAS was designed to gather data from young adults (age 18-24) on social support, community perception and involvement, substance use, stress, bullying and/or harassment experiences, psychological well-being, and help-seeking behaviors and perceptions.

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

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

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

Bullying/Harassment Experiences



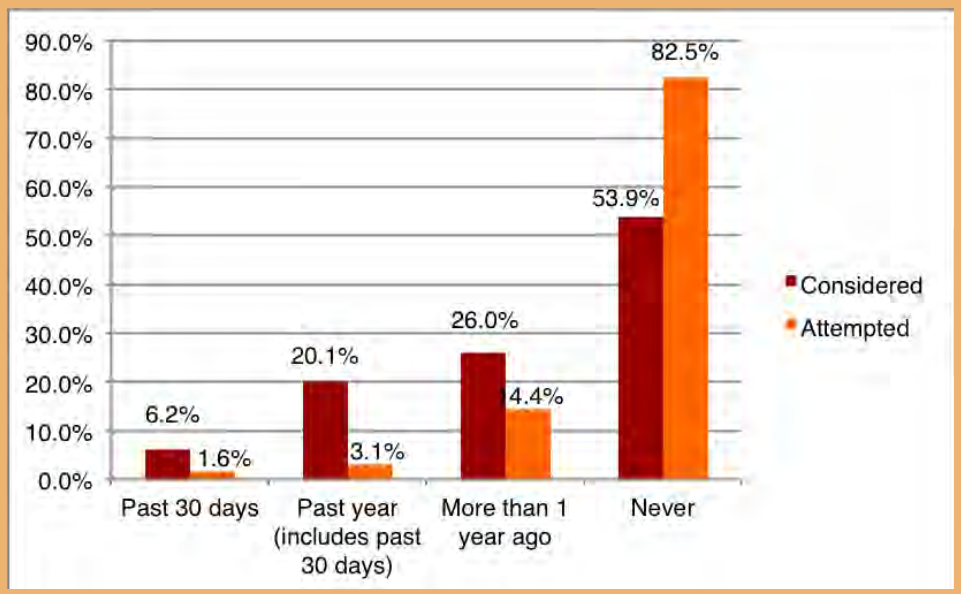
bullying or harassing behaviors. More than a quarter of respondents (29.4%) had experienced verbal bullying within the past year; 10.7% had experienced verbal bullying within the last 30 days. Fewer reported experiencing cyber bullying/harassment (17.1%) or physical harassment (8.5%) within the past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

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

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

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

Suicide Considerations & Attempts



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

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

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

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

"At the time I could not afford it."

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

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

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

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

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

"It seemed like a weird thing to do."

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

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

Another respondent commented that...

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

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

"I thought I would eventually get over it."

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

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

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

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

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

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

Psychosocial Factors

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

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

Predictors of Mental Health

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

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

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

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

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

Cooperating
Supporting
Celebrating

Focus Groups

Analysis

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

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

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

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

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

Scoring Guide for Health-Related Outcomes

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

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

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

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

Primary Bullying Domains and Descriptions

Behaviors/Types of Bullying/Definitions/Other Terms

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

Where it Happens/Context

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

Reasons/Risk Factors

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

How Bullying Makes a Person Feel/Outcomes

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

Protective Factors/Coping Strategies

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

Solutions

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

Primary Mental Health Domains and Descriptions

Signs/Outcomes of Loneliness, Sadness, Hopelessness

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

Causes/Risks

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

Stigma/Misconceptions

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

Protective Factors

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

Solutions

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

Significant Findings from Focus Group Screening*

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

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

Findings: Bullying

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Reasons For Bullying

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

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

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

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

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

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

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

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

Other participants said,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

And with regard to their own suicide attempt,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Findings: Mental Health

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Yeah, like sometimes that's why I kind of don't want to go to [my parents] for help because sometimes they're too busy so we just find other trustful adults that you can use." - 12-14 year old

A similar comment was made by another participant, who said that stress at her parents' work resulted in her feeling like they didn't have time for her. She commented,

"[My mom] quit her job because she thought she needed to spend more time with us. So she did but then now she's just really stressed out because this is her week just of work. So she's like really stressed out because she's staying up late on her laptop doing things that she needs to and she's having a lot of trouble with it. So if I'm trying to play my flute and ask her, "look at this mom for my concert coming up" she's like 'honey, I really want to be right now but I just can't. I've got too much work.' So sometimes I have to show my sister or [friend]." - 12-14 year old

Loneliness, sadness and hopelessness are often associated with grief and trauma at the family level. In many of these instances, peer support, family support (if available) and community support proved to be important factors in managing the grieving process. One participant described a circumstance where her friend lost a close family member.

"Yeah. So two of my really good friends, they're siblings, they're two brothers, and they're a few years apart, and recently, in like August, the older brother committed suicide. And they were both very in – they are both like very involved in the community. They both did a lot of things with folk festival. Different music groups. And community service. No one expected the older brother would do something that he did. And the brothers were really, really close. So the younger brother didn't know what to do. He was just lost. His older brother was his best friend. His like – they were super close. So all of our friends we made sure to take care of him, and made sure he was okay, and constantly were checking up on him, making sure he felt safe, and well, because we didn't want to lose him as well, since they were both extremely close. So he had a lot of trouble in the first week. And then we tried to help him. We would take him hiking, take him to movies. We would take turns taking care of him, and tell him that he's a great person, and make him feel good, and feel strong, so he could keep on going." - 14-18 year old

This quote suggests that while community participation and engagement may be protective factors in some contexts, there is often pain a person experiences on the inside that may not be immediately visible. Another participant elaborated,

"I don't think this is really just Anchorage, but when somebody experiences something tragic or devastating, they just kind of focus on that and it's hard to get your mind off of something that's sad." - 14-18 year old

While tragedy was viewed as unavoidable in many cases, opportunities for connecting with peers, getting involved in events or activities in school or in the community (including involvement in a church or faith-based group), or simply acknowledging

that a person has worth and value were viewed to be protective. As one participant explained in the context of school,

"It's kind of like a teacher when they ask you all the time, like let's say you don't really do your homework in a class, and teacher's always like, where's your homework, where's your homework. They care about you, that's why they always ask. So it's kind of like you may not like it but in your mind you're like they're always asking me about my homework, they must really want me to succeed. They care about me. Or it's like your parents are like 'what are you doing, what are you doing', always ask you what you're doing, and you're like, leave me alone. But then if they don't, it's like they don't care about you. Your parents always ask you what you're doing and stuff because they really care about you. And I think you might not realize that but deep down it kind of gives you positive reinforcement, the way you feel." - 14-18 year old

Other participants cited opportunities to participate in activities that involve interaction with peers or others less fortunate in the community as potentially helpful to youth who may be struggling with feelings of loneliness, sadness or hopelessness. One participant further explains,

"I think sports are one of the main activities that a lot of people go to. And some activities – like, helping with your community and seeing activities to help people – like, the less fortunate – that's good for some people. But sports are the main one that I can think of." - 12-14 year old

Quotes from participants highlight the delicate balance of what support looks like, whether it's coming from parents, friends, teachers or school officials or other trusted adults in the community, including coaches and pastors. On the one hand, checking in can be viewed as a form of nagging or bugging and may actually push someone further away towards social isolation if they are feeling lonely, sad or hopeless. However, that check in was also viewed as a visible expression that someone cares and values the person.

Eighteen to 24 year olds specifically spoke to being in an age of transition and how that impacts their mental well-being. Much of their experiences related to societal expectations (e.g., graduating college, finding a job, being happy) as well as moving away from close family and friends. As one participant said, "And everybody's kind of scattered when you're in your 20s. So that's what I imagine can contribute to loneliness" (18-24 year old).

"When you move to a new place you kind of have to find your people, especially if you're far away from your family if you know a very few people who live here. And if you don't find your people or your community you can feel kind of left out and lonely and like you're seeking maybe that support that you found in other places that you've lived or childhood friends or college friends." - 18-24 year old

"I was just thinking the times when I felt most helpless were when I felt stuck and like I wasn't transitioning. I had these huge expectations on me and I didn't know how to - I just felt paralyzed and not able to go or have - I'm trying to say that there's a huge economic component of like how many people in our age group realistically think that they can have a meaningful job that also pays them well?" - 18-24 year old

Stigma and misconceptions. Stigma and misconceptions around mental health can be very damaging. Youth and young adults spoke how stigma and misconceptions might exacerbate mental health symptoms, make it difficult for youth to identify mental health issues, and create barriers for youth in trying to find help. Youth spoke about stigma among the general population, for example that mental health isn't talked about and that adults set the example for youth. As one youth stated,

"The counselors came in and talked about bullying, and they're always there. And we learned about it a little in health. Mental illness, and where to go if you're sad and stuff. But it's just not talked about that much. And it needs to be." - 14-18 year old

Youth also spoke how people have misconceptions about treatment centers.

"...like North Star, I think that the general population who hasn't been there probably thinks of it as a prison where mental asylum people go..." - 14-18 year old

"Because you try to teach kids to not be judgmental and be open-minded, but when you see adults judging people, not only kids that go to North Star but just judging a homeless person on the street or all that, it's harder to teach kids 'Do what I say, not as I do.' It should be 'Do as I do.' And so, I just think teaching not only kids but adults not to be so judgmental of kids that are going through hard times, and anyone who's going through a hard time." - 14-18 year old

Participants also cited examples of stigma and misconceptions among their peers. One participant recalled when a peer had gone to North Star and how the other students in her class were spreading rumors that the individual was "bullying herself for popularity" or "faking the whole cutting thing," which would be equivalent to victim blaming. Among the 18 to 24 year olds there was a sentiment of having to "make it on your own." Meaning they had this misconception that they are adults now and should be able to solve these issues on their own.

"How something like you have a problem and thinking in your head like, 'I should be able to figure this out. I'm an adult. I'm a young adult. I should be able to figure this out but I can't really go to my parents in that situation.' And grappling with all of those bigger life questions all at the same time." - 18-24 year old

Additionally, youth and young adults admitted they were reluctant to seek help because of stigma, "... maybe when they are feeling lonely they don't feel like they can seek higher help - like professional help - in that situation just because I think especially for our age group that stigma could affect us more than other age groups." (18-24 year old). And one youth specifically mentioned that stigma was what was holding their friend back and when they could get past the stigma they were better able to move forward.

"It's just the way I was raised. I don't really like to talk to professionals about it. Because then in my mind I wouldn't need a professional, because then I have family there. I have family and friends. I wouldn't need to call a crisis hotline. And I'm just like I don't really like to tell people I don't know over the line about that. You know? Even though they're supposed to help me. I like to keep myself private, to people I do know." - 14-18 year old

"I guess the person that I'm thinking of, what really helped them was when they were able to kind of get past the stigma of no it's okay that you're feeling this way. That doesn't mean there's anything wrong with you. And there are definitely places you can get help. And when they were able to talk about it that's what really helped get them through. But I know that it was largely a self-journey for them to be okay with the fact that they were feeling this way." - 18-24 year old

Protective factors. As is described in the literature, focus group participants noted several protective factors for favorable mental well-being, or, to put another way, as a deterrent to feeling sad, lonely and/or hopeless. Having trusted relationships and being able to seek support when needed was discussed by most youth and young adults as important. Participants listed both *a) peer support* (friends, siblings, teammates) and *b) adult support* (parents/adult family members, school professionals, community members, helping professionals). "Trusted" relationships, especially when it came to seeking support from adults, was emphasized, as was the preference to seek

support from friends or family over someone from the helping profession. Additionally, participants noted they preferred face-to-face interaction over other types of communication.

There appeared to be a continuum from the low risk groups where they sought out support from any trusted person, to the high risk groups where they tended to seek support from friends or peers first, and finally to the highest risk group, primarily homeless youth in the 18-24 year old group, where they tended to have less trust and relied more on themselves.

Several participants in the high risk groups, indicated a preference for seeking support from friends over adults, including parents. One youth in a high risk group said when describing why someone would go to their friends for support, "... because their friends give them support when they need it. And they're there for them (14-18 year old). While another said, "If they talked to someone it's probably one of their friends because most people trust their friends more than their family I think." (14-18 year old).

"I know personally if I'm feeling sad or lonely I definitely reach out to my mom and friends that I feel like know me on a very deep level - more than maybe acquaintances or even like counselors or adults like in a college setting, like a health center. I would first go to my parents and close friends." - 18-24 year old

"Yeah like trust is a big thing. I know my school nurse for example is really chill and I'm pretty sure she wouldn't – Like a lot of times it's really hard for kids to talk to adults about things that are going wrong in their life because if you talk to adults they're going to be like, "Here is the politically correct way to deal with this." And it's really hard to talk to them because it's like I don't need a uniform. I don't need a counselor. I just want to talk to you. And I feel like I can talk to my school nurse and she won't go telling all these other adults that, '[Participant's name] is not feeling safe.'" - 14-18 year old

"I think my friends – I mean I don't think anyone really knows how to deal with it when like out of nowhere just starts sobbing in the middle of class. But I know that my friends have kind of learned to understand that going like, "Hey are you okay? What happened? What's wrong?' That doesn't always – Nothing always happened. It's just like I think my friends have kind of come to terms to realize sometimes I just feel upset and I don't really – It's not really anything that triggered it. It just kind of came out of nowhere." - 14-18 year old

"I think it would be more common for people to go to their friends just because it's kind of like "The blood of the covenant is thicker than water of the womb." You know just like stuff where it's like you trust your friends sometimes more than you trust your family." - 14-18 year old

"I guess that really depends on the person whether or not they go to a friend or a family member or if they just keep it to themselves. I know a lot of people that would go to a close friend and talk to their friend about it. Or I also know people that'll just keep it to themselves." - 14-18 year old

Focus group participants also described meaningful activities as a way to allay feelings of sadness, hopelessness, or loneliness, or to improve their mental well-being. Meaningful activities fell into two categories, either *a) social engagement* or *b) introspective/individual*. Some activities fell into both categories. Participants emphasized these activities really depended on the individual and that there was not one activity that would serve as a protective factor for all.

Social engagement included a variety of meaningful activities including sports/exercise, volunteering or helping others, clubs, and school based activities. An example of sports/exercise included playing basketball to relieve stress. Examples of volunteering or helping others included working with children, volunteering within the school or

church community, or tutoring. One participant described how volunteering made her feel,

"And just knowing that I'm helping other people and I can make someone else feel a little better just makes me feel good and makes me feel like I matter and that I'm here for a reason, for a purpose" - 14-18 year old

One participant indicated how the community could help:

"[The community] can help youth and young adults by just continuing to do organizations like this [focus group]. I think this is really great. They can have just a lot of involvement by starting organizations, groups, just a lot of volunteer stuff that has a lot to do with giving time and self-sacrificing their time." - 14-18 year old

Examples of clubs and/or school-based activities included Change of Heart—a school-based group focused on mental well-being, and the "waffle club" a school club focused on making waffles and socializing. One participant described the power of school-based activities as, "I think school activities is a great way because you get to communicate and be around people that you are around every day most of the time" (14-18 year old). Another youth described feeling better when considering others who were less fortunate, "I look at other people's worst situations and it's not nice but it helps me. I think, 'I'm not going through that so I should start being happy and appreciate what I don't have to go through'" (12-14 year old).

Introspective activities included expressing themselves through social media or writing, setting goals for themselves and practicing positive thinking and gratitude.

"I think that addressing the issue of being lonely I would – Or for me I would just focus on myself, figure out what I need to do to not feel so lonely. What I would do is I would go drive around and look at the scenery and just enjoy what I have instead of being so lonely and just being in a dark place. So that's why – Just being thankful of what I have as of right now whereas not, and being surrounded by positive people." - 14-18 year old

Three additional activities that fell under both categories were being outside in nature, participating in religious or spiritual activities, and listening to music. Several participants described the natural environment in and around Anchorage as peaceful and calming. Some described how they enjoy going for walks while others said they just enjoy the scenery. Examples of spiritual or religious activities included participating in organized religion, such as attending church or a religious youth group, or individual spiritual activities such as meditating. Listening to music was mentioned by several youth as a way to relax and to get their minds off their worries. Two participants described it as,

"...just meditate, relax your mind from overthinking, from worrying too much, and just have self-peace, inner peace. Or blast music, anything that helps" - 14-18 year old

"I'll call a friend and we'll just go on a walk – just complete silence walking. It's the fresh air and the sunlight and just complete silence" - 14-18 year old

Having safe spaces was an overarching theme the youth emphasized when talking about ensuring mental well-being. Safe schools, and safe places to hang out with friends was seen as important by several of the youth we listened to. Safe places to hang out were described as locations that had space for both active participation (such as a gym), and for quiet and relaxation (with comfortable chairs and places to listen to music, study, or talk

quietly with friends). There was also an emphasis on the safety of the place, including a place that you would not be 'judged.'

"I don't know if there's a set group activity that the community could do. More as just like a safe place that someone could go and just sit or talk or do whatever they need to do without being judged." - 14-18 year old

Feeling connected to the community and to the people who live here, was seen as important to several youth. Youth described several ways they felt or could feel connected to the community including through acknowledgement and value in the community, giving back to the community through volunteering, or participating in a faith community. Participants described feeling connected as,

"It takes time. A lot – it takes a lot of time, and it takes a lot of guts, and it takes a lot of work, but I think just – you have to not give up hope. And they just keep going. And having people around you that care about you – really care about you and want to help you helps a lot." - 14-18 year old

"Seeing people that you kind of know. Smiling. Asking how your day is. Reassuring. Stuff like that. Also, school. They care about your grades and getting you into college. They care about your future.They care that they want to make sure you do good in your life." - 14-18 year old

"Just know that there's someone around who would ask how I'm doing and would genuinely care what the answer is. That makes me feel like I matter to at least that person or those around me who I'm most connected to. And you know more easily I can then want to give back. It's a circle." - 14-18 year old

"...I think it's tough to know whether you know you matter. But I think giving back a little bit helps you feel like you're a little more part of the community and then in that way you feel like you matter a little bit more if you're able to make a little bit more of difference, whether that's giving back through your job or if you're just participating with other people. Or just interactions I think. Being involved is an important part." - 18-24 year old

Youth also described a community where they felt connected because of racial and cultural diversity. One participant described this as,

"I think the diversity helps, too. Like because you get like different cultures point of view. And different like perspectives from different types of people on how they were raised" - 14-18 year old

There was also a sense of community, when individuals faced common struggles. For example, one 12-14 year old youth described feeling connected to the community because the ethnic group, of which she was a part, faced similar challenges.

Solutions: Intervening in loneliness, sadness, and hopelessness. Youth participant suggestions for how to intervene in loneliness, sadness, and hopelessness fell into broad categories of intervention including: a) interpersonal, b) personal, c) community, d) school, and e) professional interventions. The largest subdomain that emerged was the interpersonal category, primarily between peers, followed by family, and then teachers, amongst others. Teachers, security guards, school counselors, and professional counselors were mentioned in terms of being well positioned for interpersonal interventions, however, youth groups and community based groups were brought up more frequently. Participants across groups expressed a preference for interpersonal interventions by people with many different roles in

their lives, as long as the person is chosen, trusted, non-judgmental, compassionate, practices being present, and is an active listener. Community based interventions brought up focused on peer support groups and community centers.

Solutions: Interpersonal and personal interventions. According to participants, small, interpersonal things people can do to support youth feeling lonely, sad, or hopeless include: a) asking the youth to help with something important so they feel they are making a contribution; b) validating the youth's feelings, rather than encouraging their concealment, or denying the importance of those feelings; c) expressing an interest in the youth's interests; and e) expressing appreciation by saying thank you when youth help in different capacities. Below are quotes from three different focus groups, and four different youth describing useful interpersonal interventions:

"I think validation is huge. Like either giving yourself or this other person the opportunity to feel okay with being really sad or depressed or feeling hopeless. The safe space is really important." -18-24 year old

"...if people ask you to do something, [it] lets you know that they trust you and have faith in you to get something done which kind of makes you feel better." -14-18 year old

"And a lot of the times people will always say that they understand. But sometimes the best thing for it is for people to understand that they don't understand. And you don't need to understand to make it better. You just need to kind of be there." -14-18 year old

"For short term I think humor helps a lot. Two, just being there for them, just staying by their side through bad times and good times. And three, just listening. Sometimes people don't need a response or advice. They just need someone to listen to them. Sometimes if you can't understand. If you can't then just listen." -14-18 year old

Participants talked about the importance of meaningful activities as a way to intervene in loneliness, sadness, and hopelessness. The importance of meaningful activities also came up in focus groups around bullying, both as a way of coping with being bullied, and as a way to help youth stop engaging in bullying behaviors. Youth reported that meaningful activities included safe spaces, and safe people, and often entailed giving back in order to receive, such as with tutoring, and volunteering through youth groups. Engaging in meaningful activities was described as protective of extreme loneliness/sadness/hopelessness, a way to cope with such feelings, as well as a way to conceal such feelings.

Meaningful activities were considered both an interpersonal and personal way of intervening in loneliness/sadness/hopelessness. They were interpersonal when done socially, to create meaning in relationships with others; and they were personal where they happen individually, when youth are alone, such as through writing, listening to music, dancing, or walking a dog. While the majority of participants talked about interpersonal ways of intervening, several youth distinctly countered this by arguing that some people prefer to process alone i.e. that "giving space" is imperative. One 14-18 year old participant reflected:

"...a lot of people are saying important things to do or to do activities and stuff. But a lot of times when you're sad and lonely it's hard to motivate to get to these activities. So it's kind of just like you have to do something that you can do just by yourself anywhere."
– 14-18 year old

As with interventions in bullying, the idea came up repeatedly that experiences of, and interventions in loneliness/sadness/hopelessness are very personal and depend on the person:

"...it's different for every single person out there. Like what makes me happy and bring me out of my depression might not bring the person in a room next to me doing that. It's very individualized for each person. And I think their friend group or the people that are closest to them know..." -14-18 year old

Solutions: Community based interventions. One older participant mentioned: "it can be hard to know where to go to get help for mental health" (18-24 year old). While other youth did not share this explicitly, specific names of mental health resources were also not brought up. When asked about interventions, another youth responded: "as a community making sure we remove stigma" (18-24 year old).

There seemed to be consensus across focus groups that peers were of primary importance when it comes to community level interventions in loneliness/sadness/hopelessness, as well as in bullying. Participants mentioned volunteering as a way to feel like they matter to the community, such as by tutoring, or working with youth groups. In intervention efforts, youth emphasized that it's possible to help youth feel like they matter to the community by doing something that matters:

"I think when you feel that you matter if your self-worth but I feel like you won't matter until you do something worthwhile." - 12-14 year old

"...giving back a little bit helps you feel like you're a little more part of the community." - 18-24 year old

As with personal and interpersonal interventions, it was clear that youth thought a variety of community based interventions was necessary. While most participants talked about social, group interventions, at least two participants wanted to remind us that not all youth benefit from group work:

"I feel that people who are sad and lonely won't really come to groups – youth groups. I feel like youth groups or people that are concerned for them should come to them because I feel like they won't really reach out." - 14-18 year old

That being said, by far the most commonly mentioned community level intervention ideas had to do with youth groups. Several participants mentioned that groups should be based on common experiences so that youth can "relate" to others in the group. Most participants shared that groups should be activities based, such as with volunteering, gaming, and rotating activities, rather than primarily discussion based groups.

"I think that you can also have like your personal interest communities and then that's how you also kind of build off of that community. Like here specifically there are a lot of people that are involved in outdoor activities. And then you bond more with those people. There's a lot of skiing and that whole area. And I think that creates a sense of you kind of belong to your own little community. Even if you don't know anyone you just kind of have things in common with those people and I think that builds a network for you." - 18-24 year old

Participants frequently mentioned community centers, with an emphasis on affordable entry fees, and accessible transportation to them. Here are quotes from two different participants about the use of community centers in possible future interventions:

"Like have activities that involves everybody and not just like adults but also kids. So have just like a little neighborhood thing even just like go to the park. My parents can talk and kids can play. So just have activities that everybody can go to and enjoy, not just certain people." -12-14 year old

"Kind of like community centers but more diverse. Like if they had a place where you could – We touched on this a lot. A lot of people require different things to make them feel better about themselves. And so if you had a more diverse community center, like maybe just one place where you can just chill and be quiet, but the other places where there are activities that you can do. And then there are places that you can also go to do homework." -14-18 year old

Additionally, several mentioned the usefulness of the focus groups themselves as an intervention. While recommendations for interpersonal, and support group interventions were prominent findings in this project's primary data collection, additional focus groups explicitly seeking youth feedback about intervention ideas should be considered.

Finally, participants in a 14-18 year old focus group had rich ideas about community support groups as a possible intervention, including:

- regularly meeting youth groups centered around both activities, and social support through discussions:

"...If anyone has a problem, they can kind of bring it to their group, and everyone can kind of help them out about it. So like let's say these things two hours – they last around two hours – and you can hang out and do stuff for the first hour and a half. But for the last half hour, if anyone has any problems, people can go like, does anyone have anything they want to talk about?" - 14-18 year old

- bringing together the youth groups once a year as a convention or just a celebration with dancing, to learn from each other about activities and topics discussed throughout the year e.g. activities like bowling, sports, anime, movies, video games, role play, skiing, hiking, writing; and topics like bullying, problem solving, and sadness:

"...having an annual get together to combine some really popular things together, so people could go and try new things. Have a part of it like anime and sports, just kind of bring all those things that don't normally go together all that well kind of into one area so people can learn" - 14-18 year old

- having youth groups meeting throughout the year, as well as the annual convention/celebration meet at a common building, or a set of buildings across town, so that youth become familiar with what's going on where.

Moving Playing Enjoying

Synthesis & Recommendations

Considering the results of the secondary and primary data as they are discussed throughout this report and synthesized here, it is recommended for the next steps that the ACC focus on the following three intermediate variables for youth aged 12 to 24: **a) feeling alone, b) trusted relationships, and c) youth feeling they matter to the community. These three intermediate variables as evidenced** throughout this report and data analysis are key variables for having an impact on bullying, sadness/hopelessness, and suicide and thus improving the mental health of Anchorage youth. Below is a summary of how the ACC community assessment process led to this recommendation.

The community assessment began with a broad analysis of behavioral health indicators among Anchorage youth by thoroughly reviewing data from multiple sources (i.e., YRBS, BRFSS, NSDUH, PRAMS, SCCS, TR, NCHA, BVS, ADEED, OCS). This early phase of assessment was intended to identify the highest priority among the behavioral health indicators of suicide, substance use, and mental health. The secondary data results were presented to the ACC and community partners. Based on a careful review of the data, the coalitions and community partners prioritized mental health along with the intermediate variables of feeling alone, sadness, hopeless, and bullying. These behavioral health indicators and intermediate variables were prioritized due to increasing or static trends in the data, while substance use was not included as trends generally appeared to be decreasing over time.

The second phase of the assessment included primary data collection using various methods (i.e., APAY survey, YAS, and focus groups) to further investigate the priority area (mental health) and associated intermediate variables (feeling alone, sadness, hopeless, and bullying). Secondary and primary data methods, analyses, and key findings are thoroughly described in prior sections of this report. It is evidenced in both the secondary and primary data outcomes that there are critical relationships between suicide, mental health (i.e., feeling alone, sad, and hopeless), and bullying. Although, substance use was not considered a priority area it is worth noting that substance use was significantly correlated with bullying in the YRBS data and focus group participants also identified substance use as a mechanism for coping with negative feelings from being bullied. Other outcomes from being bullied that were identified by focus group participants included bullying (i.e., bullying as a result of being bullied) and violence/crime. Both secondary data analysis and primary data support the relationship that being bullied leads to poor mental health and suicide, as well as the relationship that poor mental health is a precursor to suicide. That poor mental health may be a precursor to suicide was evidenced in quantitative YRBS data, and supported through qualitative evidence in focus groups.

Several risk factors map onto at least two, if not all three variables of bullying, mental health/depression, and suicide. These crossovers further support the relationships among variables described above. For example, having been bullied is a risk factor for suicide and for feelings of sadness/hopelessness, as evidenced in focus groups and YRBS data. According to the YRBS data analysis, feeling alone is the highest risk factor for sadness/hopeless and suicide. Mixed-race was a risk factor for both bullying and sadness/hopelessness. Risk factors that crossed bullying, sadness/hopelessness, and suicidal ideation, as evidenced in YRBS, included unsafe schools and being female.

The primary data was also intended to supplement the secondary data by filling data gaps. One of the primary gaps in the secondary data was the limited amount of information regarding the behavioral health of young adults aged 18 to 24 in the Municipality of Anchorage. The secondary data (i.e., National College Health Assessment, 2009) indicated that 45.9% of University of Alaska Anchorage students aged 18 to 24 reported high stress during the previous 12 months. During the

screening process for focus groups, which included 18-24 year olds who had not engaged in higher education, stress was found to be significantly higher in 18-24 year olds when compared to school ages youth 12-18. The results of the Young Adult Survey indicated stress as a risk factor for sadness/hopeless among 18 to 24 year olds.

As with risk factors, there were several similar protective factors for the variables of bullying, sadness/hopelessness, and suicide. As evidenced by both focus groups and the Young Adult Survey, individual factors such as optimism, self-esteem, self-awareness are protective for bullying and sadness/hopelessness. That is, youth perceived individuals with higher self-esteem and self-awareness to be less impacted by bullying and also less likely to be bullied. With regard to the Young Adult Survey, being more optimistic was associated with better mental health. The protective factors of most significance that crossed over all three variables included youth feeling like they matter to their community and youth having trusted relationships, both peer and adult.

According to YRBS strength of association findings, youth feeling like they matter to their community is the second ranked protective factor against bullying, feeling sad/hopeless, suicide ideation, and a planned attempt at suicide. This was also evidenced in the focus group discussion, where youth elaborated on what it meant to matter in their community and the importance of feeling engaged in one's community. Regarding trusted relationships, YRBS data indicated the highest ranked protective factor against being bullied was having a teacher who cares. Having a teacher who cares also meant youth were less likely to feel sad or hopeless and less likely to consider or plan a suicide attempt. While trusted adults were mentioned in focus groups as a resource and support, it was only second to peer relationships. Peers were highly regarded across focus groups as the first line of defense for bullying and mental health concerns. Individuals often said they would talk to and rely on their peers first before seeking adult or professional help. It is important to note that while youth in focus groups refer to peer relationships, there is no measure of peer relationships in YRBS.

In summary, it is demonstrated through a variety of means (i.e., secondary data, primary data, quantitative and qualitative data) that bullying, mental health, and suicide are not independent constructs. As a result, there are a number of risk and protective factors that are associated with at least two if not all three of these variables. Therefore, it would be highly beneficial and efficient to focus interventions and next steps on intermediate variables that cross the main variables of focus, thereby increasing the potential impact of the intervention. For example, having trusted relationships is a protective factor for bullying, sadness/hopelessness, and suicide, and therefore an intervention focused on establishing trusted relationships would potentially reduce bullying behaviors, feelings of depression, and suicide ideation/attempts.

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Alaska Department of Education and Early Development (ADEED)

Note: For this report, data was only analyzed on suspensions/expulsions, dropout, and graduation rates in the Anchorage School District

Purpose: to collect relevant school information (e.g., attendance, graduation rates, suspensions/expulsions) on Alaska public school students

Dates Collected: On-going data collection

Participants: Data collected on students attending Alaska's public schools.

Limitations: Data are presented by counts instead of percentages (in the absence of total student population for each year). ASD graduation and dropout rates were calculated differently prior to the 2009-2010 school year.

Website: http://www.eed.state.ak.us/

UAA Assessment Team Rating: Validity-2 Consistency-1 Sensitivity-1

Behavioral Risk Factor Surveillance System (BRFSS)

Purpose: to collect data on preventive health practices and risk behaviors linked to chronic diseases, injuries, and preventable infectious diseases.

Dates Collected: Yearly since 1984. Computer Assisted telephone interviewing began in 2005.

Participants: Nationwide survey. Participants are non-institutionalized civilian adults 18 and older.

Website: http://www.hss.state.ak.us/dph/chronic/hsl/brfss/default.htm

UAA Assessment Team Rating: Validity-2 Consistency-2 Sensitivity-1

Bureau of Vital Statistics (BVS)

Purpose: to collect information on infant mortality, cancer and chronic disease deaths, other leading causes of death, unintentional injuries, pregnancy rates, marriage and divorce rates.

Dates Collected: On-going data collection

Participants: Data collected from all birth, death, marriage and divorce statistics (vital statistics) in state of Alaska.

Limitations: The data includes all vital statistic information occurring in the state and the data can be used to assess trends over time.

Website: http://www.hss.state.ak.us/dph/bvs/

UAA Assessment Team Rating: Validity-2 Consistency-2 Sensitivity-1

National College Health Assessment (NCHA)

Purpose: to collect information on college students' health habits, behaviors and perceptions.

Dates Collected: UAA collected in 2009

Participants: Students enrolled in university participating in the survey

Limitations: Only one year of data so trend data not available

Websites: http://www.acha-ncha.org/overview.html

http://www.achancha.org/

UAA Assessment Team Rating: Validity-1 Consistency-2 Sensitivity-1

National Survey of Drug Use and Health (NSDUH)

Purpose: to collect US national and state-level data on the use of tobacco, alcohol, illicit drugs, and mental health. Used to assess and monitor drug and alcohol use and consequences of abuse.

Dates Collected: 1990-present conducted every year. 1972-1990 conducted every two-three years.

Participants: Randomly selected individuals age 12 and older

Limitations: Excludes individuals without households (i.e, homeless, military, living in dorms, living in institutions like jails, prisons, and hospitals).

Website: http://www.oas.samhsa.gov/nsduh.htm

UAA Assessment Team Rating: Validity-2 Consistency-2 Sensitivity-1

Office of Children's Services (OCS)

Purpose: to collect information on children and families utilizing OCS and on providers for out-of-home placements.

Dates Collected: on-going

Participants: Participants using Office of Children's Services

Limitations: Not all data is publically available.

Website: http://dhss.alaska.gov/ocs/Pages/default.aspx

UAA Assessment Team Rating: Validity-1 Consistency-1 Sensitivity-1

Pregnancy Risk Assessment Monitoring System (PRAMS)

Purpose: to collect information on state-specific population-based maternal attitudes and experiences before, during, and after pregnancy.

Dates Collected: 1990 to present. On-going data collection

Participants: Stratified random sample of approximately 1 in 6 mothers of live births in Alaska (minimum of two months and a maximum of six months have passed since the date of birth). Stratification is on both race (native and non-native) and birth weight (<2500 g and ≥ 2500 g).

Limitations: Only collected from mothers with live births, therefore pregnancy issues generalized to that population.

Websites: http://www.epi.hss.state.ak.us/mchepi/PRAMS/default.stm

http://www.cdc.gov/prams/

UAA Assessment Team Rating: Validity-2 Consistency-2 Sensitivity-1

School Climate and Connectedness Survey (SCCS)

Purpose: to measure student and staff perceptions of school climate and connectedness

Dates Collected: Yearly since 2005; ASD--2007-present

Participants: Survey offered to Alaska school districts. Additional questions included in Anchorage School district (ASD) survey to address issues unique to ASD. Participants are public school staff with student contact and students. For the ASD the grades are 3-12.

Limitations: self-reported which is subject to recall bias and social desirability; less than 10 years data

which limits availability of trend data

Website: http://alaskaice.org/wordpress/wp-content/uploads/2010/11/SCCS-2014-Statewide-Report-combined.pdf)

http://www.alaskaice.org/material.php?matID=529

UAA Assessment Team Rating: Validity-2 Consistency-2 Sensitivity-1

Trauma Registry (TR)

Purpose: to collect information on trauma patient injury and treatment from Alaska's acute care hospitals

Dates Collected: 1991-present

Participants: 24 of Alaska's acute care hospitals contribute to the registry

Limitations: The Trauma Registry includes all poisoning injuries reported for children (patients under age 18), but limits the reporting of poisoning injuries for adults. Initially the Trauma Registry included unintentional occupational, unintentional inhalational and self-inflicted poisoning injuries for adults. As of January 1, 2011, the Trauma Registry no longer included self-inflicted poisoning injuries for adults age 18 and older. This includes drug-related suicide attempts, which account for the majority of suicide attempts in Alaska.

Website: http://dhss.alaska.gov/dph/Emergency/Pages/trauma/registry.aspx

UAA Assessment Team Rating: Validity-2 Consistency-1 Sensitivity-2

Youth Risk Behavior Survey (YRBS)

Purpose: to measure the prevalence of behaviors and protective factors that most influence the health of youth in grades 9-12.

Dates Collected: 1990, but Alaska first participated in 1995. Conducted every other year.

Participants: Nationwide survey established by CDC. Participants are public high school students in grades 9-12.

Limitations: Cross-sectional survey which does not allow for researchers to establish causation; self-reported which is subject to recall bias and social desirability; conducted only in English (Anchorage School District reported 99 languages in 2014); does not collect information on socioeconomic status, gender identity/sexual orientation, and neighborhood environment; in Alaska, it cannot be administered without written parent permission (active parental consent beginning in 2001).

Websites: http://www.hss.state.ak.us/press/2007/YRBS_2007_fact_sheet.pdf

http://www.hss.state.ak.us/dph/chronic/school/YRBS.htm

UAA Assessment Team Rating: Validity-2 Consistency-2 Sensitivity-2

Appendix A:
Data Review & Prioritization Tool

Data Review and Prioritization Tool

Based on your review of the data, select two (2) issues that you feel are the top behavioral health priorities (of most concern) for Anchorage youth ages 12 – 24. These may be protective factors or risk factors.

To help you in prioritizing, please focus on these three considerations:

1) Prevalence of the issue
2) Trends over time
3) Urgency

Also, please consider these questions:

- For each of the issues you have identified, which population seems most at risk?
- If the issue you have prioritized is a risk factor, do you see a protective factor that you feel correlates with or influences that risk factor?
- As you reviewed the data and went through the prioritization process, did any additional questions pop up for you? Is there anything else you wish you knew that the data didn't tell you? ***(Please record this information on the back of this sheet)***

Issue #1:
1) What is the prevalence of this issue?
2) What is the trend?
3) What is the urgency?
4) Which population seems most at risk?
5) Risk Factor or Protective Factor?
6) If Risk Factor, is there a related protective factor that appears to be an influence? (Please identify the protective factor)

Issue #2:
1) What is the prevalence of this issue?
2) What is the trend?
3) What is the urgency?
4) Which population seems most at risk?
5) Risk Factor or Protective Factor?
6) If Risk Factor, is there a related protective factor that appears to be an influence? (Please identify the protective factor)

Appendix B:
Survey & Focus Group Instruments

UAA Justice Center
UNIVERSITY of ALASKA ANCHORAGE

Adult Perceptions of Anchorage Youth: 2015 Survey

Your answers are completely confidential. When you submit your completed questionnaire, your name will be deleted from the mailing list and never connected to your answers in any way. When the data is made public, no names or addresses will be connected to your answers, and handwritten answers will not be included in the public data file. This survey is voluntary. However, you can help us very much by taking a few minutes to share your experiences and opinions about underage use of alcohol, marijuana, and prescription drugs in Anchorage.

If you would prefer to take this survey online please use the following link to log in to the survey. You will be asked for a password and a PIN. Your individual PIN number is on the back cover of this survey. Once you have logged in please follow the directions for completing the survey. The questions on either the online or this paper version are the same, and for either version your answers to the survey are completely voluntary and confidential. Again, only compete the survey (online or paper form) if you are an adult, over the age of 18.

Website URL: **http://tinyurl.com/nbb74uj**

If you have questions about the research project, please call Dr. Cory Lepage at the UAA Justice Center (907-786-4302). If you have questions regarding participation in the research project, please call Sharilyn Mumaw at the Office of Research Integrity and Compliance at (907-786-1099).

_____

Signature indicating consent to participate.

Would you like a copy of this signed consent form returned to you? ☐Yes ☐No

If you are a minor, under the age of 18, please do not complete the survey. Simply return the survey in the enclosed return envelope, and feel free to keep the $2 gift.

Underage Substance Use Problem

1. **How concerned are you about the problem of...**

	Very concerned	Somewhat concerned	Not at all concerned	Don't know
…drunk driving	○	○	○	○
...youth under 21 drinking alcohol	○	○	○	○
...youth under 21 smoking tobacco	○	○	○	○
...marijuana use by youth 18 or younger	○	○	○	○
...use of prescription drugs without a prescription by youth 18 or younger	○	○	○	○
…use of spice by youth 18 or younger	○	○	○	○

2. **Please answer the following questions about underage drinking:**

	No	Yes	Don't know
Do you think it's ever okay for a person who is 12-14 years old to drink alcohol?	○	○	○
Do you think it's ever okay for a person who is 15-17 years old to drink alcohol?	○	○	○
Do you think it's ever okay for a person who is 18-20 years old to drink alcohol?	○	○	○
Do you think it's ever okay for a person who is 25 years old to drink alcohol?	○	○	○

3. **Please indicate your level of agreement with the following statements:**

	Strongly agree	Agree	Disagree	Strongly disagree	Don't know
It is okay for youth under 21 to drink at parties if they don't get drunk.	○	○	○	○	○
Youth under 21 should be able to drink as long as they don't drive afterwards.	○	○	○	○	○
In my community, there is a lot of social pressure for youth under 21 to drink.	○	○	○	○	○
In my community, drinking among youth under 21 is acceptable.	○	○	○	○	○
With marijuana legalized for use by those 21 and older, use of marijuana by teens will likely increase.	○	○	○	○	○

4. **How easy is it for youth in your community to…**

	Very easy	Sort of easy	Sort of hard	Very hard	Don't know
…get an older person to buy alcohol for them?	○	○	○	○	○
…sneak alcohol from their home or their friend's home?	○	○	○	○	○
…get their parents to give alcohol to them?	○	○	○	○	○
…get alcohol at a party at someone's house?	○	○	○	○	○
…get alcohol at a public or community event like a festival?	○	○	○	○	○
…get alcohol at a family celebration such as a wedding, barbecue, or birthday?	○	○	○	○	○
…steal alcohol from a retailer (i.e. restaurant, bar, or liquor store)?	○	○	○	○	○
…purchase alcohol from a retailer (i.e. restaurant, bar, or liquor store)?	○	○	○	○	○
…get marijuana from a friend?	○	○	○	○	○
…buy marijuana?	○	○	○	○	○
…get their parents to give marijuana to them?	○	○	○	○	○
… sneak prescription drugs that are not prescribed to them from their home?	○	○	○	○	○
…get their parents to give youth prescription drugs that are not prescribed to the youth?	○	○	○	○	○

5. **Please share your personal knowledge of youth access to alcohol and drugs:**

	No	Yes	Don't know
Would youth under 21 that you know be able to access any alcohol that you have purchased without your knowledge?	○	○	○
Would youth under 21 that you know be able to access any marijuana that you have grown or purchased without your knowledge?	○	○	○
Would youth under 21 that you know be able to access any of your prescription drugs without your knowledge?	○	○	○

6. **What percentage of students in your local high school do you think used the following substances in the last month?**

	%
Alcohol	_____
Prescription drugs to get high	_____
Marijuana	_____

7. **How much do you think youth under 21 risk harming themselves (physically or in other ways) if they:**

	No Risk	Slight Risk	Moderate Risk	Great Risk
Take one or two drinks of an alcoholic beverage nearly every day.	○	○	○	○
Have five or more drinks of an alcoholic beverage once or twice a week.	○	○	○	○
Try marijuana once or twice.	○	○	○	○
Smoke marijuana once or twice a week.	○	○	○	○
Smoke marijuana once or more a day.	○	○	○	○
Try prescription drugs (painkillers, sedatives, stimulants, etc.) that are not prescribed to them once or twice.	○	○	○	○
Use prescription drugs not prescribed to them at least once a month	○	○	○	○
Try spice once or twice	○	○	○	○

8. **Please indicate your level of agreement with the following statements about the relative safety of various substances used by youth:**

	Strongly agree	Agree	Disagree	Strongly disagree	Don't know
Marijuana use by youth is safer than alcohol use by youth under 21.	○	○	○	○	○
Youth use of prescription drugs to get high is safer than alcohol use by youth under 21.	○	○	○	○	○
Alcohol use by youth under 21 is safer than youth marijuana use.	○	○	○	○	○
Youth use of prescription drugs to get high is safer than youth marijuana use.	○	○	○	○	○

9. **Following are some consequences associated with youth substance use. Please indicate your level of concern for each of the risks listed below:**

		Not at all concerned	Not very concerned	Somewhat concerned	Very concerned	Don't know
Alcohol	Youth might drink to excess or become addicted to alcohol	○	○	○	○	○
	Youth might drink and drive	○	○	○	○	○
	Youth's brain development might be adversely affected	○	○	○	○	○
	Youth might be involved in unwanted and/or unprotected sexual behavior	○	○	○	○	○
	Youth's drinking could lead to depression or suicide	○	○	○	○	○
	Youth could lose out on scholarship or some other opportunity	○	○	○	○	○
	Youth's grades might suffer	○	○	○	○	○
	Youth might end up in trouble with the police	○	○	○	○	○
	Youth might move on to other drugs	○	○	○	○	○
Prescription Drugs	Depressed breathing from prescription drug use without a prescription	○	○	○	○	○
	Death due to overdose by prescription drug use without a prescription	○	○	○	○	○
Marijuana	That marijuana use will lead to use of other more dangerous drugs	○	○	○	○	○
	That marijuana use will lead to a decrease in grades	○	○	○	○	○

Adult Influences on Underage Substance Use

10. At what age (in years) is it appropriate to begin talking to a child about underage alcohol use? _____
    At what age (in years) is it appropriate to begin talking to a child about youth marijuana use? _____
    At what age (in years) is it appropriate to begin talking to a child about youth prescription drug use to get high? _____

11. At what age (in years) is it appropriate to begin monitoring a child's behavior with regard to alcohol? _____
    At what age (in years) is it appropriate to begin monitoring a child's behavior with regard to youth marijuana use? _____
    At what age (in years) is it appropriate to begin monitoring a child's behavior with regard to youth prescription drug use to get high? _____

12. **How much influence do you think each parental example would have on the drinking decisions of their youth under 21:**

	Not at all influential	Not very influential	Somewhat influential	Very influential	Don't know
Occasionally joke or tell a funny story about their past drinking behavior in front of their youth under 21.	○	○	○	○	○
Use alcohol to relieve stress or anxiety, saying things such as “I’ve had a tough week; I need a beer.”	○	○	○	○	○
Have 5 or more drinks in one evening in front of their youth under 21.	○	○	○	○	○
Ask their youth under 21 to get alcoholic beverages for them, such as getting a beer from the refrigerator.	○	○	○	○	○
Have alcohol at youth-centered events (i.e. kids' birthday parties, spiritual celebrations, sporting events, etc.).	○	○	○	○	○
Pressuring other adults to consume alcoholic beverages in front of their youth under 21.	○	○	○	○	○

13. **Please indicate your level of agreement with the following statements:**

	Strongly agree	Agree	Disagree	Strongly disagree	Don't know
Parents’ use of alcohol has no influence on a youth under 21’s use of alcohol.	○	○	○	○	○
Parents should know where their youth are when not at home.	○	○	○	○	○
Parents should know whom youth are with when not at home.	○	○	○	○	○
Parents should have specific rules about youth alcohol use.	○	○	○	○	○
Parents should have specific consequences for youth who break family rules about alcohol use.	○	○	○	○	○

14. **Please share your personal knowledge of or belief about the following:**

	No	Yes	Don't know
Do you know of parents or adults who permit their own children under the age of 21 to consume alcohol under their supervision?	○	○	○
Do you think it's ever okay for parents to offer their own children under 21 alcohol in their home?	○	○	○
Do you know of parents or adults who permit anyone under the age of 21 (other than their own children) to consume alcohol under their supervision?	○	○	○
Do you think it's ever okay for parents to offer anyone under 21 (other than their own children) alcohol in their home?	○	○	○
Do you think it's ever okay for youth to attend a party where youth under 21 are drinking as long as a parent is present?	○	○	○
Do you know anyone under the age of 21 who uses alcohol?	○	○	○

15. **Please share the following regarding prescription drugs (pain relievers, tranquilizers, stimulants, or sedatives) in the home:**

	No	Yes	Don't know
Are there prescription drugs in your home?	○	○	○
If there are prescription drugs in your home, do any children in your home know that prescription drugs are kept in your home?	○	○	○
Is it necessary for parents or guardians to take steps to keep children and youth from having access to prescription drugs in the home?	○	○	○

16. **If you have prescription drugs in your home (pain relievers, tranquilizers, stimulants, or sedatives) do you take any of the following steps to keep youth in your home from having access to these prescriptions?:**

	No	Yes	Don't know
Keep track of the number of pills	○	○	○
Lock the pills up	○	○	○
Hide the pills	○	○	○
Keep the pills with you when you leave home	○	○	○
Other: _____ _____	○	○	○

Substance Use

17. **Please answer the following questions about your substance use as a youth:**

	No	Yes	Don't know
As a youth under 21, was there ever a time when you drank alcoholic beverages at least once a week?	○	○	○
As a youth under 21, was there ever a time when you drank five or more alcoholic beverages in one day?	○	○	○
As a youth under 18, was there ever a time when you smoked marijuana once per week or more frequently?	○	○	○

18. **How long has it been since you last drank an alcoholic beverage?**

- ○ Within the past 30 days
- ○ More than 30 days ago but within the past 12 months
- ○ More than 12 months ago

19 **During the past 30 days, on how many days during did you use**

	None	1 or 2 days	3 to 5 days	6 to 9 days	10 to 19 days	20 to 29 days	All 30 days
Alcohol	○	○	○	○	○	○	○
Marijuana	○	○	○	○	○	○	○
Prescription Drugs to get high	○	○	○	○	○	○	○

Community Readiness

20. **Please answer how knowledgeable you are...**

	Very knowledgeable	Knowledgeable	Somewhat knowledgeable	Not knowledgeable
….. about bullying among Anchorage's youth?	○	○	○	○
... about extreme sadness/hopelessness among Anchorage's youth?	○	○	○	○
... about Anchorage youth feeling alone in their lives?	○	○	○	○
... about suicide among Anchorage's youth?	○	○	○	○

Community Climate

21. **Please answer how concerned you are...**

	Very concerned	Concerned	Somewhat concerned	Not concerned
….. about bullying among Anchorage's youth?	○	○	○	○
... about extreme sadness/hopelessness among Anchorage's youth?	○	○	○	○
... about Anchorage youth feeling alone in their lives?	○	○	○	○
... about suicide among Anchorage's youth?	○	○	○	○

Knowledge of Efforts

22. **Efforts mean any programs, activities, or services in the community. To what degree would you say there are efforts in the community to address…**

	A lot	Some	A little	Nothing
….. the bullying among Anchorage's youth?	○	○	○	○
... the extreme sadness/hopelessness among Anchorage's youth?	○	○	○	○
... feeling alone among Anchorage's youth?	○	○	○	○
... suicide among Anchorage's youth?	○	○	○	○

The next set of questions ask about your engagement in youths' lives as a parent and/or community member. If you are not currently parenting youth or do not have regular interaction with any youth who are at least 12 years old, please answer the following questions as you would if you were parenting or had regular interaction with one or more youth age 12 or older.

23. **How likely are you/would you be to…**

	Very likely	Likely	Somewhat likely	Not likely
… talk to youth about how they are doing in school every day?	○	○	○	○
... help youth seeking help from you in addressing important questions affecting their life?	○	○	○	○
... help make youth feel that they are not alone in their life?	○	○	○	○
... help make youth feel like they matter in your community?	○	○	○	○
… encourage youth to take part in organized after school, evening, or weekend activities	○	○	○	○

School Environment

The next set of questions asks you about your perception of youths' school environment.

24. **To what degree would you say that in general…**

	Strongly agree	Agree	Somewhat agree	Disagree
… teachers in Anchorage really care and give a lot of encouragement to youth?	○	○	○	○
... junior high and high schools in Anchorage have clear rules and consequences for youth behavior?	○	○	○	○

Respondent Background Information

This demographic information helps researchers at the university to better understand features of community and civic attitudes as they relate to individual characteristics. These responses will be kept confidential, and your answers to these and all of the questions in this survey will not be traceable to you.

Nonetheless, if there are any questions that you do not wish to answer, please simply skip those items and move onto the next question in the survey. Your answers remain valuable whether you choose to answer every question or not.

25. **How old were you on your last birthday?** ____

26. **What is your gender?** ○ Female ○ Male

27. **Are you of Hispanic or Latino background or origin?** ○ No ○ Yes ○ Don't know

28. **What race or ethnicity would you say best describes you?** (Please mark all that apply.)

- ○ Alaska Native or American Indian
- ○ Asian
- ○ Black or African American
- ○ Native Hawaiian, Samoan, or Other Pacific Islander
- ○ White or Caucasian
- ○ Other (please specify) _____

29. **What is your current marital status?**

- ○ Single, Never Married
- ○ Married
- ○ Separated
- ○ Divorced
- ○ Widowed

School Environment

30. **What is the highest degree or level of school you have completed?**

- ○ A graduate or professional degree
- ○ A bachelor degree
- ○ An associate degree
- ○ One or more years of college, but no degree
- ○ High school diploma or GED
- ○ No degree - specify last grade **completed** _____

31. **Which of the following best describes your current primary employment status?** (Please select one.)

- ○ Currently on active military status
- ○ Working full-time, that is 35 or more hours per week in one or more jobs, including self-employment
- ○ Working part-time
- ○ Have a job, but out due to illness/leave/furlough/or strike
- ○ Have seasonal work, but currently not working
- ○ Unemployed or laid off and looking for work
- ○ Unemployed and not looking for work
- ○ Full-time homemaker
- ○ In school only
- ○ Retired
- ○ Disabled for work
- ○ Don't know/Not applicable
- ○ Other (please specify) _____

32. **Household composition**

Including yourself, how many people currently live in your home?	____
How many people under the age of 21 currently live in your home?	____
How many people between the ages of 13-17 currently live in your home?	____

Interaction with Youth

33. Are you currently parenting one or more youth who are 12 to 24 years old? ○ Yes ○ No

34. Do you have regular interaction with any youth who are 12 to 24 years old? ○ Yes ○ No

35. **Is there anything else that you would like to tell us about underage substance use in Anchorage, or things that you think we should have asked but didn't?** Please share your feedback.

[PLEASE WRITE YOUR RESPONSE IN THIS BOX.]

Please return your completed questionnaire in the envelope provided to:
Justice Center
University of Alaska Anchorage
3211 Providence Drive
LIB 213
Anchorage, AK 99508

Anchorage Young Adult Survey

1. What is your current age? _____

2. What is your biological sex? Male Female Intersex

3. Do you currently live in the Municipality of Anchorage (includes Anchorage Bowl, JBER, Indian, Girdwood, Eagle River, Birchwood, Peters Creek, Chugiak, Eklutna)? Yes No

3a. How long have you lived in Anchorage? (If you have lived in Anchorage more than one time, please list only the number of years during this current period of time.) _____ years

3b. Have you lived in Anchorage previously? Yes No

3c. How many total years did you previously live in Anchorage? ____ years

["Please indicate the extent to which you agree or disagree with the following statement:"]

4. In my community, I feel like I matter to people.

Strongly agree Not sure Disagree
Agree Strongly Disagree

["For each statement below, indicate your response using the provided scale"]

5a. I have chances to talk to someone I trust about my problems.
5b. I receive love and affection.
5c. I have people who care about me.
5d. I spend time with family and/or friends.

1	2	3	4	5
Much less than I would like				As much as I would like

6. During an average week, on how many days do you take part in organized activities, such as clubs; community center groups; music, art, or dance lessons; church; or cultural or other organized activities?

I do not take part in organized activities.
I take part in organized activities occasionally, but not regularly.
I take part in organized activities regularly, but less than 1 day per week.
1 day/week
2 days/week
3 days/week
4 days/week
5 days/week
6 days/week
7 days/week

["Please indicate the extent to which you agree or disagree with each of the following statements:"]

7a. I have important goals for my life.
7b. I believe I have what it takes to succeed in my life.
7c. I believe that somebody will take care of me when I am old.

7d. I believe that my future will work out.
7e. I believe that if you work hard enough, you can accomplish anything.

Always agree	Agree half the time	Rarely agree
Usually agree		Never agree

8. What is the highest level of education that you plan to attain?

Less than high school diploma	Associate degree
High school diploma or GED	Bachelor's degree
Trade/technical/vocational training	Graduate or professional degree
Some college, no degree	

9. Within the last 30 days, on how many days did you use:

a. Alcohol
b. Marijuana
c. Illicit drugs (including cocaine, methamphetamines, hallucinogens, opiates)
d. Prescription drugs not prescribed to you

{Matrix table with same choices for all:}

Never used	6-9 days
Have used, but not in last 30 days	10-19 days
1-2 days	20-29 days
3-5 days	Used daily

{Only for those that selected some alcohol use in last 30 days}

10. Over the last two weeks, how many times have you had *five/four* or more drinks of alcohol at a sitting? *five for men; four for women

N/A; I don't drink	3 times	7 times
None	4 times	8 times
1 time	5 times	9 times
2 times	6 times	10 or more times

11. Within the last 12 months, how would you rate the overall level of stress you have experienced?

No stress	Average stress	Tremendous stress
Less than average stress	More than average stress	

The next few questions are about bullying and/or harassment. When answering these questions, please think about aggressive behavior that is intended to hurt, humiliate, or harm another person either physically or emotionally. Please do not include instances of domestic violence or aggressive behavior by or toward an intimate partner.

12. In the past 12 months, have you ever:

a. Been cyber bullied or harassed (such as via text, Facebook, Snapchat, or other electronic methods).
b. Been verbally bullied or harassed.
c. Been physically bullied or harassed.

{Matrix table with same choices for all:}

No, never
No, not in the last 12 months
Yes, in the last 2 weeks
Yes, in the last 30 days
Yes, in the last 12 months

{if yes} Please describe your most recent experience of being bullied or harassed. [open-ended]

13. In the past 12 months, have you ever:

a. Engaged in cyber bullying or harassment toward someone else (such as via text, Facebook, Snapchat, or other electronic methods).
b. Engaged in verbal bullying or harassment toward someone else.
c. Engaged in physical bullying or harassment toward someone else.

{Matrix table with same choices for all:}

No, never
No, not in the last 12 months
Yes, in the last 2 weeks
Yes, in the last 30 days
Yes, in the last 12 months

{if yes} Please describe your most recent experience of engaging in bullying or harassment.

14. In the past 12 months, have you ever:

a. Felt things were hopeless
b. Felt overwhelmed by all you had to do
c. Felt very lonely
d. Felt very sad
e. Felt so depressed that it was difficult to function
f. Seriously considered suicide
g. Attempted suicide

{Matrix table with same choices for all:}

No, never
No, not in the last 12 months
Yes, in the last 2 weeks
Yes, in the last 30 days
Yes, in the last 12 month

15. Have you ever had a problem or issue for which you thought psychological or mental health services would be helpful?

Yes, as a minor (<18 years old)
Yes, as an adult (18+)
Yes, both as a minor and an adult
No, never

16. Have you ever received psychological or mental health services… (Select all that apply.)

	Yes, as a minor (<18 years old)	Yes, as an adult (18+)	No
a. from a counselor, therapist, and/or psychologist?			
b. from a psychiatrist?			
c. from a medical provider other than a psychiatrist (e.g. pediatrician, family physician, nurse practitioner)?			
d. from a minister, priest, rabbi, or other clergy?			
e. from someone else? Please specify:			

*{if 15=yes AND 16=no}*You indicated that you once had a problem or issue for which you thought psychological or mental health services would be helpful and that you have never received such services.

17. Why did you not seek services? {open-ended}

18. If in the future you were having a personal problem that was really bothering you, would you consider seeking help from a mental health professional? Yes No

18a. Why or why not? {open-ended}

19. When was the last time you visited a medical provider (e.g. physician, physician's assistant, nurse practitioner, public health nurse) for any reason?

Within the last week
Within the last month
1-3 months ago
4-6 months ago
7-12 months ago
More than one year ago

20. During the average week, how many hours do you work for pay?

0 hours
1-9 hours
10-19 hours
20-29 hours
30-39 hours
40 hours
More than 40 hours

21. During the average week, how many hours do you volunteer?

I do not volunteer.
I volunteer occasionally, but not regularly.
I volunteer regularly, but less than 1 hour per week.
1 hour/week
2 hours/week
3-5 hours/week
6-10 hours/week
11 or more hours/week

22. In the past 6 months, where have you been living most of the time?

Apartment, house, or room that I rent or own
Parent or relative's apartment, house, or room
Apartment, house, or room of someone unrelated to you
Dormitory/college residence
Halfway house
Institution (residential treatment, hospital, jail/prison)
Shelter
Street/outdoors (sidewalk, park, public or abandoned building)

23. What is the highest level of education that you have completed?

Less than high school diploma
High school diploma or GED
Trade/technical/vocational training
Some college, no degree
Associate degree
Bachelor's degree
Graduate or professional degree

24. Are you currently enrolled as a student?

Yes, part-time
Yes, full-time
No

25. Do you have health insurance? Yes No Unsure

26. I identify as…
A man
A woman
Transgender
Gender non-conforming
_____

27. Which best describes your sexual orientation?
Asexual
Bisexual
Gay/Lesbian/homosexual
Pansexual
Straight/heterosexual
_____

28. What is your race? (Select all that apply.)
Alaska Native
American Indian/Native American
Asian/Asian American
Black/African American
Native Hawaiian/Other Pacific Islander
White/Caucasian
Other. Please specify: _____

29. Are you Hispanic or Latino/a? Yes No

30. Are you a refugee? Yes No

31. Have you served in the Armed Forces, the Reserves, or the National Guard?
Yes, I am currently serving.
Yes, I have previously served but am separated or retired.
No, I have not served in the Armed Forces, the Reserves, or the National Guard.
{if yes} **31a. Have you ever been deployed to a combat zone?** Yes No

32. What is your marital status?
Single
Married
Unmarried, living with partner
Divorced/Separated
Widowed

33. Do you have children?
Yes, I have one or more children and one or more lives with me at least part-time.
Yes, I have one or more children and none live with me.
No.

34. Do you currently qualify for or receive public assistance such as WIC, SNAP, and/or Medicaid due to your income? Yes No Unsure

ACC Youth Focus Groups (ages 12 - 18)
Background Survey

You are being asked to complete a survey before participating in the focus group. Your participation in this survey and focus group are voluntary. You can choose to skip questions you do not want to answer. You have the right to change your mind and leave at any time. You will receive a $20 gift card for participating in the survey and focus group. This is yours to keep even if you decide to leave.

Your responses to this survey are confidential. You will get an Alaska place nametag and we will only call you by your place name. Please do not put your real name on this survey. After completing the survey, return it to one of the facilitators. Other focus group participants will not see your survey responses.

We will use this information and focus group responses to write a report for the ACC. We may also use the information to write journal articles and give presentations. Identifying information will not be used.

We will read the focus group consent out loud after everyone completes the survey. You will be divided into smaller groups for the focus group discussion.

Questions about this focus group, contact:
Danielle Reed
University of Alaska Anchorage
Center for Human Development
907-272-8270
danielle@alaskachd.org

Questions about your rights as a research participant, contact:
Sharilyn Mumaw
Compliance Officer
UAA Office of Research & Graduate studies
907-786-1099
simumaw@uaa.alaska.edu

☐ Check the box if you have read the above information, you agree to participate, and you agree to have your answer included with others.

Alaska Place Name: _____

Age: _____ *If under 12, stop here and see the facilitator.*

What grade are you in? _____
If you are not in grades 6th to 12th, stop here and see the facilitator.

Have you lived in Anchorage for at least 6 months in your lifetime? ☐ Yes ☐ No
If no, stop here and see the facilitator.

Have you ever:

Select only one answer to each statement.

	No, never.	Yes, but not in the last 12 months	Yes, in the last 12 months.
Been cyber bullied (such as via text, Facebook, Snapchat, or other electronic methods).	▫	▫	▫
Been verbally bullied.	▫	▫	▫
Been physically bullied.	▫	▫	▫

Have you ever:

Select only one answer to each statement.

	No, never.	Yes, but not in the last 12 months	Yes, in the last 12 months.
Engaged in cyber bullying toward someone else (such as via text, Facebook, Snapchat, or other electronic methods).	▫	▫	▫
Engaged in verbal bullying toward someone else.	▫	▫	▫
Engaged in physical bullying toward someone else.	▫	▫	▫

Have you ever:

Select only one answer to each statement.

	No, never.	Yes, but not in the last 12 months	Yes, in the last 12 months.
Felt things were hopeless.	▫	▫	▫
Felt very lonely.	▫	▫	▫
Felt very sad.	▫	▫	▫
Felt so depressed that it was difficult to function.	▫	▫	▫

Within the last 12 months, how would you rate the overall level of stress you have experienced?
Circle only one answer.

No stress	Less than average stress	Average stress	More than average stress	Tremendous stress

Gender: ▫ Young Man ▫ Young Woman ▫ Something else _____

What is your race/ethnicity? *Select all that apply.*

▫ Alaska Native

▫ American Indian/Native American

▫ Asian/Asian American

▫ Black/African American

▫ White/Caucasian

▫ Native Hawaiian/Other Pacific Islander

▫ Hispanic

▫ Latino/a

▫ _____

Are you a refugee? ▫ Yes ▫ No

In the past 12 months, were you homeless or did you have to sleep outside, in a car, or in a shelter? ▫ Yes ▫ No

Have your parent(s) served in the Armed Forces, the Reserves, or the National Guard?

▫ Yes, currently serving.

▫ Yes, previously served but are separated or retired.

▫ No, my parent(s) have not served in the Armed Forces, the Reserves, or the National Guard.

Thank You! Please make sure your Alaska place name is on this form and return it to the facilitator.

ACC Young Adult Focus Groups (ages 18 – 24)
Background Survey

You are being asked to complete a survey before participating in the focus group. Your participation in this survey and focus group are voluntary. You can choose to skip questions you do not want to answer. You have the right to change your mind and leave at any time. You will receive a $20 gift card for participating in the survey and focus group. This is yours to keep even if you decide to leave.

Your responses to this survey are confidential. You will get an Alaska place nametag and we will only call you by your place name. Please do not put your real name on this survey. After completing the survey, return it to one of the facilitators. Other focus group participants will not see your survey responses.

We will use this information and focus group responses to write a report for the ACC. We may also use the information to write journal articles and give presentations. Identifying information will not be used.

We will read the focus group consent out loud after everyone completes the survey. You will be divided into smaller groups for the focus group discussion.

Questions about this focus group, contact:
Danielle Reed
University of Alaska Anchorage
Center for Human Development
907-272-8270
danielle@alaskachd.org

Questions about your rights as a research participant, contact:
Sharilyn Mumaw
Compliance Officer
UAA Office of Research & Graduate studies
907-786-1099
simumaw@uaa.alaska.edu

☐ Check the box if you have read the above information, you agree to participate, and you agree to have your answer included with others.

Alaska Place Name: _____

Age: _____ *If under 18, stop here and see the facilitator.*

Have you lived in Anchorage for at least 6 months in your lifetime? ☐ Yes ☐ No
If no, stop here and see the facilitator.

Have you ever:

Select only one answer to each statement.	No, never.	Yes, but not in the last 12 months	Yes, in the last 12 months.
Been cyber bullied or harassed (such as via text, Facebook, Snapchat, or other electronic methods).	▫	▫	▫
Been verbally bullied or harassed.	▫	▫	▫
Been physically bullied or harassed.	▫	▫	▫

Have you ever:

Select only one answer to each statement.	No, never.	Yes, but not in the last 12 months	Yes, in the last 12 months.
Engaged in cyber bullying or harassment toward someone else (such as via text, Facebook, Snapchat, or other electronic methods).	▫	▫	▫
Engaged in verbal bullying or harassment toward someone else.	▫	▫	▫
Engaged in physical bullying or harassment toward someone else.	▫	▫	▫

Have you ever:

Select only one answer to each statement.	No, never.	Yes, but not in the last 12 months	Yes, in the last 12 months.
Felt things were hopeless.	▫	▫	▫
Felt very lonely.	▫	▫	▫
Felt very sad.	▫	▫	▫
Felt so depressed that it was difficult to function.	▫	▫	▫

Within the last 12 months, how would you rate the overall level of stress you have experienced? *Circle only one answer.*

No stress	Less than average stress	Average stress	More than average stress	Tremendous stress

What is the highest level of education that you have completed?

- ☐ Currently in high school
- ☐ Less than high school diploma
- ☐ High school diploma or GED
- ☐ Trade/Technical/Vocational training
- ☐ Some college, no degree
- ☐ Associate's degree
- ☐ Bachelor's degree
- ☐ Graduate or professional degree

Are you currently enrolled as a student? ☐ Yes ☐ No

Gender: ☐ Man ☐ Woman

Which best describes your sexual orientation?

- ☐ Asexual
- ☐ Bisexual
- ☐ Gay/Lesbian/homosexual
- ☐ Pansexual
- ☐ Straight/heterosexual

What is your race/ethnicity? *Select all that apply.*

- ☐ Alaska Native
- ☐ American Indian/Native American
- ☐ Asian/Asian American
- ☐ Black/African American
- ☐ White/Caucasian
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Hispanic
- ☐ Latino/a
- ☐ _____

Are you a refugee? ☐ Yes ☐ No

In the past 12 months, were you homeless or did you have to sleep outside, in a car, or in a shelter? ☐ Yes ☐ No

In the past 12 months, have you been involved with the criminal justice system? ☐ Yes ☐ No

Have you served in the Armed Forces, the Reserves, or the National Guard?

- ☐ Yes, I am currently serving.
- ☐ Yes, I have previously served but I am separated.
- ☐ No, I have not served in the Armed Forces, the Reserves, or the National Guard.

Thank You! Please make sure your Alaska place name is on this form and return it to the facilitator.

Focus Group Questions (12-18):

Bullying

Opening warm-up question

1. How long have you lived in Anchorage and what is one thing you like about living here?

Define bullying

2. When I say "bullying", what do you think of?
    a. What other words would you use for "bullying"?
    b. How would you define bullying type behavior for your age group?
    c. What are some examples of bullying or bullying behavior?
3. Now thinking about your age group and the behavior you all described,
    a. For your age group, where does bullying take place?
    b. For your age group, who does it happen between?
    c. For your age group, why do some people bully?

Impact of bullying

4. How much of a problem is bullying for people in your age group?

Support

5. Think of someone who experienced bullying and during that time seemed to be ok. It might be you, a friend, or an acquaintance.
    a. What helps them to cope with it?
    b. What is it about the individuals involved?
    c. What is it about that situation?
6. What can we do to address bullying among your age group?
    a. What would help young adults/youth to not bully?

Focus Group Questions (12-18):
Feeling lonely, sad, and hopeless

Opening warm-up questions

1. How long have you lived in Anchorage and what is one thing you like about living here?

Definition

2. How do you know when someone your age is lonely, sad, or hopeless?
    a. What do they do?
    b. Who or where do they go to for support? Why?

Why youth/young adults feel lonely, sad, and/or hopeless

3. Feelings of loneliness have been increasing among youth in Anchorage over the past 10 years. Why do you think this is happening?
4. Around 30% of youth in Anchorage report feeling so sad or hopeless every day for two weeks or more that they stopped doing usual activities. Why do you think so many youth feel sad and hopeless?

Support

5. What helps Anchorage young adults/youth who feel lonely, sad, or hopeless?
    a. What kind of activities might help?
    b. How do young adults/youth help their peers?
    c. How does the community help?
6. Think of someone who has felt lonely, sad, or hopeless and is now doing ok. It might be you, a friend, or an acquaintance.
    a. What helped them to get through it?
7. Feeling like you matter to your community promotes wellbeing.
    a. How do you know you matter to your community?
    b. How can the Anchorage Community help young adults/youth feel like they matter?

Wrap-up

8. The ACC is interested in the mental wellness of Anchorage youth. They are looking to create programs to support young adults'/youth's mental wellbeing.
    a. What kinds of programs or activities could they do that would be helpful and would engage young adults/youth your age?

Focus Group Questions:
Bullying

Opening warm-up question

1. How long have you lived in Anchorage and what is one thing you like about living here?

Define bullying

2. When I say "bullying", what do you think of?
    a. What other words would you use for "bullying"?
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    a. For your age group, where does bullying take place?
    b. For your age group, who does it happen between?
    c. For your age group, why do some people bully?

Impact of bullying

4. How much of a problem is bullying for people in your age group?

Support

5. Think of someone who experienced bullying and during that time seemed to be ok. It might be you, a friend, or an acquaintance. If you can't think of a current situation think back to high school.
    a. What helps them to be ok?
    b. What is it about the individuals involved?
    c. What is it about that situation?
6. What can we do to address bullying among your age group?
    a. What would help young adults/youth to not bully?

Focus Group Questions:
Feeling lonely, sad, and hopeless

Opening warm-up questions

1. How long have you lived in Anchorage and what is one thing you like about living here?

Definition

2. How do you know when someone your age is lonely, sad, or hopeless?
    a. What do they do?
    b. Who or where do they go to for support? Why?

Why youth/young adults feel lonely, sad, and/or hopeless

3. Among a sample of 18-24 year olds in Anchorage more than 35% reported feeling very lonely in the past month. Why do you think so many young adults feel lonely?
4. Among a sample of 18-24 year olds in Anchorage over 35% reported feeling very sad and over 20% reported feeling hopeless. Why do you think so many young adults feel sad or hopeless?

Support

5. What helps Anchorage young adults/youth who feel lonely, sad, or hopeless?
    a. What kind of activities might help?
    b. How do young adults/youth help their peers?
    c. How does the community help?
6. Think of someone who has felt lonely, sad, or hopeless and is now doing ok. It might be you, a friend, or an acquaintance.
    a. What helped them to get through it?
7. Feeling like you matter to your community promotes wellbeing.
    a. How do you know you matter to your community?
    b. How can the Anchorage Community help young adults/youth feel like they matter?

Wrap-up

8. The ACC is interested in the mental wellness of Anchorage youth. They are looking to create programs to support young adults'/youth's mental wellbeing.
    a. What kinds of programs or activities could they do that would be helpful and would engage young adults/youth your age?

UAA Center for Human Development
UNIVERSITY of ALASKA ANCHORAGE

UAA Center for Behavioral Health Research & Services
UNIVERSITY of ALASKA ANCHORAGE

UAA Department of Health Sciences
UNIVERSITY of ALASKA ANCHORAGE

UAA Justice Center
UNIVERSITY of ALASKA ANCHORAGE