State of Idaho
Substance Abuse
Strategic Prevention Plan
March 2014

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ODP
Idaho Office of Drug Policy

ACKNOWLEDGEMENTS

The 2014 State of Idaho Substance Abuse Strategic Prevention Plan is a collaborative effort between the Office of Drug Policy and numerous State agencies and organizations. The document represents the work of multiple contributors who offered the insight, discussion and research necessary to develop a statewide substance abuse prevention strategic plan.

The Idaho Office of Drug Policy acknowledges the following groups for their contributions to the development of this strategic plan and the successful implementation of this project:

➢ The Idaho Strategic Prevention Framework Advisory Council (Page 9)

➢ The Idaho State Epidemiologist Outcome Workgroup (Page 11)

➢ The Idaho State Evidence Based Workgroup (Page 12)

➢ The Idaho State Priority Scoring Sub-Committee (Page 22)

➢ The Boise State University Evaluation Team

DISCLAIMER

This document was produced by the Idaho Office of Drug Policy under the Idaho Strategic Prevention Framework State Incentive Grant (SPF SIG). The Idaho SPF SIG is part of a federal initiative created by the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Prevention (CSAP) to assist states and US territories to prevent the abuse of alcohol, tobacco and other drugs (ATOD). Publication of this document does not necessarily reflect the opinions or policies of the sponsoring agencies that participated in or funded the aforementioned.

The document was produced by the Idaho Office of Drug Policy as part of its efforts to develop a practical and user-friendly ATOD needs assessment for Idaho and its communities.

MISSION AND VISION

Mission: The Strategic Prevention Framework Advisory Council leads Idaho's substance abuse policy and prevention efforts by developing and implementing strategic action plans and collaborative partnerships to reduce drug use and related crime, thereby improving the health and safety of all Idahoans.

Figure 1: Idaho State Flag

Vision: The Strategic Prevention Framework Advisory Council envisions an Idaho free from the devastating social, health, and economic consequences of substance abuse.

GOALS AND PRIORITIES

SPF Goals:

➢ Prevent the onset and reduce the progression of substance abuse, including underage drinking;

➢ Reduce substance abuse related problems in communities; and

➢ Build prevention capacities and infrastructure at the state/tribal and community levels.

State Priorities:

➢ Prescription Drug Use

➢ Alcohol Health Outcomes

➢ Marijuana Use

INTRODUCTION AND BACKGROUND

Idaho received the Strategic Prevention Framework State Incentive Grant (SPF SIG) from the Substance Abuse Mental Health Services Administration (SAMHSA) on August 1, 2013. There are three overarching goals of the project, which include:

➢ Prevent the onset and reduce the progression of substance abuse, including underage drinking;

➢ Reduce substance abuse related problems in communities; and

➢ Build prevention capacities and infrastructure at the state/tribal and community levels.

Figure 2 *Five Steps of the Strategic Prevention Framework*

One of the major requirements of the SPF SIG is to develop a state substance abuse prevention plan using the Strategic Prevention Framework (SPF) model. SPF is an outcomes-based prevention model that focuses on the substance abuse consequences and consumption patterns that need to be changed. The SPF model also uses a public health approach that focuses on achieving positive health outcomes for the entire population, rather than a sub-set of individuals.

The purpose of the project is to implement the five components of the SPF planning model at both state and community levels in Idaho. Figure 2 details this process (*Center for Substance Abuse Prevention, 2005*).

Each of the steps is briefly described below and in more detail throughout the plan.

Assessment – Collect data to determine needs and identify resources and readiness to address both needs and service gaps.

Capacity – Mobilize and build capacity (e.g., financial and organizational) by engaging stakeholders to address identified needs.

Planning – Develop a comprehensive strategic plan that includes the state's vision and substance abuse prevention priorities, including essential training and educational activities and the allocation of resources to community coalitions.

Implementation– Build infrastructure and capacity to support the implementation of policies, programs, and practices at the community level.

Evaluation – Measure the changes in the state's targeted priority consequences and consumption patterns and the overall effectiveness of the state strategic plan.

Cultural competence and sustainability are at the center of the model and these concepts must be addressed at every step of the process. At the state and regional levels, the system infrastructure that supports prevention work must be ingrained with the ideals of cultural competence and inclusion. At the local level, it is critical to recognize that every community is composed of subgroups with unique and complex cultural needs and that these diverse groups must be included in every facet of prevention planning. At the state, regional, and community levels, sustainability – the process of ensuring adaptive and effective systems that achieve and maintain desired long-term results – requires that adaptable, effective prevention systems demonstrate organizational capacity and benefit from the commitment of key stakeholders who leverage both financial and non-financial support.

The SPF SIG represents an opportunity to transform the way substance abuse prevention is planned and implemented into a data-driven, outcome-based prevention system addressing one of the most costly health problems of the nation: Use and abuse of substances. At the state level, the SPF SIG will advocate for inter-agency coordination for the allocation of prevention funds, as well as for coordination of services in order to reduce possible gaps and adequately address the needs of communities. The structural approach is fundamental to ensure that the SPF SIG model is institutionalized and sustained at the state level beyond the period of federal funding.

The Idaho Office of Drug Policy (ODP) serves as the state agency overseeing the implementation of the SPF SIG. The SPF SIG requires that each state utilize a SPF Advisory Council (SPFAC), a State Epidemiological Outcomes Workgroup (SEOW), and an Evidence Based Practices Workgroup (EBP).

Table 1: 2013/2014 Idaho Strategic Prevention Framework Advisory Committee

Strategic Prevention Framework Advisory Committee	
Name	**Agency**
Alan Miller	Dept. of Juvenile Corrections
Bill Lutz	DEA
Cady Snell	High School Student
Darin Burrell	Community Coalitions of Idaho
Don Maestas	CAPT West Resource Team
Donna Honena	Shoshone-Bannock Tribe
Elisha Figueroa	ODP Administrator, NPN
Ivie Smart	Project Filter
Kendra Knighten	Office of the Governor
Mary Burke	Office of Highway Safety
Leon Duce	Association of Idaho Cities
LeQuyen Tran	SAMHSA/CSAP Project Officer
Lisa MacKenzie	Center for Health Policy
Luke Malek	State Representative
Margie Gonzalez	Idaho Com. on Hispanic Affairs
Marv Hagedorn	State Senator
Matt McCarter	Dept. of Education
Nathan Drashner	ODP, Epidemiologist/Analyst
Patricia Tobias	Idaho Courts
Penny Jones	RAC Chair, Region 3
Rosie Andueza	Dept. of Health and Welfare
Russ Wheatley	Alcohol Beverage Control
Norma Jaeger/Ryan Porter	Supreme Court
Sandina Begic	Boise State University
Sharlene Johnson	ODP, SPF SIG Project Director
Stephanie Lindsay	Center for Health Policy
Tammy Rubino	Community Coalitions of Idaho
Tedd McDonald	Boise State University
Teri Carrigan	RADAR Network Center

Idaho's SPFAC membership (Table 1) was determined by the grant guidelines, current partnerships in Idaho, and identified needed partnerships. Of note, membership includes two representatives of the Governor's Office: Kendra Knighten, Special Assistant for Health and Human Services, and Elisha Figueroa, Administrator of the Idaho Office of Drug Policy, Executive Office of the Governor. All members of the Council bring to the table their knowledge and agency's resources. The SPF Advisory Council provides ongoing advice and guidance to SIG staff, the SEOW, the EBP Workgroup and other ad-hoc workgroups deemed necessary as the project is implemented. The statewide needs assessment, capacity building, statewide strategic plan, implementation and evaluation of the project are conducted under the direction and guidance of the Council.

In 2006, Idaho's Department of Health and Welfare was awarded a subcontract with the federal contractor handling the development of State Epidemiological Outcome Workgroups (SEOW) for Center for Substance Abuse Prevention. The 19-member Idaho SEOW (Table 2) is already well established and has completed all the annual deliverables required by the SEOW contract. In addition to these accomplishments the SEOW also enacted components of the SPF process by setting priorities using risk and protection factors, developing a web-based monitoring system, and developing a state wide community level prevention survey (Idaho Youth Prevention Survey).

Additionally the SEOW is tasked with the following SPF SIG objectives:

1) Developing a set of key data indicators for use in describing substance use/abuse in Idaho including:
   a) Patterns of consumption over time;
   b) Magnitude and distribution of substance related consequences;
2) Conducting a careful, systematic review and analysis of data;
3) Interpreting and communicating findings;
4) Recommending objectives for review, modification and/or approval by the Advisory Council;
5) Considering and recommending which data indicators are appropriate for evaluation purposes;
6) Serving as consultant to the SPF Advisory Council in determining resource allocation methods.

| Idaho's State Epidemiological Outcomes Workgroup (SEOW) ||
Name	Agency
TSgt. Janie Ramos	Idaho National Guard
Dr. Steve Meier	U of I, Dept. of Psychology
Sarah Siron	H&W, Family and Community
Dr. Robert Graff	H&W, Health
Rob Owens	Supreme Court
Pam Harder	H&W, Vital Stats
Monty Prow	Dept. of Juvenile Corrections
Janeena Wing	ID State Police
Nathan Drashner	ODP, Epidemiologist/Analyst
Cathy McCabe	Department of Correction
Terry Pappin	H&W
Kathy Eroschenko	ISU, College of Pharmacy
Tedd McDonald	Boise State University
Sharlene Johnson	ODP, SPF SIG Project Director
Matt McCarter	Dept. of Education
Tammy Rubino	Community Coalitions of ID

Idaho's EBP Workgroup (Table 3) will be responsible for several related functions. This workgroup will provide communities with information and technical assistance regarding effective programs, practices, and policies; how to implement these with fidelity; and how to evaluate their effectiveness.
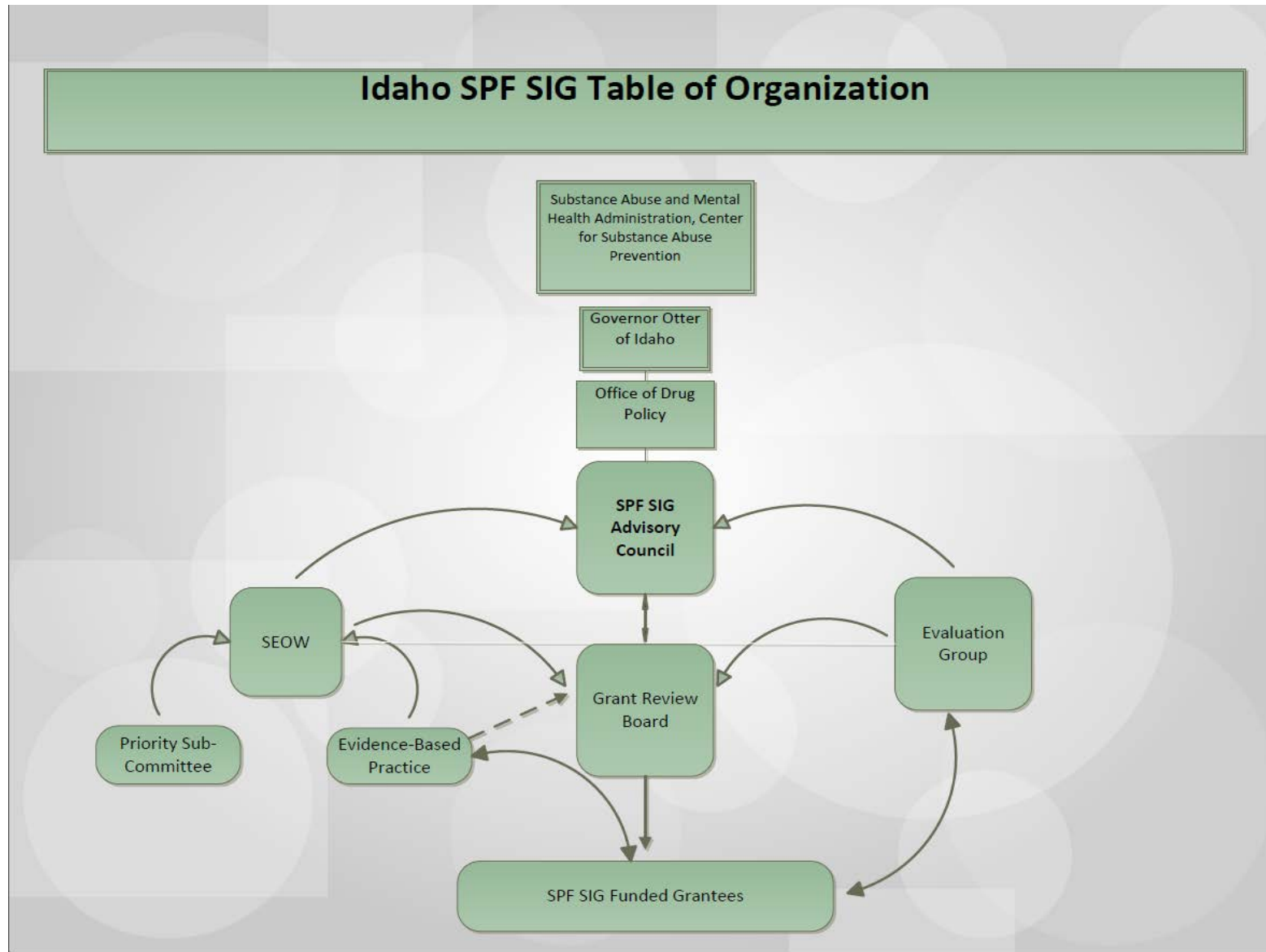
More specifically it is tasked with:

1) Reviewing and approving/disapproving strategies proposed by sub-recipient communities based on whether or not they achieve a certain level of evidence;
2) Creating and disseminating an evidence-base practices guidance document;
3) Reviewing and approving a list of evidence-based programs, practices, and policies for use by funded coalitions;
4) Developing a process by which coalitions can submit for approval interventions not already listed; creating evidence-based practices "Best Fit" forms for coalitions to use when submitting their proposed strategies for review.

Evidence Based Practice Work Group (EBP)	
Name	**Agency**
Alisha Passey	Bonneville Youth Development Council
Charlotte Combe	Lutheran Community Services
Don Maestas	CAPT West Resource Team
Joni Ward	Idaho Department of Juvenile Corrections
Kerri Wilfong	Kootenai Alliance for Children and Families
Ryan Porter	Idaho Supreme Court
Monty Prow	Dept. of Juvenile Corrections
Janeena Wing	ID State Police
Nathan Drashner	ODP, Epidemiologist/Analyst
Terry Basolo	Blaine County Anti-Drug Coalition
Tedd McDonald	Boise State University
Sharlene Johnson	ODP, SPF SIG Project Director
Matt McCarter	Dept. of Education
Marianne King	Office of Drug Policy-SAPT Director
Tammy Rubino	Community Coalitions of ID

Once adopted, The State of Idaho Substance Abuse Strategic Prevention Framework Plan will be reviewed and updated yearly based on input from the SPFAC, SEOW and EBP workgroup's. It is anticipated that communities will be able to effectively move chosen indicator data in a positive way in their local communities, thereby moving the construct data of the statewide priorities. This will also guide the annual review and update of this plan.

Table 4 Idaho SPF-SIG Organizational Chart

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ASSESSMENT

Demographics

The State of Idaho is predominantly rural in character and culture, reflecting traditional morals, values, and lifestyles, with pockets of cultural and ethnic diversity. Its largest metropolitan area, the Treasure Valley, which includes both Ada and Canyon Counties, contains about 37% of the state's population. Idaho's urban, suburban, rural, and tribal lands have very different historical, social, and cultural features. Each community's needs and perspectives about ATOD may differ from those of other groups and subcultures. Within these communities, prevention efforts must take into special account the role social and economic conditions play in problems associated with ATOD (e.g., poverty, inequity, inequality), and the need to engage community leaders and networks in prevention.

Idaho is a geographically large state with vast frontier expanses and relatively few heavily populated areas. To provide a better understanding of the state of Idaho, the following six maps highlight demographic characteristics at the county level in Idaho. (See Appendix B for a map of Idaho counties.)

Idaho Population per Square Mile, 2010

Legend:
- 0.6 - 4.8 people
- 4.801 - 11.8 people
- 11.81 - 45.9 people
- 45.91 - 105.3 people
- 105.4 - 370.1 people

Source: US Census Bureau
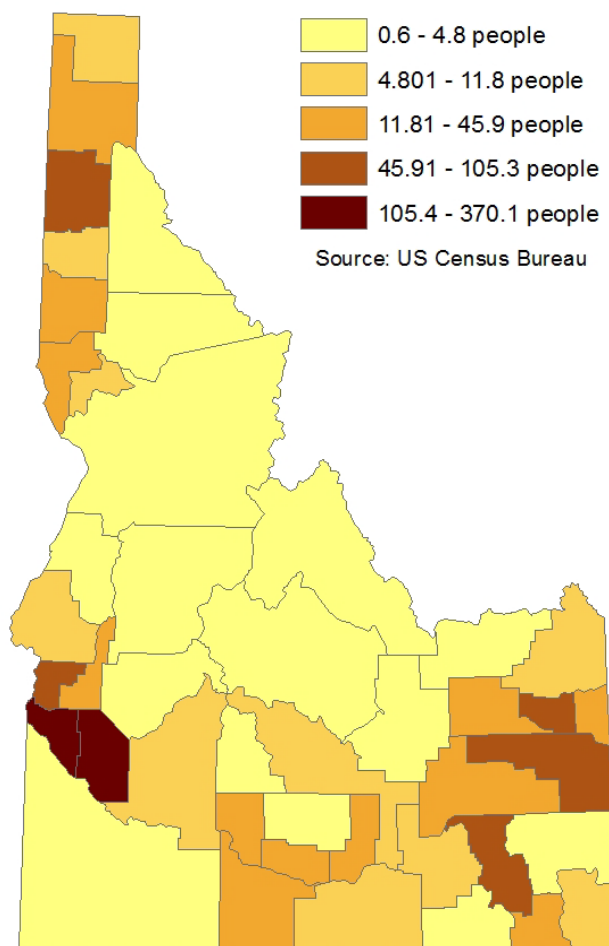
Figure 3

Idaho's most populated counties are Ada, Canyon, and Kootenai counties. Idaho's population in 2010 was 1,567,582, up 21.1% from the 2000 Census. During the 1990's the population in Idaho increased by 28.5%, with this rate of growth still occurring in some areas. It should be noted that the population growth in metropolitan areas has continuously outpaced growth in nonmetropolitan areas. This is important to keep in mind in relation to capacity.

Idaho Population Change, 2000 to 2010

Legend:
- -7.3% - -1.9%
- -1.8% - 6.6%
- 6.7% - 20.1%
- 20.2% - 43.7%
- 43.8% - 69.5%

Source: US Census Bureau
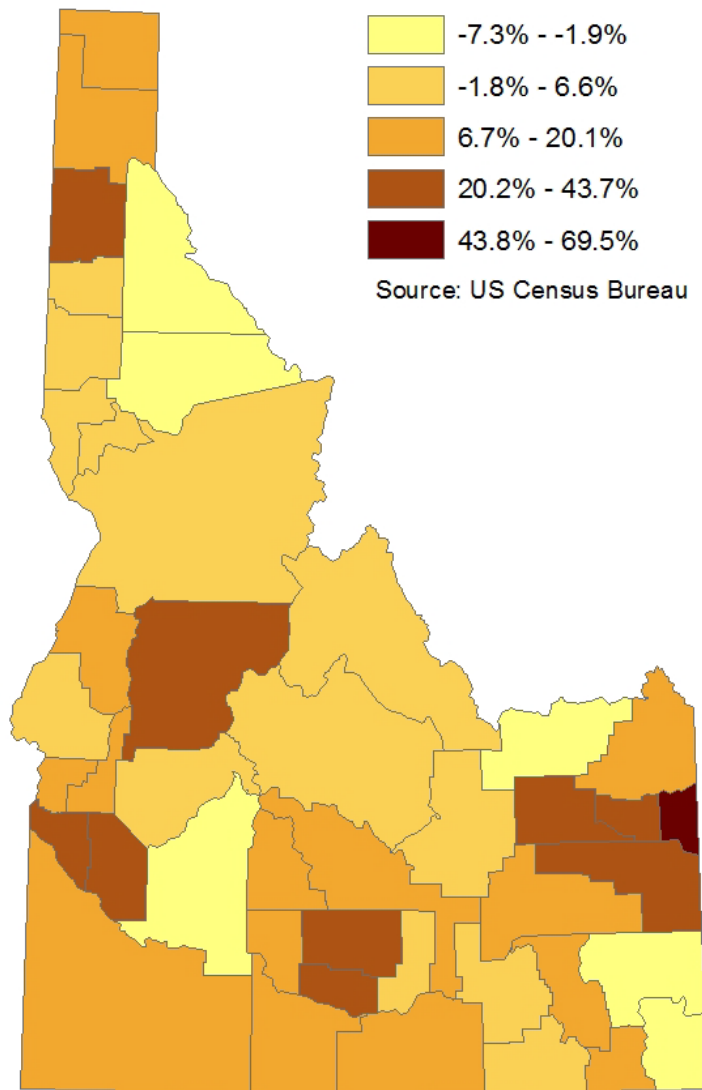
Figure 4

Counties which experienced the highest levels of population growth from 2000 to 2010 were urban or resort based economies. Counties with natural resource based economies often experienced declines in population. Like population density, growth rate can also affect capacity. Additionally, extreme population growth or contraction can affect the nature of problems that communities are dealing with on a local level.

Percent Population age 25+ in Idaho with Bachelor's Degree or Higher, 2009
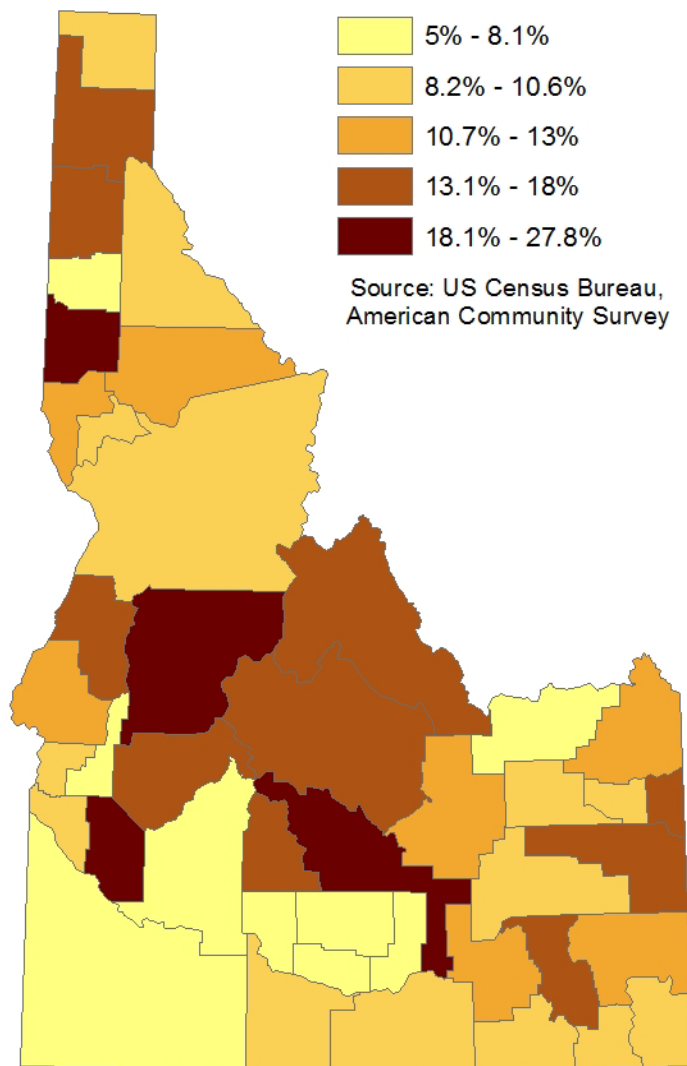
Figure 5

The percent of the population age 25 and over that has earned either a Bachelor's Degree or higher is 27.9% nationally compared with Idaho's rate of 24.3%. Educational attainment is a commonly addressed risk factor that can be linked to a variety of community level social issues including substance abuse.

Percent of Idaho Households with Income below Poverty Level, 2009
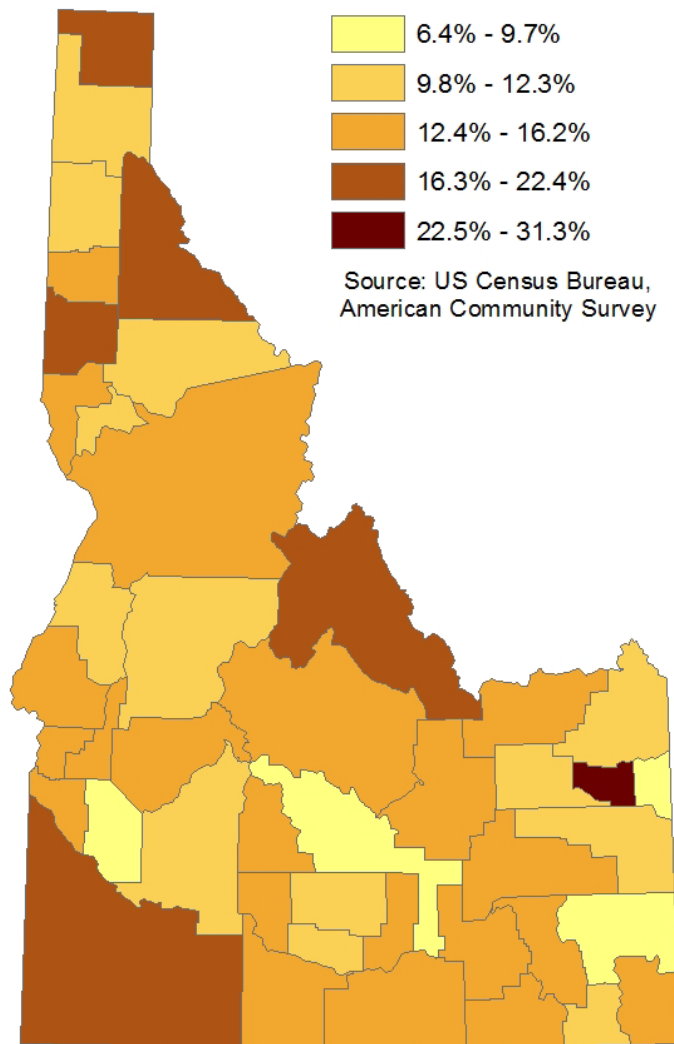
Figure 6

In 2009, nationally the percent of the population in poverty was 14.3%, and interestingly in Idaho the rate was also 14.3%. The counties with the lowest percent of the population in poverty were Ada, Blaine, Caribou and Teton. The community with the highest rate of poverty was Madison with 31.1%. Like educational attainment, poverty level has been shown to have a strong correlation with substance abuse issues and is a common risk factor.

Idaho Median Household Income, 2010

Legend:

- $33,773.00 - $37,628.00
- $37,628.01 - $40,853.00
- $40,853.01 - $45,759.00
- $45,759.01 - $50,155.00
- $50,155.01 - $67,189.00

Source: US Census Bureau,
ESRI Forecast for 2010
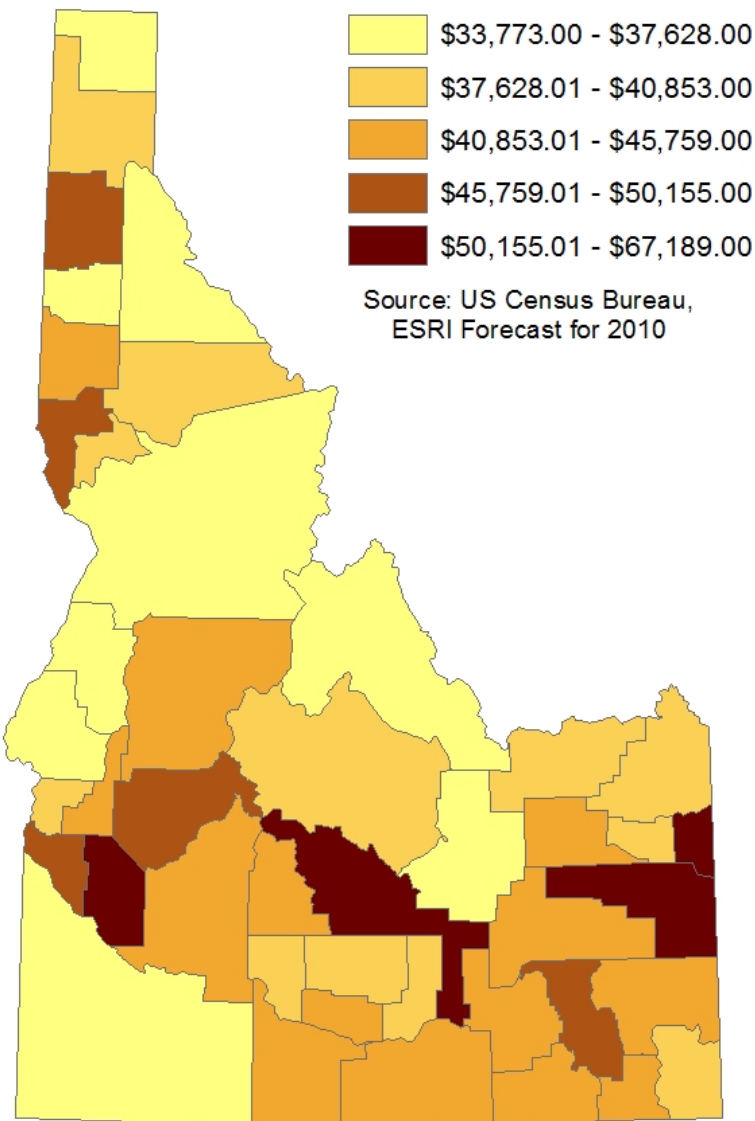
Figure 7

Within Idaho the median household income in 2010 was $46,423, while nationally this figure was $51,914. Median household income in the counties ranged from a low of $33,773 in Clark County to a high of $67,189 in Blaine County.

Idaho Unemployment Rate, March 2011

4.5% - 5.6%	
5.7% - 7.9%	
8.0% - 10.2%	
10.3% - 12.4%	
12.5% - 14.9%	

Source: Idaho Department of Labor,
Communications & Research
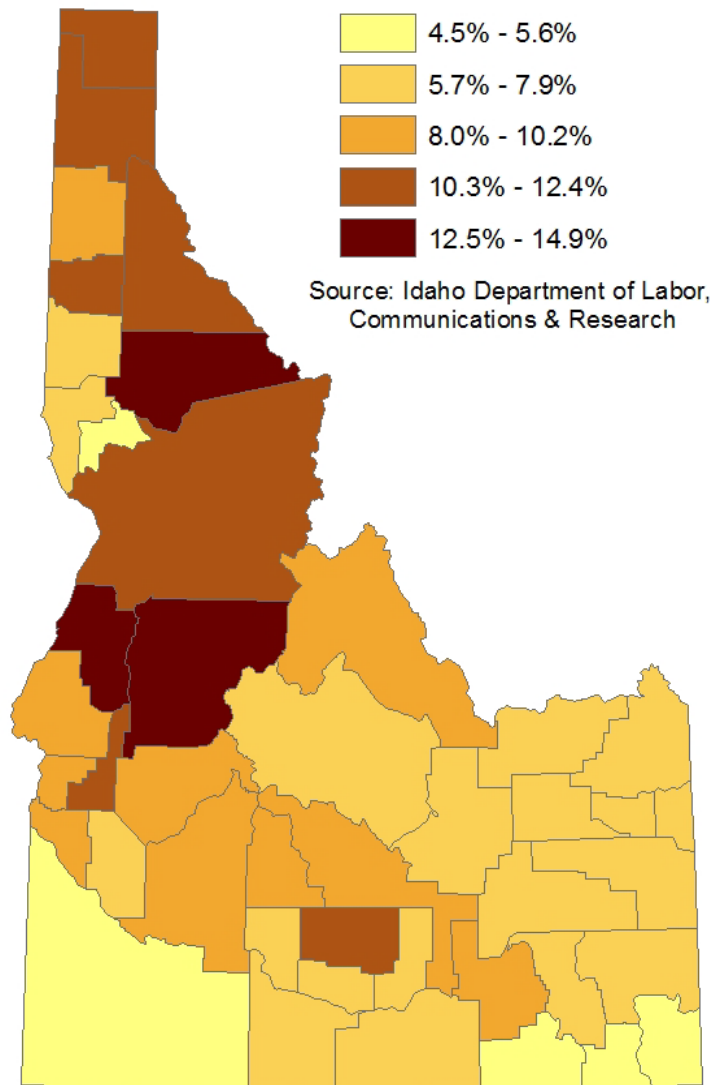
Figure 8

The March 2011 unemployment rate in Idaho was 8.7%, compared to 8.8% for the nation. This ranged from an unemployment rate of 4.5% in Owyhee County to 14.9% in Adams County.

METHODOLOGY

GENERAL REVIEW

The State of Idaho Substance Abuse Needs Assessment was developed under the direction of the SEOW and in turn the methodology used to develop the report is a standard format provided to all SEOWs. The following is a review of that methodology developed by the Pacific Institute for Research and Evaluation (PIRE).

Substance abuse prevention planning begins with a clear understanding of alcohol, tobacco, and other drug use (ATOD), the risk and protective/causal factors associated with ATOD use and the chief consequences of their use (Figure 9). In such an outcome-based approach, understanding the nature and extent of substance use and its related problems (consumption and consequences) is critical for determining prevention priorities and aligning relevant and effective strategies to address them. The Center for Substance Abuse Prevention (CSAP) recommends that state epidemiological profiles and assessments predominantly focus on substance use and related consequences as the first step in developing an outcomes based approach to prevention. Focusing on consumption and consequences does not by any means undermine the importance of measuring and understanding causal factors that lead to substance abuse and substance abuse-related consequences. Understanding the factors that contribute to substance use and related problems (also referred to as "intervening variables or "risk and protective factors") is the logical next step after the State has developed a full understanding of the substance use patterns and consequences it seeks to address. Following this guidance, the following consumption and consequences information was compiled for Idaho.

Figure 9: Outcomes-based prevention model

CONSUMPTION:

Consumption is defined as the use and high-risk use of alcohol, tobacco, and illicit drugs. Consumption includes patterns of use of alcohol, tobacco, and illicit drugs, including initiation of use, regular or typical use, and high-risk use.

CONSEQUENCES:

Substance-related consequences are defined as adverse social, health, and safety consequences associated with alcohol, tobacco, or illicit drug use. Consequences include mortality and morbidity and other undesired events for which alcohol, tobacco, and/or illicit drugs are clearly and consistently involved. Although a specific substance may not be the single cause of the consequence, scientific evidence must support a link to alcohol, tobacco, or illicit drugs as a contributing factor to the consequence.

Each of these two major groupings can be broken down into discrete categories or prevention-related "constructs" for each of the major substance types. The Idaho SEOW chose to break substances into five categories; alcohol, tobacco, prescription drugs, marijuana and other drugs. The constructs provide a way to conceptualize and organize key types of consumption patterns and consequences.

For example, with respect to alcohol, constructs related to consequences include mortality and crime, and constructs related to consumption patterns include current binge drinking and age of initial use. For each construct, Idaho attempted to find one or more specific data measures (or "indicators") to assess and quantify the prevention-related constructs. Idaho's indicator data is collected and maintained by various community and government partners. Numerous constructs and indicators for substance use and related consequences exist at the national, state, and sub-state level. As such, assembling and interpreting all of the available prevention-relevant data would be unproductive. Therefore, starting with a set of key constructs assisted Idaho in organizing and narrowing the search for data relevant to decision making in Idaho. As suggested by PIRE, Idaho was guided in this process by what information was needed rather than starting with an inventory of all the data available. That is, the existence of data did not drive decisions about which problems to focus on. Rather, constructs of real interest were determined followed by the identification of indicators available to measure those constructs. If insufficient data was available, that construct was not represented.

Given the Office of Drug Policy's focus on building and strengthening Idaho's prevention system, the Idaho SEOW focused on those constructs and indicators that will prove most useful for prevention decision-making. All indicators included

in this assessment have been found to be valid and reliable measures of the constructs they were intended to reflect. Additionally, with respect to consequences, constructs for which there is strong research evidence regarding the causal influence of substances abused were used.

INDICATOR SELECTION

The Idaho SEOW went through a four step process to determine appropriate indicators.

Step 1: A review of the literature was conducted by the research staff establishing a comprehensive list of over 150 possible indicators grouped by substance and construct type. A factor which complicates data in Idaho is that although we have a significant breadth of sources, due to small populations we struggle to provide granularity to that data. With that in mind, the SEOW chose to look at the problem in the context of the whole state. The SPF Advisory Council next addressed subpopulations and communities of interest in detail. Over the next three months a Priority Setting Subcommittee composed of SEOW membership and SPF Advisory Council membership worked together to review the data, indicators and analysis and develop the State Needs Assessment Report. The subcommittee's work concluded by setting a list of priorities upon which the state will focus.

Step 2: Driven by the aforementioned interest of having data sources that would reflect a wide scope, the workgroup reviewed the indicators and their sources. This resulted in a narrowed list of 129 indicators. While this list was narrowed from the original review, it was the consensus of the workgroup that criteria needed to be established to further guide the process, with the goal of the workgroup to reduce the list to a manageable level of approximately 40 indicators. The criteria established were as follows:

1) Five years of data had to be available on the indicator.
2) At least one indicator in each construct had to be collected on a community or regional geographic level.
3) At least one indicator in each construct had to be available with data regarding the key subpopulations of transition-aged youth (18-25); military, veterans and their families; Native Americans; Hispanics; and/or individuals exposed to adverse childhood experiences.
4) At least one indictor in each construct had to be available with data regarding youth (under 18).
5) Indicators should be prioritized based on data sources' level of contact.
6) Constructs must have at least three indicators available to be considered.

For the purposes of the fifth criterion, level of contact was defined as "at what point does each dataset interact with their population". For example, arrest records interact with an individual before court records do, which precedes the correctional system involvement. With that in mind, arrest records are the first level of contact, courts are the second, and correctional systems the third.

In regard to the sixth criterion, when insufficient indicators were available in a construct, the indicators were merged with the indicators from another construct to create a new broader construct. A construct with a single indicator could result in priorities that are driven by isolated phenomena. By ensuring constructs contain multiple indicators only, constructs that clearly demonstrate a consistent trend across multiple indicators will emerge. An example of this is in the Prescription Drugs category. While the SEOW felt strongly that prescription drugs should be considered, Idaho lacks the depth of data to adequately portray both consumption (use) and consequences (crime). As a result, indicators were included from both constructs to create a general Prescription Drug Use construct. So while constructs were eliminated based on this criterion, indicators were not eliminated due to this criterion.

Step 3: After applying these criteria to each indicator, the workgroup reassembled and further eliminated 51 indicators. In the process of reviewing the criteria, the fifth criterion, prioritizing data sources based on level of contact, was further refined to reflect a relevance rating and record type. Relevance rating was on a scale of one to three, with one being very relevant and three being not very relevant. After some discussion, the SEOW found that while expression of an indicators "level of contact" was critical to establish, it was better represented by providing a score of "relevance" and classifying each indicator by record type. Each indicator's relevance score was provided by the SEOW member who provided the indicator after some group discussion. Record type was a classification of each indicator based on if it was an administrative or survey based source. Table 5 is an example of the scoring system employed. Scoring for all indicators can be found in Appendix A. At this point, the resulting list of 78 indicators was turned over to SEOW staff to further elimination.

Table 5 Indicator Scoring Example

Constructs	Constructs and Indicators		Criteria						
	Indicators	Sources	Community/ Regional Collection	5 years of data	Sub Population Data Available	Youth Data Available	Relevance	Record Type
	Alcohol Consumption							
Current use	Percent of students in grades 9-12 reporting use of alcohol in the past 30 days	YRBS	N	Y	N	Y	2	S
	Idaho gallons sales per capita	Liquor	Y	Y	N	N	1	A
	Percent of adults (aged 18 or older) reporting use of alcohol in past 30 days	BRFSS	Y	Y	Y	N	1	S

Step 4: SEOW staff employed a hybrid Delphi method to further eliminate 40 indicators. The Delphi method was developed as a forecasting tool by the RAND Corporation in the 1960s. While initially developed to address national security forecasting, it has since been deployed to deal with any number of complex issues in many fields. By relying on the opinions of a panel of experts in multiple rounds of questioning (or scoring, in our case) it has been found a "correct" answer can be established through consensus. The process is concluded after a pre-determined point is reached. In the case of Idaho's efforts this was two rounds of review.

First, recommendations were collected from each content expert regarding each indicator. These suggestions were then reviewed and a second round of analysis was conducted by two additional content experts, following which their recommendations were implemented. The resulting indicator list (See "Final Indicator Table" in Appendix B) is composed of 12 constructs and 38 indicators.

CONSTRUCTS AND INDICATORS

An effort was made to ensure that as many constructs as possible were represented in the needs assessment, but not at the expense of reliability. This resulted in the identification of roughly the same number of constructs that Idaho has identified in past epidemiological profiles. However, significantly more indicators are represented with a greater capacity to review subpopulations.

It should be noted that the BRFSS changed methods for collecting and analyzing survey data starting in 2011. Changes made in 2011 increased the representation of formerly underrepresented adults such as those living in cell phone-only households, those with lower incomes, minorities, and younger adults. Due to these improvements, 2011 estimates may vary slightly from previous years. Because of the new methods, figures for 2011 and forward cannot be statistically compared with those from 2010 and earlier. Shifts in observed prevalence from 2010 to 2011 for BRFSS measures may simply reflect improved methods of measuring risk factors, rather than true trends in risk-factor prevalence.

For a more comprehensive review of data sources please see Appendix C. It should be noted that while the SEOW often choose to cite state data sources over their corresponding national aggregates, in many cases that state data source is providing the information that is found in the national data source. Typically the data in those national data sources is simplified from what is collected at the state level. A strong example of this is in the case of the Uniform Crime Reports (UCR) program. As a state, Idaho collects data using the National Incident Based Reporting System which provides a much more comprehensive data source than UCR program. Additionally using state data sources enhances the partnerships the SEOW has built over the past 6 years and allows for quicker responses should questions arise at the local level.

While the SEOW reviewed subpopulations, due to a high degree of variance created by small denominators, the determination was made that they should not be published. From an ethical perspective it would be irresponsible to do so and may only serve to create confusion or undue bias. The data around the subpopulations is maintained by the SEOW and may be used on a case by case basis with appropriate cultural sensitivity.

While comparisons to national metrics were considered, they often were found to be irrelevant due to Idaho generating significantly lower rates on some indicators. In many cases, there was simply a lack of adequate national comparisons.

Finally, it should be noted that the SEOW elected to merge both consequences and consumption on the substance abuse areas of marijuana and prescription drugs. Due to limited data sources, there simply were not indictors of sufficient relevance to have constructs representing both consumption and consequences for these substances. That said, the SEOW felt both marijuana and prescription drug abuse were sufficiently important to justify remaining distinct from other substances.

The following pages include graphs and tables on the specific constructs the SEOW selected for Idaho. By displaying the constructs in this format, it is hoped that the document can be more easily disseminated to, and used by, stakeholders and policy makers.

Current Use of Alcohol

Alcohol Consumption		
Construct	**Indicator**	**Source**
Current use	% of students gr. 9-12 reported use of alcohol past 30 days	**YRBS**
	Idaho gallons sales per capita	**Liquor Division**
	% of adults(aged 18 or older) reporting use of alcohol past 30 days	**BRFSS**

Table 6: Current Use of Alcohol Construct

Note that due to the aforementioned sampling methodology change in 2011 of the BRFSS, a definitive conclusion should be approached with caution. Additionally, the YRBS is only sampled in the spring of odd years.
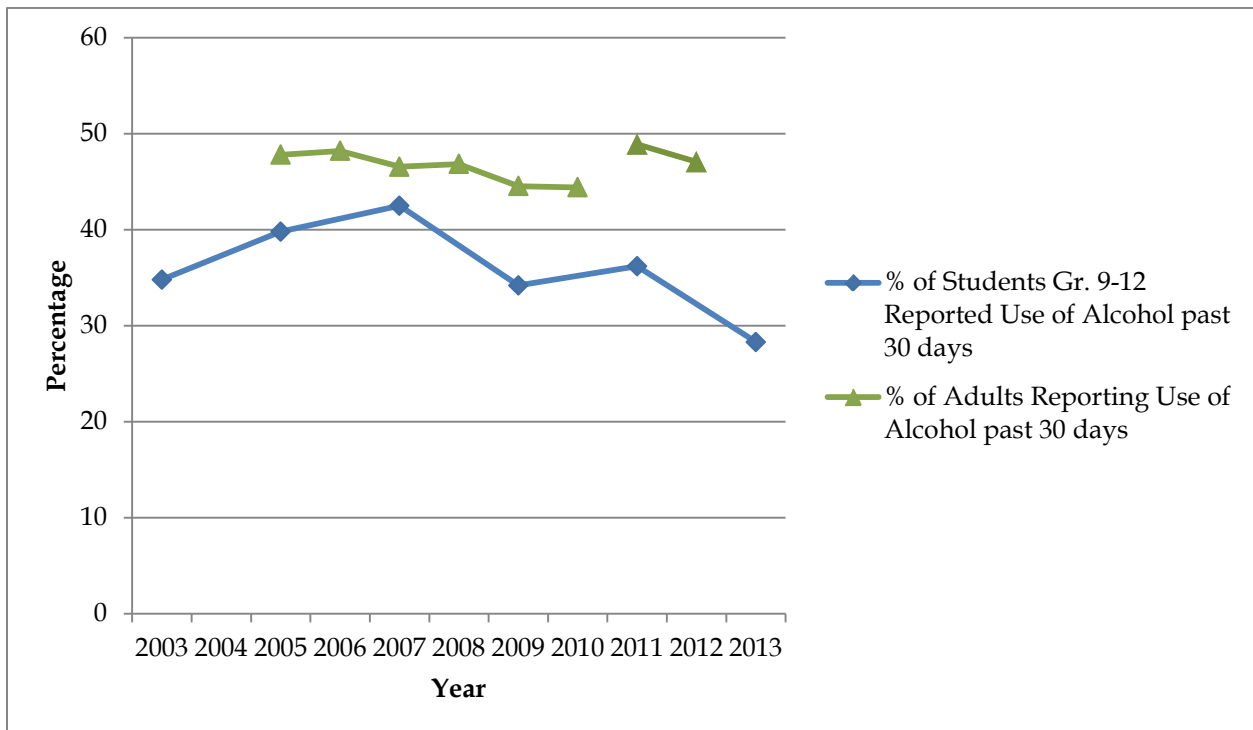
Figure 10: Alcohol Consumption Indicator Trends

While alcohol consumption seems to be steady, it is interesting that sales remain consistently on the rise.
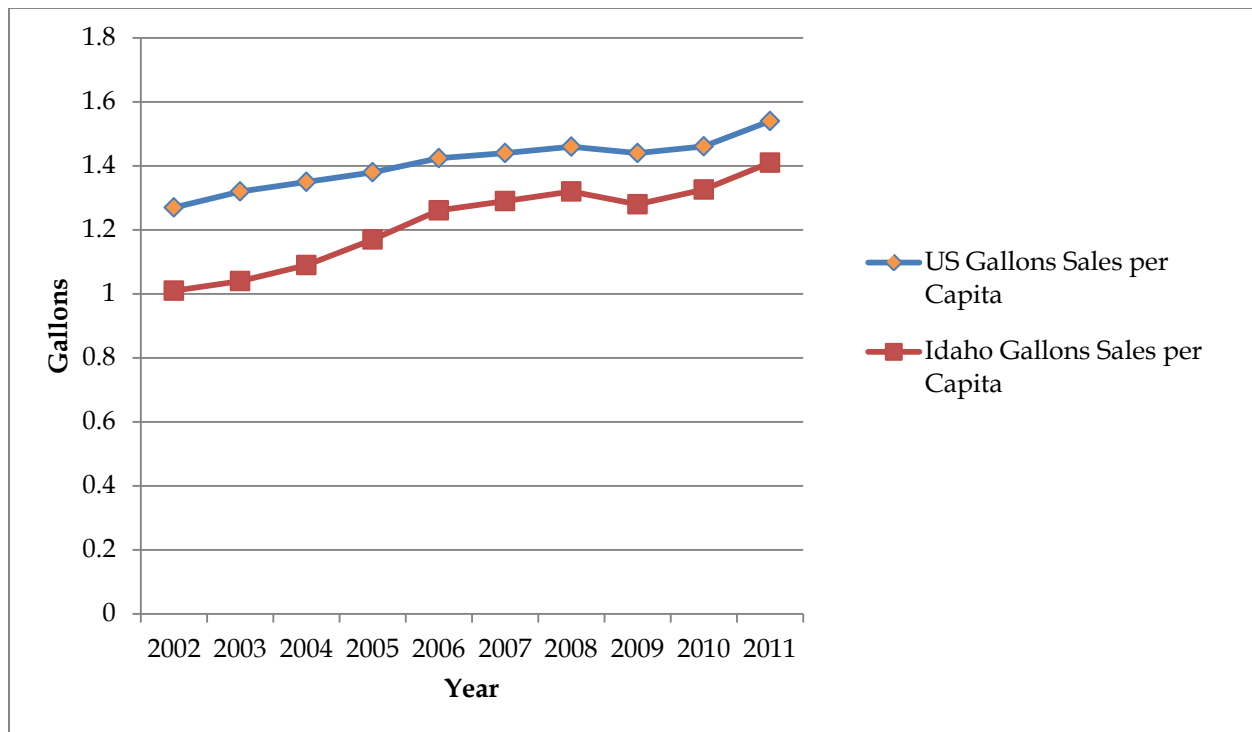
Figure 11: Alcohol Sales Indicator Trends

Excessive Drinking

Alcohol Consumption		
Construct	**Indicator**	**Source**
Excessive Drinking	% of adults aged 18 and older reporting average daily alcohol consumption greater than two (male) or greater than one (female) per day in past 30 days	**BRFSS**
	% of students in gr. 9-12 reporting 5+ drinks in a row within a couple of hours in the past 30 days	**YRBS**
	Percent of adults (aged 18 or older) binge drinking of alcohol in past 30 days	**BRFSS**

Table 7: Excessive Drinking Construct

While the significant changes among BRFSS variables due to the change in sampling methodology is notable, the consistent pattern of overall decreasing trends since 2007 is encouraging.
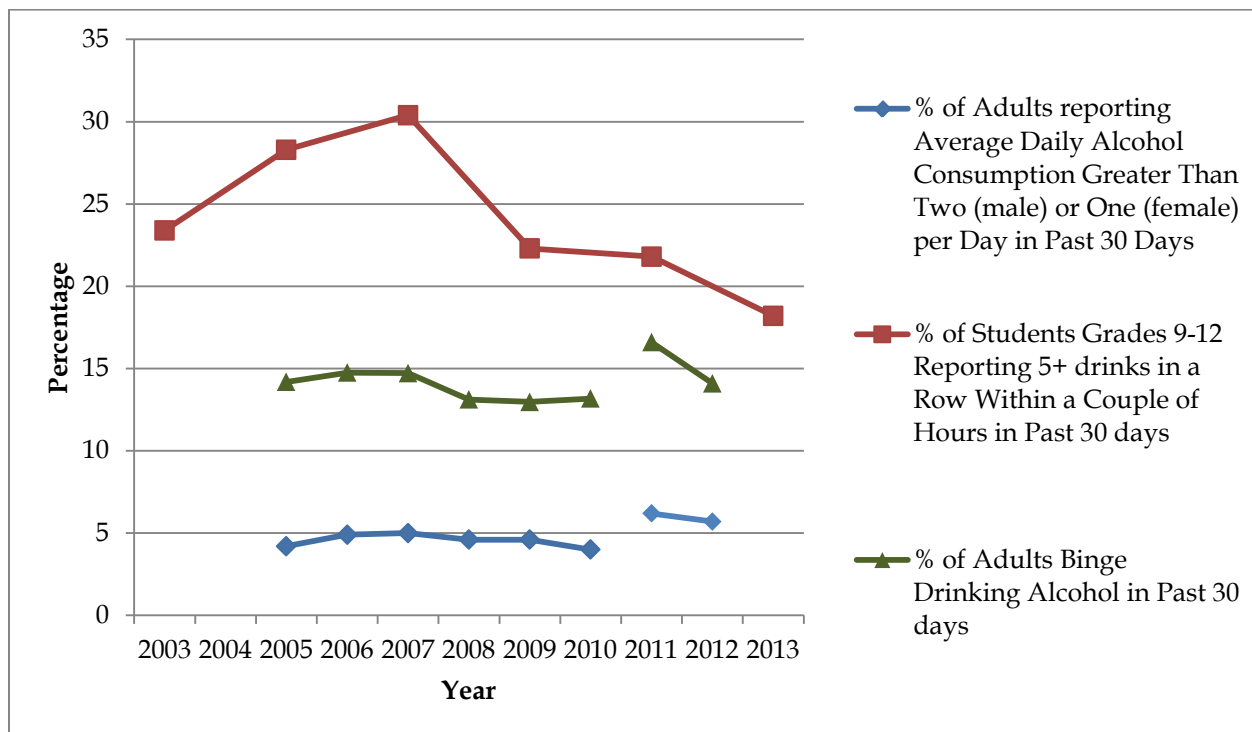
Figure 12: Excessive Drinking Indicator Trends

Alcohol Related Mortality

Alcohol Consequences		
Construct	**Indicator**	**Source**
Alcohol Related Mortality	Rate of alcoholic liver disease deaths per 100,000	**DHW-VS**
	Rate alcohol induced deaths per 100,000	**DHW-VS**
	Deaths sustained in alcohol related vehicular crashes per 100,000	**ITD**

Table 8: Alcohol Related Mortality Construct

While most alcohol mortality data is trending up, like DUI rates, traffic fatalities due to drivers under the influence of alcohol is on the decline.
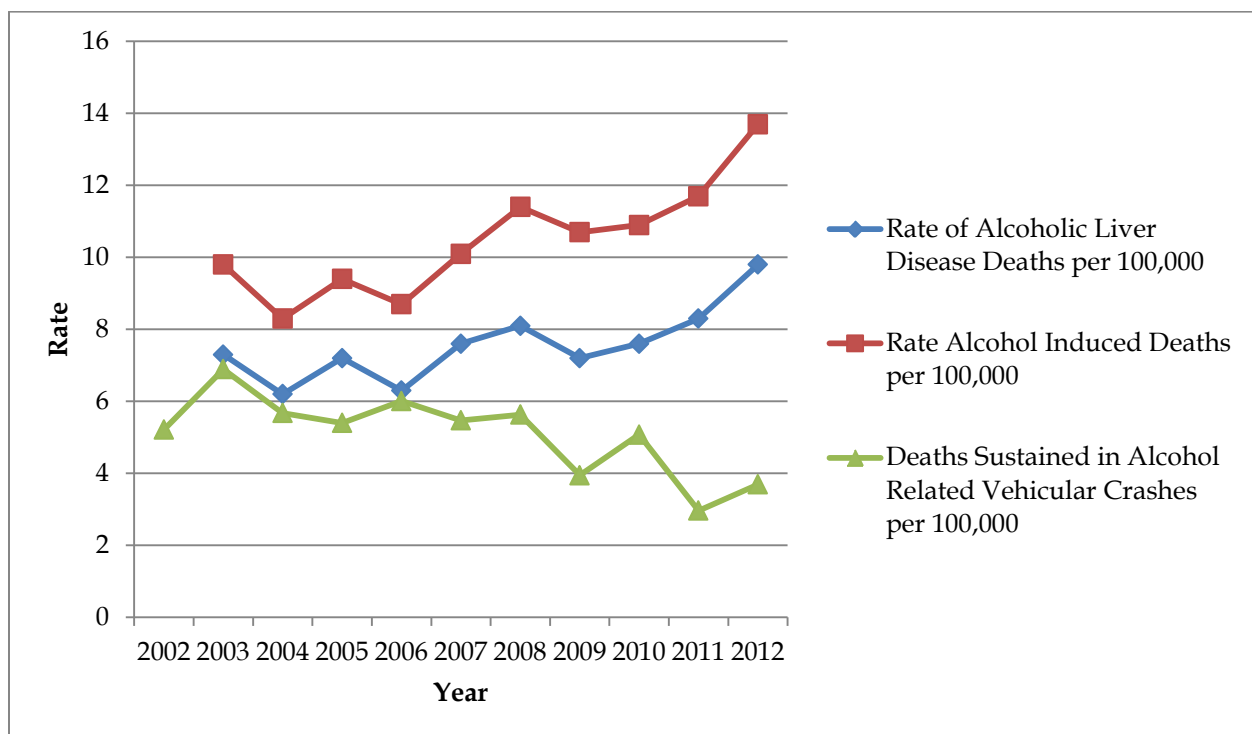
Figure 13: Alcohol Related Mortality Indicator Trends

Crime Related to Alcohol

Alcohol Consequences		
Construct	**Indicator**	**Source**
Crime	DUI arrests per 1,000	IBRS
	Alcohol related crashes per 1,000	ITD
	Alcohol related arrests per 1,000	IBRS
	Underage alcohol-related arrests per 1,000	IBRS

Table 9: Crime Related to Alcohol Construct

All crime related to alcohol has been on the decline since 2009. Please note on the following page that of the counties that experienced high DUI rates, several are resort communities (Blaine, Boise, Kootenai and Valley Counties).
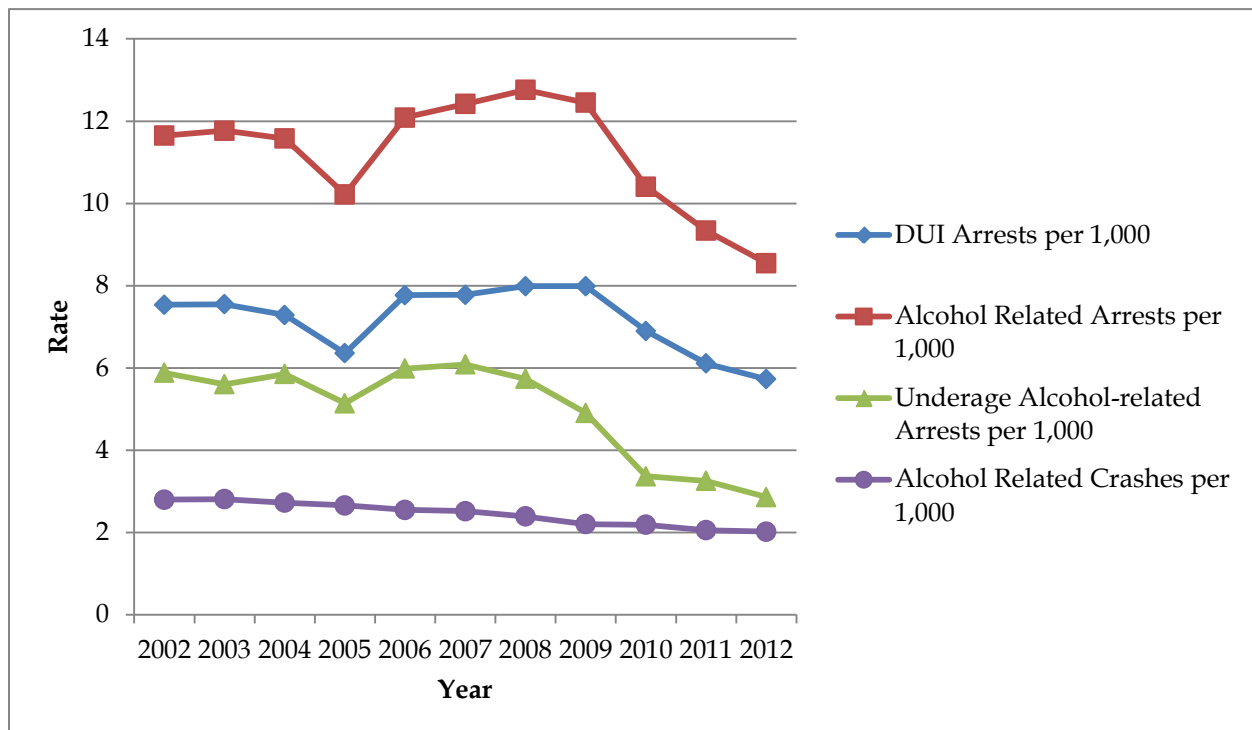
Figure 14: Crime Related to Alcohol Indicator Trends
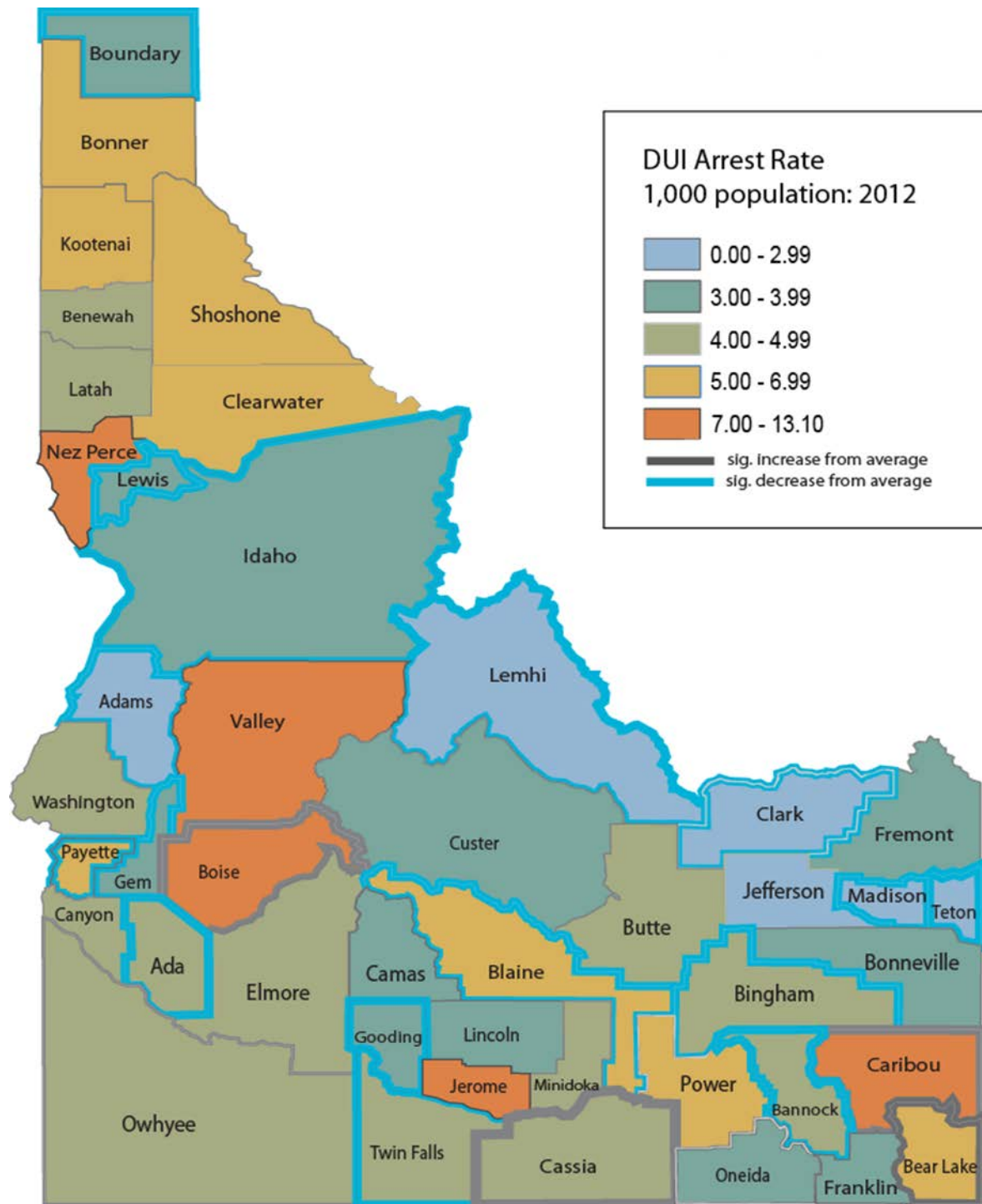
Figure 15: DUI Arrest Rate by County Map

Abuse and Dependence of Alcohol

Alcohol Consequences		
Construct	**Indicator**	**Source**
Abuse and Dependence	% reporting alcohol as primary substance of use upon treatment entry	**TEDS**
	% reporting alcohol as substance of use upon treatment entry	**TEDS**
	% of persons needing but not receiving treatment for alcohol use	**NSDUH**

Table 10: Abuse and Dependence of Alcohol Construct

Alcohol being reported as a substance of use upon treatment entry has been on the decline. It should be noted that due to changes in substance abuse treatment policy and funding it can be difficult to draw conclusions from these types of measures.
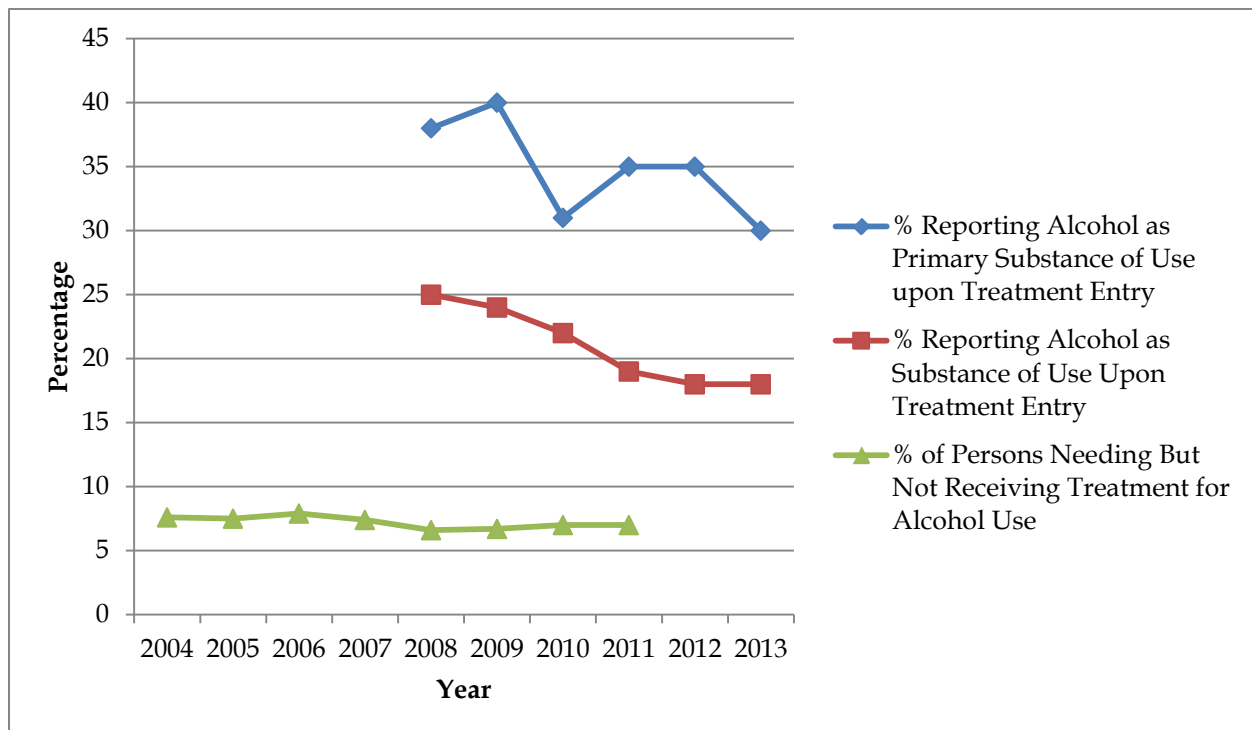
Figure 16: Abuse and Dependence of Alcohol Indicator Trends

Use of Tobacco

Tobacco Consumption		
Construct	**Indicator**	**Source**
Use	% of students in grades 9-12 that smoked cigarettes on 20 or more days in the last 30 days	**YRBS**
	% of adults who smoke everyday	**BRFSS**
	% of adults ever using smokeless tobacco	**BRFSS**

Table11: Use of Tobacco Construct

Measures of tobacco use have all been steady or falling since 2009. Note that due to the aforementioned sampling methodology change in 2011 of the BRFSS, a definitive conclusion should be approached with caution.
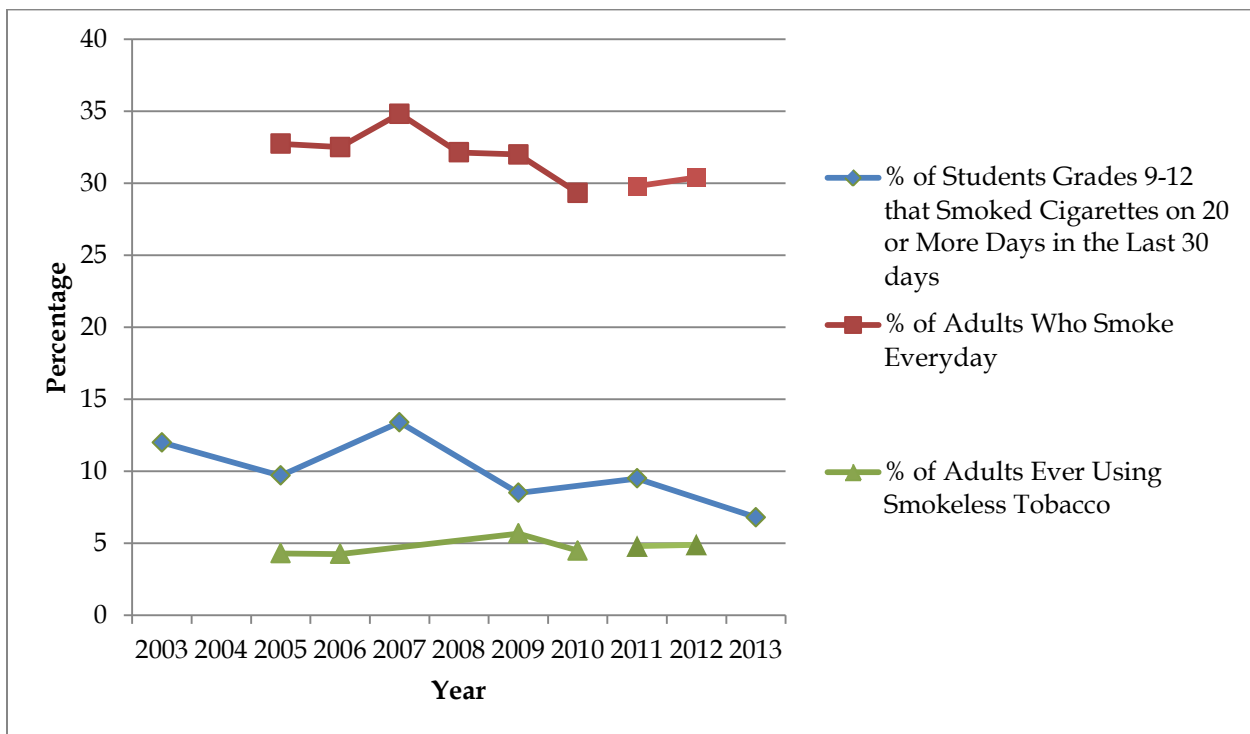
Figure 17: Use of Tobacco Indicator Trends

Use of Prescription Drugs

Prescription Consumption & Consequence		
Construct	**Indicator**	**Source**
Use	Nonmedical Use of pain relievers in the past year per 1,000	**NSDUH**
	Prescription drug distribution rates	**ARCOS**
	Number of deaths from drug induced mortality per 100,000 population	**DHW-VS**
	Prescription Drug Seizures per 100,000 population	**IBRS**

Table 12: Use of Prescription Drugs Construct

Due to limited data sources, there simply were not indictors of sufficient relevance to have constructs representing both consumption and consequences for these substances.

Note that "Deaths from Drug Induced Mortality per 100,000" is displayed on the secondary axis to allow for it to be included in the same slide as the other indicators of prescription drug use. While drug induced mortality is not exclusive to prescription drugs, a large portion of the mortalities coded with a known drug type are prescription medications.
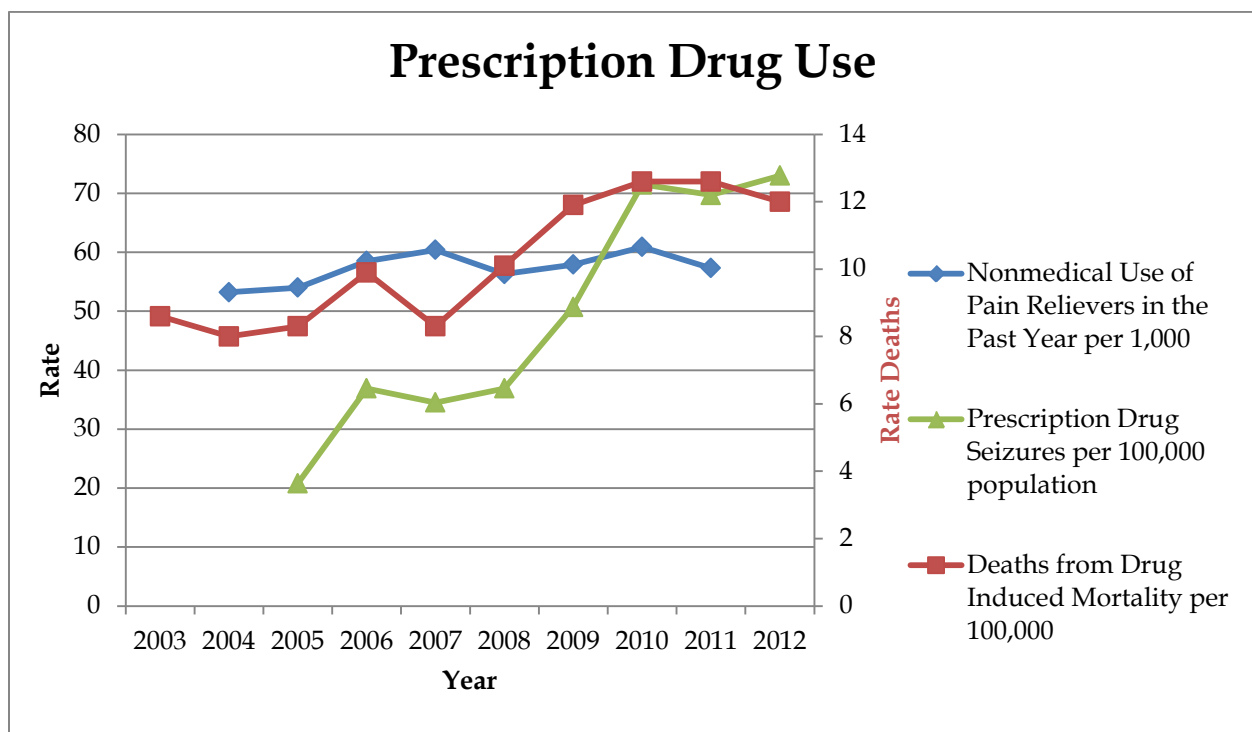
Figure 18: Use of Prescription Drugs Indicator Trends

This data, coupled with the previous graph, shows that all indicators of prescription drug use are on the rise.
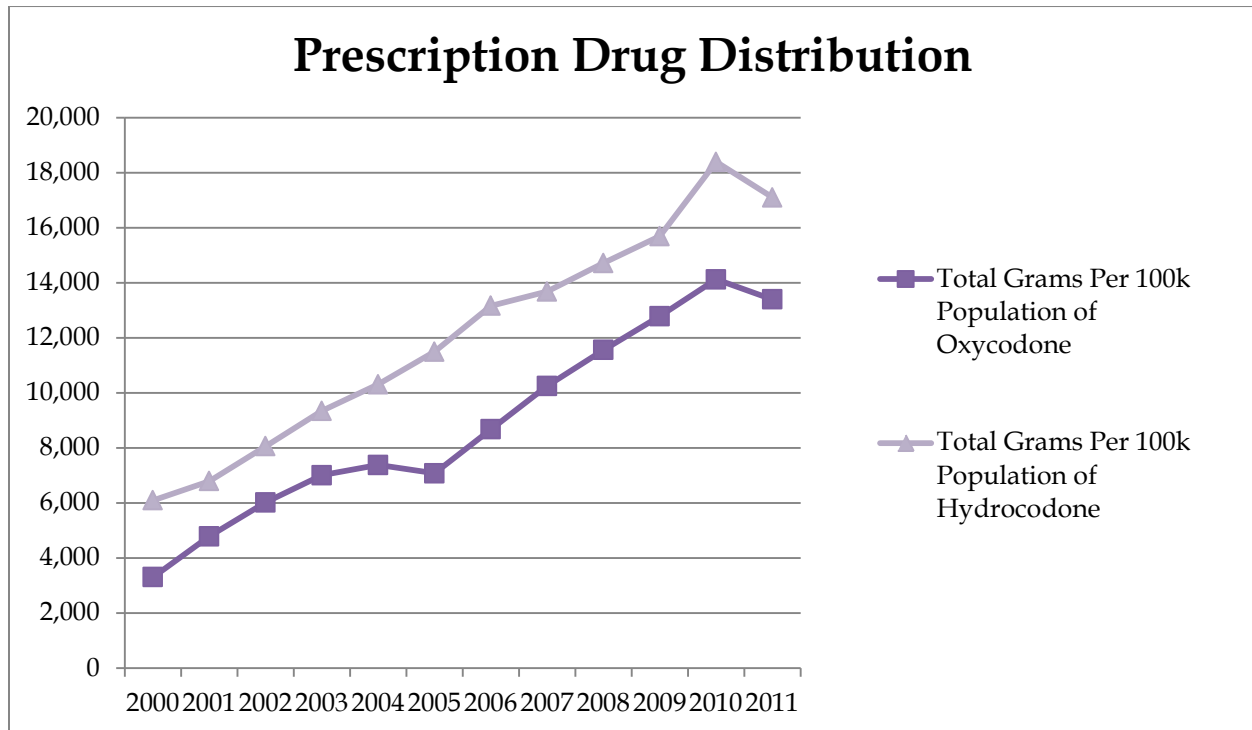
Figure 19: Prescription Drug Distribution Indicator Trends

Health Outcomes of Marijuana

Marijuana Consumption		
Construct	**Indicator**	**Source**
Use	% reporting marijuana primary substance of use upon treatment entry	**TEDS**
	% students in grades 9-12 who used marijuana one or more times during the past 30 days	**YRBS**
	% report marijuana as substance of use upon treatment entry	**TEDS**

Table 13: Health Outcomes of Marijuana Construct

It should be noted that due to changes in substance abuse treatment policy and funding it can be difficult to draw conclusions from these types of measures.
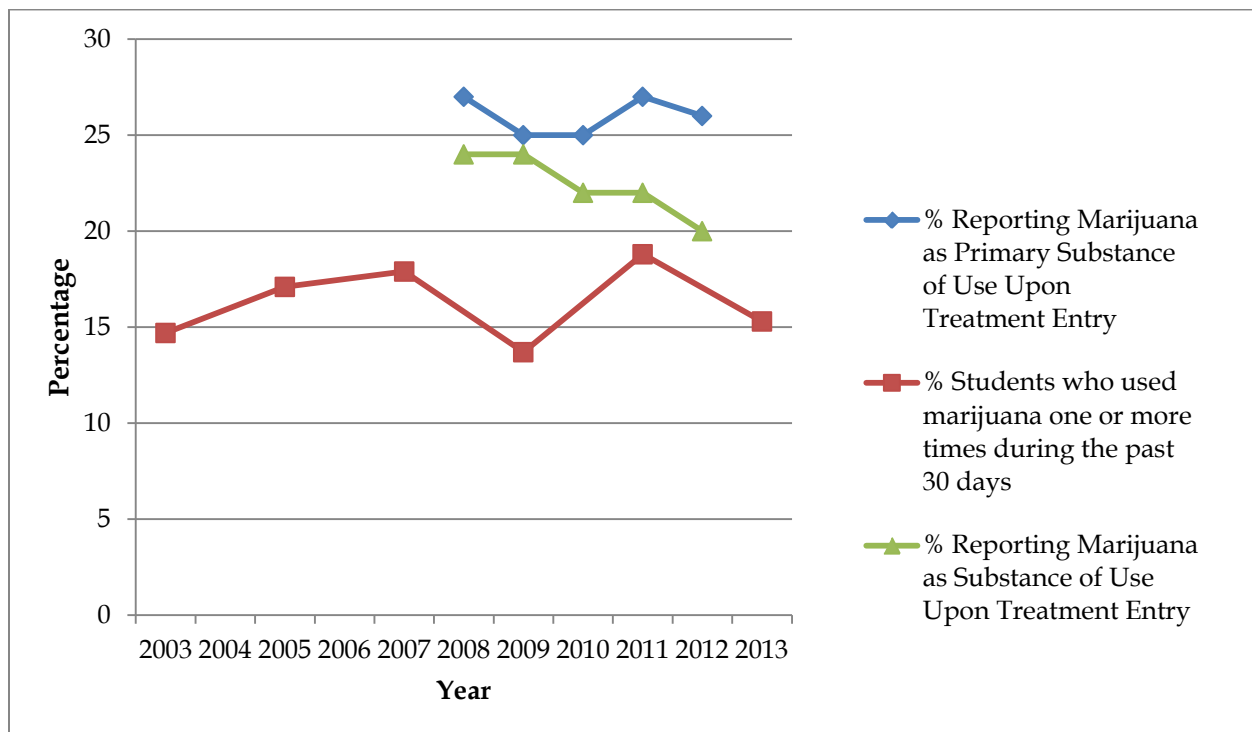
Figure 20: Health Outcomes of Marijuana Indicator Trends

Crime Related to Marijuana

Marijuana Consequence		
Construct	**Indicator**	**Source**
Crime	Marijuana possession arrests per 1,000	**IBRS**
	Marijuana trafficking arrests per 100,000	**IBRS**
	Marijuana seizures per 1,000	**IBRS**

Table 14: Crime Related to Marijuana Construct

All crime related to marijuana is on the rise, but the increase in trafficking arrests is particularly noteworthy.
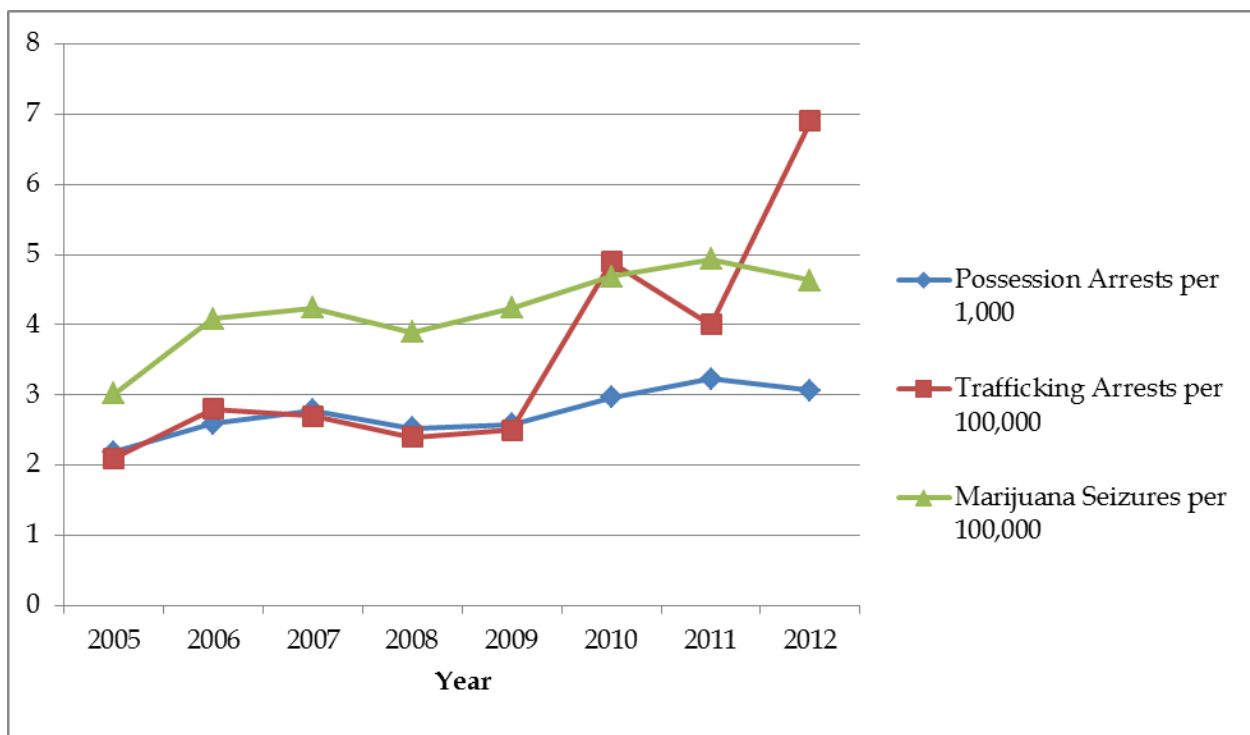
Figure 21: Crime Related to Marijuana Indicator Trends

Use of Other Drugs

Other Drug Consumption		
Construct	**Indicator**	**Source**
Use	Illicit drug use other than marijuana past month per 1,000	**NSDUH**
	Drug seizures per 100,000	**IBRS**
	Lifetime illicit drug use per 1,000	**BRFSS**

Table 15: Use of Other Drugs Construct

Like other seizure rates, the seizure of other drugs has been consistently on the rise. It should be noted that "Lifetime Illicit Drug Use per 1,000" includes all illicit drugs and not just other drugs. It was included as the SEOW felt it was a strong indicator of trends within the state.   Note that due to the aforementioned sampling methodology change in 2011 of the BRFSS, a definitive conclusion should be approached with caution.
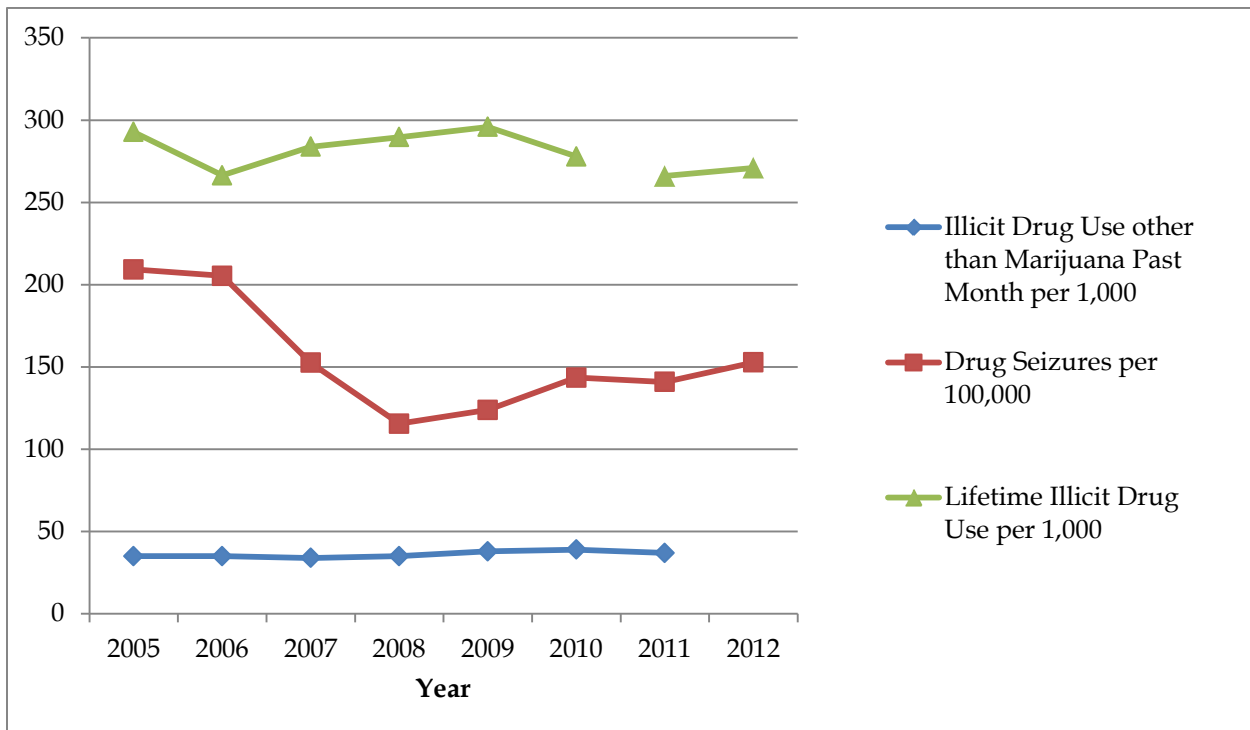
Figure 22: Use of Other Drugs Indicator Trends

The map on the following page shows other drug arrests per county. Please note that a large number of the counties reflecting a high number of other drug arrests are geographically proximate to the state's freeway system.
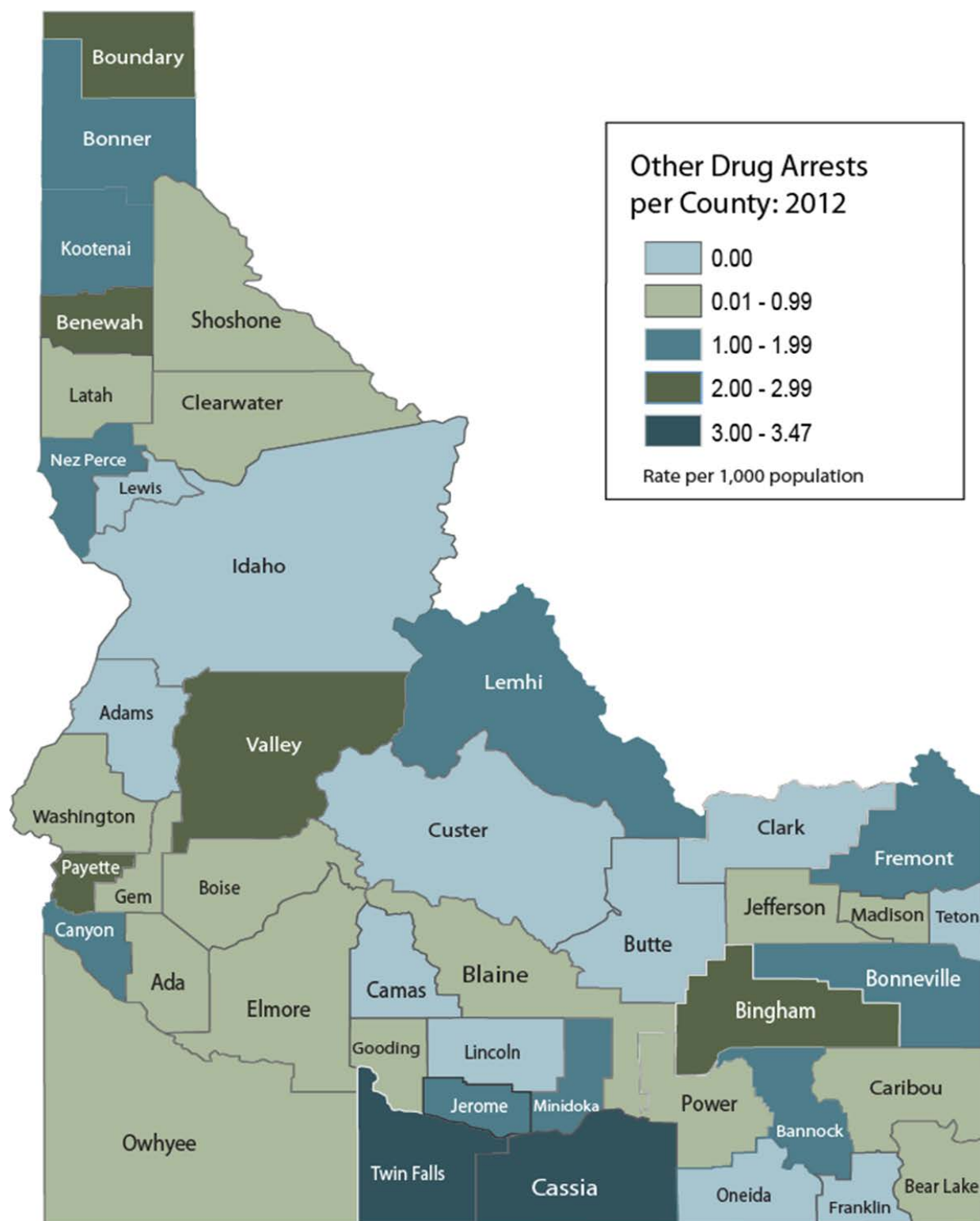
Figure 23: Other Drug Arrests by County Map

Health Outcomes of Other Drugs

Other Drug Consumption & Consequences		
Construct	**Indicator**	**Source**
Health Outcome	% reporting other drugs as primary substance of use upon treatment entry	**TEDS**
	Adult drug induced mortality per 100,000	**DHW-VS**
	% reporting other drugs as substance of use upon treatment entry	**TEDS**

Table 16: Health Outcomes of Other Drugs Construct

Similar to alcohol being reported as a substance of use upon treatment entry, one should be cautioned about drawing conclusions from TEDS based data. It is possible that these trends are created by changes in substance abuse treatment policy. "Adult Drug Induced Mortality per 100,000" is displayed on the secondary axis in order to appropriately display it alongside the other indicators.
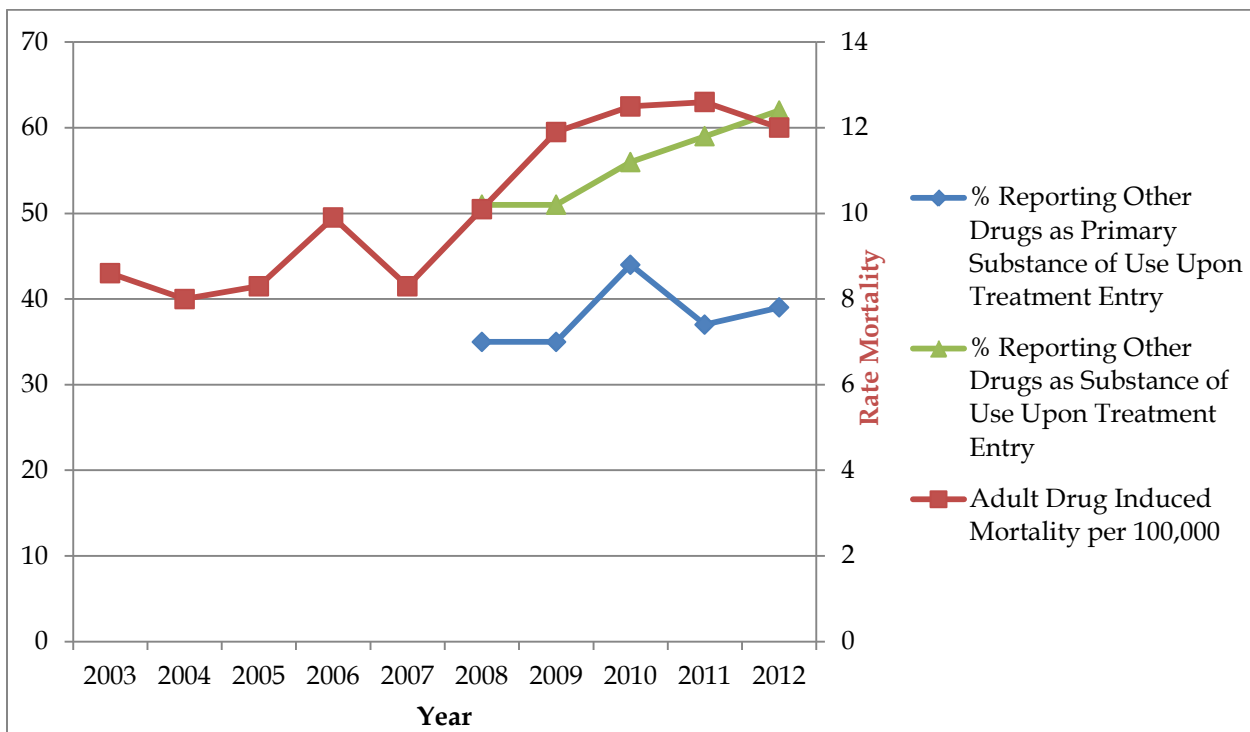
Figure 24: Health Outcomes of Other Drugs Indicator Trends

Crime Related to Other Drugs

Other Drug Consequences		
Construct	**Indicator**	**Source**
Crime	Other drug possession arrests per 1,000	**IBRS**
	Other drug trafficking arrests per 100,000	**IBRS**
	Other drug seizures per 100,000	**IBRS**

Table 17: Crime Related to Other Drugs Construct

While crime related to other drugs is still down from 2005 levels, the upward trend since 2008 is concerning. Regarding trafficking arrests, the extreme variance is the result of small numerators. Small numerators are largely a result of removing marijuana trafficking charges from the indicator. The majority of trafficking charges in the state of Idaho are marijuana related and can be found in the construct of "Crime Related to Marijuana" on page 33.
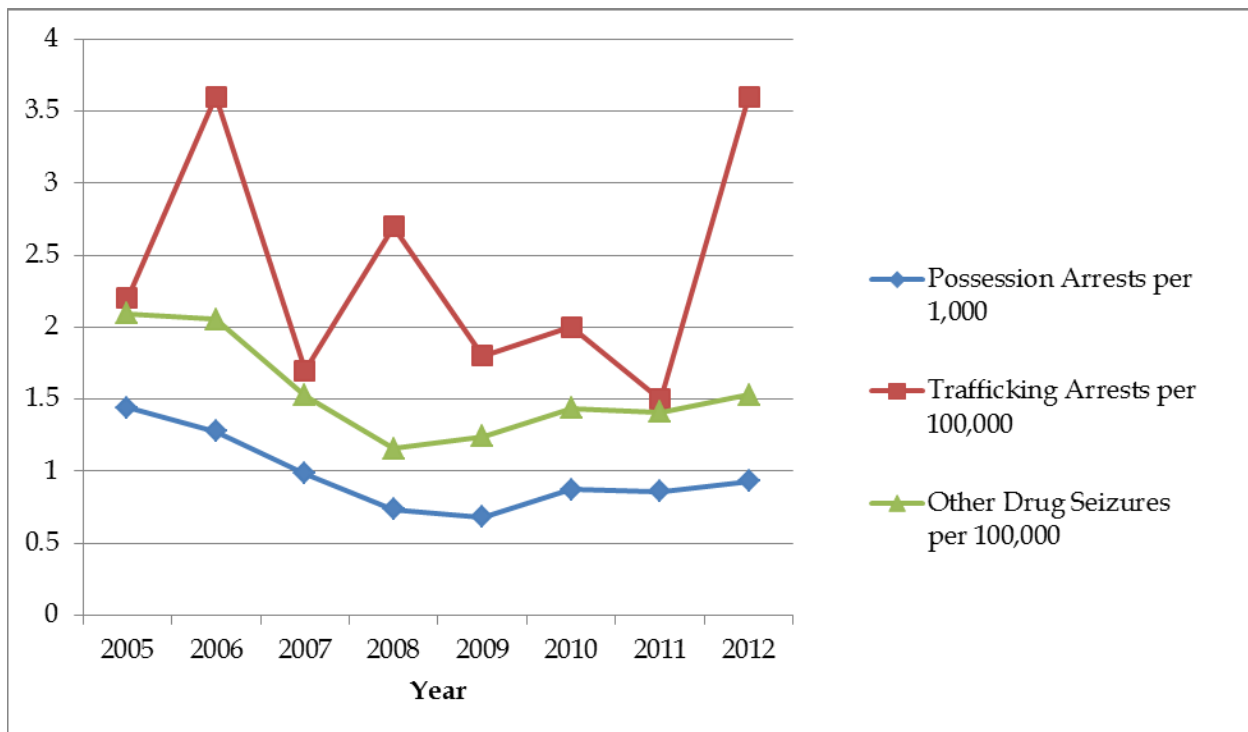
Figure 25: Health Outcomes of Other Drugs Indicator Trends

Figure 26 – Idaho state map with counties labeled
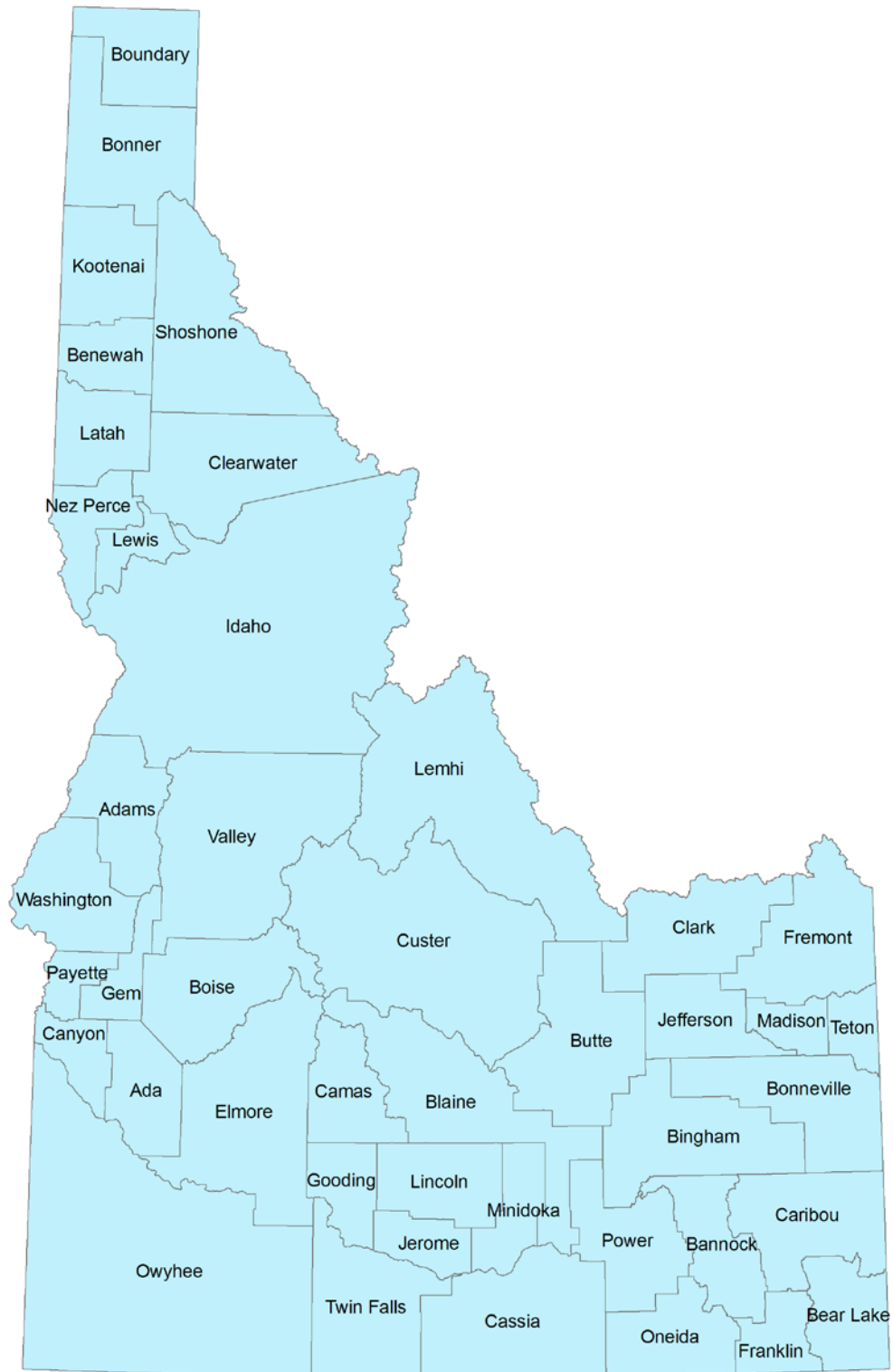
CAPACITY AND READINESS

>   *Local*

In regards to community capacity and readiness, the SEOW felt that these were not issues they could adequately or appropriately address through either the data available or the knowledge base of the membership. In order to address this complication, a search was made for an adequate tool to measure a community's capacity and the Coalition Kaizen was found.

The Coalition Kaizen is a survey that measures a coalition's ability to implement essential processes and the Strategic Prevention Framework. The National Guard facilitates the survey which is conducted during the course of a normal coalition meeting. Digital survey collection tools (somewhat like mobile phones) are used so that all responses are anonymous. Questions are projected for the whole group to see, as the results are available several minutes after the survey is completed. The Kaizen process produces a multipage diagnostic (see Appendix D for example) along with other supporting reports that provide more detail and recommendations. The two-page diagnostic highlights coalition strengths in green, caution areas in yellow, and weaknesses in red. This allows coalitions to quickly and easily interpret results, celebrate strengths, and make plans to improve weaknesses. The Kaizen results can be used in many ways including: To help a coalition create a capacity development plan; to provide the data for grant or scholarship applications; and to allow the team to track progress over time.

In addition, the National Guard has made this tool available to communities at no expense. Over the coming months the SEOW will work to have community coalitions in each region of the state conduct Coalition Kaizens, the results of which will be used in conjunction with the state needs assessment to assess appropriate priorities at the community level.

>   *State*

In order to appropriately address capacity and readiness on a state level the SEOW enlisted the efforts of the Priority Setting Subcommittee. This group was comprised primarily of SPF Advisory Council members, with some representatives from the SEOW. Because of the special expertise possessed by these individuals, this group was better suited to address the issues of capacity & readiness.

While the SEOW did not feel confident in addressing this issue, they did design the methodology to do so. Borrowing from a ranking system that Wyoming used to analyze their indicators, Idaho produced a score sheet (see Appendix E) for the

Priority Setting Subcommittee. Unlike Wyoming, however, Idaho used this score sheet on constructs as opposed to indicators. This needs assessment was used by the Priority Setting Subcommittee (Table 18) to inform their scores that are recorded on the score sheet. The constructs resulting in high scores were then reviewed in the context of subpopulations and geography to select appropriate priorities for the State to address with SPF SIG funds.

Idaho State Priority Scoring Sub Committee	
Name	**Agency**
Darrin Burrell	Freemont County Juvenile Corrections
Janeena Wing	ID State Police
Nathan Drashner	ODP, Epidemiologist/Analyst
Penny Jones	Prevention Provider
Tedd McDonald	Boise State University
Sharlene Johnson	ODP, SPF SIG Project Director
Matt McCarter	Dept. of Education
Tammy Rubino	Community Coalitions of ID

Table 18: State of Idaho Priority Scoring Sub Committee

Prioritization

➢ *Scoring*

Under the guidance of the methodology developed by the SEOW, criteria was established as size, seriousness, capacity, changeability and readiness (see Appendix E for tool that was developed). As earlier mentioned the SEOW focused on addressing size and seriousness.

In order to appropriately assess size and seriousness each indicator was scored based on a formula developed by the SEOW. To create a score for size, a simple comparison of each indicator's rate was done. To appropriately compare indicator's to each other they were grouped into two categories: "rate per 1000" and "rate per 100,000." The indicator's were then assigned a score of 1 to 4 based on which quartile they fell in in comparison to the other indicator's in their group.

In regards to seriousness, an index was created to generate a score based on the indicator's by scoring each indicator based on the severity of the outcome which they are tracking (we referred to this as the "severity score") and the trend of the

data associated with the indicator. The severity scores were generated and assigned by looking at the following factors in relation to the indicator in question:

- If an indicator's outcome was related to mortality it was scored a 4.
- If an indicator's outcome had both long term and short term health effects it was scored a 3.
- If an indicator's outcome had long term or short term health effects it was scored a 2.
- If an indicator's outcome had no effect on health it was scored a 1.

Each indicator was also assigned a score based on the trend of the data that was available using the following rules:

- If the indicator was trending up it was assigned a score of 1.5.
- If the indicator was steady it was assigned a score of 1.
- If the indicator was trending down it was assigned as score of .5.

These scores were then multiplied together to create the score for the seriousness criteria using the formula below.

Seriousness score = severity score x trend score

At this point the work done was turned over to the Priority Scoring Sub Committee to complete scoring on capacity, changeability, and readiness, as well as generate a mechanism to score each construct and in turn determine the state's priorities. The Priority Scoring Sub Committee confirmed the SEOWs position of prioritizing based on construct and as a result the indicator scores for the criteria of size and seriousness were averaged together based on construct to create the scores we find in Appendix A. The methodology developed by the SEOW called for the Priority Scoring Sub Committee to provide a process by which scoring on capacity, changeability, and readiness would be scored. After some discussion the Sub Committee reached the conclusion that capacity was a combination of both changeability and readiness. With this in mind the Sub Committee, on an individual basis, scored each construct based on changeability and readiness. After this step was completed they came together as a group and compared scores and discussed. In some cases individuals selected to rescore the construct based on the input of the group, in others scores remained the same. These scores were then averaged together to create a score for each construct on both criteria.

In discussing how best to combine the scores of readiness and changeability to create the score for the criteria of capacity, the conclusion was made that both mattered a great deal so multiplying them together was a logical step. The following formula was created to generate the score for capacity:

Capacity score = readiness score x changeability score

> ➢ *Prioritization*

Several options were discussed by the Priority Scoring Sub Committee to generate the final scores which prioritization would be based. The following formula was settled on:

Final Score = (Size + 2 x Seriousness) x Capacity

This algorithm was selected for a couple of reasons. First, it is very similar to the process Wyoming employed. The major difference between Idaho's scoring and Wyoming's is that Idaho was based on addressing constructs where Wyoming bypassed constructs and focused on indicator's. The second reason was that the formula gives particular credit to capacity. The Priority Scoring Sub Committee felt that capacity is essential if a priority is to be successfully addressed. The resulting scores can be found in Appendix A.

While many indicators relevant to substance abuse seem to be steady or declining, there are multiple notable indicators on the rise. Although several indicators of alcohol use are falling, alcohol sales continue to rise and are closing the gap in relation to the rest of the nation. In addition, there is a consistent rise in most indicators of alcohol mortality. Also of note, tobacco indicators are steady or declining, prescription drug abuse is clearly increasing, and of particular interest, marijuana trafficking charges have nearly tripled since 2009.

The data regarding alcohol consumption in Idaho is somewhat complicated. According to self-response surveys, alcohol consumption would seem to be decreasing. This is of note considering sales of liquor in the state have consistently been on the rise and have risen in relation to the rest of the nation. While in recent years this may be explained to a degree by individuals coming to Idaho from other states to purchase alcohol. The majority of that phenomenon was only recently created by increasing prices in Washington. Even when controlling for these factors, the Idaho State Liquor Division has found the sales rate for Idaho residents is on the rise.

Alcohol induced mortality data is significantly clearer. While most other mortality indicators have been declining or stagnant, almost all alcohol induced mortality rates have been on the rise (with the exception of vehicular related incidents). This is of note because nationally similar variables have been stagnant or dropping over the same period. Also, over the same period as the rise in alcohol related mortality, Idaho has seen a decline in alcohol related crime.

The research reveals that rates of tobacco use among all populations in Idaho are on the decline or steady over the course of the last decade. This would seem to suggest that current efforts to prevent tobacco use are effective and finding success.

The SEOW's concern regarding prescription drug abuse over the past two years has clearly emerged. With this assessment it becomes very apparent that prescription drug use is of notable concern. The increasing rate of seizures, coupled with the startling continued rise in drug related mortality which is primarily driven by prescription drugs, lines up alongside the increasing prescription distribution rates within the state to make it very clear that there is potential for an epidemic.

Additionally, the limited duration of the SPF grant made it important to focus on indicators that would respond quickly to project efforts; and the indicators need to be measurable at the community level.

Finally, the extreme rise in marijuana trafficking charges since 2009 may be a result of legalization of the drug for both medicinal and recreational purposes in neighboring states. The timing of the increase is curious given that in 2008 Washington state adopted new policies around private cultivation. More research will be done in coming months by the SEOW to better explain the occurrence, but issues like this would seem to suggest that there may be intervening variables that could be addressed.

Based on all of these factors the SPFAC selected the following as the priorities to be addressed. The constructs (1, 2, 3) are the state priorities, while the indicators are the specific target areas our sub-recipients will be required to address in their grant applications and submitted strategic plans. It is anticipated that communities will be able to effectively move the indicator data in a positive way in their local communities, thereby moving the construct data of the statewide priorities.

> 1) Prescription Drug Use (*sub-recipients are required to choose at least one indicator):*
>   a) Nonmedical use of pain relievers;
>   b) Prescription drug distribution rates;
>   c) Number of deaths from drug induced mortality;
>   d) Seizure rates;
> And one of the following (Not required):

2) Alcohol Health Outcomes *(sub-recipients may choose at least one indicator):*
   a) Rate of alcohol liver disease;
   b) Rate of alcohol induced deaths;
   c) Alcohol as primary substance of use upon treatment entry;
   d) Percent of persons 12 and older reporting alcohol dependence/abuse;

3) Marijuana Use *(sub-recipients may choose at least one indicator):*
   a) Marijuana possession arrests;
   b) Marijuana trafficking arrests;
   c) Marijuana seizures;
   d) Percent report marijuana as primary substance use upon treatment;
   e) Percent of students in grade 9-12 who used marijuana one or more times in the past 30 days;
   f) Percent report marijuana as substance of use upon treatment area.

Figure 27: Lock Your Meds Idaho Media Campaign

CAPACITY BUILDING

CAPACITY ASSESSMENT

Collaborative partnerships and community capacity building have taken a prominent role in the United States as a way to address social problems, including the prevention of substance abuse. In accordance with this perspective, Idaho places great importance on Step 2 of the Strategic Prevention Framework model, capacity building, as a pillar to make the model work and sustain over time. Capacity building refers to the investment of people at a collective level and focuses on a developmental process that enhances or increases knowledge, skills, and understanding. Therefore, empowering the citizens of a community to create change and have the skills to manage change is essential to capacity building.

Although prevention programming and strategies are being implemented through a variety of organizations and methods throughout Idaho, there is currently no overarching, comprehensive strategic plan for implementation and evaluation of the various prevention programs other than those funded through the SAPT block grant. Each organization sets its own prevention priorities and it is not known how many of the prevention service providers are using best or evidence-based practices. Current substance abuse prevention projects are conducted by community coalitions, individual schools and school districts, healthcare organizations, local law enforcement agencies, private providers, youth serving organizations and state agencies with funding coming from a variety of sources including federal grants, foundation grants, private donations, state contracts, and in-kind donations.

Idaho has identified the following assets, resources, areas of concern, service gaps, and barriers to address:

> Idaho's prevention strategies continue to be implemented in relative isolation. This may be in part due to the rural nature of the state, as well as the governmentally independent nature of many Idahoans. However, it is likely also a function of lack of a concerted effort in the past at the state level to bring these disparate entities together to advise and guide the statewide prevention system. Recognizing the need to better coordinate these statewide prevention activities, ODP in 2012 brought stakeholders together to begin formulating a statewide strategic action plan. To this end workgroups have begun to create logic models and action plans to help inform a data-driven statewide plan (Appendix F-H). With Idaho's receipt

of SPF SIG, it is the SPFAC's hope to enhance and implement these plans with the statewide priorities in mind.

➢ Idaho's current prevention data infrastructure will need to be improved. While there is currently a web-based data reporting system for SAPT funded providers, this system is very dated, having been built and implemented over a decade ago. It primarily gathers demographic data and generates basic reports based on the implementation of individual strategies. There is no system available in Idaho for collecting information about environmental strategies which would assist in providing an evaluation of their effectiveness.

➢ It is also important to note that through the work of the SEOW and ODP, strong relationships have been built between state agencies. Through this process, individual agencies have become increasingly comfortable with sharing data and information. Continued work to improve and strengthen these trust relationships will be vital to developing a prevention infrastructure with shared data.

➢ While Idaho has access to a wealth of training resources and materials, it is extremely difficult to roll that information and education out to the prevention field due to the rural nature of the state and the expense associated with travel. Therefore, through the SIG program, it will be important to design a web-based training and technical assistance system which allows for distance learning and virtual participation and attendance in trainings.

➢ In the past, Idaho required providers receiving SAPT funding to become Qualified Prevention Professionals through attendance in a prescribed list of courses. However, due to funding restraints, these courses are no longer offered. Continuing to ensure the professionalism and workforce development of prevention providers is important. Therefore, it will be important to explore credentialing or licensure options in the immediate future.

➢ It is clear that as increasing numbers of veterans return home from active duty, Idaho must better address the needs of these military members and their families. Working with local military installments in a coordinated effort will be necessary to ensure the State of Idaho is better aware of their needs and better able to serve them as necessary.

➢ Those in prevention know that the real successes occur at the community level. Relatively recently, community coalitions from throughout the state have begun meeting together three times a year and holding conference calls once per month to facilitate the sharing of resources and information. These are priceless interactions which coalitions report benefitting from greatly. However, each of these members are overtaxed with the work of their individual coalitions and have found it extremely difficult to find time to properly organize and direct the work of the Community Coalitions of Idaho. ODP has offered them technical assistance, training, and communications support; however, they require additional support in the areas of strengthening coalitions, coalition building, and facilitating their efforts. Recently through a partnership between ODP and EUDL, CCI was able to hire a full-time Executive Director to direct the work of the coalition. It is important to note however, that this is only a temporary solution, with funding only being available to fund the position for one year.

➢ There has been little to no funding in recent years to provide training and technical assistance to prevention providers at the community level. Therefore, it will be imperative that SIG funds be used to ensure that providers are well trained regarding evidence-based programs, environmental strategies, and the Strategic Prevention Framework. Many well-intentioned, passionate individuals are working hard to prevent substance abuse in their communities, but need the knowledge regarding data-based planning and implementing a strategic approach to prevention. Idaho currently offers two statewide prevention conferences; the Idaho State Department of Education's Prevention and Support Conference and the Idaho Conference on Alcohol and Drug Dependency. Through newly formed partnerships, coalition and substance abuse prevention tracks have been added to their course offerings. The prevention conferences will also be utilized to expand distribution of the SPF model education.

➢ Particularly at the community level, emphasis on data-based planning and evidence-based prevention interventions are too often seen as burdensome bureaucratic hurdles, rather than as a functional and effective process to guide substance abuse prevention.

➢ After the loss of the Substance Use, Safety, and School Climate Survey in 2008, Idaho has struggled to collect indicators that accurately describe and measure substance use among youth. Collecting data by region has also been

problematic. While it is certainly easier to discuss seven regions than it is to discuss 44 counties, a great deal of detail is lost in the conversion to regions. Since few of our counties are demographically similar to those counties that adjoin them, mean regional scores can mischaracterize trends occurring in rural and frontier counties (ISEOW, 2010). With that in mind the new Idaho Youth Risk Behavior Survey was developed, and will be implemented in school districts throughout the state in Spring 2014.

The Idaho SPF-SIG capacity building approach will use critical elements suggested by capacity building experts and incorporates the following components: **Leadership Development, Organizational Development, Partnership Development, Taking Action, Reflection and Sustainability.** The approach utilizes three main strategies (assessment, training, and technical assistance) to develop the capacity of Advisory Council members and sub-recipients. Idaho SPF-SIG's approach builds on and enhances SPF steps by:

➢ Assisting communities in **assessing** stages of readiness, asset and resource levels, and organizational capability.
➢ **Conduct training** in all the key areas of the SPF-SIG process. Capacity building training will include strategic planning, logic model design, decision-making and conflict resolution strategies, evaluation and sustainability techniques.
➢ **Provision of continuous technical assistance** throughout the life of the project.

STATE LEVEL CAPACITY BUILDING ACTIVITES

The SPFAC is engaging in strategic planning the first year of the project to ensure that the project has a healthy/solid foundation for capacity building that can be sustained beyond the SPF-SIG funding period. This process is being facilitated by Idaho SPF staff in collaboration with the SEOW, EBP, and ODP staff. Logic model technology along with identifying strategies and interventions will be used to inform the process.

ODP will continue to build capacity among professionals through the SPFAC and SEOW via trainings and technical assistance. The SPFAC will facilitate the use of the Coalition Kaizen Survey across the state. The Coalition Kaizen is a survey that measures a coalition's ability to implement essential processes and the Strategic Prevention Framework. The National Guard facilitates the survey which is conducted during the course of a normal coalition meeting. Digital survey

collection tools (somewhat like mobile phones) are used so that all responses are anonymous. Questions are projected for the whole group to see, as the results are available several minutes after the survey is completed. The Kaizen process produces a one-page diagnostic along with other supporting reports that provide more detail and recommendations. The one-page diagnostic highlights coalition strengths in green, caution areas in yellow, and weaknesses in red. This allows coalitions to quickly and easily interpret results, celebrate strengths, and make plans to improve weaknesses. The Kaizen results can be used in many ways including: To help a coalition create a capacity development plan; to provide the data for grant or scholarship applications; and to allow the team to track progress over time. In addition, the National Guard has made this tool available to communities at

Figure 28: Kaizen Logo-Japanese Translation: Continuous Movement

no expense. Over the coming months the SEOW is working to have community coalitions in each region of the state conduct Coalition Kaizens, the results of which will be used in conjunction with this report to assess appropriate priorities at the community level.

In order to build the capacity of the prevention workforce the SPFAC will explore a process to certify prevention professionals and track the needs and capacity of the prevention workforce. The SPF SIG staff will also be charged to design a web-based training and technical assistance system which allows for distance learning and virtual participation and attendance in trainings.

The SEOW will work with the SPF SIG Evaluation Team as needed to provide training and technical assistance to sub-recipients on assessment, data collection, data analysis, and data presentation in order to build community-level evaluation capacity. The SEOW will continue to maintain and update the State Epidemiological Profile and continue to monitor state- and sub-state level trends for all substance use and consequence indicators. The SEOW will also provide guidance to sub-recipients on assembling a local epidemiological workgroup, and creating a local-level epidemiological profile. In addition, the SEOW is tasked with implementing a uniform statewide evaluation tool. The Idaho Youth Prevention Survey will be implemented in Spring 2014.

The SPF staff will work with members of the SPFAC and SEOW to develop a web-based prevention data reporting system that will collect information regarding

the implementation of direct service programs as well as information about the environmental strategies being implemented throughout the state.

The Evidence Based Programs (EBP) workgroup will be asked to create a state registry of evidence-based programming and state accepted environmental strategies. The EBP will build capacity at the state and community level for SPF implementation through training and technical assistance to select, adapt and implement evidence-based policies, programs and practices at the local level. All of these activities will meet the specifications of *SAMHSA's Identifying and selecting evidence-based interventions: Guidance document for the Strategic Prevention Framework State Incentive Grant Program* (U.S. Department of Health and Human Services, 2009). Following this guidance document will ensure that local strategic plans include appropriate implementation of evidence based policies, practices and programs as well as effective capacity building activities focused on the selection, adaptation and implementation of such policies, practices and programs. It is anticipated that the Idaho Toolkit of Evidence Based Prevention Programs, Policies, and Environmental Strategies will be submitted to the SPFAC for final approval and adoption by April 30, 2014. The toolkit will be updated as new programs, policies, and environmental strategies are approved by the EBP workgroup. A process will be developed and implemented for sub-recipients to submit programs, policies and strategies not included in the toolkit for review for possible inclusion. It is anticipated that this review process will be implemented by August 1, 2014.

COMMUNITY LEVEL CAPACITY BUILDING ACTIVITIES

The main community level objective is the successful implementation of the sub-recipient strategic plan based on local need and resource assessments. Sub-recipients will develop a logic model, which is specific to the local community and identifies local priority issues and intervening variables. In turn, the logic model will serve as the basis to guide the selection of the evidence-based programs and environmental strategies, practices and policies to be adopted by the community. The EBP will assist communities in determining relevance,

appropriateness and effectiveness of potential evidence based interventions. Additionally, the EBP will assist in the identification and development of methods to sustain interventions beyond SPF-SIG funding.

At the sub-recipient level, the SEOW, EBP, and SPF staff will assist local communities in the development of a comprehensive plan that articulates the vision for organizing specific prevention programs, policies, and practices to address the identified priority issues at their local community level. Additionally the strategic plan will outline strategies to sustain efforts beyond SPF-SIG funding. The strategic plan will include a detailed sustainability plan focusing on the development of the collaborative human capital and fiscal resources. Logic modeling will be used to assist local sub-recipients in organizing the information that will be gathered through their local needs assessment and later included in their strategic plan. A strategic planning template will be developed to ensure the process is done consistently across all funded communities and to streamline the technical support that will be provided during this stage of the process. The EBP and SEOW will assure accountability of communities by: Reviewing comprehensive community plans and the justification for interventions included in the plans; identifying issues and problematic intervention selections; and targeting technical assistance to work with communities to improve and strengthen their community plans. SPFAC will provide the final approval of sub-recipient strategic plans.

The community level capacity building objectives identified include provision of SPF training at the local level, and the provision of coaching and technical assistance in the implementation of SPF interventions. SPF staff will provide technical assistance and training to funded sub-recipient communities. Sub-recipients will be provided with tri-annual trainings which focus on the topics identified as needs in the Kaizan Coalition survey. It is anticipated that between National Guard staff and SPF staff that each funded community will also receive up to ten hours of individualized in-person technical assistance per month and up to ten hours of remote support (phone, email, website).

In addition, support will be sought from the national technical assistance group provided by CSAP for the development and implementation of capacity building interventions in order to ensure successful local implementation of the five steps of SPF. Idaho SPF staff will also coordinate local training on the SPF process This training will provide coalitions the basic tools needed for success and offers links to resources to help them achieve their goals. This includes multiday trainings, which teach the SPF model. Additionally, participants will be encouraged and supported to apply for the Drug Free Communities Grant.

Expanding the reach of the Idaho SPF at the community level beyond sub-recipients is key to ensure sustainability. Historically, community based projects have been at risk due to dependence on the expertise and funding provided by government agencies, which in turn experience high turnover in funding and staffing. Intense capacity building at the community level with sub-recipient will help alleviate excessive dependence on state funded agencies.

The capacity building activities will cover topics in technical skill, sustainability and cultural competence to ensure each step of the SPF model is completed successfully.

EPIDEMIOLOGICAL CAPACITY BUILDING AT THE STATE AND COMMUNITY LEVEL

As part of the implementation of the SPF model at the community level, sub-recipients will be asked to conduct a local needs assessment. The SEOW and the Evaluator will provide training to sub-recipients in the design and development of the needs assessment. Trainings will include design, data collection, analysis and interpretation. As part of the local needs assessments, sub-recipients' will be asked to administer the new school questionnaire used by Idaho to the sub-recipients' school population or sub-sample. The SEOW and Evaluation Workgroup will process and analyze the surveys, as well as support sub-recipients in their understanding and utilization of the data.

The majority of data compiled and analyzed by the SEOW is derived from archival sources. This data is present in the state-and county-level epidemiological profiles and plays a vital role in the establishment of ATOD priorities across the state. Although archival data holds great value, the workgroup recognizes its duty to address data gaps that hinder the states prevention system's ability to advocate for and implement evidence based ATOD policies, strategies, and programs.

Consistent with the SPF model, the SEOW remains committed to the continuation of the: 1) Monitoring and analysis of ATOD trends in order to forecast emerging and current substance use-related priorities; 2) Collection of new data to address previously identified data gaps; and 3) Dissemination of data products communicating concerns related to ATOD use among Idaho citizens across the life span. From its inception the SEOW has worked to enhance and sustain these efforts. However, as with any existing structure, the SEOW can benefit from additional fortification. Work in the following areas will further strengthen an already active SEOW by: 1) Increasing the ability to collect new data across multiple data gaps; 2) Achieving greater diversification of data-dissemination products; and 3) Expanding the membership to build collaborative relationships

with organizations and/or individuals that possess desirable but previously unfilled knowledge sets within the workgroup.

The SEOW will make invitations to additional agencies and organizations with the intention of gaining an increased ability to address its identified data gaps. Establishing new relationships is vital to the workgroup's successful exploration of other data gaps. Each year the SEOW will consider new data gaps and identify additional data needs. Recognizing the need to continually build the SEOW membership will result in the fortification of an already highly accomplished workgroup.
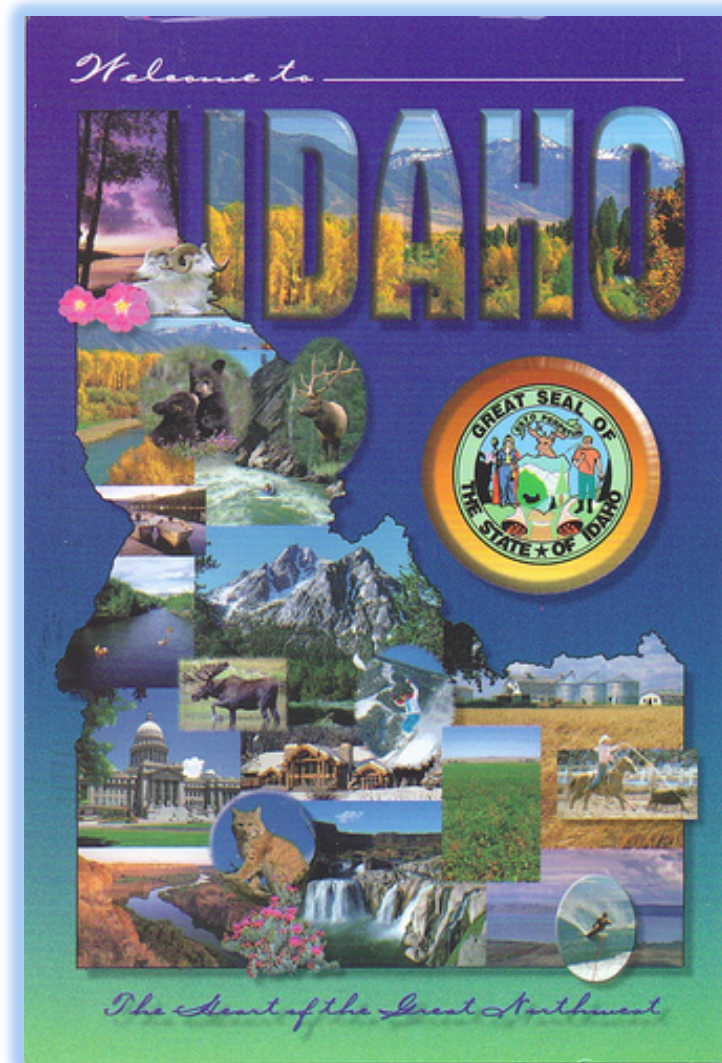
Planning

STATE PLANNING MODEL AND ALLOCATION PROCESS

As stated earlier Idaho SPF SIG funding will be directed toward three state priorities: Prescription Drug Use, Alcohol Health Outcomes, and Marijuana Use. The Idaho SPFAC has devoted many hours to determine the state's planning model, what sub-recipients would be expected to accomplish once funded, and the state's allocation approach. These decisions were based upon data presented by the SEOW, the statewide needs assessment, Idaho's mostly rural culture, and the desire for SPF SIG to impact the entire state of Idaho not just a selection of communities. Idaho considered a number of planning models that would meet the diverse needs of Idaho communities while honoring the requirements of the data driven decision making model. While the SPFAC was able to narrow state priorities to three major issues of concern through the data driven process of the needs assessment, there was not sufficient local data to identify local communities that were the highest area of need in all three priorities. Evidence suggests the three priority areas of concern are widespread throughout the entire state. Subsequently, SPF SIG application review criteria will include a balance of community capacity to implement the SPF process to address the statewide priority areas and available resources already accessible at the community level.

The primary goal of the Idaho SPF is to strengthen the infrastructure and the prevention capacity at the state and community level. Idaho has many prevention coalitions throughout the state that struggle with internal infrastructure, and common consensus points towards the belief that a SPF grant would be the boost they would need to increase their programmatic and administrative capacity to successfully implement the SPF model in their respective communities. With this in mind, Idaho will use a statewide open competitive Grant Application process based on the equity model to distribute SPF SIG resources. Reasons for choosing a statewide competitive process include the fact that Idaho already has several established coalitions that are addressing substance abuse related problems and Idaho is making a strong effort to encourage all communities to engage in substance abuse prevention efforts.

Extensive outreach will be done by SPF staff in order to ensure equal opportunity throughout the state and to encourage lower capacity level communities to apply. Five bidders' workshops will be offered to give technical assistance in the grant writing process. Two of these workshops will be held at statewide conferences that traditionally prevention coalitions attend and the other three will be offered via the internet.

It is anticipated that Idaho will fund 16 sub-recipients during the five years of the SPF SIG grant, see Table 19. Each subrecipient will be awarded for a four year period. The initial process will involve a competitive grant application, while subsequent years will be based on a non-competitive continuation application process.

Each subrecipient will be awarded in two phases. The first phase (year one) will receive funding of up to $100,000 per application. During this phase, sub-recipients will focus on the needs assessment, capacity building and strategic plan development. The subrecipient will only be allowed to utilize up to 75% of the first year allocation until their respective strategic plan has been approved. At the end of year one, sub-recipients will submit their strategic plan. Sub-recipients that submit an approved plan will be eligible for continued funding for year two through four. Phase two funding for years two through four will be allocated at up to $100,000 per year per application to begin implementation of their strategic plan.

Table 19: SPF SIG 5 Year Funding Distribution Chart

4 year grant cycle	$ 1,275,000.00	$ 1,275,000.00	$ 1,275,000.00	$ 1,275,000.00	$ 1,275,000.00
	Year 1	Year 2	Year 3	Year 4	Year 5
# of Grants		16	16	16	16
Amount		$ 100,000.00	$ 100,000.00	$ 100,000.00	$ 100,000.00
Total		$ 1,600,000.00	$ 1,600,000.00	$ 1,600,000.00	$ 1,600,000.00
Carryover	$ 1,275,000.00	$ 950,000.00	$ 625,000.00	$ 300,000.00	*$ (25,000.00)*

In order to establish the sub-recipients capacity to implement the SPF model the online applications will be scored by a panel of expert reviewers. The reviewers will use a standardized system for scoring the applications established by the rubric in Table 20 on the following page.

In terms of eligibility, every applicant must demonstrate that they represent a broad-based coalition. A single coalition (i.e., the coalition or its fiscal agent) must be the legal applicant, the recipient of the award, and the entity legally responsible for satisfying the grant requirements. Coalitions will not be required to have a 501c(3) non-profit status, but they must have a designated fiscal agent that is either a public entity or a 501c(3) to serve as the fiduciary for the grant. The fiscal agent must also be a member of the coalition.

SECTION I. ORGANIZATION BUSINESS INFORMATION (Pass/Fail)
A. Organization Information
B. Fiscal Agent Information
SECTION II. STRATEGIC PREVENTION FRAMEWORK (100 points)
A.   Community Needs Assessment (20 points total)
A1. Demographics (5 points)
A2. Problems (5 points)
A3. Causes (5 points)
A4. Current Efforts (5 points)
B.   Capacity Building (15 points total)
B1. Coalition Development and Qualifications (5 points)
B2. Staff Qualifications (5 points)
B3. Coalition Organizational Structure (5 points)
C.   Planning (20 points total)
C1. Identify Problems (5 points)
C2. Goals (5 points)
C3. Objectives (5 points)
C4. Strategies (5 points)
D.   Implementation (10 points total)
D1. Action Plan (10 points)
E.   Evaluation Methods (15 points total)
E1. Evaluation Tool (5 points)
E2. Barriers (5 points)
E3. Effectiveness (5 points)
F.   Sustainability/Cultural Competence(10 points total)
F1. Sustainability (5 points)
F2. Cultural Competence (5 points)
G. Budget Worksheet/Written Justification (10 points total)
Applicants from communities with funded Drug Free Communities grants or other federally funded anti-drug coalitions must ensure that representation from the federally funded coalition is included in the SPF applicant coalition to ensure coordination and collaboration and avoid duplication of services.
SECTION III. PROGRAM ADMINISTRATOR ASSURANCES (Pass/Fail)
Completed applications will be evaluated on the quality of the information provided in each section. Applications will be considered in light of the organization's substance abuse prevention experience, fit with the current Statewide Strategic Prevention Plan, administrative costs, and overall prevention value. *Per Federal guidelines, priority points may be assigned to qualifying current DFC grantees, Federally recognized tribal populations, communities serving veteran populations and/or rural communities.*

Table 20: SPF Grant Application Scoring Rubric

At the time of application the coalition must have at least one member/representative from at least 6 of the following sectors:

- Youth (an individual 18 or under);
- Parent;
- Business Community;
- Media;
- School;
- Youth-serving organization;
- Law Enforcement agencies;
- Religious or fraternal organizations;
- Civic and volunteer groups;
- Healthcare professionals;
- Local Health Department;
- Representative that brings perspective to cultural diversity;
- State, local or tribal governmental agencies with expertise in the field of substance abuse.

By the start of the implementation phase, all sectors must be represented on the coalition. Tribal applicants must also include representatives from at least six of these sectors or their functional equivalent. Tribal applicants must be tribal councils or coalitions applying under an approved resolution. Sub-recipients will only receive implementation funds after development of their strategic plans, which will include their selected approved evidence-based programs and environmental strategies. Until that time, sub-recipients will have funds available for hiring a coordinator, supporting their coalition growth and development, conducting their needs assessment, and training coalition members and key partners in the early stages of the SPF process.

COMMUNITY BASED ACTIVITIES

Every funded community will know their project's targets are defined by the statewide priorities. Upon receiving the award for the first cycle, the immediate activities of the sub-recipients will be focused on the completion of the first three steps of the SPF. The SPF SIG staff will provide technical assistance and training throughout the project. First, sub-recipients will conduct a comprehensive local needs assessment to determine factors contributing to the priorities. Also sub-recipients will work on

the formation of a local advisory council. Based on the knowledge attained from these activities the sub-recipients will develop a strategic plan that outlines their plan to address Idaho's priorities. For the development of strategic plan the EBP workgroup will provide a list of evidence-based programs/environmental strategies to sub-recipients from which they can choose the strategy most consistent with their findings. The strategic plan must be approved by SPF staff and the SPFAC in order to receive funding for the next cycle of the project. Sub-recipients will be expected to submit a budget and budget justification with their comprehensive plan, detailing the proposed strategies and expenses associated with implementation. Then SPF funds will support implementation of the approved strategies and the participation in evaluation activities. Furthermore, ongoing technical assistance and training will be provided. Table 21 lists the main community-based activities and key products planned for each step of the SPF.

As part of the planning process, it is critical for each coalition to address both current capacity around cultural competency as well as its plans to integrate cultural competency processes into all five steps of the SPF. Coalitions will be asked to demonstrate an active commitment to cultural competence. The following questions related to cultural competency must be answered by each coalition:

- What are the unique cultural, racial/ethnic, and linguistic patterns within the geographic area served by the coalition, and how does the coalition currently meet those needs?
- How does the coalition plan to enhance the capacity to more effectively meet those needs in the future?
- What is the extent to which there is broad-based citizen participation, including those most affected by the consequences of substance abuse, in current substance abuse prevention efforts? How does the coalition plan to increase that participation?
- What is the extent to which coalition members represent the diversity of the community with respect to race, gender, geography, ethnicity, and age? Is there adequate representation of both grassroots and agency perspectives?
- How will the coalition ensure that community prevention strategies are culturally competent (use past experience to illustrate, as appropriate)?
- What is the coalition's past experience engaging in culturally competent and inclusive assessment, capacity development, planning, strategy implementation, and evaluation? How will the coalition increase cultural competence and inclusion within these areas in the future?

The capacity to sustain desired prevention outcomes is also a key element of the planning process. Each coalition must describe its current capacity to sustain desired prevention outcomes and how it intends to expand its capacity in this area (specifically, each coalition must explain how it will build organizational and prevention system capacity, ensure strategy effectiveness, and foster community support). Also, if it is an experienced coalition, it should describe how existing prevention strategies have been sustained, and what approaches were most effective in achieving sustainability.

State bird
Mountain bluebird

State flower
Syringa

State tree
Western white pine
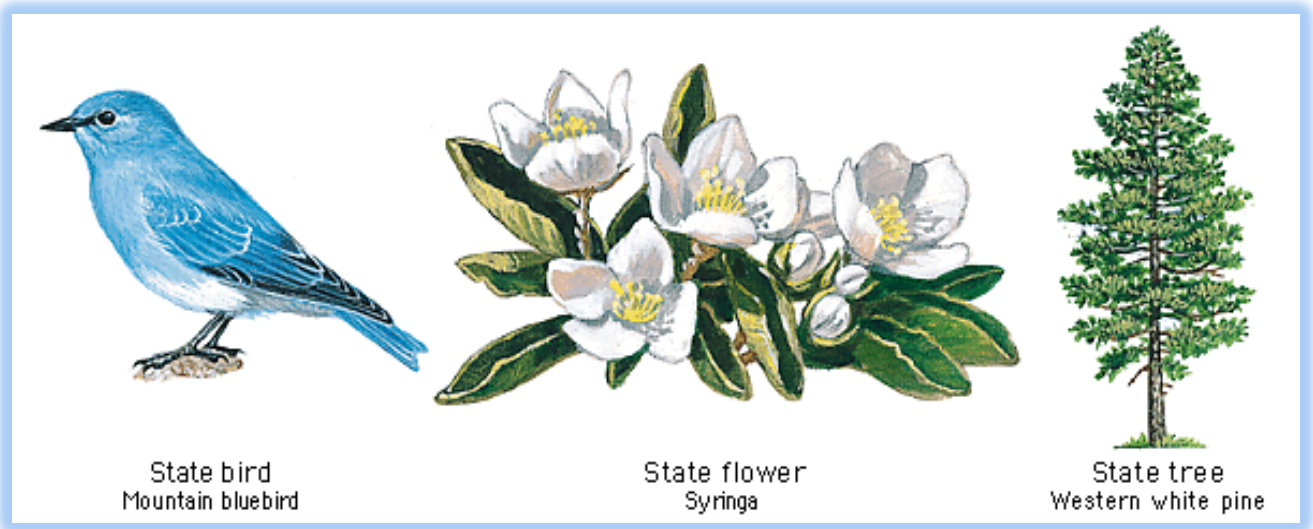
SPF Steps	Activities/Key Products
Step 1: Assessment	• Utilize resources provided by SPFAC and SEOW to access technical assistance and to conduct all elements of the needs assessment. • Identify and mobilize, across sectors, key individuals for the community to conduct a local needs assessment. • Gather local data about the use of ATOD, risk factors and intervening variables. • Build a basic community profile. • Build an inventory of community needs, local resources and prevention programs targeted at the selected population. • Develop a clear, concise, and data driven problem statement. • Assess readiness, external factors, and potential barriers to success. • Assess organizational, fiscal, and leadership capacity. • Assess the cultural competence of the organization.
Step 2: Capacity	• Actively participate in all trainings and technical assistance provided by the Idaho SPF SIG staff. • Develop a capacity building plan for all the personnel involved with the project. • Develop a plan for the sustainability of the organization's fiscal and human capital. • Create and/or strengthen partnerships. • Create an Advisory Council that included key individuals from across sectors as identified in the needs assessment.
Step 3: Planning	• Plan meetings and strategy development sessions. • Develop a logic model. • Select evidence based programs or practices and environmental strategies to address selected priority causal factors and intervening variables. • Develop a comprehensive strategic plan. • Develop an implementation plan for the strategies identified on the strategic plan, including strategies for sustainability.
Step 4: Implementation	• Implement capacity building plans. • Implement organization's fiscal and human capital sustainability plan. • Implement environmental strategies and evidence-based programs or practices with fidelity. • Meet regularly with the Advisory Council.
Step 5: Evaluation	• Participate in the local and state wide evaluation process. • Collaborate on the development of the evaluation protocol. • Gather local data for process and outcome evaluation. • Submit local data to Idaho SPF SIG staff in a timely manner. • Evaluate, in collaboration with Idaho SPF SIG staff, the effectiveness of the implemented environmental strategies and evidence based programs or practices. • Use data continuously to carry out programmatic and process improvements. • Comply with the required progress reports and maintain regular communication with Idaho SPF SIG staff. • Maintain accountability for both fiscal and programmatic deliverables.

Table 21: SPF Planned Community Based Activities

IMPLICATIONS OF ALLOCATION APPROACH

The major implication of the allocation approach is to change substance abuse priorities in a positive way at the population level. The SPF SIG will allow us to have a more systemic approach to prevention. In Idaho it is likely that major changes at the community level will produce significant changes at the state level because of the relatively small population base.

The Idaho SPFAC values the fact that all Idaho communities will be able to apply for SPF funding through the grant application process. Both high and low capacity communities have the same opportunity for funding. Although there are several sections in the grant application that ask responders to provide information about their agencies and/or existence of a coalition, communities will not be penalized for being low capacity. Scoring will be based on how well the responder completes the section. Idaho SPFAC acknowledges that perhaps a major reason lower capacity communities have significant substance abuse problems is, simply, due to their low capacity. Allowing for SPF funds to be awarded to low capacity communities may have the greatest impact on those communities who are in great need of prevention services. It is recognized that the goal of the SPF is to build prevention infrastructure, which is sorely needed in low capacity/low readiness communities. Idaho recognizes that all communities who are in great need of prevention services to address the statewide SPF priorities should have the opportunity to receive this funding, regardless of their current levels of capacity. Removing the preference for high capacity communities ensures that SPF funds are truly going to those communities who are in most need.

Idaho has the capacity to support community sub-recipient and achieve positive outcomes. The SEOW will assist sub-recipient in developing community data profiles to assist communities in the assessment process. The state will also fund the new Idaho Youth Prevention Survey every two years. Data from these surveys will be available to communities to assist them in identifying the major risk and protective factors that impact one or more of the state priorities. ODP will use the KIT Prevention online report system to track sub-recipient services. Our current consensus is that KIT Prevention will be an adequate tool to capture SPF-related activities.

Training and technical assistance will be provided to sub-recipient communities. The SPF staff with the assistance of CAPT, will develop appropriate educational tools and materials to assist communities in the application of the SPF model. Additionally, ODP is in the process of developing a statewide prevention specialist program. Once this is established, it is anticipated that all SPF sub-recipient staff

will either be certified or initiate the certification process soon after grant award. The assessment and planning phase of this process will be conducted during fiscal year 2015, with an anticipated implementation period to begin in fiscal year 2016.

Special emphasis will be placed on assessment, coalition building, evidence-based strategies, evaluation, cultural competency, and sustainability. The EBP workgroup will also review the sub-recipient applications to assure that evidence-based and environmental strategies are proposed and that they are appropriate based on the culture of the area. The EBP workgroup is in the process of developing an Idaho Toolkit of Evidence Based Prevention Programs, Policies, and Environmental Strategies. It is anticipated that this toolkit will be submitted to the SPFAC for final approval and adoption by April 30, 2014. The toolkit will be updated as new programs, policies, and environmental strategies are approved by the EBP workgroup. A process will be developed and implemented for sub-recipients to submit programs, policies and strategies not included in the toolkit for review for possible inclusion. It is anticipated that this review process will be implemented by August 1, 2014.

The Office of Drug Policy is a natural fit for the placement of the SPF SIG funding, as part of the offices mission is to research, plan, and advocate for statewide drug policy intended to reduce access of substances of abuse, including the three statewide priorities of Prescription drugs, Marijuana and alcohol. The state will also use other resources to address the priority problems. Currently the Idaho Substance Abuse Prevention and Treatment Block Grant serves 22,000 youth in all 7 Regions of the state and is anticipated to help support several of the communities that are eventually funded through the SPF project. Currently there are five Drug Free Communities grantees in the State of Idaho who are also working on substance abuse issues; it is also likely that some of the communities funded with SPF SIG will become more capable of being funded through the Drug Free Communities Grant. Finally, there are three state prevention program staff assigned to work specifically on the SPF project, including the grant project director, the epidemiologist, and the evaluator. Not to mention the hundreds of hours that will be devoted to this project by the SPFAC, SEOW, EBP workgroup and various ad hoc workgroups.

Beyond the SPF SIG positions, Idaho has several crucial aspects of existing state infrastructure that will offer invaluable assistance to the Idaho SPF project. Some of the most beneficial elements are:

Prescription Drug Use Priority Resources

- o Office of Drug Policy **Lock Your Meds** Media Campaign
- o **Idaho Meth Project** has recently added prescription drug abuse to their mission through collaboration with The Partnership at Drugfree.org.
- o **State of Idaho Prescription Drug Abuse Workgroup** (Logic Model Appendix H)
- o **Idaho State Board of Pharmacy** New Prescription Monitoring Program
- o Idaho State Police **DRE Program**
- o **Idaho DEA's Prescription Drug Task Force**

Alcohol Health Outcomes Priority Resources

- o **Idaho State Police Alcohol Beverage Control**
- o **State of Idaho Underage Drinking Workgroup** (Logic Model Appendix I)
- o **Bethe Parents.com** Website, Facebook and Twitter.
- o Underage Drinking **Media Campaign**
- o The Idaho Youth Alcohol & Drug Prevention & Education Program's **Northwest Alcohol Conference** Where individuals and groups can work together to learn from each other and improve the quality of life in their communities through education, prevention, and enforcement

Marijuana Use Priority Resources

- o **State of Idaho Marijuana Use Workgroup** (Logic Model Appendix J)
- o **State of Idaho Senate** Concurrent Resolution #112- Stating findings of the **Legislature** and affirming the Legislature's opposition to the legalization of Marijuana in Idaho for any purpose.
- o **Idaho State Police Drug Recognition Expert Program**

PARTNERSHIPS

Association of Idaho Cities

The Association of Idaho Cities is the single most important advocacy group for Idaho's 200 incorporated cities. AIC is involved on a daily basis in activities which

promote the interests of city officials and the communities they serve. AIC supports the missions of ODP.

The **Idaho RADAR Center**

The Idaho RADAR Center provides free information about alcohol, tobacco and other drugs to Idaho residents only. The Center, a Boise State University program, is administered by the Institute for the Study of Addiction in conjunction with the College of Education & the College of Health Sciences. It includes a Video Lending Library of over 900 titles and functions as a statewide information clearinghouse and resource referral center.

Community Coalitions of Idaho

The Community Coalitions of Idaho (CCI) represents community prevention coalitions throughout the State of Idaho. Their mission is to support community coalitions' efforts to prevent substance abuse in Idaho. Their vision is safe and healthy Idaho communities free of substance abuse. CCI was organized in early 2009 to strengthen advocacy efforts for substance abuse prevention in Idaho. Participating coalitions represent large and small, urban and rural communities across Idaho. Members provide support to one another while sharing ideas, strengths, information, resources and enthusiasm for healthy communities. Working with partners at the local, state and national level, CCI works to facilitate collaboration and encourage cooperation amongst Idaho community coalitions to affect policy and issues with a united voice.

IMPLEMENTATION

STATE LEVEL IMPLEMENTATION ACTIVITES

State level plans to support SPF sub-recipients have already begun in Idaho. From establishing the SPFAC, to identifying and maintaining appropriate data-driven practices, to assessing the state level infrastructure and gaps, Idaho is setting up a state prevention system that sub-recipients can mirror at the community level. The implementation of the SPF process is focused on carrying out the various components of the prevention plans developed at both the state and community (sub-recipient) level. Additionally, other SPF steps will be incorporated (such as evaluation) in order to ensure that barriers are identified and capacity is built to sustain the system.

The SPF-SIG is focused not only on the reduction of ATOD abuse and consequences, but also on developing upstream initiatives which can change the landscape of prevention. The SPFAC is tasked with addressing this essential aim of the Idaho SPF: To strengthen the state infrastructure by developing its prevention and collaboration capacity. Currently, the SPFAC, SEOW and EBP workgroup's are developing action plans and strategies related to the key goals and objectives in Table 22. These strategies and action plans are still in development and should be seen as preliminary; a further process of selection and refinement is underway. The three primary workgroups—SPFAC, SEOW, EBP—will be charged with the implementation of these state-level action plans.

The SPFAC will be responsible for monitoring and evaluating the statewide substance abuse prevention system. This means the SPFAC must develop benchmarks, and determine how implementation processes can be modified in order to more successfully achieve desired system-wide outcomes. Furthermore, SPFAC must implement, monitor, evaluate, and modify on an as-needed basis, its workforce development plan.

SPF staff will be responsible for monitoring key performance measures related to community-level implementation of the SPF plans. Staff will also receive and evaluate quarterly coalition reports, make regular site visits to communities, and work with the coalitions to make necessary adjustments as needed.

However, all of the major decisions that contributed to or flow from this strategic plan that will affect communities (e.g., selection of state priorities, sub-recipient grant awards, determination of evidence-based strategies) will be made by SPFAC. SPFAC will receive regular updates form SPF staff as well as representatives from funded community coalitions so that it can monitor progress throughout the project.

Goal 1: Build prevention capacity and infrastructure at the State and community levels.
Objective 1.1 Increase prevention capacity and infrastructure at the State level.
Activity 1.1a: Maintain a SPF Advisory Council that oversees all prevention services in the state.
Activity 1.1b: Maintain and strengthen the State Epidemiological Outcomes Workgroup
Activity 1.1c: Maintain an Evidence-Based Practices (EBP) Workgroup
Activity 1.1d: Improve State systems that collect data applicable to substance abuse and related.
Activity 1.1f: Review and update Statewide Needs Assessment.
Activity 1.1g: Update and implement a comprehensive statewide Strategic Plan based on the feedback from the SPFAC, SEOW and EBP and the information/data from the NA.
Activity 1.1h: Conduct process and outcomes evaluation of State level SPF strategies.

Goal 1: Build prevention capacity and infrastructure at the State and community levels.
Objective 1.2 Increase prevention capacity and infrastructure at the community level.
Activity 1.2a: Assist communities in establishing/enhancing and maintaining local coalitions to address local substance abuse prevention needs.
Activity 1.2b: Provide technical assistance and training to stakeholders and service providers.
Activity 1.2c: Conduct community level needs/resource assessments.

Goal 2: Prevent the onset and reduce the progression of substance abuse, including childhood and underage drinking, tobacco use, and prescription drug misuse and abuse.
Objective 2.1 The statewide rate of substance abuse among Idaho youth will decrease over the course of the grant by a percentage indicated by the needs assessment.
Activity 2.1a: Implement, on the state and local level, prevention policies, programs and practices based on the state and local needs assessment.
Activity 2.1b: Implement, on the state and local level, prevention policies, programs and practices that are proven to be effective in research settings and communities. The State will strongly encourage the implementation of environmental strategies and only evidence-based individual strategies will be supported.
Activity 2.1c: Increase the number of community providers or coalitions or both consistent with needs and resource assessment findings.
Activity 2.1d: Provide ongoing support and technical assistance to community prevention providers and coalitions.
Activity 2.1e: Conduct ongoing monitoring and evaluation of all project activities and adjust policies, programs and practices as needed based on the monitoring and evaluation.

Table 22: State Level Goals and Objectives

COMMUNITY LEVEL IMPLEMENTATION ACTIVITES

One of the first steps to facilitating effective implementation at the local level is to organize relevant local data so that coalitions focus on a data-driven process. All coalitions will also be required to hire a local evaluator to assist them in the assessment process as well as the evaluation component.

During the development of the community-level plans, it is critical to ensure that relevant and appropriate policies, practices, programs and environmental strategies are selected. As the local coalition plans are developed, the EBP Workgroup will review each coalitions selected strategies to determine not only if they are evidence

based, but also if they are culturally relevant and inclusive to the area. The workgroup will also review the process that each coalition undertakes to select strategies, and whatever input was received from those people in the community who will be most affected by them.

SPF staff will assure that appropriate technical assistance as well as tools and materials are available to all grant recipients. Special emphasis will be given to assessment, coalition building and effectiveness, evaluation, cultural competency, and sustainability. Training and technical assistance will be provided throughout the process. It will begin during the application process with information workshops provided by SPF staff. The training and technical assistance will continue throughout the planning and implementation phases. SPF staff is developing a comprehensive SPF training and education plan. This plan will be completed in advance of the grant awards.

Although every community that is funded under SPF will receive training and technical assistance on all phases of the SPF model, it is hoped that each coalition member will participate in the Kaizen survey of their coalition to help determine the current capacity and effectiveness of the coalition. The survey will also help to identify the knowledge, skills, and activities of the coalition members. The results of these surveys will allow SPF staff, along with the National Guard, to develop more specific training modules and technical assistance materials to meet the specific needs of each coalition. It is hoped that the survey will be conducted on a regular basis to assess progress and to identify future training and technical assistance needs.

The Kaizen survey is one mechanism to ensure training is successful. All formal training and educational workshops will also be evaluated by the participants using a standard questionnaire. Ultimately, SPF process data from coalitions will provide information enabling the state to assess how well grantees actually perform SPF tasks in the field.

Idaho is a state small in population, but large in land mass. This presents its own set of challenges when trying to use a systemic approach to prevention. This is not a new challenge to us. The existing prevention infrastructure is very connected. Because we are small in numbers, most of our prevention providers know one another and communicate on a monthly basis via phone and email to share ideas and resources through the Community Coalitions of Idaho (CCI). CCI also holds tri annual face-to-face meetings for networking and training each year. ODP holds quarterly Strategic State Prevention Planning Committee meetings to bring all of the prevention professionals and organizations face-to-face for planning, networking, and support. These meetings facilitate coordination and collaboration

among state government departments. It allows us to find new ways to partner on prevention issues, as well as ensure each agency knows what services the others are providing to avoid duplication of efforts.

The SPF staff and SPFAC understand the goal isn't necessarily to avoid duplication of prevention efforts, but certainly to avoid *unnecessary* duplication and to better coordinate prevention efforts in Idaho. There is great value in collaborating with other entities with similar goals, but Idaho intends on ensuring a process that promotes a consistent message coming from all partners. The hope is that SPF sub-recipients will be able to learn from and expand on good prevention work that is already being done in Idaho.

Funding will be awarded throughout the state through an open application process. Each applicant will be reviewed by a team of informed reviewers who will look at each application individually. Each applicant is asked to explain how it will ensure that there is no duplication of sub-state anti-drug funding. If the applicant is a current DFC recipient they will be asked to describe how the SPF funding will interface with the DFC grant.

EVALUATION

State-Level Surveillance, Monitoring, and Evaluation Activities

The State Evaluation Team (SET) includes faculty and staff at the Center for Health Policy at Boise State University. The SET will work closely with personnel at the Office of Drug Policy (ODP) and local evaluators (LEs) hired by the Idaho communities receiving funding through the SPF-SIG grant.

Surveillance

High-level surveillance of rates and prevalence of substance use will be performed primarily by ODP staff. This data will include those captured by ongoing statewide surveillance programs such as the Youth Risk Behavior Survey (YRBS), the Behavioral Risk Factor Surveillance System (BRFSS), the National Survey on Drug Use and Health (NSDUH), and Treatment Episode Data Set (TEDS).

Monitoring

The monitoring activities performed by the SET will essentially comprise a "process evaluation" in which the SET will provide guidance and oversight to ensure quality in both program/intervention implementation and data collection processes. The SET will work closely with LEs with respect to choice of evidence-based data collection instruments, training for data collection, and measurement of prevention program/intervention fidelity, as well as efforts for continuous quality improvement (CQI). Each of these activities is discussed in greater detail below.

➢ Although the local communities will have considerable flexibility in choosing prevention programs/interventions, it is important that the program/intervention activities be measured with data collection instruments that are demonstrated to be reliable and valid. Regardless of what prevention programs/interventions communities choose, the SET will work with the communities' program/intervention staff and LEs to select evidence-based data collection instruments.

➢ Because it is likely that many communities' program/intervention staff and LEs will be unfamiliar with at least some of the chosen evidence-based data collection instruments, the SET will provide training on the how the data should be collected, the psychometric properties of the instruments, how to perform basic analyses on the data, and how the results should be interpreted and reported at the local level. Periodic monitoring of data collection, analysis, interpretation and reporting will be conducted.

➤ Although some of the prevention programs/interventions may be designed at least in part at the local level, many or most will follow standardized protocols developed at the regional or national level. The SET will work with program/intervention staff to ensure that such staff are aware of the expectations and standards of the program/intervention designers regarding how the program/intervention is to be implemented. Periodic monitoring of the fidelity to these expectations and standards will be conducted.

➤ The SET will remain in contact with local program/intervention staff and LEs to communicate findings of both local data submitted by LEs and statewide data submitted by all communities. Areas for improvement in data collection, analysis, interpretation, reporting, and fidelity to program/intervention expectation and standards will be summarized and discussed with local program/intervention staff and LEs for CQI purposes.

Evaluation

The evaluation activities performed by the SET will be more consistent with an "outcome evaluation" than those performed in the monitoring activities. The evaluation activities will involve assessing the efficacy of the prevention programs/interventions in the 16 selected communities using data collected by the LEs. Although, due to different prevention programs/interventions in the communities, and also due to the fact that different communities will be targeting different types of problems (i.e., alcohol and prescription drug misuse, marijuana use), many of the local data collection instruments will be dissimilar. However, it is understood that all communities' programs/interventions will be required to collect the SAMHSA/CSAP National Outcomes Measures data, so there will be some standardized data across all communities. The SET plans to develop some additional standardized measures, items, or protocols for use by all communities' program/intervention staff and LEs, to allow for further cross-site comparisons as appropriate. Ideally, these standardized measures or items will allow for the capture of information on relevant dependent variables such as knowledge, attitudes, or behavior both prior to and following participation in programs/interventions.

The evaluation team plans to collect LE data on a quarterly basis, and use these data to produce quarterly report summaries for individual communities and on a statewide level. These summaries will be used both for evaluation (i.e., assessing program/intervention success on relevant indicators) and monitoring (e.g., assessing data quality, accuracy, etc.) purposes. An annual report will be prepared

featuring both individual (i.e., community-level) and aggregate (i.e., statewide) results.

In addition to collecting, analyzing, and reporting on data collected directly by LEs in the 16 selected communities, the SET will perform additional, supplementary activities to further assess program/intervention success. These activities will include the following activities, conducted on a semi-annual basis:

➢ Community stakeholder perceptions of program impact. Because many of the indicators that would be useful for tracking program success are collected only periodically (e.g., the YRBS) or are reported at levels not appropriate for evaluation of program/intervention success (e.g., at a county level rather than at the community level), proxy measures of program impact are helpful. Stakeholder perceptions, gathered through key informant interviews, focus group interviews, and/or targeted survey methods, can be an excellent proxy measure. The SET will identify community stakeholders that will likely have knowledge of the extent to which program/intervention participation has had an impact on knowledge, attitudes, or behaviors related to substance misuse or use, and will ask them to share their perceptions on these issues. Examples of such community stakeholders will be law enforcement officers, school teachers or administrators, social services providers, health district employees, or others as appropriate.

➢ Participant perceptions of program quality and satisfaction. These data will be useful for both evaluation and monitoring (especially CQI) activities.

➢ Community awareness and collaboration. In recognition that programs/interventions tend not to be successful if they are not integrated with other community programs, resources, or organizations, the STE will measure the level of community awareness of and collaboration with the program/intervention. Indicators of collaboration will include referrals to the programs/interventions, referrals from the programs/interventions, and shared knowledge (e.g., through dissemination of LE reports), among others.

Expectations of Change

Ultimately, what the SET will be expecting to change will be the quality of the 16 communities' prevention programs/interventions (in terms of fidelity, data collection practices, data quality, reporting efforts, etc.). Although it is perhaps inappropriate for the SET, as independent evaluators, to explicitly state it intends to change the level of substance misuse or use, its role without question is to help

program/intervention staff to use relevant information in CQI efforts to improve the quality of programming and in interpreting and reporting results.

At the state level, significant changes are expected to occur primarily in the building and coordination of a unified prevention infrastructure. The state system is expected to be better connected and equipped to administer more efficient and effective substance prevention efforts by the end of SPF SIG funding. It is anticipated that notable changes in consumption or consequence patterns at the state level will be minimal due to the limited number of communities that are going to be funded and the short time span of the SPF SIG. However, it is expected that there will be a vast change in these patterns at the community levels. The state has identified the following statewide priorities for SPF sub-recipients to target:

> 1) Prescription Drug Use (*sub-recipients are required to choose at least one indicator):*
>   a) Nonmedical use of pain relievers;
>   b) Prescription drug distribution rates;
>   c) Number of deaths from drug induced mortality;
>   d) Seizure rates;
> And one of the following (Not required):
> 2) Alcohol Health Outcomes *(sub-recipients may choose at least one indicator):*
>   a) Rate of alcohol liver disease;
>   b) Rate of alcohol induced deaths;
>   c) Alcohol as primary substance of use upon treatment entry;
>   d) Percent of persons 12 and older reporting alcohol dependence/abuse;
> 3) Marijuana Use *(sub-recipients may choose at least one indicator):*
>   a) Marijuana possession arrests;
>   b) Marijuana trafficking arrests;
>   c) Marijuana seizures;
>   d) Percent report marijuana as primary substance use upon treatment;
>   e) Percent of students in grade 9-12 who used marijuana one or more times in the past 30 days;
>   f) Percent report marijuana as substance of use upon treatment area.

At the state level, change will also be dependent upon a number of factors, including how many communities target a specific state priority and the size of the communities relative to the state as a whole. While state level change in the three state priorities is desired, it is not the focus of the SPF SIG evaluation, but rather a potential benefit of successful changes in SPF SIG funded communities.

However, within the communities, vast changes in the consumption and consequences patterns, particularly in the defined SPF SIG priority areas, are expected to be seen. The enhanced capacity of funded communities due to the SPF process should ultimately result in significant improvements in state priorities. Communities will assess their local needs, identify the major contributing factors, and select and implement appropriate strategies and practices.   Each community, once funded, will develop a strategic plan around their local assessed priorities. Also within the funded communities, growth in the local prevention infrastructures and capacity to continue to implement SPF strategies are expected.

Ensuring Collection of SAMHSA/CSAP National Outcome Measures

As noted in the section on Monitoring above, the SET will remain in frequent contact with LEs to ensure that all data are being collected as required. The SET will collect these data from the LEs on a quarterly basis, and will issue quarterly reports presenting basic findings and also identifying areas for improvement (e.g., if there are missing data fields) as appropriate. If the SET finds that National Outcome Measures data in one or more communities is not being submitted regularly or completely or in a timely fashion, it will work with ODP staff to rectify the situation.

Annual Reporting of GPRA Data

The SET will work with ODP staff to ensure that all reporting requirements for GPRA data are met.

CROSS CUTTING COMPONENTS AND CHALLENGES

CULTURAL COMPETENCE

<p align="right">**Figure 29: Middle Fork of the Salmon River**</p>

Idaho is a geographically large state with vast frontier expanses and relatively few heavily populated areas. The State of Idaho is predominantly rural in character and culture, reflecting traditional morals, values, and lifestyles, with pockets of cultural and ethnic diversity. Its largest metropolitan area, the Treasure Valley, which includes both Ada and Canyon Counties, contains about 37% of the state's population. Idaho's urban, suburban, rural, and tribal lands have very different historical, social, and cultural features. Each community's needs and perspectives about ATOD may differ from those of other groups and subcultures. Within these communities, prevention efforts must take into special account the role social and economic conditions play in problems associated with ATOD (e.g., poverty, inequity, inequality), and the need to engage community leaders and networks in prevention. Although the population of Idaho at first glance does not seem to include much diversity, it is important to note that the state is home to seven Native American tribes and is receiving immigrants and refugees from around the world. In addition, the state has seen steady increases in its Hispanic population. Therefore, it is vital that at both state and community levels we ensure that services and activities are customized to meet the unique cultural needs of the children, families, agencies and providers from throughout Idaho. The ethnic, cultural, language, gender, and disability variables existing in Idaho present challenges and opportunities to enhance the relevant substance abuse prevention efforts for target populations. In addition, it is important to note that there is a significant population of Church of Jesus Christ of Latter-day Saints (Mormons) in parts of the state who significantly influence the culture in those areas. The Request for Applications will specify that the project staff responsible for implementing activities associated with the project be culturally competent and reflective of the demographics of the populations being served.
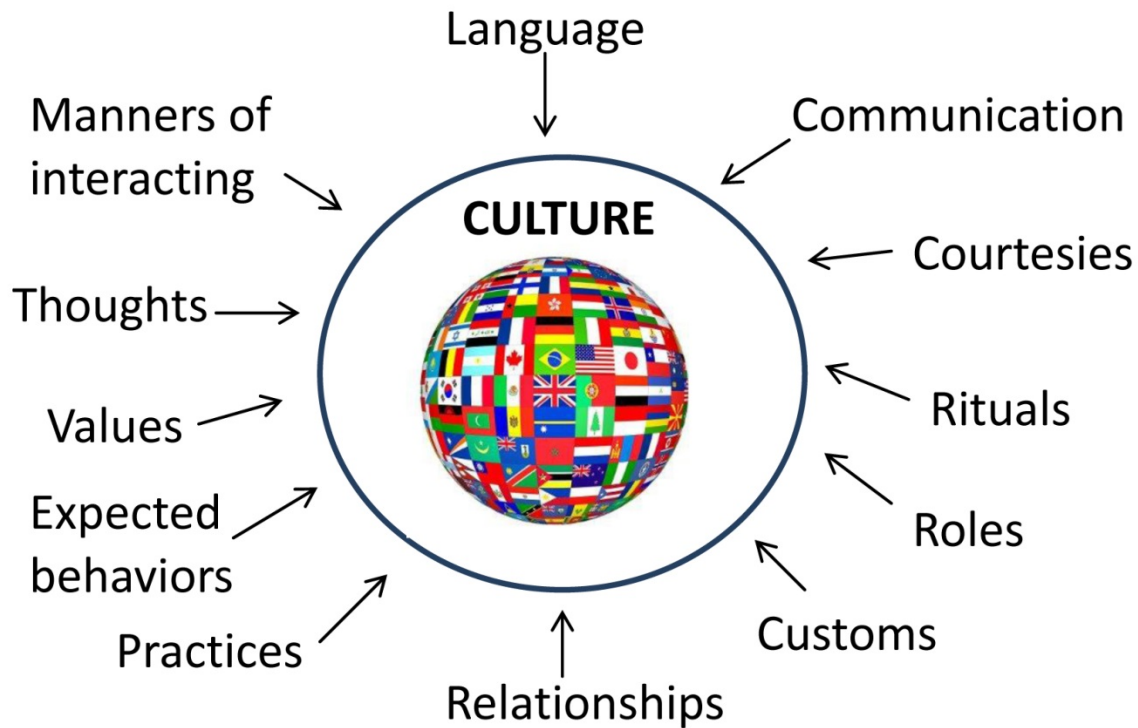
Figure 30: *In order to achieve cultural competence and proficiency, organizations need to develop a systematic framework based on sustainable models and theories. Theoretically, competence requires cross-cultural values, attributes, knowledge and skill set to work effectively.*
The key steps in implementing cultural competence are evaluating diversity and conducting cultural self-assessment. You must manage the dynamics of difference and institutionalize cultural knowledge. Finally, you must adapt to the diversity of communities through policies, structures, values and services. (dfwhcfoundation.org)

The understanding and appreciation of cultural differences and similarities within and between subpopulations is an integral part of the Idaho SPF. The practice of intentionally working to ensure the right of all of a community's diverse populations to participate fully and equally in decision-making, policy development, and implementation of programs, policies, and practices is a critical piece to Idaho's cultural competence. Idaho's SPFAC will ensure that all SPF SIG tools, practices and processes are inclusive, appropriate, and culturally responsive to Idaho's identified diverse subpopulations. Three specific subpopulations have been identified as potential ad hoc subcommittees of the SPFAC.
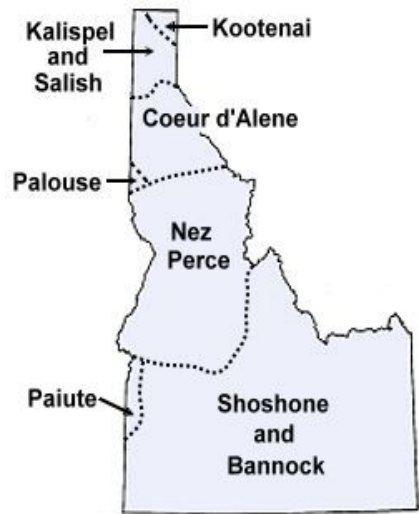
Figure 29: Native American Tribes of Idaho Map
Courtesy of www.native-languages.org

The Idaho SPFAC understands the sovereignty of the seven **Native American Tribes** in Idaho. One of the first steps of the SPF SIG project will be to meet with each of the Tribal Councils to discuss the project and opportunities this project presents to ATOD prevention on their reservations. Approval from each Tribal Council will be necessary before they can begin collaborative efforts on the SPF SIG in Tribal Communities. The continued cultural mistrust of governmental service system and academic based research must be considered and overcome by the Idaho SPF SIG Project. A potential Federal resource with strong Native American ties has been identified to help overcome this obstacle. The Native American Center for Excellence (NACE) is a Native American-run project funded by CSAP and SAMHSA to promote effective substance abuse prevention programs in Native American communities throughout the United States. It identifies innovative and promising programs and practices that prevent substance abuse and related problems among Native Americans and provides Native communities and reservations with technical support and training to assist adaptation of Evidence Based Practices.

A significant increase in Idaho's **Hispanic** population has occurred in both rural and urban areas, in part due to a growing migrant population and employment in the agriculture industry. The Hispanic subpopulation in Idaho is sizeable, representing approximately 11% of Idaho's population. This is the largest subpopulation in Idaho, with a population that approximately totals all other subpopulation groups combined. In some smaller, rural counties, the Hispanic population represents up to 40% of the population. According to the 2010 U.S. Census, the largest subpopulation of Hispanics was in Clark County at 40%, while the smallest subpopulation was in Adams County at just over 2%. Input from the Hispanic subpopulation on the SPFAC would assist in addressing problems unique to Hispanics. Currently, Margie Gonzalez, with the Idaho Commission on Hispanic Affairs is a member of our SPFAC, and her input is invaluable as we seek to be inclusive of the problems related to substance abuse prevention that are unique in the Hispanic communities.

Veterans make up approximately 8% of Idaho's population, according to the 2010 U.S. Census, which is approximately 1% above the national average. The State of Idaho has several organizations within state government to assist veterans in business and other needs. The U.S. Department of Veterans Affairs has multiple clinics and medical centers throughout Idaho. There is currently one military base in Idaho. Mountain Home Air Force Base just outside Boise. The availability of treatment for Veterans through VA hospitals and clinics should be considered and veteran input on the SPFAC would be helpful. It is clear that as increasing number of veterans return home from active duty, Idaho must better address the needs of these military members and their families. Working with local military installments in a coordinated effort to ensure the State of Idaho is better aware of their needs and better able to serve them is necessary.

Cultural competency and inclusion are built into every component of the Idaho SPF SIG planning process. During the process of assessing readiness for engaging in social change, Idaho SPF SIG sub-recipient communities will be required to be inclusive of all populations, and to include examination of attitudes towards sub-populations as part of their assessment process. In addition, they will be required to assess and prioritize issues related to cultural competency and inclusion within their community partnerships, and to develop a plan to address those issues. Specifically, coalitions receiving SPF SIG funding will have to develop and implement plans to achieve the following cultural competency capacities (Adapted from CADCA Capacity Primer):

> ➢ The capacity to ensure that coalition members represent the diversity of the community served, with respect to race, gender, geography, ethnicity, and age:
> ➢ The capacity to ensure broad-based citizen participation—including the participation of those most affected by the consequences of substance abuse – throughout the process;
> ➢ The capacity to meet the unique cultural, racial/ethnic, and linguistic need patterns within the geographic area served; and
> ➢ The capacity to ensure that all community prevention strategies are culturally competent and inclusive.

SUSTAINABILITY

Substance abuse is a pressing issue in Idaho as well as across the nation. It is understood that SPF is a limited funding opportunity for the state of Idaho, and thus we need to move toward ensuring an adaptive and effective system that achieves and maintains long-term results. Idaho's SPFAC is composed of those individuals that have a stake in successful prevention outcomes, and those agencies, institutions, and organizations whose mission includes substance abuse prevention. Idaho is committed to developing, enhancing, and maintaining effective, coordinated prevention systems at the state, regional, and community levels. These systems will provide the infrastructure to support data-driven strategic planning for prevention whereby local needs, readiness, and resources are assessed, and evidence-based strategies are selected, implemented, and evaluated in order to achieve population level positive outcomes.

A commitment to sustainability at the state level means that the various partners that make up the SPFAC are committed to working together to develop strong, effective, coordinated and adaptable prevention partnerships. These partnerships will cooperatively initiate prevention capacity building and infrastructure development activities in order to strengthen the statewide prevention system, for it is this statewide system that provides the foundation for regional and community level prevention work. If positive substance abuse prevention outcomes are to be sustained within communities, they must be supported by effective systems from the grassroots level on up.

Sustainability at the state level means that the SPFAC, including the SEOW and EBP workgroup, will continue long past the end of SPF funding. In order to achieve this end, Idaho will use the SPF process as a vehicle to strengthen its existing prevention system. Strengthening the system entails focusing on the CAPT's three keys to sustainability: (1) Building organizational capacity; (2) Strengthening commitment to substance abuse prevention among key allies and champions by nurturing collective ownership in both the problems of substance use

and abuse, as well as solutions to those problems; and (3) Demonstrating effectiveness by successfully supporting regional and community entities in order to achieve positive population level changes in substance abuse over the long term.

Part of building organizational capacity involves the coordinated leveraging of resources form the variety of state agencies engaged in substance abuse prevention work. Coordination between agencies and organizations means that agencies will work together to ensure that data collection, funding streams, and targeted prevention initiatives are synchronized and working in harmony to achieve desired results.

In order to nurture a sense of collective ownership in substance abuse prevention activities at the state level, key allies and champions must be identified and their support must be cultivated. Currently the SPFAC, SEOW and EBP workgroup's already include strong representation from key infrastructure partners within a variety of sectors. However, in order to strengthen and broaden that foundation, SPFAC will conduct outreach to additional state-level entities, with particular focus on those whose mission includes prevention for populations whose needs are not currently being addressed by existing partners.

Training and technical assistance will be provided to sub-recipient communities to develop a comprehensive sustainability plan. Sub-recipient will be required to develop this plan as part of their overall strategic plans for prevention that address the key components of sustainability:

- **Organizational capacity:** All of the organizations and agencies delivering the strategies must have the structure and capacity to develop the administrative functions related to the effective implementation of the strategies, secure adequate resources, and acquire appropriate expertise.

- **Effectiveness:** The organizations and agencies must have the capacity to demonstrate that they have reached the target population with effective strategies that have been tracked through careful evaluation.
- **Community support:** The organizations and agencies also need the capacity to develop positive relationships among key stakeholders, identify and nurture leaders and champions, and build a collective ownership among those who have a stake in sustaining the outcomes of a prevention intervention.

UNDERAGE DRINKING

Idaho has identified Alcohol Health Outcomes as a state priority. Scientific evidence points to the importance of utilizing environmental strategies to achieve large reductions in underage drinking. Therefore, the effectiveness of the statewide strategy is contingent upon the integration and environmental perspective (laws, enforcement, promotion, retail availability and price). This collaboration will require a change in the landscape of state agencies and in their cultures. Historically, state agencies in Idaho have worked in silos, even though they may have been doing complementary work in the area of substance abuse prevention. The SFAC was carefully recruited and selected to have representation of all the key players in order to successfully address this challenge. Also, the SPFAC is taking all of this into account while developing the detailed action plan for each selected priority.

At the community level the challenges will be different. Historically community-based organizations implement individual-level interventions rather than focusing at the environmental level. We anticipate a paradigmatic shift will be required at the sub recipient level in order to fully embrace environmental interventions for reducing underage drinking. The proposed design for capacity building and support for sub-recipient previously described in this document has taken into account these anticipated challenges, and training and technical support specific to this topic will be provided. Underage drinking is likely to be addressed by several sub-recipients for three primary reasons. First, underage drinking is a huge problem in Idaho, and is recognized as such by communities across the state; second, many of Idaho's substance abuse prevention coalitions already have extensive experience addressing the underage drinking problem. In all likelihood, several of these coalitions will be funded by SPF, and as a result will have the opportunity to expand their work in this area. Finally, many of Idaho's substance abuse prevention coalitions have collected good local data related to underage drinking that will enhance the assessment and evaluation process.

Challenges

Although the target of the SPF SIG is a reduction in the consumption and consequences of the identified priority substances, these targets take time to achieve and significant differences may not be observed in the community level data during the SPF funding period. There is a considerable level of capacity that must be achieved in order for sub-recipients to learn how to participate in data driven planning, implementation, and evaluation, not taking into account the time it takes to document positive results. Outcomes will depend upon exposure and reach of the chosen evidence based practices, and effectiveness of the environmental strategies. A paradigm shift from individual level approaches to environmental strategies among community organizations, and their perceived and actual efficacy for successful implementation is a successful outcome in itself.

The coordination of resources at the local and state level throughout the process may be challenging. Training and technical assistance will need to be provided to several communities that covers vast geographical area, and to coalitions with varying levels of capacity, working in turn in communities with varying levels of readiness for prevention. SPF staff, CAPT, and the National Guard will be responsible for providing the training and technical assistance, but must strive to ensure that training is timely and consistent across the state, and that it adequately meets local needs.

Another challenge SPF staff may encounter during implementation is assuring that there is open communication and sharing of information between the state and local evaluators and between local evaluators. Open communication channels should produce better evaluation results because issues and problems can be surfaced and addressed immediately. An environment that fosters open communication has a greater potential to nurture cross-site learning through a free exchange of information between evaluators.

Also, similar to the recognition that meaningful changes in substance use require environmental approaches, it is recognized that sustainable outcomes will only be achieved when the environmental context for ATOD prevention changes. This includes the human and fiscal capacity of state agencies and local organizations, as well as the collaboration and coordination between these parties. Idaho SPF SIG will continue to strive to engage the necessary stakeholders to allow for these upstream initiatives to be successful.

TIMELINE AND MILESTONES

Table 23: Idaho SPF Timeline

Key Activity	Timeline	Responsible Staff	Status
Notice of Award	8/1/2013		Completed 8/1/2013
Recruit, hire, orient and train Research Analyst/Epidemiologist	8/1/2013	Elisha Figueroa	Completed 8/1/2013
Establish SPF Advisory Council	10/1/2013	Elisha Figueroa Sharlene Johnson	Completed 11/27/2013
Conduct SEOW meeting with additional meetings occurring at least quarterly	10/1/2013	Nathan Drashner	Ongoing Start 9/17/2013
Conduct first SPF Advisory Council Meeting with additional meetings occurring	11/1/2013	Elisha Figueroa	Ongoing Start Date 11/27/2013
Recruit, hire, orient and train Project Director	9/1/2013	Elisha Figueroa	Completed 9/2/2013
Establish Evidence-Based Practices workgroup	11/1/2013	SEOW	Completed
Conduct first EBP workgroup meeting with additional meetings occurring monthly	11/1/2013	SEOW	Ongoing Start Date 1/30/2014
Sub-contract implemented for Evaluation	12/1/2013	Sharlene Johnson Nathan Drashner	Completed 12/19/2013
Broaden and enhance Statewide needs assessment with updates occurring annually	January 2014 and annually thereafter	Nathan Drashner, SEOW	Completed 11/27/2013

Key Activity	Timeline	Responsible Staff	Status
Approval of sub-recipient funding mechanism	3/1/2014	SPF Advisory Council	Planned
Develop Idaho's Statewide Strategic Plan	3/1/2014	SPF Advisory Council	Planned
Release of RFA	4/14/2014	Sharlene Johnson	Planned
Implement statewide SPF training program	April/May 2014	Sharlene Johnson	Planned
Funding of all sub-recipients	7/1/2014	SIG Staff	Planned
Hold new grantee training	9/1/2014	SIG Staff	Planned
Submit state level progress reports	Quarterly	Sharlene Johnson	Planned
Based on the SPF Plan, work with local communities to conduct local needs assessments and create local SPF plans	March 2015 and annually thereafter	SIG staff	Planned
Implementation of sub-recipients' programs, policies, and practices	March 2015, then ongoing	Sub-recipients	Planned
Receive sub-recipient evaluation reports	Twice per year	Nathan Drashner	Planned
Conduct a state level evaluation of Idaho's SPF Project and submit state level outcomes	May and November each year	Evaluator	Planned
Provide technical assistance to sub-recipients	Ongoing	SIG Staff	Planned

Acronyms

ARCOS	Automation of Reports and Consolidated Orders System
ATOD	Alcohol, Tobacco & Other Drugs
BRFSS	Behavioral Risk Factor Surveillance Survey
CADCA	Community Anti-Drug Coalitions of America
CAPT	Center for the Application of Prevention Technologies
CCI	Community Coalitions of Idaho
CQI	Continuous Quality Improvement
CSAP	Center for Substance Abuse Prevention
DHW	Department of Health & Welfare
DEA	Drug Enforcement Administration
DFC	Drug Free Communities
EBP	Evidence Based Practices Workgroup
EUDL	Enforcing Underage Drinking Laws
IBRS	Incident Based Reporting System
ITD	Idaho Transportation Department
ISU	Idaho State University
LE	Local Evaluator
NACE	Native American Center for Excellence
NPN	National Prevention Network
NSDUH	National Survey on Drug Use and Health
ODP	Office of Drug Policy
PIRE	Pacific Institute for Research and Evaluation
RAC	Regional Advisory Committee
RADAR	Regional Alcohol Drug Awareness Resource
SAPT	Substance Abuse Prevention and Treatment
SAMHSA	Substance Abuse and Mental Health Services Administration
SEOW	State Epidemiological Outcome Workgroup
SET	State Evaluation Team
SPF	Strategic Prevention Framework
SIG	State Incentive Grant
SPF	Strategic Prevention Framework
TEDS	Treatment Episode Data Set
VS	Vital Statistics
YRBS	Youth Risk Behavior Survey

Appendix A - Priority Setting Score Sheet of Final Indicators

Construct	Indicator	Data Source	Size	Seriousness	Capacity	Final Score
Alcohol Consumption						
Current use	Percent of students in grades 9-12 reporting use of alcohol in the past 30 days	YRBS	3.0	1.8	1.8	11.8
	Idaho gallons sales per capita	Liquor				
	Percent of adults (aged 18 or older) reporting use of alcohol in past 30 days	BRFSS				
Excessive Drinking	Percent of adults aged 18 and older reporting average daily alcohol consumption greater than two (male) or greater than one (female) per day in past 30 days	BRFSS	1.7	1.7	1.6	7.8
	Percent of students in grades 9-12 reporting 5+ drinks in a row within a couple of hours in the past 30 days	YRBS				
	Percent of adults (aged 18 or older) binge drinking of alcohol in past 30 days	BRFSS				
Alcohol Consequences						
Crime	DUI arrests per 1,000	IBRS	2.0	1.4	2.6	12.6
	Alcohol related arrests per 1,000	IBRS				
	Alcohol related crashes 1,000	ITD				
	Underage alcohol related arrests per 1,000	IBRS				
Alcohol Health Outcomes	Rate of alcoholic liver disease deaths per 100,000	DHW-VS	2.3	4.1	2.0	21.0
	Rate of Alcohol Induced Death per 100,000	DHW-VS				
	Percent report alcohol as primary substance of use upon treatment entry	TEDS				
	Percent of persons aged 12 and older reporting alcohol dependence/abuse	NSDUH				

Appendix A - Priority Setting Score Sheet of Final Indicators

Construct	Indicator	Data Source	Size	Seriousness	Capacity	Final Score
Tobacco Consumption						
Use	Percent of students in grades 9-12 that smoked cigarettes on 20 or more days in the last 30 days	YRBS	2.0	1.7	2.7	14.2
	Percent of adults 18 and older who smoke everyday	BRFSS				
	Percent of adults ever using smokeless tobacco	BRFSS				
Prescription Drug						
Use	Nonmedical Use of Pain Relievers per 1,000	NSDUH	3.8	3.8	4.0	45.0
	Prescription drug distribution rates per 100,000 population	ARCOS				
	Number of deaths from drug induced mortality per 100,000 population	DHW-VS				
	Seizure rates per 100,000 population	IBRS				
Other Drug Consumption						
Use	Illicit drug use other than marijuana past month per 1,000	NSDUH	4.0	2.0	1.7	13.4
	Drug seizures per 100,000	IBRS				
	Lifetime illicit drug use per 1,000	BRFSS				
Other Drug Consequences						
Health Outcome	Percent report other drugs as primary substance of use upon treatment entry	TEDS	3.7	4.5	1.6	19.8
	Adult Drug Induced Mortality per 100,000	DHW-VS				
	Percent report other drugs as substance of use upon treatment entry	TEDS				
Crime	Other drug Possession Arrests per 1,000	IBRS	1.3	1.7	2.1	9.9
	Other drug Trafficking Arrests per 100,000	IBRS				
	Other Drug Seizure per 100,000	IBRS				

Appendix A - Priority Setting Score Sheet of Final Indicators

Construct	Indicator	Data Source	Size	Seriousness	Capacity	Final Score
	Marijuana Consequences					
Use	Percent report marijuana primary substance of use upon treatment entry	TEDS	2.5	3.4	2.6	24.1
	Percent of students in grades 9-12 who used marijauana one or more times during the past 30 days	YRBS				
	Marijuana trafficking arrests per 100,000	IBRS				
	Marijuana seizures per 1,000	IBRS				

Appendix B Final Indicator Table

Constructs	Indicators	Sources	Community/Regional Collection	5 years of data available	Sub Population Data Available	Youth Data Available	Relevance	Record Type
	Constructs and Indicators		Criteria					
Alcohol Consumption								
Current use	Percent of students in grades 9-12 reporting use of alcohol in the past 30 days	YRBS	N	Y	N	Y	2	S
	Idaho gallons sales per capita	Liquor	Y	Y	N	N	1	A
	Percent of adults (aged 18 or older) reporting use of alcohol in past 30 days	BRFSS	Y	Y	Y	N	1	S
Excessive Drinking	Percent of adults aged 18 and older reporting average daily alcohol consumption greater than two (male) or greater than one (female) per day in past 30 days	BRFSS	Y	Y	Y	N	1	S
	Percent of students in grades 9-12 reporting 5+ drinks in a row within a couple of hours in the past 30 days	YRBS	N	Y	N	Y	2	S
	Percent of adults (aged 18 or older) binge drinking of alcohol in past 30 days	BRFSS	Y	Y	Y	N	1	S
Alcohol Consequences								
Alcohol related Mortality	Rate of alcoholic liver disease deaths per 100,000	DHW-VS	Y	Y	Y	Y	2	A
	Rate of Alcohol Induced Death per 100,000	DHW-VS	Y	Y	Y	Y	2	A
	Deaths sustained in alcohol related vehicular crashes per 100,000	ITD	Y	Y	N	Y	1	A
Crime	DUI arrests per 1,000	IBRS	Y	Y	Y	Y	2	A
	alcohol related arrests per 1,000	IBRS	Y	Y	Y	Y	2	A
	Alcohol related crashes 1,000	ITD	Y	Y	N	Y	1	A
	underage alcohol related arrests per 1,000	IBRS	Y	Y	Y	Y	2	A
Abuse and Dependence	Percent report alcohol as primary substance of use upon treatment entry	TEDS	Y	N	Y	Y	2	A
	Percent report Alcohol as substance of use upon treatment entry	TEDS	Y	N	Y	Y	2	A
	Percent of persons aged 12 and older reporting alcohol dependence/abuse	NSDUH	N	Y	Y	Y	1	S
Tobacco Consumption								
Use	Percent of students in grades 9-12 that smoked cigarettes on 20 or more days in the last 30 days	YRBS	N	Y	N	Y	2	S
	Percent of adults 18 and older who smoke everyday	BRFSS	Y	Y	Y	N	1	S
	Percent of adults ever using smokeless tobacco	BRFSS	Y	Y	Y	N	1	S
Prescription Drug								
Use	Rate of prescription drug use past month	NSDUH	N	Y	Y	Y	1	S
	Prescription drug distribution rates	ARCOS	N	Y	N	N	3	A
	Number of deaths from drug induced mortality per 100,000 population	DHW-VS	Y	Y	Y	Y	2	A
	Seizure rates per 1000 population	IBRS	Y	Y	Y	Y	2	A
Other Drug Consumption								
Use	Illicit drug use other than marijuana past month per 1,000	NSDUH	N	Y	Y	Y	1	S
	Drug seizures per 100,000	IBRS	Y	Y	Y	Y	2	A
	Lifetime illicit drug use per 1,000	BRFSS	Y	Y	Y	N	1	S

Apendix B Final Indcator Table

	Other Drug Consequences							
Health Outcome	Percent report other drugs as primary substance of use upon treatment entry	TEDS	Y	N	Y	Y	2	A
	Adult Drug Induced Mortality per 100,000	DHW-VS	Y	Y	Y	Y	2	A
	Percent report other drugs as substance of use upon treatment entry	TEDS	Y	N	Y	Y	2	A
Crime	Other drug Possession Arrests per 1,000	IBRS	Y	Y	Y	Y	2	A
	Other drug Trafficking Arrests per 1,000	IBRS	Y	Y	Y	Y	2	A
	Other Drug Seizure per 100,000	IBRS	Y	Y	Y	Y	2	A
	Marijuana Consequences							
Health Outcome	Percent report marijuana primary substance of use upon treatment entry	TEDS	Y	N	Y	Y	2	A
	Percent of students in grades 9-12 who used marijauana one or more times during the past 30 days	YRBS	N	Y	N	Y	2	S
	Percent report marijuana as substance of use upon treatment entry	TEDS	Y	N	Y	Y	2	A
Crime	Marijuana possession arrests per 1,000	IBRS	Y	Y	Y	Y	2	A
	Marijuana trafficking arrests per 1,000	IBRS	Y	Y	Y	Y	2	A
	Marijuana seizures per 1,000	IBRS	Y	Y	Y	Y	2	A

Appendix C - National and State Data Sources

	Data Sources for Needs Assessment						
Acronym	Data Source	Availability	Validity	Consistency	Collection/Timeliness	Sensitivity	Limitations
State Data Source							
ISTARS	Convictions data from Idaho Statewide Trial-Court Automated Records System (ISTARS)	Data are readily available to Idaho Supreme Court staff through automated reports.	All convictions of possession and trafficking offenses in Idaho.	ISTARS records are not the official court record. Because it serves primarily as a case management tool for individual courts, there is some variability in how data are entered across the state. However, with respect to entry of convictions, we believe there is a relatively high level of consistency.	1995-Present. Data are readily retrievable from the county databases and data entry is typically within a few days of being up to date.	Can feasibly compare conviction trends by years or months. Can also compare regions of the state down to the county level.	Fluctuations in conviction rates may have to do with factors other than trafficking or possession. For example, shifts in political climate, prosecutorial practices, or statutory changes can influence conviction numbers.
RMPDC	Idaho Poison Control Data Base, Idaho Department of Health and Welfare, Bureau of Community & Environmental Health, Injury Prevention & Surveillance Program (Rocky Mountain Poison and Drug Center)	Data developed by the Nebraska Regional Poison Center (NRPC) is provided quarterly to the IDHW.	Call volume associated with human poisoning exposures to NRPC from Idaho residents, health care facilities, and law enforcement seeking poisoning and drug information and consultation.	The National Poison Data System (NPDS) is the only comprehensive poisoning exposure surveillance database in the United States. Maintained by the American Association of Poison Control Centers, NPDS contains information from the human poison exposure case phone calls taken by the Nebraska Regional Poison Center from Idaho residents, health care facilities, law enforcement, and others. The Idaho Poison Control Data Base is the repository for data characterizing Idaho poisoning exposure case phone calls on an annual basis. Data quality is maintained in accordance with the American Association of Poison Control Centers (AAPCC) data quality standards.	2009-2012 (Digital, annual) (Note that hardcopy data is available 2001-2008.)	Poisoning exposure of Idaho residents characterized by age, gender, site of exposure (e.g., residence, health care facility, law enforcement, etc.), majorly pharmaceutical/non-pharmaceutical drug or substance(s) of concern, and other perspectives.	Poisoning data recorded by the Nebraska Regional Poison Center (NRPC) are used as a surrogate in the absence of such hospital discharge data in Idaho. Although some qualitative data on patient outcomes are reported from calls received from health care facilities, these cases only represented about 17-percent of the total case call volume in 2012. Only information shared with the NRPC specialist in poison information (SPI) is entered into the case call record. NRPC does follow-up on calls received from health care facilities.
DHW-VS	Tobacco Mortality: Lung cancer, Emphysema, Cardiovascular, Smoking-Attributable Mortality	Pam Harder, Bureau of Vital Records and Health Statistics, harderp@dhw.idaho.gov. Web: www.healthstatistics.idaho.gov	Total number of deaths per year and rate per 100,000 population	Population-based, state-wide mortality data sets maintained by the Bureau of Vital Records and Health Statistics, Idaho Department of Health and Welfare.	Prior to 1984 and 1984-present (Annual). The 10th revision of the International Classification of Diseases (ICD-10) took place in 1999	Able to detect changes in mortality rates over time by age group, gender, race and ethnicity.	The death certificate was revised in 2003 and some data prior to 2003 are not comparable with data in 2003 - present.
DHW-VS	Drug-Induced Mortality	Pam Harder, Bureau of Vital Records and Health Statistics, harderp@dhw.idaho.gov. Web: www.healthstatistics.idaho.gov	Total number of deaths per year and rate per 100,000 population	Population-based, state-wide mortality data sets maintained by the Bureau of Vital Records and Health Statistics, Idaho Department of Health and Welfare.	NCHS defined drug-induced deaths based on ICD-10. The 10th revision of the International Classification of Diseases (ICD-10) took place in 1999. 1999-2012 annually.	Able to detect changes in mortality rates over time by age group, gender, race and ethnicity.	Drug-induced mortality include deaths due to natural causes, accidental overdose, suicide, homicide, and undetermined external causes. Drug-induced deaths can be broken into prescription or non-prescription. Approximately 35% of death certificates do not report type of drug(s) involved in the death. Accidental deaths such as MVA with drugs involved are not included.

Appendix C - National and State Data Sources

Data Sources for Needs Assessment							
Acronym	Data Source	Availability	Validity	Consistency	Collection/Timeliness	Sensitivity	Limitations
DHW-VS	Alcohol-Induced Mortality	Pam Harder, Bureau of Vital Records and Health Statistics, harderp@dhw.idaho.gov. Web: www.healthstatistics.idaho.gov	Total number of deaths per year and rate per 100,000 population	Population-based, state-wide mortality data sets maintained by the Bureau of Vital Records and Health Statistics, Idaho Department of Health and Welfare.	NCHS defined alcohol-induced deaths based on ICD-10. The 10th revision of the International Classification of Diseases (ICD-10) took place in 1999. 1999-2012 annually.		Alcohol-induced mortality include deaths due to natural causes, accidental overdose, suicide, homicide, and undetermined external causes. Accidental deaths such as MVA with alcohol involved are not included.
DHW-VS	Morbidity, Oral and lung cancer	Chris Johnson, Cancer Data Registry of Idaho, cjohnson@teamiha.org. Web: www.idcancer.org	Total number of cases per year and rate per 100,000 population	Population-based cancer registry for assessing the extent of cancer burden in a specified geographic area. The Cancer Data Registry of Idaho (CDRI) is a population-based cancer registry that collects incidence and survival data on all cancer patients who reside in the state of Idaho or who are diagnosed and/or treated for cancer in the state of Idaho.	1995-2010 (Annual)	Able to detect changes in incidence over time, monitor trends and patterns of cancer incidence over time, and identify high-risk populations	Persons diagnosed with cancer may not have lived in Idaho when they attained cancer.
BRFSS	Behavioral Risk Factor Surveillance Survey	Chris Murphy, Behavioral Risk Factor Surveillance System Program Director, murphyc@dhw.idaho.gov. Web: www.healthstatistics.idaho.gov.	Prevalence among Idaho adults aged 18 and older.	The Behavioral Risk Factor Surveillance System (BRFSS) is an ongoing public health surveillance program developed and partially funded by the Centers for Disease Control and Prevention (CDC). The BRFSS uses surveys of adults aged 18 and older to estimate the prevalence of risk factors for the major causes of morbidity and mortality in the United States. For certain state and national objectives, the BRFSS is the only source of data.	New methodology began in 2011 with the inclusion of cell phones in the survey sample. Data in 2011-2012 are not comparable with data prior to 2011.	Trends for 2001-2010 and two points in time, 2011-2012. Data are available by gender, age group, education, employment, income, and ethnicity	Alcohol consumption is self-reported. Any drinking is based on adults who had at least one drink of alcohol in the past 30 days. Binge drinking is based on males consuming 5+ drinks and females consuming 4+ drinks on an occasion in the past 30 days. Heavy drinking is based on males consuming >60 drinks or females consuming >30 drinks in the past 30 days. Youth are not included in the survey.
BRFSS	Tobacco: cigarette smoking	Chris Murphy, Behavioral Risk Factor Surveillance System Program Director, murphyc@dhw.idaho.gov. Web: www.healthstatistics.idaho.gov.	Prevalence among Idaho adults aged 18 and older.	The Behavioral Risk Factor Surveillance System (BRFSS) is an ongoing public health surveillance program developed and partially funded by the Centers for Disease Control and Prevention (CDC). The BRFSS uses surveys of adults aged 18 and older to estimate the prevalence of risk factors for the major causes of morbidity and mortality in the United States. For certain state and national objectives, the BRFSS is the only source of data.	New methodology began in 2011 with the inclusion of cell phones in the survey sample. Data in 2011-2012 are not comparable with data prior to 2011.	Trends for 2001-2010 and two points in time, 2011-2012. Data are available by gender, age group, education, employment, income, and ethnicity	Cigarette smoking is self-reported and based on smoking at least 100 cigarettes in their lives and currently smoked every day or some days. Youth are not included in the survey.
BRFSS	Illicit drug use	Chris Murphy, Behavioral Risk Factor Surveillance System Program Director, murphyc@dhw.idaho.gov. Web: www.healthstatistics.idaho.gov.	Prevalence among Idaho adults aged 18 and older.	The Behavioral Risk Factor Surveillance System (BRFSS) is an ongoing public health surveillance program developed and partially funded by the Centers for Disease Control and Prevention (CDC). The BRFSS uses surveys of adults aged 18 and older to estimate the prevalence of risk factors for the major causes of morbidity and mortality in the United States. For certain state and national objectives, the BRFSS is the only source of data.	New methodology began in 2011 with the inclusion of cell phones in the survey sample. Data in 2011-2012 are not comparable with data prior to 2011.	Trends for 2001-2010 and two points in time, 2011-2012. Data are available by gender, age group, education, employment, income, and ethnicity	Illicit drug use is self-reported and based on using prescription drugs when not prescribed by a doctor or using drugs to get high or for curiosity. BRFSS survey does not distinguish between types of illicit drugs. Youth are not included in the survey.

Appendix C - National and State Data Sources

	Data Sources for Needs Assessment						
Acronym	Data Source	Availability	Validity	Consistency	Collection/Timeliness	Sensitivity	Limitations
IBRS	Idaho Incident Based Reporting System	Idaho Statistical Analysis Center (ISAC) http://www.isp.idaho.gov/CrimeInIdaho2/toQuery.action and Idaho State Police Bureau of Criminal Identification (BCI) http://www.isp.idaho.gov/BCI/ucr/crimeinidaho2012.html	Nearly complete (99.9%) reporting of NIBRS from all police jurisdictions in the state (some states have jurisdictions reporting a combination of NIBRS and UCR). We are very lucky in this regard.	Idaho law enforcement agencies submit reports to the Idaho State Police repository. ISP provides an online web application by the ISAC and yearly publication by BCI. In addition, specific types of requests can be obtained from ISAC. The repository contains information on all incidents (date/time and reporting agency), offense information (property or violent crime, weapon(s) used, type of criminal activity such as trafficking, buying/selling, or manufacturing, offense location, suspected use of alcohol or drugs by offender), victim information (age, race, sex, ethnicity, injury, victim/offender relationship), offender information (age, race sex) and arrestee information (age, race sex/ethnicity, arrest date).	Yearly counts are available in July of the following year. 2013 data will be available in July of 2014.	Able to detect changes (with reservations due to the limitations) associated with substance use over time	Limited by coding of drug types. No information regarding synthetics is available and prescription drugs is not a perfect reflection, but rather notes pill seizure arrests. Also, is a reflection of police activity and not a true indicator of consumption or consequences throughout the state.
iCARE	Child Welfare data is from iCARE, our Statewide Automated Child Welfare Information System	Sarah Siron, Division of Family and Community Services, sirons@dhw.idaho.gov	Child welfare workers enter case information into iSTARS in accordance with the national AFCARS (Adoption and Foster Care and Reporting System) and Idaho Child Welfare Standards	iCARE data is entered by child welfare social workers at critical points during the child welfare case.	2000 - present. Data is retrievable from iCARE dependent on social worker timely entry	Can compare child protection trends by years or months. Can also compare regions of the state down to the county level.	Presence of substance use is limited to whether or not the worker enters it as a contributing condition to the child protection referral. This is dependent upon it being present at the time of referral, if it was a contributing factor to child's safety, and whether it gets entered period because it is not a required field.
iSEE	Idaho System for Education Excellence	Data available in aggregate form only.	Incidents of crime and violence in schools and disciplinary actions. ISEE has robust data quality controls in place.	Monthly uploads are required for every school district and public charter school in the state.	Monthly- during the school year.	Able to identify trends throughout the year	Data availability limitations exist due to the sensitivity of the data established by FERPA.

Appendix C - National and State Data Sources

Data Sources for Needs Assessment							
Acronym	Data Source	Availability	Validity	Consistency	Collection/Timeliness	Sensitivity	Limitations
TEDS	Treatment Episode Dataset	Tony Jones, Division of Behavioral Health	Contains all publicly funded substance abuse treatment episodes.	Reporting standards have varied over the years. Data is consistent from 2008 onward.	1998- current Reported annually to the federal government but available within 2 weeks of case action.	Fairly accurate and responsive but since it only covers publicly funded treatment the data is limited to what funding and policy dictate and does not actually represent need or circumstance.	In addition to the limitations listed in sensitivity before 2009 the data is very suspect. Poor database management and quality assurance was rampant. From 2009 until current things have been better but going forward from 2012 due to a new reporting system the data will be most reliable.
OMS	Offender Management System (OMS) Data from the Idaho Department of Correction	Contact IDOC Research and Analysis for data		IDOC collects data on incarcerated and probation/parole offenders. Data including demographics, crime type, sentence length, programming and education, location, assessments, etc. is collected.	ongoing. Typically download data once a month, but IDOC is moving to a data warehouse functionality which will allow for more real time reporting		Data is only as good as what is entered. Many different people within the IDOC enter data into the Offender Management System, and errors can occur.
ITD	Idaho Statewide Traffic Crash Database CIRCA (Crash Information Retrieval ,Collection, and Analysis system)	Data is available through the Office of Highway Safety or directly using WebCARS. WebCARS is an online reporting and analysis system for the Idaho Statewide Crash Database. Accounts are provided to any governmental or non-profit agencies. Data is also available on the OHS website at www.itd.idaho.gov/ohs	All traffic crashes involving a motor vehicle that are unintentional, occur on a public roadway and result in an injury or more than $1,500 in property damage to any one person in the crash. Prior to 2006, the property damage threshold was $750.	Every law enforcement agency in the State of Idaho uses eIMPACT as the data collection tool for motor vehicle crashes. The software was created and provided to each agency, free of charge, as per Idaho Statute 49-1307. The crash data elements have been evaluated and changes were implemented in 1997 and in 2011.	1987 to Present - As of 2010, all eIMPACT crash reports are transmitted electronically to the Office of Highway Safety upon completion of the crash investigation. The reports are available, but incomplete, in WebCARS the day after they are received. The information is checked for accuracy and additional information is added to each report before it is completed in CIRCA. Typically, there is about a 2 to 3 month delay in completing the crashes.	As per Idaho Statute 49-1311, reports are subject to disclosure according to title 3, chapter 9, Idaho Code , and shall be used for accident prevention purposes. Can feasibly compare crash trends by years or months. Can also compare regions of the state down to the county or city level.	Reportable crashes are those that are unintentional, occur on a public roadway and result in an injury or more than $1,500 in property damage to any individual involved in the crash. Crashes not meeting the Reportable criteria are in the database and coded as non-reportable. The additional information is not added to these reports and information provided by the law enforceme3nt agency is not checked. There is no consistency to which these reports are transmitted to the OHS.
YRBS	Youth Risk Behavior Survey	Data available in aggregate form only. Available via web	Self reports of youth risk behaviors- reported on	A sample of 9-12 grade responses are collected in the Spring of the odd years.	Every other year in the Spring.	Able to detect prevalence and changes through time.	Small sample size, self reporting.

Appendix C - National and State Data Sources

Data Sources for Needs Assessment							
Acronym	Data Source	Availability	Validity	Consistency	Collection/Timeliness	Sensitivity	Limitations
National Data Source							
ARCOS	Automation of Reports and Consolidated Orders System	By request from the DEA	ARCOS is an automated, comprehensive drug reporting system which monitors the flow of DEA controlled substances from their point of manufacture through commercial distribution channels to point of sale or distribution at the dispensing/retail level - hospitals, retail pharmacies, practitioners, mid-level practitioners, and teaching institutions. Included in the list of controlled substance transactions tracked by ARCOS are the following: All Schedules I and II materials (manufacturers and distributors); Schedule III narcotic and gamma-hydroxybutyric acid (GHB) materials (manufacturers and distributors); and selected Schedule III and IV psychotropic drugs (manufacturers only).	ARCOS accumulates these transactions which are then summarized into reports which give investigators in Federal and state government agencies information which can then be used to identify the diversion of controlled substances into illicit channels of distribution. The information on drug distribution is used throughout the United States (U.S.) by U.S. Attorneys and DEA investigators to strengthen criminal cases in the courts.	2000-2011, released semi annually and provided by request of the DEA	Tracks all legal drug production and distribution but is subject to stockpiling and warehousing issues.	In additional to the limitations listed in sensitivity the database can be difficult to acquire. The DEA requires special requests in writing be made and it helps significantly if you have a Special Agent fronting your efforts.
NSDUH	National Survey on Drug Use and Health	https://nsduhweb.rti.org/	The National Survey on Drug Use and Health (NSDUH) is an annual nationwide survey involving interviews with approximately 70,000 randomly selected individuals aged 12 and older. The Substance Abuse and Mental Health Services Administration (SAMHSA), which funds NSDUH, is an agency of the U.S.Public Health Service in the U.S. Department of Health and Human Services (DHHS). Supervision of the project comes fromSAMHSA's Center for Behavioral Health Statistics and Quality (CBHSQ).	A scientific random sample of households is selected across the United States, and a professional RTI interviewer makes a personal visit to each selected household. Once a household is chosen, no other household can be substituted for any reason. This practice is to ensure the NSDUH data represent the many different types of people in the United States. After answering a few general questions during the in-person visit by the interviewer, one or two residents of the household may be asked to participate in the survey by completing an interview. It is possible no one will be selected for the interview. If an individual is selected for the interview, their participation is voluntary, but no other person can take their place. Since the survey is based on a random sample, each selected person represents more than 4,500 United States residents. At the end of the completed interview, the selected person will receive $30 in cash.	1997-current, released annual for the prior year and conducted year round to normalize for seasonal implications	Stratified and sampled based on population demographics.	Uses imputation and weighting to adjust for variations is sampling and sampling inconsistences.

Appendix D – Kaizen Diagnostic Process Report

	Completed: Measures if the task has been completed by your coalition.	**Participation:** Measures the extent to which members were involved in the task.	**Consensus:** Measures how much members agree with the decisions made in this area.	**Utility:** Measures if the members have found the decisions or plans to be useful.
Coalition Process SPF Report				
Assessment & Planning				
Mission Statement	🟩	🟨	🟨	🟩
Goals/Objectives	🟩	🟨	🟨	🟨
Problem Analysis	🟩	🟨	🟨	🟨
Logic Models	🟩	🟨	N/A	🟨
Action Plan	🟩	🟨	🟨	🟨
Capacity				
Clearly Defined Structure	🟩	🟨	N/A	🟩
Clearly Defined Rules	🟩	🟨	N/A	🟨
Technical Assistance	🟩	🟩	🟥	🟩
Implementation				
Community Change	🟩	🟨	N/A	N/A
Services Provided	🟩	🟨	N/A	N/A
Media	🟩	🟨	N/A	N/A
Evaluation				
Evaluation Plan & Data	🟩	🟥	🟨	🟨
Community Level Data	🟩	N/A	N/A	🟩
Sustainability				
Sustainability Plan	🟩	🟨	🟨	🟨
Cultural Competency				
Not Assessed	N/A	N/A	N/A	N/A

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Your coalition's overall assessment score is 1.62.

Scores by Dimension				
1.00	Completed	2.14	Consensus	*The scale ranges from 1 to 3. A score of 1 is the ideal score.*
2.00	Participation	1.64	Utility	

Coalition Summary

Your coalition may want to review its mission statement to determine if it needs to be updated.

Your coalition appears to have some goals and objectives. However, you may want to further clarify these goals and objectives with member input.

It appears that you have conducted a problem analysis but you may want to review it to determine if it is still accurate and useful for guiding your coalition's work.

Right on - your coalition has a diagram or picture of your community problem (logic model) and why it is happening. Remember to make this is available to all members and to use it regularly to guide your work.

Your coalition appears to have an action plan to guide its work. However, you may want to review it and update it with coalition member input.

Your coalition appears to have a somewhat defined structure but it may need to be better defined for role clarity and structured in a way that makes more sense to members.

Your coalition appears to have some rules but they may need to be clarified and/or more comprehensive to help guide decision-making and your ability to take action.

Your coalition members appear to receive technical assistance, training, and/or coaching. A benefit of being a coalition member is the opportunity to develop skills - thank you for making that available to your members.

Your coalition should determine if it can facilitate change faster with more input and assistance from your members. It takes a lot of lending hands to facilitate collective impact.

Your coalition might be able to better optimize the services in its community by seeking more help from coalition members and coalition partners.

Your coalition can take its media effort to the next level by involving the sectors you are trying to inform in the campaign development. It can also be helpful to seek outside help from media experts in your community to help with your media initiatives.

Your coalition appears to have an evaluation plan but it may need to be reviewed and improved upon. This plan should be easy for your members to communicate to others in the community

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and utilize in guiding their work.

Your coalition has done a great job of utilizing available data to describe the drug trends in your community. Keep up the good work and remember to routinely seek additional data as it becomes available.

Your coalition appears to have somewhat of a sustainability plan but it may need to be reviewed with coalition members and further enhanced or developed.

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Appendix E - Priority Setting Score Sheet of Final Indicators

Construct	Indicator	Data Source	Size	Seriousness	Capacity	Changeability	Readiness	Final Score
	Alcohol Consumption							
Current use	Percent of students in grades 9-12 reporting use of alcohol in the past 30 days	YRBS						
	Idaho gallons sales per capita	Liquor						
	Percent of adults (aged 18 or older) reporting use of alcohol in past 30 days	BRFSS						
Excessive Drinking	Percent of adults aged 18 and older reporting average daily alcohol consumption greater than two (male) or greater than one (female) per day in past 30 days	BRFSS						
	Percent of students in grades 9-12 reporting 5+ drinks in a row within a couple of hours in the past 30 days	YRBS						
	Percent of adults (aged 18 or older) binge drinking of alcohol in past 30 days	BRFSS						
	Alcohol Consequences							
Alcohol related Mortality	Rate of alcoholic liver disease deaths per 100,000	DHW-VS						
	Rate of Alcohol Induced Death per 100,000	DHW-VS						
	Deaths sustained in alcohol related vehicular crashes per 100,000	ITD						
Crime	DUI arrests per 1,000	IBRS						
	Alcohol related arrests per 1,000	IBRS						
	Alcohol related crashes 1,000	ITD						
	Underage alcohol related arrests per 1,000	IBRS						
Abuse and Dependence	Percent report alcohol as primary substance of use upon treatment entry	TEDS						
	Percent report Alcohol as substance of use upon treatment entry	TEDS						
	Percent of persons aged 12 and older reporting alcohol dependence/abuse	NSDUH						

Appendix E - Priority Setting Score Sheet of Final Indicators

Construct	Indicator	Data Source	Size	Seriousness	Capacity	Changeability	Readiness	Final Score
	Tobacco Consumption							
Use	Percent of students in grades 9-12 that smoked cigarettes on 20 or more days in the last 30 days	YRBS						
	Percent of adults 18 and older who smoke everyday	BRFSS						
	Percent of adults ever using smokeless tobacco	BRFSS						
	Prescription Drug							
Use	Rate of prescription drug use past month	NSDUH						
	Prescription drug distribution rates	ARCOS						
	Number of deaths from drug induced mortality per 100,000 population	DHW-VS						
	Seizure rates per 1000 population	IBRS						
	Other Drug Consumption							
Use	Illicit drug use other than marijuana past month per 1,000	NSDUH						
	Drug seizures per 100,000	IBRS						
	Lifetime illicit drug use per 1,000	BRFSS						
	Other Drug Consequences							
Health Outcome	Percent report other drugs as primary substance of use upon treatment entry	TEDS						
	Adult Drug Induced Mortality per 100,000	DHW-VS						
	Percent report other drugs as substance of use upon treatment entry	TEDS						
Crime	Other Drug Possession Arrests per 1,000	IBRS						
	Other Drug Trafficking Arrests per 100,000	IBRS						
	Other Drug Seizure per 100,000	IBRS						

Appendix E - Priority Setting Score Sheet of Final Indicators

Construct	Indicator	Data Source	Size	Seriousness	Capacity	Changeability	Readiness	Final Score
Marijuana Consequences								
Health Outcome	Percent report marijuana primary substance of use upon treatment entry	TEDS						
Health Outcome	Percent of students in grades 9-12 who used marijauana one or more times during the past 30 days	YRBS						
Health Outcome	Percent report marijuana as substance of use upon treatment entry	TEDS						
Crime	Marijuana possession arrests per 1,000	IBRS						
Crime	Marijuana trafficking arrests per 100,000	IBRS						
Crime	Marijuana seizures per 1,000	IBRS						

Prescription Drug Abuse

March 2013

PMP/POLICY **LAW ENFORCEMENT** **PHYSICIAN EDUCATION** **PUBLIC PREVENTION**

Accessibility

Available on the streets

Activity: **Research effective law enforcement strategies** Responsible Party: Janeena Wing, ISP Target Date: July 2012 Indicators of Success: Janeena will share with the group the results of her research. The workgroup will then work with law enforcement to identify which strategies could be implemented or improved upon..

Activity: **Receive updates regarding DEA actions or changes in policy** Responsible Party: Board of Pharmacy Target Date: Ongoing Indicators of Success: Board of Pharmacy will update workgroup partners regarding any change in policy or procedure from DEA.

Activity: **Contact prosecutors and representatives from law enforcement and to further identify strategies they may be able to implement to reduce RX drug abuse and what additional information/assistance they may need from workgroup partners.** Responsible Party: Office of Drug Policy Target Date: 1) May/June 2012, 2) June 2012, 3) July 2012 Indicators of Success:1) Potential barriers of current controlled substance laws will be identified. 2) Potential barriers to prosecution of controlled substances cases will be identified. 3) Potential partnerships that will be advantageous to prosecutors and law enforcement will be identified and connections made.

Fraudulently obtaining

Lack of disposal options

Available from friends and relatives

Activity: **Conduct mapping exercise of Idaho prescription data with Brandeis University** Responsible Party: Theresa (Board of Pharmacy) Target Date: Indicators of Success:

Activity: **Identify data that would be most helpful to this group in combating RX drug abuse, then conduct research project to gather that data. Possibilities are: 1) The demographics of those receiving prescriptions in ID, 2) How many reports of possible abuse from the Board of Pharmacy to law enforcement are successfully prosecuted, 3) Number of law enforcement requests to the Board of Pharmacy.** Responsible Party: Board of Pharmacy, Office of Drug Policy, Janeena Wing (ISP) Target Date and Indicators of Success: May 2012 – ODP and ISP will identify researchers and connect them with Theresa at Board of Pharmacy. June 2012 – Board of Pharmacy will meet with researchers and select one to work with. August 2012 – Board of Pharmacy and researcher will decide on the scope of the research project and data to be collected. December 2012 – Research will be conducted and provided to the workgroup. December 2012 – Data will be available to support future funding requests for enhancements to the Board of Pharmacy systems, if deemed necessary.

Activity: **Unsolicited PMP reports begin** Responsible Party: Theresa (Board of Pharmacy) Target Date: September 2012 Indicators of Success: 1) New board of Pharmacy employee will be hired and trained. 2) Unsolicited reports will begin to be distributed as appropriate.

Activity: **Interstate PMP data sharing** Responsible Party: Mark (Board of Pharmacy) Target Date: June 2013 Indicators of Success: 1) IT portion of project will be ready, 2) MOU's between the states will be signed, 3) System will be tested and meet all federal requirements

Medicine Cabinet

Activity :Emphasize the issue Responsible Party: Representative Rusche Target Date: Aug 2012 Indicators of Success: 1) Increase knowledge of public, legislators, professional community as to scope, 2) Identify methods to insure awareness and sources of information and assistance. 4) Outcome measure: Information disseminated to public, legislators, and professional community in Idaho.

Activity: **Conduct pilot project for sticker blast in the Boise area** Responsible Party: Melanie Curtis Target Date: 1) June 2012 2) Summer/Fall 2012 Indicators of Success:1) Plan developed for implementing and evaluating sticker blast campaign. 2) Conduct and evaluate sticker blast campaign.

Activity: **Begin statewide media campaign** Responsible Party: Office of Drug Policy (lead), all partners Target Date: July 2013 Indicators of Success: Statewide media campaign will be received in communities throughout Idaho. The public will be better informed regarding RX drug abuse and steps they can take to prevent it.

Activity: **Apply for grant/Millennium Fund monies to conduct a statewide media campaign** Responsible Party: Office of Drug Policy (lead), all partners will contribute information) Target Date: Fall 2012 Indicators of Success: A strong, compelling application will be completed and submitted for review, which includes an evaluation component.

Communication between stakeholder

Activity: **Provide information to local communities regarding opportunities to dispose of their old medications properly, as well as information to law enforcement regarding how to establish and operate a turn-in program**. Responsible Party: Office of Drug Policy Target Date: May/June 2012 Indicators of Success: DEA or other take-back events will be well publicized and relevant information will be provided to law enforcement agencies.

Activity: **Implement evaluation component of media campaign** Responsible Party: Office of Drug Policy (lead) Contracted evaluator Target Date: Fall 2013 Indicators of Success: Evaluation of the campaign will be able to determine is attitudes or behaviors of Idaho citizens were changed as a result of the campaign.

Physician Education

Activity: **Work with statewide coalitions and prevention agencies to coordinate statewide media campaign** Responsible Party: Office of Drug Policy Target Date: Spring 2013 Indicators of Success: 1) Local organizations will provide information regarding available best for prevention Use in their communities, 2) Local organizations will assist in securing airtime, ad space, etc. for the campaign, 3) Local organizations will plan and conduct special events in their communities in conjunction with the media campaign to further educate their communities.

Prescription Drug Abuse

March 2013

PMP/POLICY

LAW ENFORCEMENT

PHYSICIAN EDUCATION

PUBLIC PREVENTION

Perception of Risk is Low

Social Norm

Lack of education

Prescribed by doctor

Physician Education

Few legal ramifications

Physiological Effects

Patient's left untreated

Good "high"

Activity :**Define scope of problem in Idaho** Responsible Party: Erwin Sonnenberg Target Date: Aug 2012 Indicators of Success: 1) Data on number of deaths/cause of death, 2) Review of records for prescribed versus illegally obtained medication, 3) Review of records to r/o suicide or accidental overdose, 4) Methadone deaths, 5) Comparative data Idaho to other states, 6) Outcome measure: Data collected, analyzed and used in education objective.

Activity :**Identify available prescriber tool**s Responsible Party: TBD Target Date: July 2012 Indicators of Success: 1) What tools are available to prescribers in Idaho (i.e. PMP), 2) Assess availability of tools to all prescribers in Idaho. 3) Other tools and calculators available to assist prescribers. 4) Outcome measure: Tools identified, evaluated and information disseminated to prescribers in Idaho.

Activity :**Identify education providers and approvers** Responsible Party: Nancy Kerr Target Date: July 2012 Indicators of Success:1) Identify all prescribers of controlled substances in Idaho. 2) Identify the professional education approvers at the national and state level. 3) Identify professional education providers in Idaho for each profession identified, 4) Outcome measure: Professional education providers offer continuing education programs to prescribers in Idaho.

Activity: **Research what is happening nationally with regard to prescriber education**. Responsible Party: Representative Chew Target Date: Summer 2012 Indicators of Success: The workgroup will have a good understanding of the education prescribers nationwide receive and where Idaho stands in relation.

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Problem	Root Causes	Local Conditions	Strategies
March 2013	Accessibility	1. Low cost	1-a. No privatization – increase research, create position papers, etc.
		2. Untrained servers/clerks	1-b. Enforce current tax laws a) malt beverages, increase communication with beer and wine lobbyists, engage the AG's Office, tax on actual alcohol concentration
		3. Lack of Enforcement	1-c. Engage CCI and support their advocacy
		4. Parents supply	2-a. Promote training through distributors and coalitions a) help coalitions to encourage local businesses, b) promote online training options like TIPS and ServSafe
			2-b. Post sample local server training ordinances on BTP
			2-c. Create newsletters and materials through RADAR or other entity and post online (liquor dispensary website?)
			3-a. Hire and train ABC Officers
			3-b. Research and find clear data on how decreasing Underage Drinking leads to a reduction in crime
Underage Drinking			3-c. Increase Training; a) officer training through POST, b) education on the entrapment issue, c) chiefs and sheriff's training, peer-to-peer training
			3-d. Funding of OT, compliance checks, etc., through highway safety
			4-a. Social Host ordinances
			4-b. Partner with PTA to distribute information
			4-c. Distribute information through school nurses
			4-d. Parents Who Host Lose the Most campaigns
	Demand	1. Alcohol marketing/media	1-a. Form media subcommittee to advise on use of UAD media funds
		2. Peer influence	1-b. Determine if ID law needs to be updated to properly address social media access to minors
			2-a. Support the work of youth organizations such as BYDC, IDFY, youth councils, and coalitions
	Low perception of risk	1. Social Norm	1-a. Continuing informational/educational campaign; a) define goals and measurable outcomes, b) traditional and social media, c) research funding options
		2. Lack of knowledge regarding social & economic costs	1-b. Media literacy training (CADCA)
			1-c. Research ads targeting youth; a) Idaho has outdated laws to deal with social media, b) virtual mapping
		3. Lack of knowledge regarding brain development & increased risk of dependence	2-a. Distribute PIRE's Costs of UAD in ID.
			3-a. Continue Be The Parents campaign

Problem	Root Causes	Local Conditions	Strategies

Marijuana Use

Accessibility

Lack of enforcement resources
- Investigate use of forfeiture laws
- Investigate fine on arrested persons which would fund enforcement/prevention

Paraphernalia in stores and on the internet
- Work with law enforcement to conduct raids
- Work with municipalities on business licensing and zoning laws

Demand

Youth targeted in marketing/media
- School social norming campaigns
- Educator in-service possibly using nat'l curriculum for impairment (could be filmed and distributed via IEN)
- Expose by Scott Evans re: clothing, paraphernalia, etc.

Social norms encouraging use are increasing
- Press releases through the State
- Survey through DFC's
- In-service for students debunking MMJ myths

Low perception of risk

Medicalized/couched in medical terms
- IMA conference session to educate physicians

No champions promoting non-use
- Reach out to tobacco prevention organizations
- Train the trainers through POST for LE, coalitions, etc.

Public unaware of important MMJ issues: Legal consequences, effects on economy, public safety, liability, loss of federal funds, addiction, etc.
- Increase enforcement period for drugged driving campaign
- Social media information dissemination
- Education of cities/counties through AIC

March, 2013