

State of Idaho Substance Abuse Prevention Needs Assessment 2015



Funded by: Strategic Prevention Framework State Incentive Grant

Prepared by: Idaho State Epidemiological Outcomes Workgroup

Idaho Office of Drug Policy

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Idaho's State Epidemiological Outcomes Workgroup (SEOW) guided the development and production of this report. SEOW members include:

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Beyond the SEOW members, the following partners provided data and support:

Steve Rich	Idaho Transportation Department – Office of Highway Safety
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Disclaimer

The Idaho SPF SIG is part of a federal initiative created by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Prevention (CSAP) to assist states and U.S. territories in preventing the abuse of alcohol, tobacco and other drugs (ATOD). The State of Idaho Substance Abuse Needs Assessment was produced by the Idaho Office of Drug Policy (ODP) under the Idaho SPF SIG in an effort to develop a practical needs assessment to address ATOD in Idaho. Publication of this document does not necessarily reflect the opinions or policies of the sponsoring agencies that participated in or funded the aforementioned.

Executive Summary

The State of Idaho Substance Abuse Needs Assessment contains information from on-going 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). This report provides baseline and trend information on substance use, abuse, and dependence in Idaho.

The previous needs assessment was used as a foundation for the SPF Advisory Council's creation of the SPF SIG Strategic Plan, and assisted partners in implementing substance abuse prevention strategies. Currently, this needs assessment will also inform decisions regarding the allocation of SPF SIG funding to Idaho communities. Data in this document should not only guide the SPF SIG project, but also serve as a state-level overview from various sources to help researchers, program managers, policymakers, and other interested parties in their decision making processes.

This document details the assessment process undertaken to narrow substance-related consumption and consequence data to a targeted need. The SEOW followed a rigorous four-step process to determine which indicators are most appropriate for statewide substance abuse prevention planning. Based on the outcomes of this process and the resulting assessment, the SEOW encouraged the SPF Advisory Council to consider the following while planning and implementing Idaho's SPF SIG project.

Over the past several years, Idaho has seen several positive trends in regards to substance abuse epidemiology:

- ❖ Since 2007, 9th-12th grade 30-day alcohol use and binge drinking has decreased and is typically below the national average.
- ❖ Idaho has experienced a decline in alcohol-related arrests and motor vehicle crashes.

These are welcome improvements, but there continues to be areas of concern:

- ❖ Liquor sales per capita continue to increase.
- ❖ Alcohol- and drug-induced mortality rates have increased.
- ❖ Marijuana trafficking arrest rate has more than quadrupled since 2009.
- ❖ Other drug trafficking arrest rate has increased 3.5 times since 2011.
- ❖ After a considerable decline, drug possession arrests and seizures have increased.

Introduction

ODP was awarded the SPF SIG in August 2013 and is responsible for overseeing the implementation of the grant. The goals of the SPF SIG include:

1. Prevent the onset and reduce the progression of substance abuse, including childhood and underage drinking
2. Reduce substance abuse related problems in the communities
3. Build prevention capacity and infrastructure at the state, tribal, territorial and community levels

Figure 1. Strategic Prevention Framework



These goals are accomplished through the implementation of the SPF (shown in Figure 1) which includes five steps, with special attention paid to sustainability and cultural competence throughout the process.

The SPF requires states and communities to systematically *assess* their prevention needs based on epidemiological data; build their prevention *capacity*; develop a strategic *plan*; *implement* effective community prevention programs, policies, and practices; and *evaluate* their efforts for outcomes.

This first phase of the SPF is Assessment, which is used to gain better understanding of substance use and abuse patterns both within different substance abuse typologies and geographic areas. This assessment was conducted by the Idaho SEOW and involves the collection of data to understand population's needs, review the resources that are required and available, and identify the readiness of the community to address prevention needs and service gaps.

The Idaho SEOW is a multidisciplinary workgroup whose members are connected to key decision making and resource allocation bodies in the state. The Idaho SEOW was established in 2006 under the SEOW contract. In regards to the SPF SIG process, the SEOW is responsible for:

1. Developing a set of key data indicators for use in describing substance use and 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 SPF Advisory Council
5. Considering and recommending which data indicators are appropriate for evaluation purposes
6. Serving as consultants to the SPF Advisory Council in determining resource allocation methods

This needs assessment relies mainly on three potential sources of data: surveys containing self-reported substance use, alcohol- and drug-related arrests, and alcohol- and drug-related mortality. While these information sources are useful, they do have limitations. As such, this assessment should be used in conjunction with other data sources (e.g. local experts' accounts, other archival data, etc.) to provide a more thorough basis for understanding substance use within specific areas of the state.

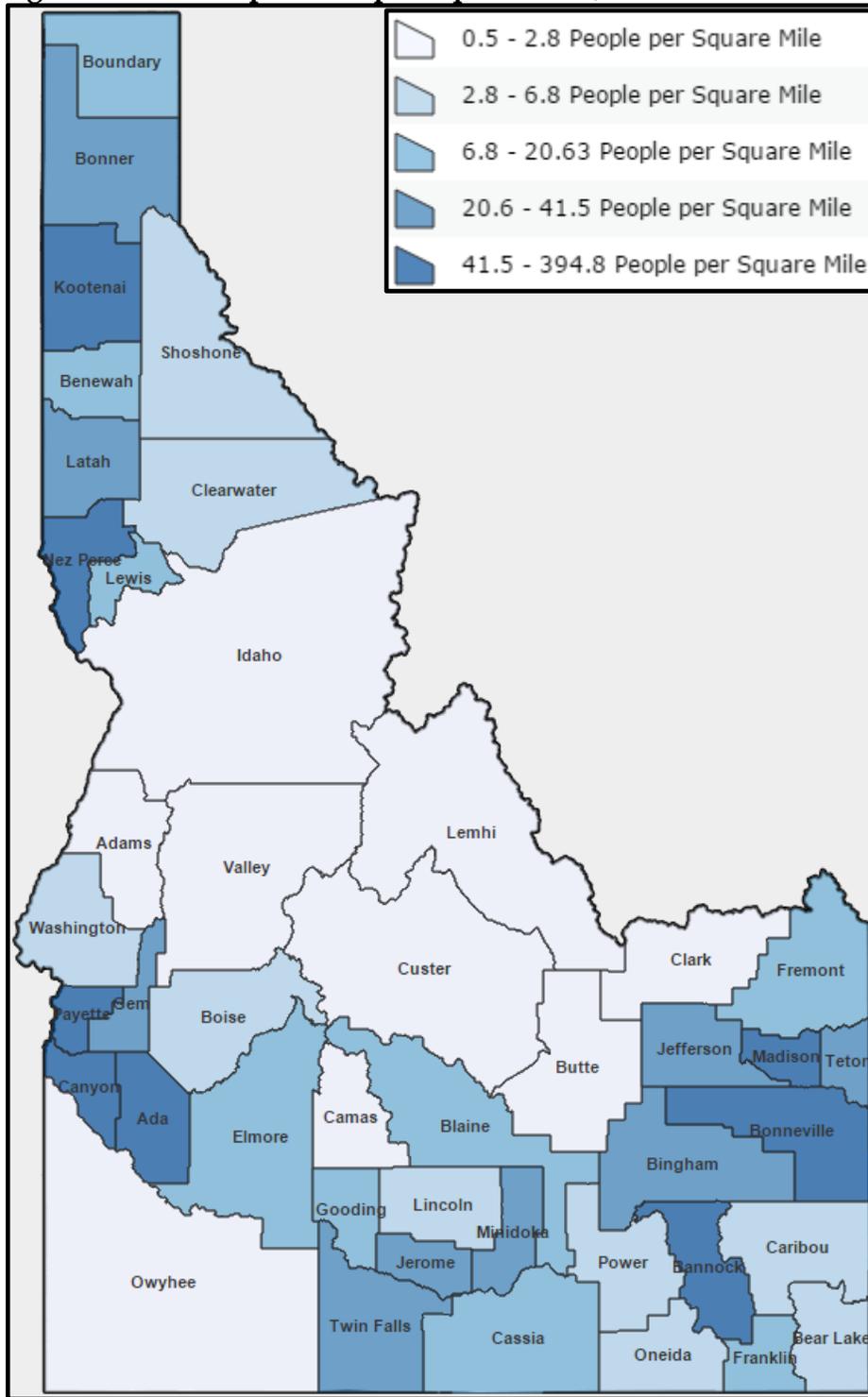
In an effort to provide a more useable product to our stakeholders, the Idaho SEOW elected to update and change the format implemented in past years for the State of Idaho Epidemiological Profile. For methodological and purpose driven reasons, some previously reported data that is still available was not reported in this assessment. In other cases, new data has been reported in-depth. For any questions beyond the contents of this report, please contact the appropriate contact listed in the "Availability" column on Appendix C.

Idaho 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. According to the United States Census Bureau, Idaho's largest metropolitan area, the Treasure Valley which includes both Ada and Canyon Counties, contains over 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 cultures. Within these communities, prevention efforts must focus on 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.

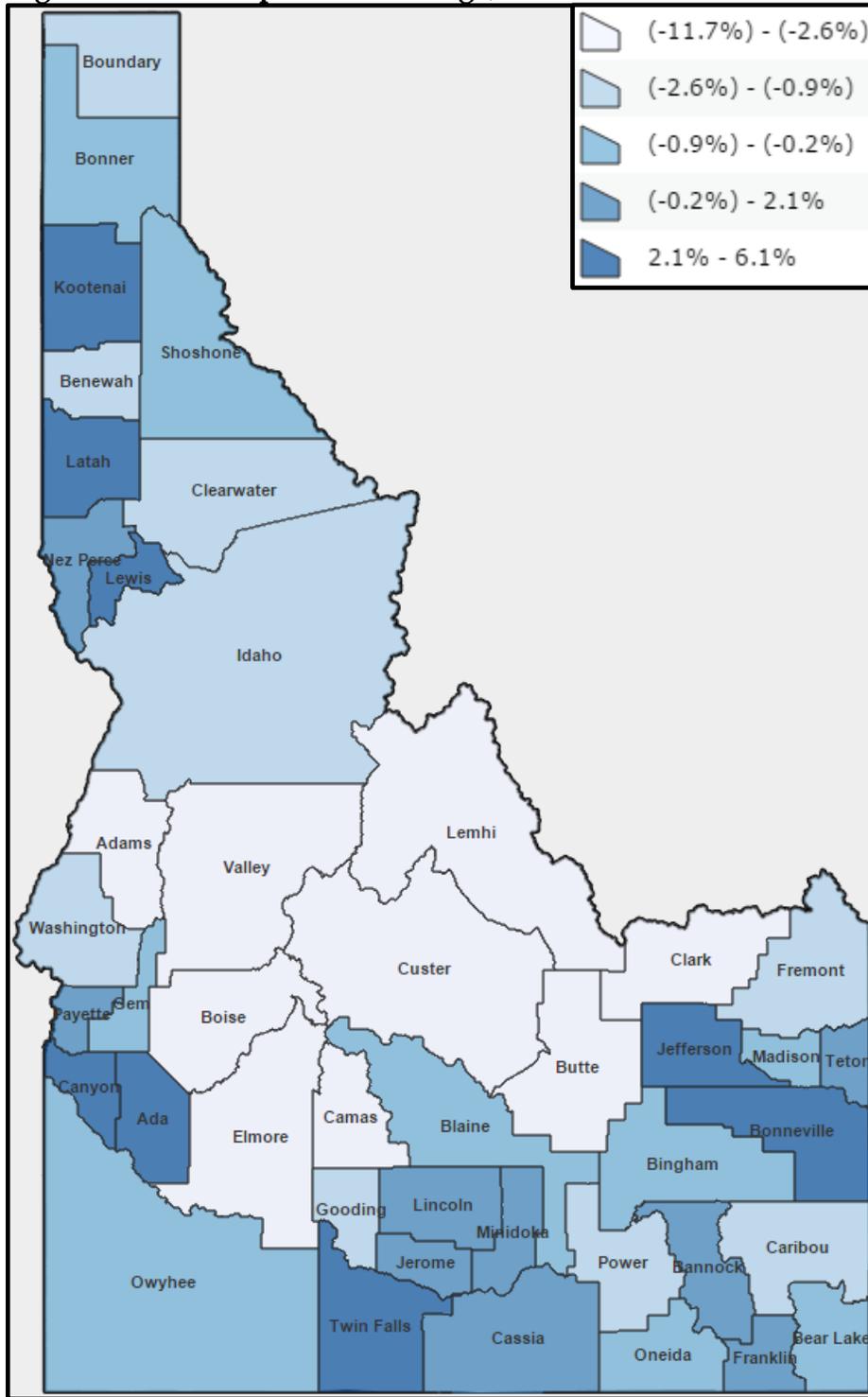
Idaho is a geographically large state with vast frontier expanses and relatively few heavily populated areas. To provide a better understanding of the state, the following six maps highlight demographic characteristics at the county level in Idaho.

Figure 2. Idaho Population per Square Mile, 2013



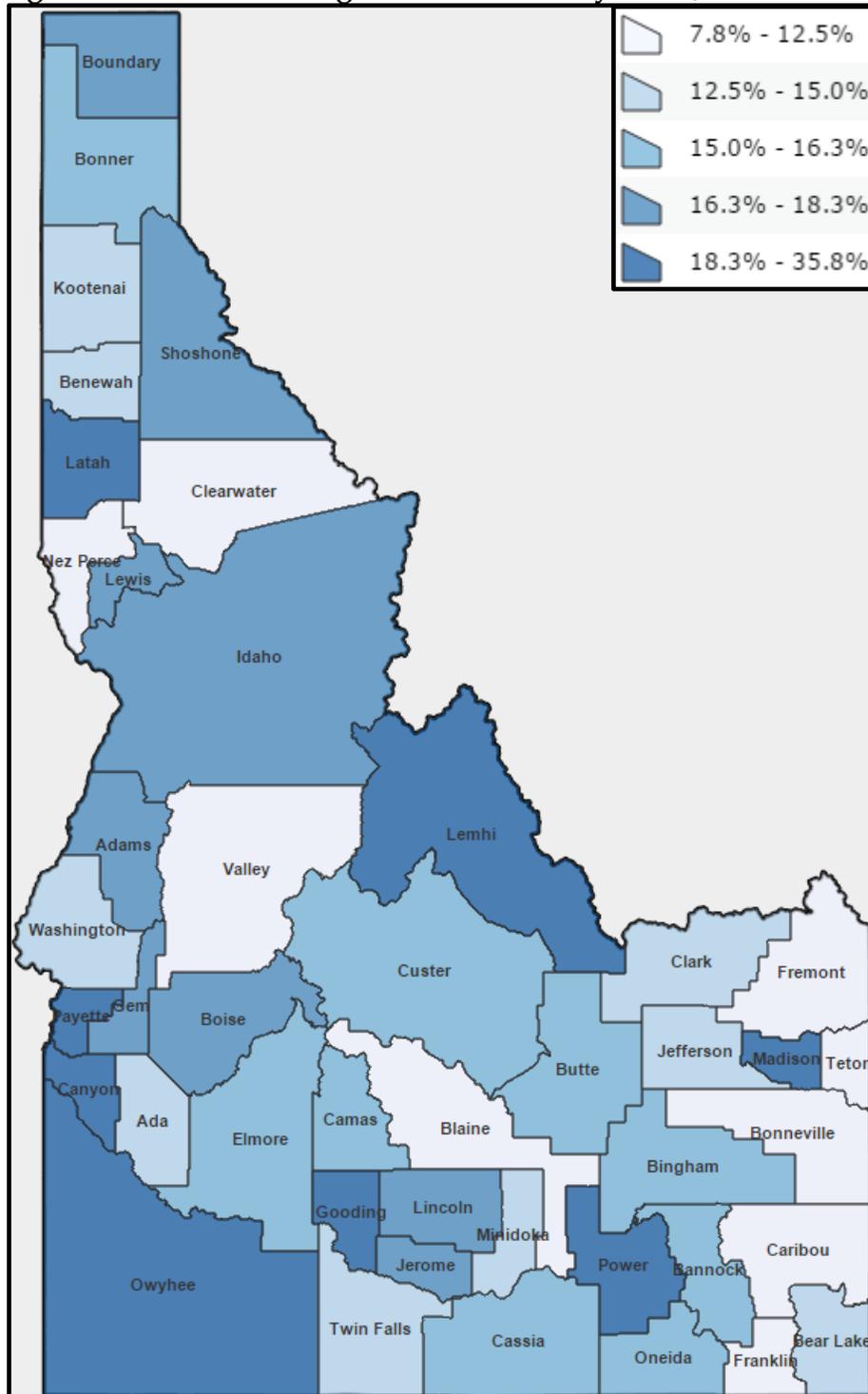
According to the 2010 Census, the average number of people per square mile nationally was 87.4, compared to 19 in Idaho. According to the 2013 Census population estimate, the counties with the highest number of people per square mile were Ada County (394.8), Canyon County (337.1), and Kootenai County (115.9). The counties with the lowest number of people per square mile were Clark County (0.5), Custer County (0.9), and Camas County (1.0). Ada County and Canyon County had significantly more people per square mile than the state as a whole.

Figure 3. Idaho Population Change, 2010-2013



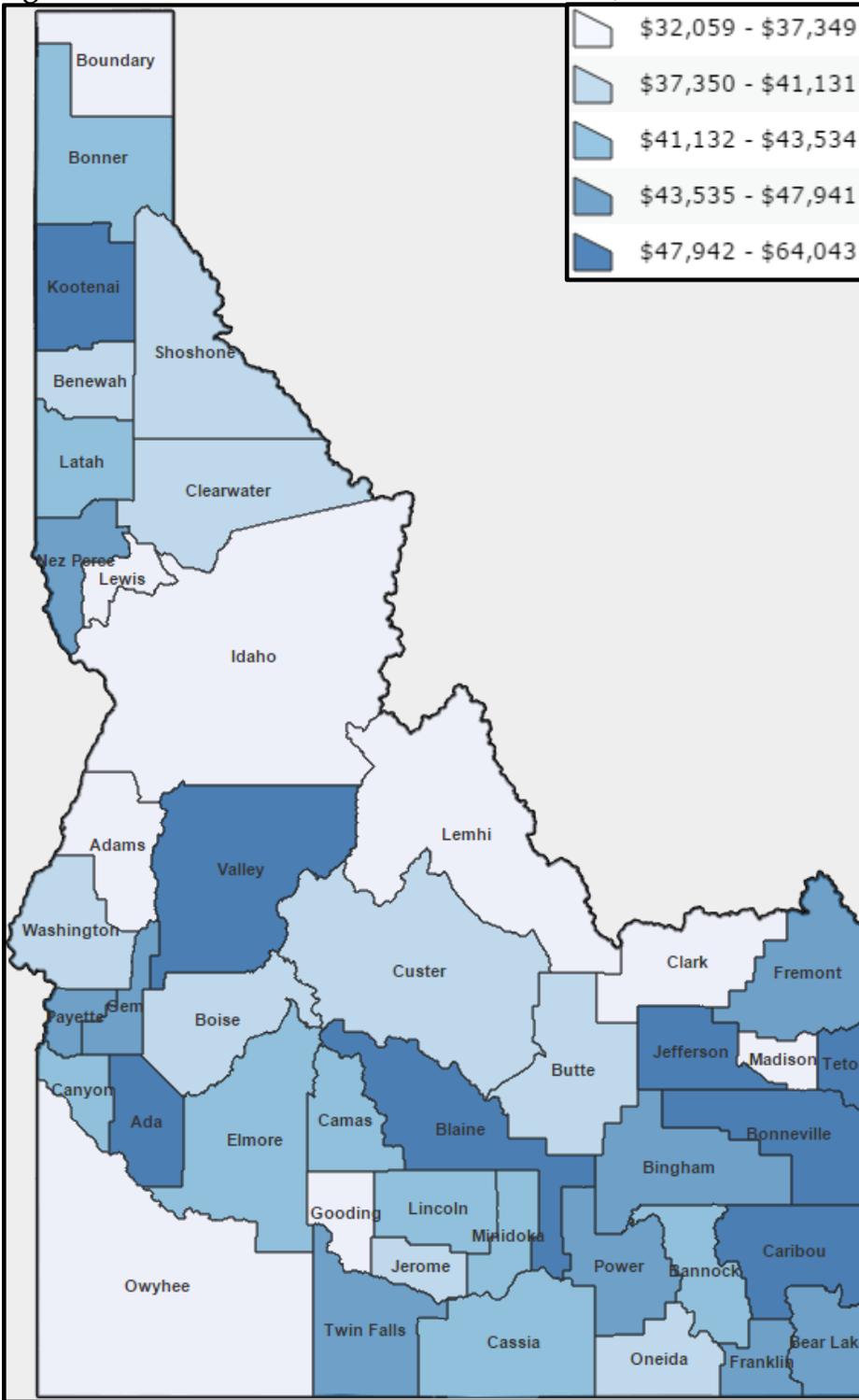
According to the Census Bureau, the population of the United States increased 2.4%, compared to 2.8% in Idaho between April 1, 2010 and July 1, 2013. The counties with the greatest positive population change were Ada County (6.1%), Canyon County (5.3%), and Kootenai County (4.2%). The counties with the greatest negative population change were Clark County (-11.7%), Butte County (-8.7%), and Camas County (-6.7%). Butte County's and Clark County's populations changed significantly between 2010 and 2013, as to the state as a whole.

Figure 5. Idahoans Living below the Poverty Level, 2009-2013



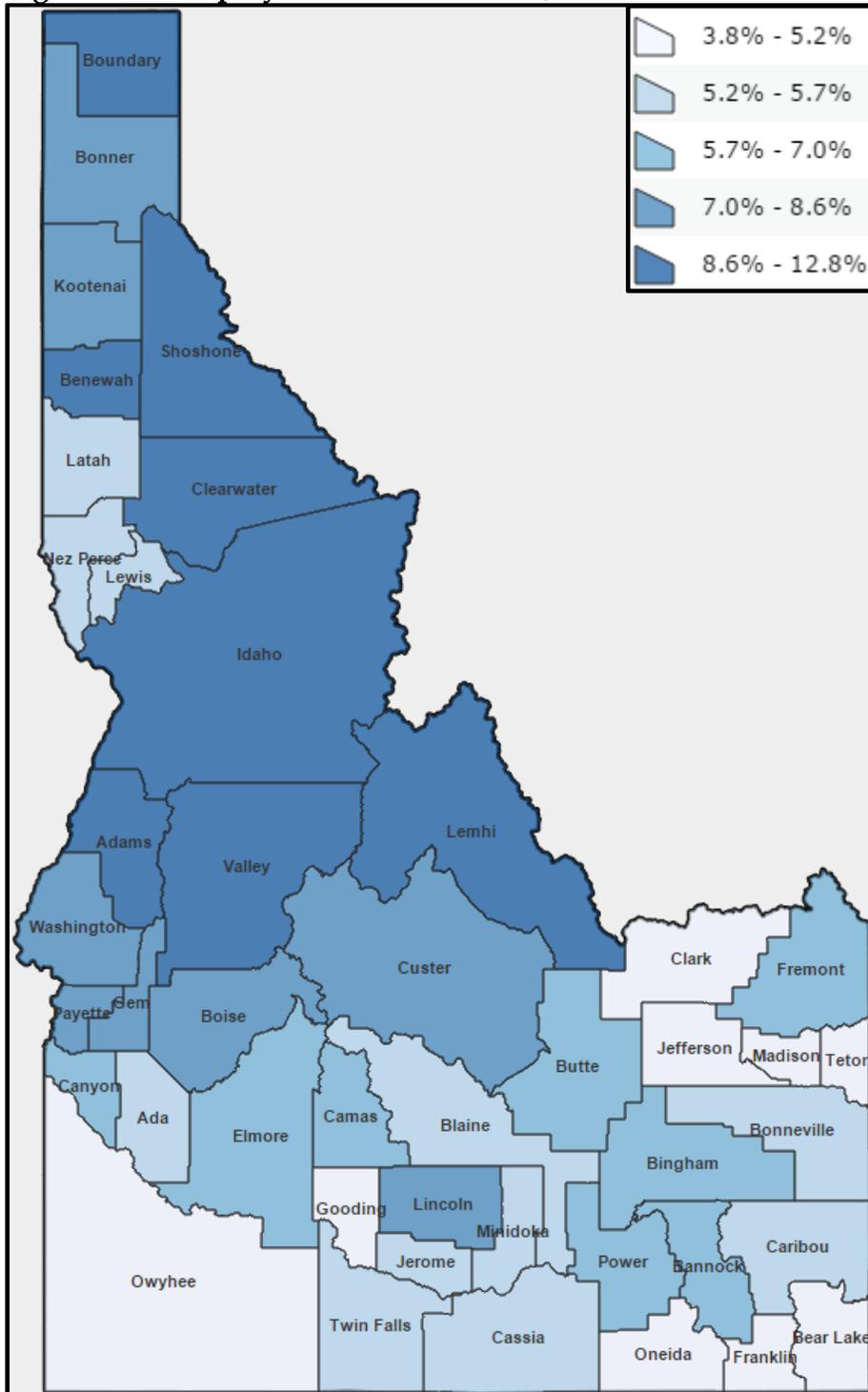
According to the Census Bureau, the percentage of the population living below the poverty level was 15.4% nationally, compared to 15.5% in Idaho. The counties with the lowest percentage of individuals living below the poverty level were Caribou County (7.8%), Blaine County (8.3%), and Valley County (9.5%). The counties with the highest percentage of individuals living below the poverty level were Madison County (35.8%), Owyhee County (24.2%), and Power County (23.9%). Madison County had a significantly higher percentage of the population living below the poverty level than the state as a whole.

Figure 6. Median Household Income in Idaho, 2009-2013



According to the Census Bureau, the median income was \$53,046 nationally compared to \$46,767 in Idaho. The counties with the highest median household income were Blaine County (\$64,042), Ada County (\$55,210), and Teton County (\$53,931). The counties with the lowest median household income were Madison County (\$32,059), Owyhee County (\$32,175), and Clark County (\$33,200). Blaine County had a significantly higher median household income than the state as a whole.

Figure 7. Unemployment Rate in Idaho, 2013



According to the Bureau of Labor Statistics, the average unemployment rate was 7.4% nationally compared to 6.2% in Idaho on average in 2013. The counties with the lowest unemployment rate were Oneida County (3.8%), Franklin County (3.9%), and Bear Lake County (4.5%). The counties with the highest unemployment rate were Adams County (12.8%), Clearwater County (12.1%), and Shoshone County (11.3%). Clearwater County and Adams County have significantly higher unemployment rates than the state as a whole.

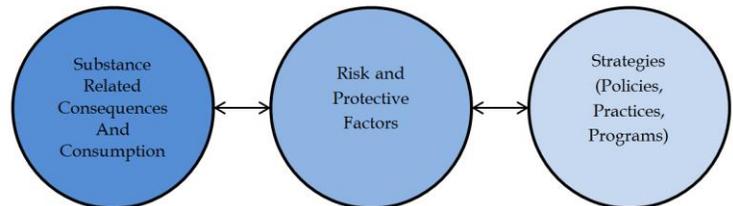
Methodology

General Review

The State of Idaho Substance Abuse Needs Assessment has been developed under the direction of the SEOW, and in turn, the methodology used to develop this report is a standard format provided to all SEOWs across the nation. 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 ATOD, the risk and protective factors associated with ATOD use, and the primary consequences of ATOD use, see Figure 8.

Figure 8. Outcome-Based Prevention Model



In 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 subsequent consumption and consequences information was compiled for Idaho:

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, 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 classify 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 include current use and excessive use. For each construct, Idaho attempted to find one or more specific data measures (indicators) to assess and quantify the prevention-related constructs. Idaho's indicator data is collected and maintained by various community and government partners.

Numerous 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 and relevant prevention 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. 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, specific constructs of interest were ascertained, and then indicators were identified to measure those constructs. If sufficient data was not available for a particular construct, it was not represented.

Given ODP's focus on building and strengthening Idaho's prevention system, the Idaho SEOW concentrated on constructs and indicators that will prove most useful for prevention decision-making. All indicators included in this assessment are valid and reliable measures of the constructs. Additionally, with respect to consequences, constructs with clear evidence of causation for substances abuse were used.

Indicator Selection

The Idaho SEOW implemented a four step process to determine appropriate indicators:

Step 1: Review Data Indicators

A review of the literature was conducted, establishing a comprehensive list of over 150 possible indicators grouped by substance and construct type. Although Idaho has a substantial breadth of indicators, the size of the population complicates the reliability of the data. Therefore, the SEOW chose to consider the indicator in the context of the whole state. The Priority Setting Subcommittee, composed of SEOW and SPF Advisory Council members, worked together to review the data indicators.

Step 2: Incorporate 6 Criterion

Driven by the aforementioned interest of requiring data sources that would reflect a statewide scope, the workgroup reviewed the indicators and their sources, which 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 be established to

further refine the list of to 40 indicators. The criteria established were as follows:

1. Five years of available data for each indicator
2. At least one indicator in each construct collected on a community or regional level
3. At least one indicator in each construct regarding the key subpopulations:
 - a. Youth aged 18-25
 - b. Military veterans and their families
 - c. American Indians/Alaska Natives
 - d. Hispanics/Latinos
 - e. Individuals exposed to adverse childhood experiences
4. Youth under 18 needed to be represented in at least one indicator in each construct
5. Indicators should be prioritized based on data sources' level of contact
 - a. The level of contact is the point at which each indicator interacts with the population. For example, arrest records are document in an earlier phase of contact than court records, which precedes correctional system involvement. Therefore, arrest records are the first level of contact, courts the second, and the correctional system records the third.
6. Constructs must have at least three indicators available
 - a. When an insufficient number of indicators were available in a construct, the SEOW created a new, broader construct. A construct with a single indicator could result in priorities that are driven by an isolated phenomenon. An example of this is in the prescription drugs category. While the SEOW felt strongly that prescription drugs should be considered, Idaho lacked the number of indicators to adequately portray both consumption and consequences constructs. As a result, indicators were included from both consumption and consequences constructs to create a general prescription drug use construct. Due to the sixth criterion listed above, constructs were eliminated, but indicators were not.

Step 3: Identify Relevance and Record Type

After applying the criteria of Step 2 to each indicator, the SEOW further eliminated 51 indicators. The SEOW refined indicators to reflect a relevance rating and record type.

Relevance

The relevance rating was on a scale of one to three, with 1 being *Very Relevant* and 3 being *Not Relevant*. After some group discussion, each indicator's relevance was scored by the SEOW member who provided the indicator.

Record Type

The record type was a classification of each indicator based on the source, administrative (A) or survey-based (S). Table 1 is an example of the scoring system employed. Scoring for all indicators can be found in Appendix B.

Table 1. Sample of Appendix B

Constructs and Indicators			Criteria					
Construct	Indicator	Source	Community or Regional Data	Five Year Data	Subpopulation Data	Youth Data	Relevance	Record Type
Alcohol								
Current Use	Percent of students in 9 th -12 th grade reporting alcohol use in the past 30 days	YRBS	N	Y	N	Y	2	S
	Idaho liquor sales per capita	ISLD	Y	Y	N	N	1	A
	Percent of adults reporting alcohol use in the past 30 days	BRFSS	Y	Y	Y	N	1	S

Step 4: Score

The SEOW employed a hybrid Delphi method to further eliminate 40 indicators. In the Delphi method, a panel of experts convenes to participate in multiple rounds of scoring, after which, the final product is reached by a consensus.

For the SEOW, recommendations were collected from each content expert regarding each indicator. These suggestions were then reviewed, and a second round of scoring was conducted by two additional content experts. The resulting indicator list (see Appendix D) 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, considerably 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 in 2011. Changes made in 2011 increased the representation of formerly underrepresented adults such as those living in cell phone-only households, minorities, younger adults, and those with lower incomes. Due to these improvements, 2011 estimates may vary slightly from previous years, and therefore, cannot be compared with data from 2010 and earlier. Shifts in observed prevalence from 2010 to 2011 for indicators measured by the BRFSS may simply reflect improved methods of measuring risk factors, rather than true trends.

For a more comprehensive review of data sources, see Appendix C. It should be noted that while the SEOW often chose to cite statewide data sources over their corresponding national aggregates, in many cases, statewide data sources provide the information that is found in the national data source. Typically, the data in national sources are simplified from data collected at the state-level. A strong example of this is in the case of the

Uniform Crime Reports (UCR) program. Idaho uses the National Incident Based Reporting System (NIBRS) which provides more comprehensive data than the UCR program. Using state-level data sources enhances partnerships and allows for quicker responses, should questions arise at the local level. When available, national metrics were included when data was gathered using the same methodology. In some cases, there was a lack of adequate national comparison.

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 were not a sufficient number of relevant indicators to represent both consumption and consequences constructs for these substances. With that being said, the SEOW felt both marijuana and prescription drug abuse were important to justify, remaining distinct from other substances.

Priority Setting Subcommittee

Table 2: Priority Scoring Subcommittee

Idaho State Priority Scoring Sub Committee	
Name	Agency
Darrin Burrell	Freemont County Juvenile Corrections
Janeena Wing	Idaho Statistical Analysis Center
Nathan Drashner	Office of Drug Policy
Penny Jones	Prevention Provider
Tedd McDonald	Center for Health Policy
Sharlene Johnson	Office of Drug Policy
Matt McCarter	Department of Education
Tammy Rubino	Community Coalitions of Idaho

After indicators and constructs were compiled, the SEOW was tasked with prioritizing the efforts by substance. Although all substances that can be abused have negative consequences, some substances warrant more immediate action than others. In order to determine which substances deserved

priority in terms of prevention in Idaho, the Priority Setting Subcommittee (Table 2) was developed. This group was composed primarily of SPF Advisory Council members with some representatives from the SEOW.

The SEOW designed the priority setting methodology by borrowing from a ranking and scoring system that Wyoming used. The previous needs assessment was used by the Priority Setting Subcommittee to inform their scores. 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.

Scoring

Under the guidance of the methodology developed by the SEOW, scoring addressed size and seriousness of each substance.

Size:

To create a score for size, the Priority Setting Subcommittee compared the indicator’s rate of effect per 10,000 or 100,000 population, depending on the type of indicator. The

indicators were then assigned a score of 1 to 4 based on which quartile they fell in when compared to the other like indicators.

Seriousness:

A seriousness index was created by tracking the severity of the outcome for each indicator, which was used to calculate the severity score in combination with trend data associated with the indicator.

Severity:

The severity scores were generated and assigned by analyzing 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.

Trend:

Each indicator was also assigned a score based on the trend of the data by the following guidelines:

- ❖ If the indicator was trending upward it was assigned a score of 1.5
- ❖ If the indicator was remaining relatively consistent it was assigned a score of 1
- ❖ If the indicator was trending downward it was assigned as score of 0.5

These scores were then multiplied together to create the seriousness score using the formula below:

$$\text{Seriousness Score} = \text{Severity Score} \times \text{Trend Score}$$

Capacity

After some discussion, the Priority Setting Subcommittee reached the conclusion that capacity was a combination of both changeability and readiness. Changeability and readiness were independently scored by each member, and then scores were discussed in a group setting. These scores were then averaged together to create a score for each construct for both changeability and readiness.

The following formula was created to generate the score for capacity:

$$\text{Capacity Score} = \text{Readiness Score} \times \text{Changeability Score}$$

Prioritization

The Priority Setting Subcommittee discussed several options to generate the final scores for which prioritization would be based. The following formula was derived:

$$\text{Final Score} = [\text{Size Score} + (2 \times \text{Seriousness})] \times \text{Capacity Score}$$

This algorithm used was similar to the one in which Wyoming employed, which provided assurance to the Priority Setting Subcommittee. Additionally, the algorithm allowed the Priority Setting Subcommittee to consider capacity, which is an integral step in the SPF. The Priority Scoring Subcommittee felt that including capacity was essential for a priority to be successfully addressed. Based on all of these factors the SPF Advisory Council selected prescription drugs, alcohol, and marijuana to be addressed.

Prescription Drugs

In recent years, the Centers for Disease Control and Prevention declared prescription drug abuse an epidemic. The increasing rate of seizures, prescription distribution rates, and drug-related mortality primarily driven by prescription drugs within the state clarifies that Idaho is no immune to the epidemic.

Alcohol

Although several indicators of alcohol use are falling, such as alcohol-related arrests, alcohol sales continue to rise and are emulating rates that are experienced by the nation as a whole. This is especially alarming because, historically, alcohol consumption in Idaho is below the national average.

Despite the increase in alcohol sales, according to self-report surveys, alcohol consumption seems to be decreasing. The increase in alcohol sales may be explained, to a degree, by individuals from other states, namely Washington, traveling to Idaho to purchase alcohol at a lower price. In recent years, Washington privatized liquor, increasing alcohol prices in the Evergreen State. However, according to the Idaho State Liquor Division, even when controlling for these factors, the alcohol sales rate for Idaho residents is increasing.

While most other mortality indicators have been declining or stagnant, almost all alcohol-induced mortality rates have been increasing, with the exception of alcohol-related motor vehicle fatalities. This is of note because nationally, similar variables have been stagnant or dropping over the same time period.

Marijuana

Although it does not appear that marijuana consumption has increased, arrests relating to marijuana have. Marijuana trafficking charges have nearly quadrupled since 2009, and seizures and possession arrests are also increasing. The rise in trafficking may be a result of the trend of policies relating to private cultivation, decriminalization, and marijuana legalization in neighboring states. Due to the sudden shifts in cultural attitudes, perception of harm, and availability, marijuana consumption and related consequences warrant particular surveillance.

Indicators for State Priorities

The indicators below were chosen to show change in the state priorities. SPF sub-recipients will be required to address these priority areas and indicators in their grant applications and submitted strategic plans. It is anticipated that communities will be able to effectively improve outcomes in their local communities, thereby improving outcomes statewide.

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 or both of the following (*sub-recipients are not required to choose either construct*):

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 grades 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

Continuous Change

Throughout the years, data measures change due many unforeseeable reasons (e.g., changing agency responsibility, changing priorities or foci, lack of sustainability or funding, etc.). For this reason, some original indicators assessed by the SEOW in 2013 are not the same indicators as reported in this needs assessment.

In 2013, the Treatment Episode Data Set (TEDS) was delivered to the Idaho Department of Health and Welfare using a new data system, the Web Infrastructure for Treatment Services (WITS), which changed the reporting mechanisms available. For that reason, the following previously reported indicators cannot be reported in this needs assessment: percent reporting alcohol as a substance of use upon treatment entry, percent reporting marijuana as a substance of use upon treatment entry, and percent reporting other drugs as a substance of use upon treatment entry. Additionally, due to the changes in data management systems, the data points in 2013 will be absent for the following indicators: percent reporting alcohol as the primary substance of abuse, percent reporting marijuana as the primary substance of abuse, and percent reporting other drugs as the primary substance of use. Furthermore, since addressing prescription drug abuse was selected as one of Idaho's priorities, it is appropriate to add the

indicator: percent reporting prescription drugs as the primary substance of abuse upon treatment entry.

Updated ARCOS data will also not be reported in this needs assessment. Obtaining ARCOS data is not sustainable for the SEOW, as it must be requested every year from the DEA. Additionally, the DEA has recently implemented stricter confidentiality requirements for the data. Consequently, the data cannot be accessed in the absence of a pending investigation.

Despite the limitations in existing data sources, other data sources are emerging. In 2014, the Office of Drug Policy, the SEOW, and the Department of Education collaborated to develop the Idaho Youth Prevention Survey (IYPS). The IYPS was purposed to glean county level data from 6th, 8th, 10th, and 12th grade students regarding school climate, emotional health, physical health, parental attitudes, and substance use.

Additionally, the Office of Drug Policy has added questions to the BRFSS regarding the perception of risk of using marijuana once or twice a week and using prescription medication not prescribed. Moreover in 2015, adults will be asked about their perception of risk for underage drinking. Items regarding use were also added to the BRFSS and include the use of marijuana and prescription medication in the past 30 days.

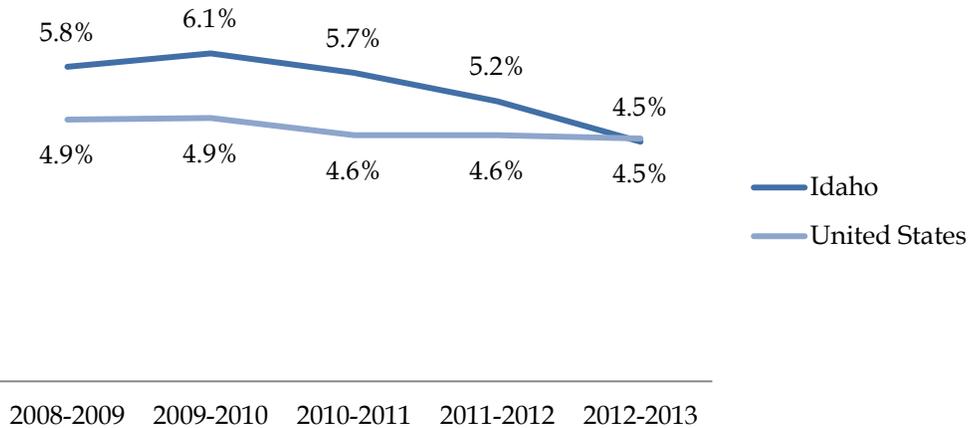
Despite the SEOW’s work to identify the best substance abuse indicators available, data measurements are continuously being modified or removed. For this reason, it is important to develop and implement new data sources that may be used in the future.

Prescription Drugs

Table 3: Prescription Drugs Use Construct

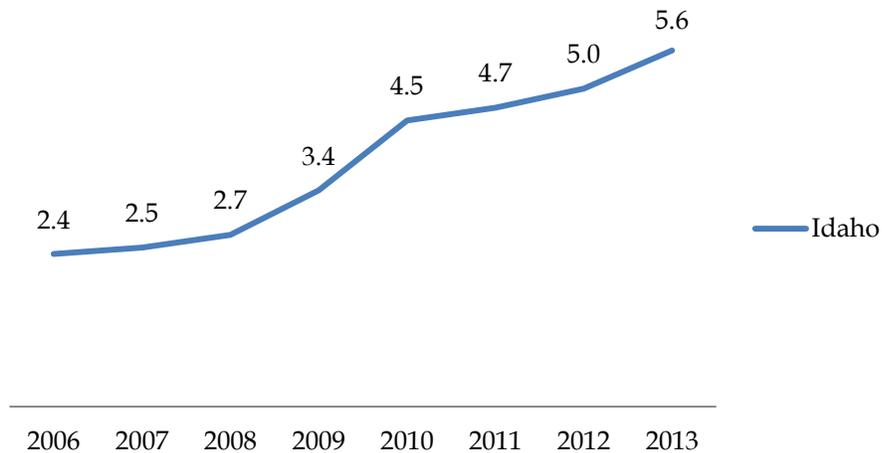
Prescription Drug Consumption & Consequence		
Construct	Indicator	Source
Use	Nonmedical use of prescription pain relievers in the past year	NSDUH
	Prescription drug seizures per 100,000 population	IBRS
	Percentage of students in grades 6 th -12 th who used prescription pain medication without a doctor’s prescription by region	IYPS

Figure 9.
Non-medical use of prescription pain relievers (percent 12 years and older) have been slightly higher than the national rate but over time, the difference has diminished.



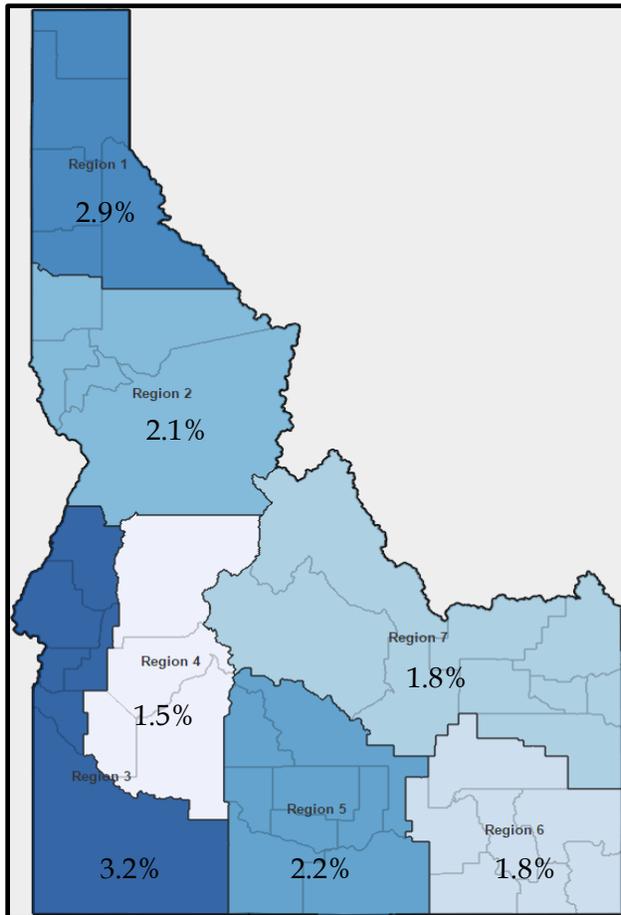
Between 2009 and 2013, the percentage of individuals 12 and older who used prescription pain relievers for non-medical use in the past 12 months has slightly decreased, with the percentage in Idaho consistently higher than that of the United States as a whole. The lowest percentage of pain reliever usage in Idaho was 4.5% in 2012-2013, and the highest was 6.1% in 2009-2010. Nationally, the lowest percentage of pain reliever usage was also in 2012-2013 at 4.5%, and highest at 4.9%, also in 2009-2010.

Figure 10.
Prescription drug seizures (rate per 10,000 population) have been increasing over time.



Between 2006 and 2013, the rate of prescription drug seizures has increased. The lowest rate of prescription drug seizures was 0.24 seizures per 1,000 population in 2006, and the highest was 0.55 per 1,000 population in 2013.

Figure 11.
Non-medical use of pain relievers (percent using in the past 30 days) among 6th-12th grade students vary across regions.



According to the Idaho Youth Prevention Survey (2014), 2.2% of 6th-12th grade students in Idaho used prescription pain medication not prescribed to them in the past 30 days. Region 3 (3.2%), Region 1 (2.9%), and Region 5 (2.2%) had higher percentages of prescription pain medication usage for this age group. Region 4 (1.5%), Region 6 and Region 7 (both 1.8%), and Region 2 (2.1%) had lower percentages of prescription pain medication usage for this age group. Region 3 had a significantly higher percentage of students in grades 6-12 that reported past 30-day prescription pain medication use when compared to the state as a whole.

Alcohol

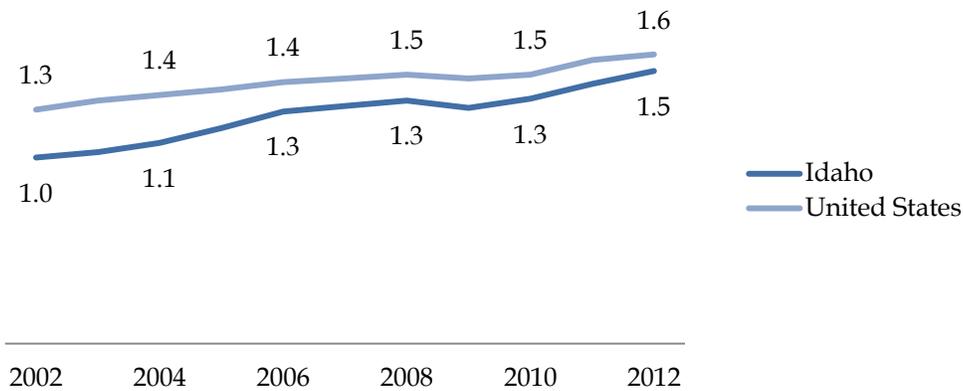
Current Alcohol Use

Table 4. Current Alcohol Use Construct

Alcohol Consumption		
Construct	Indicator	Source
Current Use	Idaho gallons sales per capita	ISLD
	Percent of students grades 9-12 reported use of alcohol past 30 days	YRBS
	Percent of adults 18 and older reporting use of alcohol past 30 days	BRFSS
	Percent of students in grades 6-12 reporting past 30-day alcohol use by region	IYPS

Figure 12.

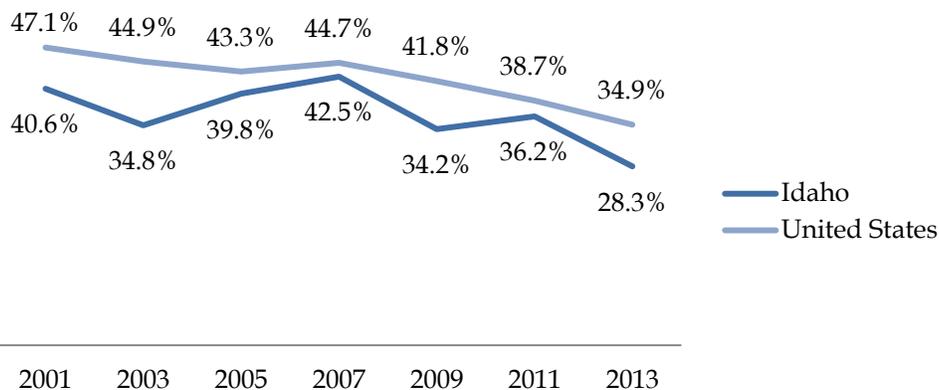
Idaho liquor sales (gallons per capita) have been slightly lower than the national rate, but over time the difference has diminished.



Between 2002 and 2012, liquor sales have increased, with the rate in Idaho consistently lower than that of the United States as a whole. The lowest rate of liquor sales per capita in Idaho was 1 gallon in 2002 and the highest in Idaho in 2012 at 1.5 gallons. Nationally, the lowest rate of liquor sales per capita was also in 2002 at 1.3 gallons, and highest in the United States also in 2012, at 1.57 gallons.

Figure 13.

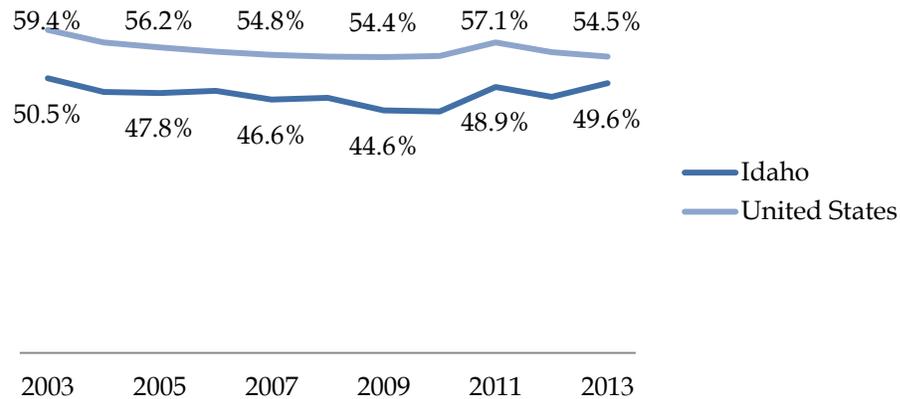
Alcohol use (percent using in the past 30 days) among 9th-12th grade students has been slightly lower than the national rate.



Between 2001 and 2013, 30-day alcohol use among 9th-12th grade students has been declining, with the percentage in Idaho consistently lower than that of the United States as a whole. The lowest percentage of 9th-12th grade 30-day alcohol use in Idaho was 28.3% in 2013, and the highest in 2007 at 42.5%. The lowest percentage nationally was also in 2013 at 34.9%, and highest at 47.1% in 2001.

Figure 14.

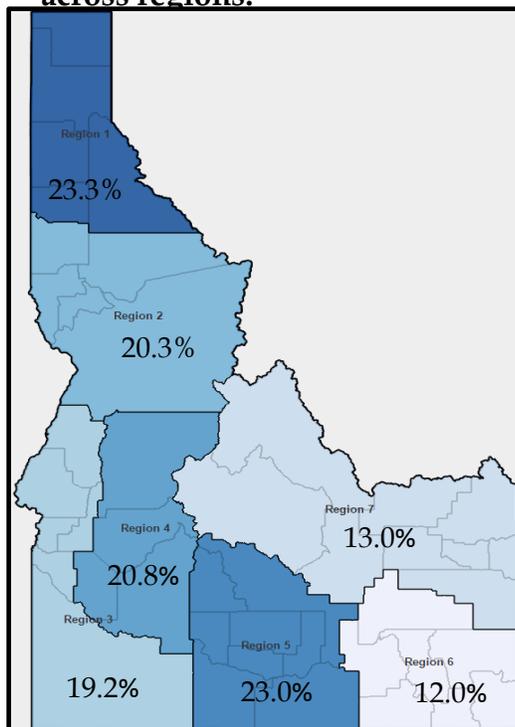
Alcohol use (percent using in the past 30 days) among adults has been slightly lower than the national rate, but over time the difference has diminished.



Between 2011 and 2013, adult past 30-day alcohol use has remained fairly stable, with the percentage in Idaho consistently lower than that of the United States as whole. **Any change in 30-day alcohol use after 2011 may be a result in the change in methodology in the BRFSS. For this reason, data prior to 2011 cannot be statistically compared to data after 2011.** From 2011 to 2013, the lowest percentage of adult past 30-day alcohol use in Idaho was 47.1% in 2012, and the highest at 49.6% in 2013. Nationally, the lowest percentage of adult past 30-day alcohol use was in 2013 at 54.5%, and highest nationally at 57.1% in 2011.

Figure 15.

Alcohol use (percent using in the past 30 days) among 6th-12th grade students varies across regions.



According to the IYPS, 18.2% of 6th-12th grade students in Idaho drank beer, alcopops or liquor in past 30 days in 2014. Region 1 (23.3%), Region 5 (23.0%), Region 4 (20.8%), Region 2 (20.3%), and Region 3 (19.16%) had higher percentages of alcohol usage for this age group. Region 6 (12.0%) and Region 7 (13.03%) had significantly lower percentages of 6th-12th grade students past 30-day alcohol use when compared to the state as a whole.

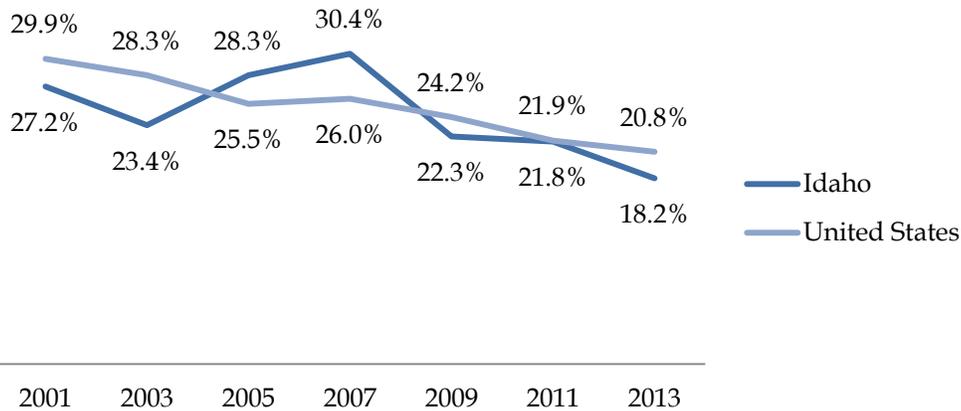
Excessive Alcohol Use

Table 5. Excessive Alcohol Use Construct

Alcohol Consumption		
Construct	Indicator	Source
Excessive Use	Percent of students in grades 9-12 reporting five or more drinks in a row within a couple of hours in the past 30 days	YRBS
	Percent of adults aged 18 and older reporting heavy alcohol use in past 30 days	BRFSS
	Percent of adults aged 18 or older binge drinking of alcohol in past 30 days	BRFSS

Figure 16.

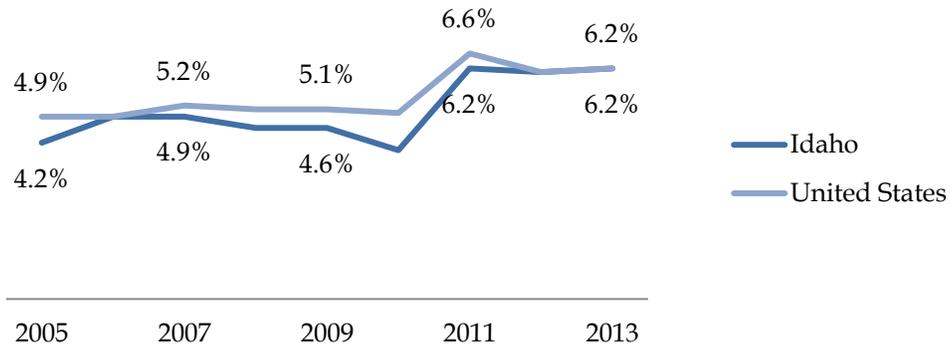
Past 30-day binge drinking (consuming 5 or more drinks in a row) among 9th-12th grade students have been frequently lower than the national rate.



Between 2001 and 2013, 9th-12th grade binge drinking has decreased, with the rate in Idaho fluctuating considerably. The lowest percentage of binge drinking among 9th-12th grade students in Idaho was 18.2% in 2013, and the highest in 2007 at 30.4%. Nationally, binge drinking among 9th-12th grade students was lowest also in 2013 at 20.8%, and highest in 2001 at 29.9%.

Figure 17.

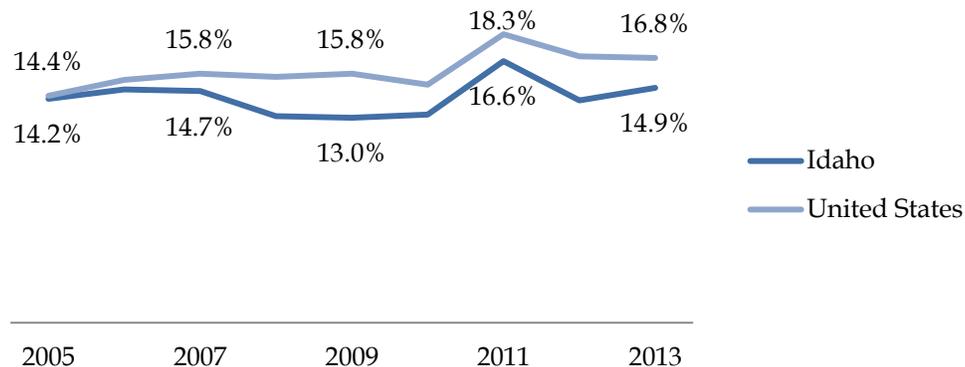
Past 30-day heavy alcohol use (consuming more than 2 drinks per day) among adults has been slightly lower than the national rate, but over time the difference has diminished.



Between 2011 and 2013, adult heavy drinking has stayed consistent, with the percentage of heavy drinkers in Idaho similar to that of the United States as a whole. **Although it appears that heavy drinking has increased dramatically in 2011, the increase may be a result in the change in methodology in the BRFSS. Data prior to 2011 cannot be compared to data after 2011.** In Idaho from 2011 to 2013, adult heavy drinking has not changed more than one-tenth of a percent. Additionally, the percentage of adults who participate in heavy drinking is identical to the percentage nationally in 2012 (6.1%) and 2013 (6.2%).

Figure 18.

Past 30-day binge drinking (consuming 5 or more drinks in a row) among adults has been slightly lower than the national rate.



Between 2011 and 2013, adult binge drinking has decreased, with Idaho drinking consistently binge drinking less than that of the nation as a whole. **Although it appears that binge drinking has increased dramatically in 2011, the increase may be a result in the change in methodology in the BRFSS. For this reason, data prior to 2011 cannot be compared to data after 2011.** From 2011 to 2013, the lowest percentage of binge drinking in Idaho was 14.1% in 2012, and the highest in Idaho in 2011 at 16.6%. During the same timeframe, nationally the lowest percentage of binge drinking was in 2013 at 16.8%, and highest also in 2011 at 18.3%.

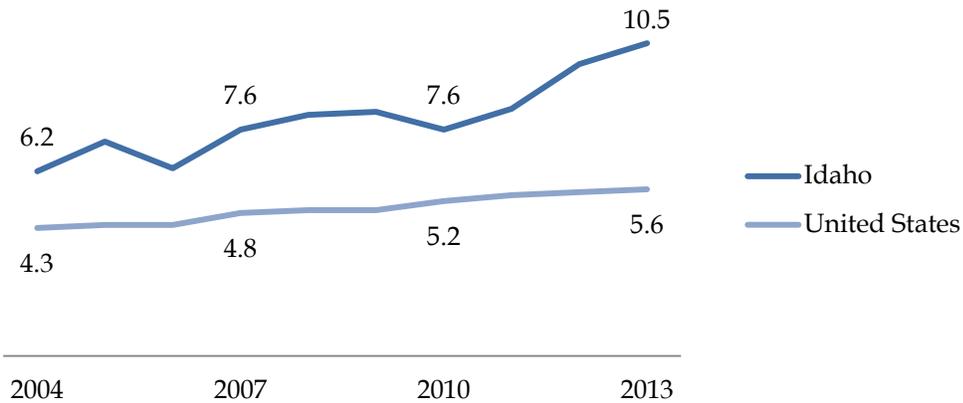
Alcohol-Related Mortality

Table 6. Alcohol-Related Mortality Construct

Alcohol Consequences		
Construct	Indicator	Source
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 10,000	ITD

Figure 19.

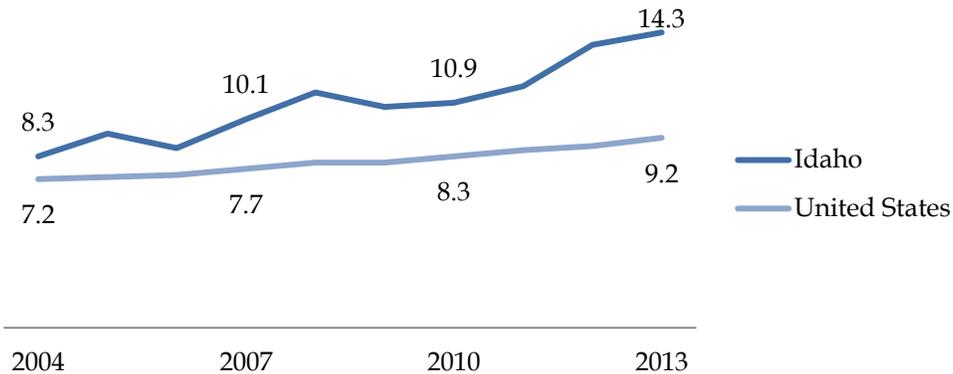
Alcoholic liver disease mortality (rate per 100,000 population) among adults is higher than the national rate, and over time the difference has increased.



Between 2004 and 2013, alcoholic liver disease mortality has increased, with the rate in Idaho consistently higher than that of the United States as a whole. The lowest rate of alcoholic liver disease mortality in Idaho was 6.2 per 100,000 population in 2004, and the highest in Idaho in 2013 at 10.5 per 100,000 population. Nationally, the lowest rate of alcoholic liver disease mortality was also in 2004 at 4.3 per 100,000 population, and highest also in 2013 at 5.6 people per 100,000 population.

Figure 20.

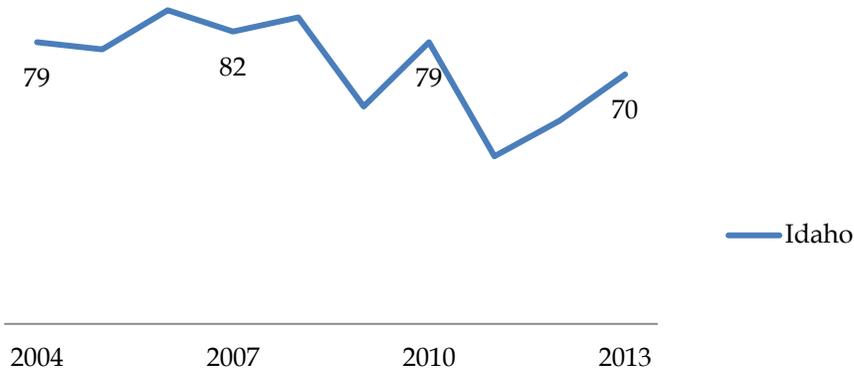
Alcohol-induced mortality (rate per 100,000 population) among adults is higher than the national rate, and over time the difference has increased.



Between 2004 and 2013, alcohol-induced mortality has increased, with rates in Idaho consistently higher than those in the United States as a whole. The lowest rate of alcohol-induced mortality in Idaho was 8.3 per 100,000 population in 2004, and the highest in 2013 at 14.3 per 100,000, population. Nationally, the lowest rate of alcohol-induced mortality was also in 2004 at 7.2 per 100,000 population, and highest also in 2013 at 9.2 per 100,000 population.

Figure 21.

Alcohol-related motor vehicle fatalities (rate per 10,000 population) have fluctuated over the years.



Between 2004 and 2013, alcohol-related motor vehicle fatalities have fluctuated. The lowest rate of alcohol-related motor vehicle fatalities was 47 per 10,000 population in 2011, and the highest was in 2006 at 88 fatalities per 10,000 population.

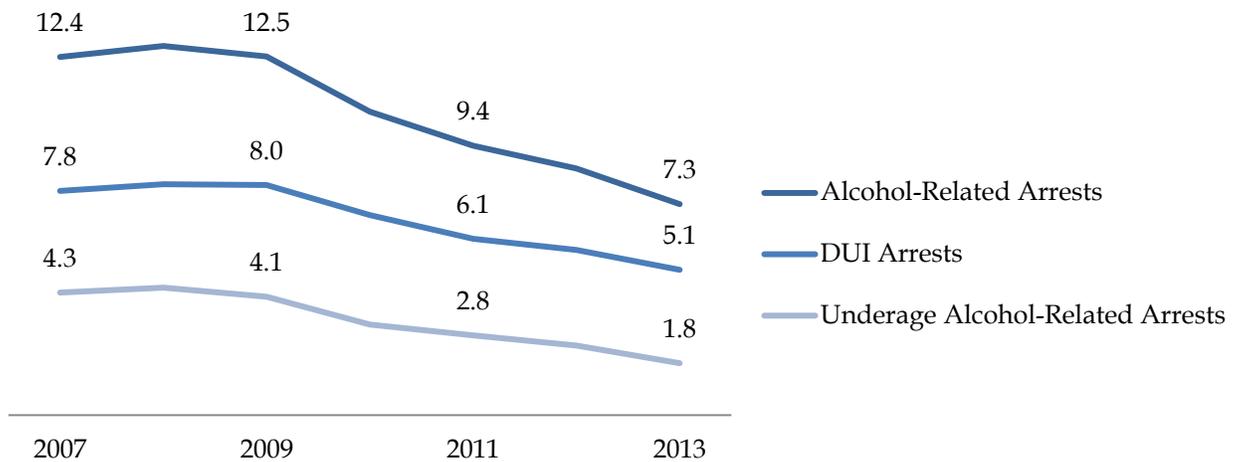
Alcohol-Related Crime

Table 7. Crime Related to Alcohol Construct

Alcohol Consequences		
Construct	Indicator	Source
Crime	Alcohol-related arrests per 1,000 per 1,000 population	IBRS
	Driving under the influence (DUI) arrests per 1,000 population	IBRS
	Underage alcohol-related arrests per 1,000 population	IBRS
	Alcohol-related crashes per 1,000 population	ITD

Figure 22.

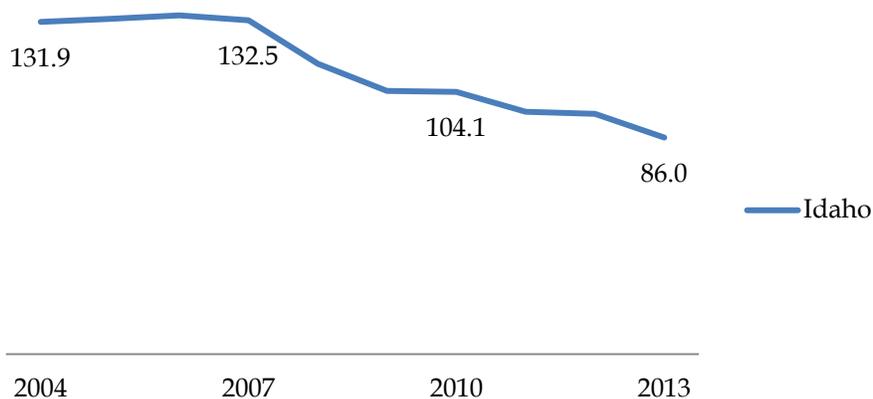
All alcohol-related arrests in Idaho (rate per 1,000 population) have decreased over the years.



Between 2007 and 2013, alcohol-related arrests have decreased in Idaho. The lowest rate of alcohol-related arrests was 7.3 per 1,000 population in 2013, and the highest in 2008 at 12.8 per 1,000 population. The lowest rate of DUI arrests was 5.1 per 1,000 population also in 2013, and the highest also in 2008 at 8.0 per 1,000 population. The lowest rate of underage alcohol-related arrests was 1.8 per 1,000 population also in 2013, and the highest was also in 2008 at 4.4 per 1,000 population.

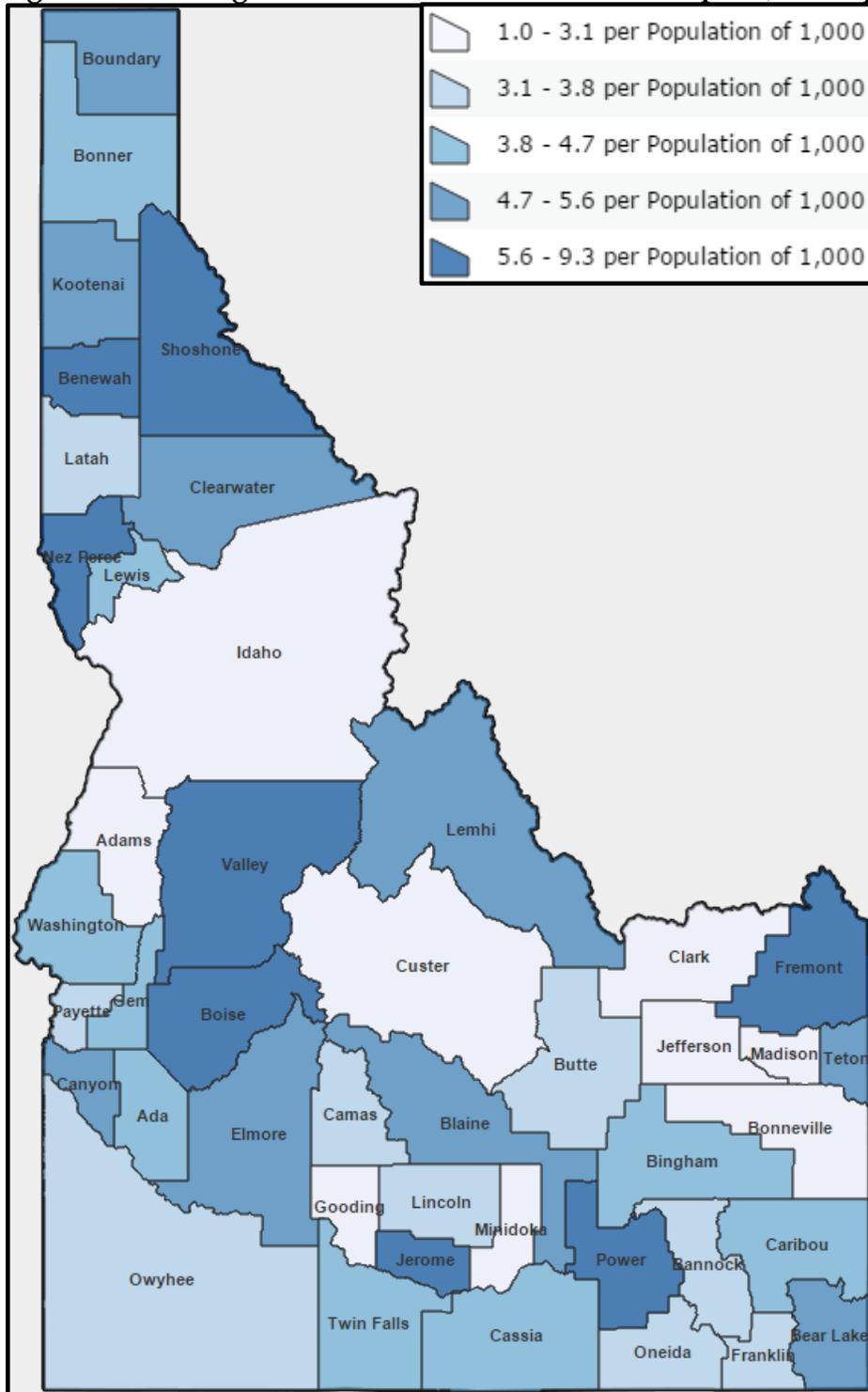
Figure 23.

Alcohol-related motor vehicle crashes (rate per 1,000 population) have decreased over the years.



Between 2004 and 2013, alcohol-related motor vehicle crashes have been decreasing. The lowest rate of alcohol-related motor vehicle crashes was 86 per 1,000 population in 2013, and the highest was in 2006 at 134.5 crashes per 1,000 population.

Figure 24. Driving Under the Influence Arrest Rate per 1,000 Population: 2013



According to the Idaho Statistical Analysis Center, the DUI arrest rate in Idaho was 5.0 per 1,000 population in 2013. The counties with the lowest DUI arrests per 1,000 population were Madison County (1.0), Adams County (1.3), and Gooding County (1.8). The counties with the highest DUI arrests per 1,000 population were Valley County (9.3), Benewah County (8.1), and Jerome County (7.5). Both Valley County and Benewah County had significantly higher DUI arrest rates than the rest of the state as a whole.

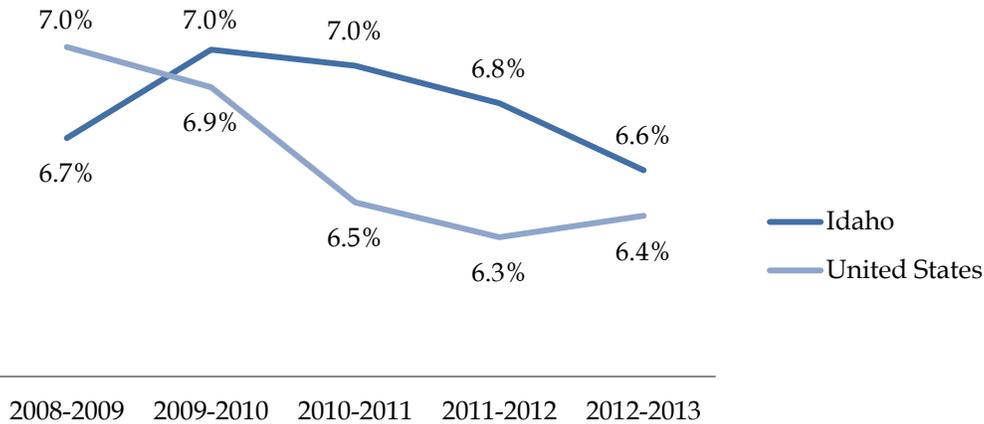
Alcohol Abuse and Dependence

Table 8: Abuse and Dependence of Alcohol Construct

Alcohol Consequences		
Construct	Indicator	Source
Abuse and Dependence	Percentage of people 12 and over needing but not receiving treatment for alcohol in the past year	NSDUH
	Rate of treatment admissions in which alcohol was reported as the primary substance of use upon treatment entry	TEDS

Figure 25.

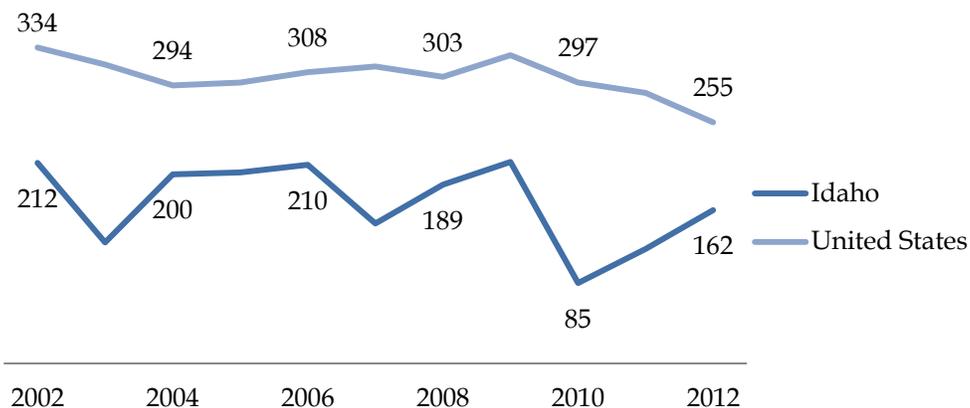
The percentage of individuals needing but not receiving treatment for alcohol dependence is similar to the national rate.



Between 2008 and 2013, the percentage of individuals 12 and over needing but not receiving treatment for alcohol dependence has stayed relatively consistent, with the percentage in Idaho similar to that of the United States as a whole. The lowest percentage of individuals needing but not receiving treatment for alcohol dependence in Idaho was 6.6% in 2012-2013 and the highest in Idaho in 2009-2010 at 7.0%. Nationally, the lowest rate of people needing but not receiving treatment for alcohol dependence was in 2011-2012 at 6.3%, and highest at 7.0% in 2008-2009.

Figure 26.

The rate (per 100,000 population) of people entering treatment in which alcohol is a primary substance of abuse is lower than the national rate.



Between 2002 and 2012, the rate of treatment admissions for alcohol as a primary substance of abuse has fluctuated, with the rate in Idaho consistently lower than that of the United States as a whole. The lowest rate of treatment admissions for alcohol as a primary substance of abuse in Idaho was 85 per 100,000 population in 2010, and the highest in 2009 at 213 per 100,000 population. Nationally, the highest rate of alcohol as a primary substance of abuse upon treatment entry was in 2002 at 334 admissions per 100,000 population, and lowest in 2012 at 255 per 100,000 population.

Marijuana

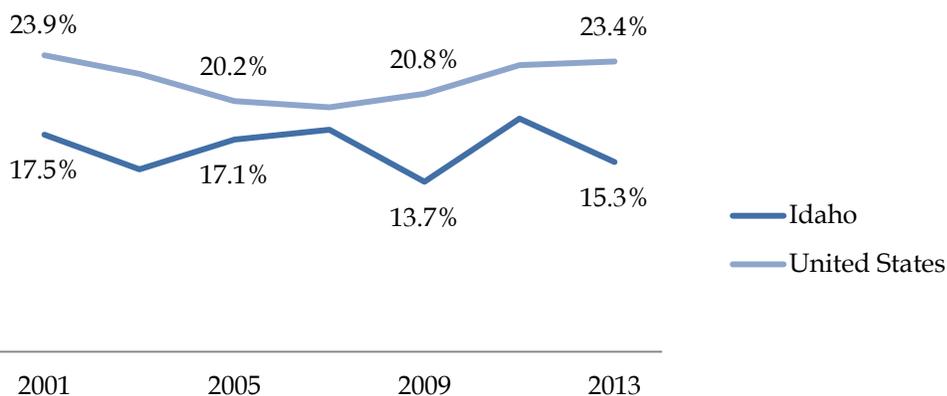
Marijuana Use

Table 9: Marijuana Use Construct

Marijuana Consumption		
Construct	Indicator	Source
Use	Percentage of students in grades 9-12 reporting marijuana usage one or more times during the past 30 days	YRBS
	Marijuana as a primary substance of use upon treatment entry per 100,000	TEDS
	Percentage of students in grades 6-12 reporting marijuana usage one or more times during the past 30 days by region	IYPS

Figure 27.

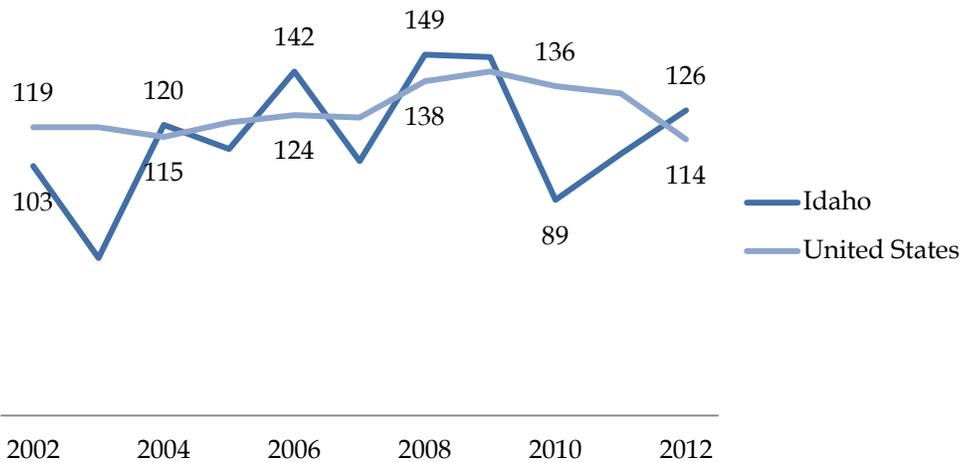
Marijuana use (percent using in the past 30 days) among 9th-12th grade students have been slightly lower than the national rate.



Between 2001 and 2013, the percentage of students in grades 9-12 who used marijuana in the past 30 days has stayed relatively stable, with the percentage in Idaho consistently lower than that of the United States as a whole. The lowest percentage of students in grades 9-12 who have used marijuana in the past 30 days in Idaho was 13.7% in 2009, and the highest in 2011 at 18.8%. Nationally, the highest percentage of 9th-12th grade students who used marijuana in the past 30 days was in 2013 at 23.4%, and the lowest in 2007 at 19.7%.

Figure 28.

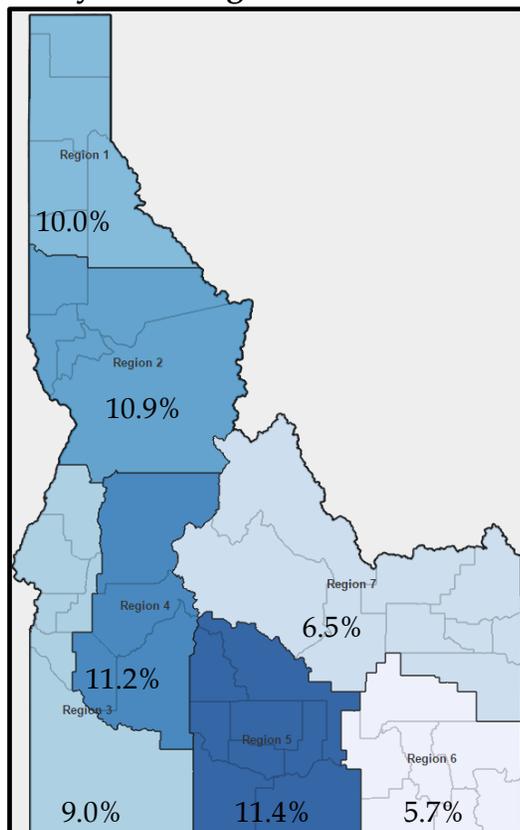
The rate (per 100,000 population) of people entering treatment in which marijuana is a primary substance of abuse is similar to the national rate.



For the previous 10 years, the rate of treatment admissions in which marijuana is the primary substance of abuse has fluctuated, with the rate in Idaho similar to that of the United States as a whole. The lowest rate of treatment admissions for marijuana as the primary substance of abuse in Idaho was 65 per 100,000 population in 2003, and the highest in 2008 at 149 per 100,000 population. Nationally, the lowest rate of treatment admissions for marijuana as the primary substance of abuse was in 2012 at 114 per 100,000 population, and highest at 142 per 100,000 population in 2009.

Figure 29.

Marijuana use (percent using in the past 30 days) among 6th-12th grade students vary across regions.



According to the Idaho Youth Prevention Survey, 8.9% of 6th-12th grade students in used marijuana in past 30 days in 2014. Region 5 (11.4%), Region 4 (11.2%), Region 2 (10.9%), Region 1 (10.0%), and Region 3 (9.0%) had higher percentages of marijuana usage for this age group. Region 6 (5.7%) and Region 7 (6.5%) had significantly lower percentages of 6th-12th grade students who reported past 30-day marijuana use.

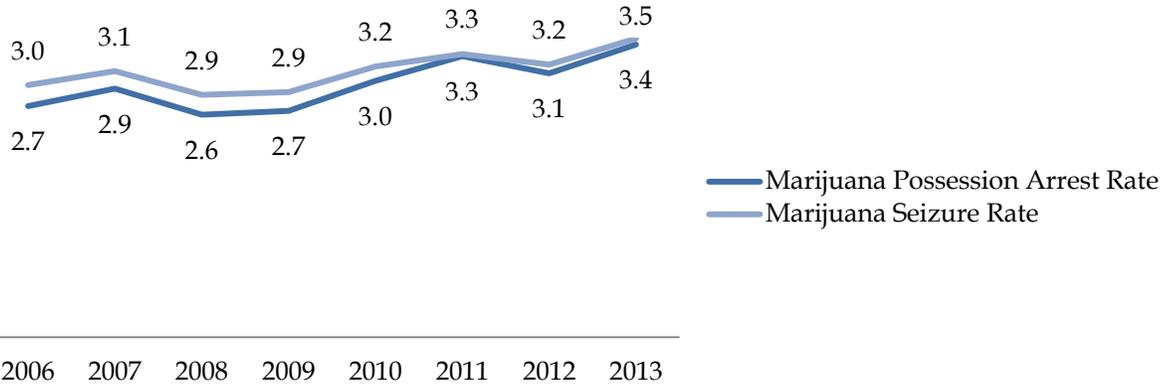
Marijuana-Related Outcomes

Table 10. Marijuana-Related Outcomes Construct

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

Figure 30.

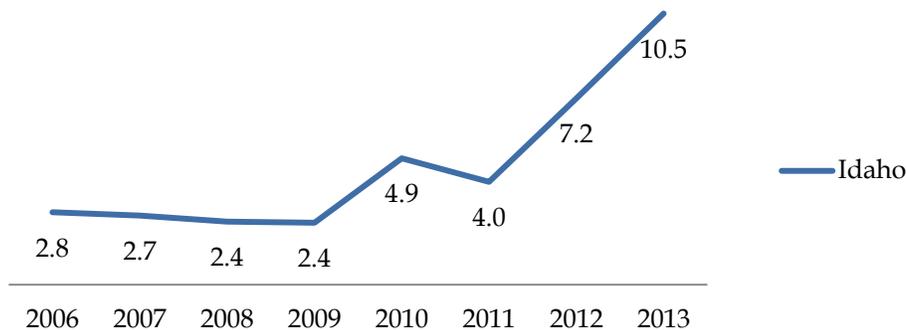
Marijuana possession and seizures (rates per 1,000 population) have increased slightly over the years.



Between 2006 and 2013, marijuana possession arrests and marijuana seizures have increased. The lowest rate of marijuana seizures was 2.9 per 1,000 population in 2008, and the highest was in 2013 at 3.5 arrests per 1,000 population. The lowest rate of marijuana possession arrests was 2.6 per 1,000 population also in 2008, and the highest was also in 2013 at 3.4 arrests per 1,000 population.

Figure 31.

Marijuana trafficking arrests (rates per 1,000 population) have increased dramatically over the years.



Between 2006 and 2013, the lowest rate of marijuana trafficking arrests was 2.40 per 100,000 population in 2009, and the highest was in 2013 at 10.49 arrests per 100,000 population.

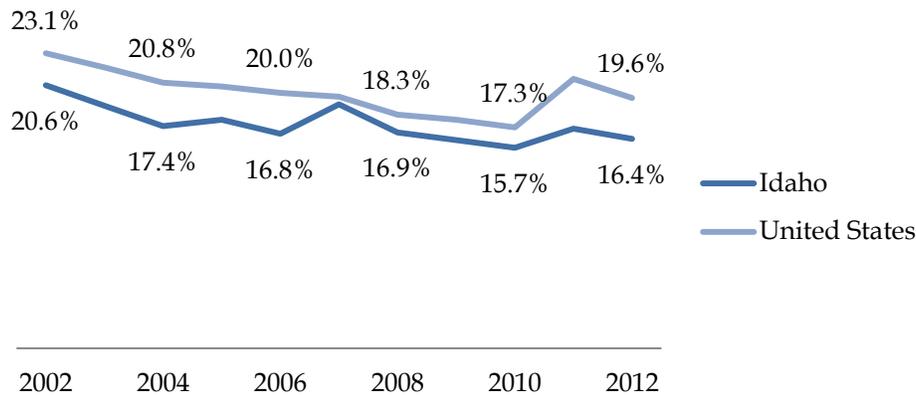
Tobacco

Table 11: Tobacco Use Construct

Tobacco Consumption		
Construct	Indicator	Source
Use	Percentage of adults who have smoked at least one cigarette in the past 30 days	BRFSS
	Percentage of adults ever using smokeless tobacco	BRFSS
	Percentage of 9 th -12 th grade students who smoked cigarettes on 20 or more days in the last 30 days	YRBS

Figure 32.

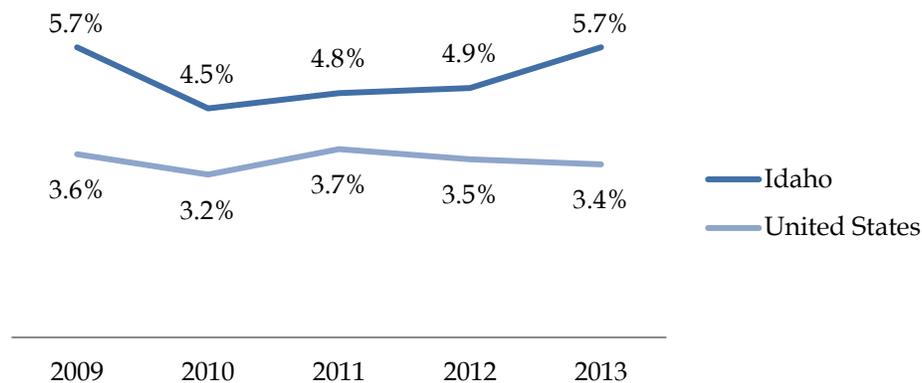
Cigarette use (percent using in the past 30 days) among adults has been slightly lower than the national rate.



Between 2011 and 2012, adult 30-day cigarette use has stayed consistent, with smoking in Idaho consistently lower than that of the United States as a whole. **Although it appears that 30-day cigarette smoking has increased dramatically in 2011, the increase may be a result in the change in methodology in the BRFSS. For this reason, data prior to 2011 cannot be compared to data after 2011.** Between 2011 and 2012, adult cigarette smoking decreased from 17.2% to 16.4% in Idaho and 21.1% to 19.6% nationally.

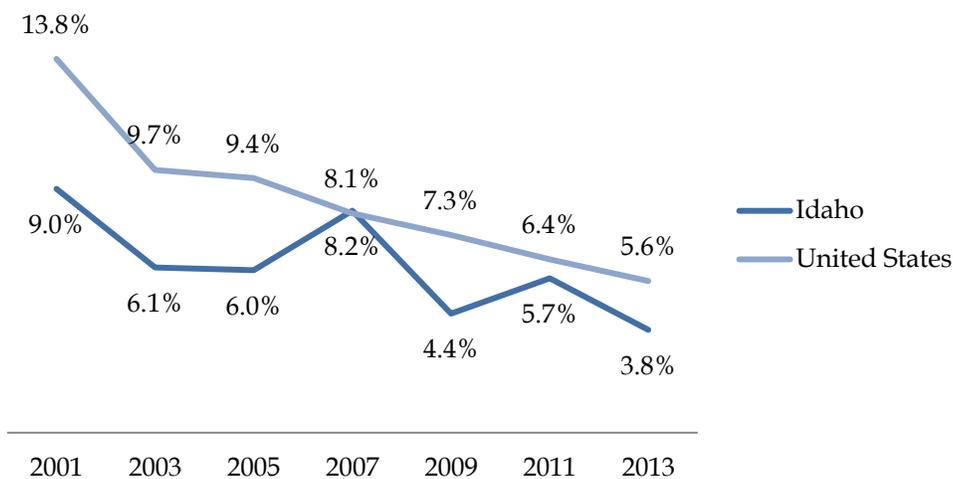
Figure 33.

Smokeless tobacco use (percent using in their lifetimes) among adults has been slightly higher than the national rate.



Between 2011 and 2013, the percentage of adults who have used smokeless tobacco has stayed consistent, with the percentage in Idaho consistently higher than that of the United States as a whole. **Any change in lifetime smokeless tobacco use after 2011 may be a result in the change in methodology in the BRFSS. For this reason, data prior to 2011 cannot be compared to data after 2011.** Between 2011 and 2013, the lowest percentage of adults using smokeless tobacco in Idaho was 4.8% in 2011, and the highest in Idaho was in 2013 at 5.7%. During the same time frame nationally, the lowest percentage of adults who used smokeless tobacco was in 2013 at 3.4%, and highest at 3.7% in 2011.

Figure 34.
Cigarette use (percent using in the past 30 days) among 9th-12th grade students have been slightly lower than the national rate.



Between 2001 and 2013, the percentage of 9th-12th grade students who have smoked cigarettes in the past 30 days has decreased, with the percentage in Idaho consistently lower than that of the United States as a whole. The lowest percentage of students in grades 9-12 who have smoked cigarettes in the past 30 days in Idaho was 3.8% in 2013, and the highest in 2001 at 9%. Nationally, the lowest percentage of 9th-12th grade students who smoked cigarettes in the past 30 days was also in 2013 at 5.6%, and highest also in 2001 at 13.8%.

Other Drugs

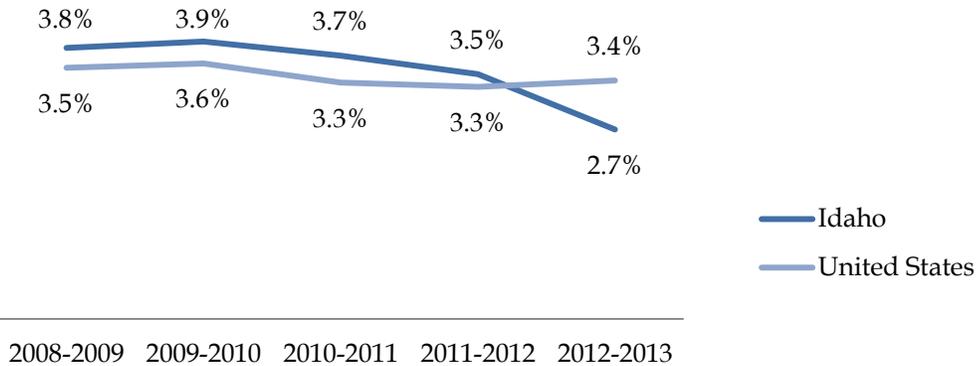
Other Drug Use

Table 12: Other Drug Use Construct

Other Drug Consumption		
Construct	Indicator	Source
Use	Percent of the population 12 and over reporting illicit drug use other than marijuana in the past month	NSDUH
	Lifetime illicit drug use per 1,000 population	BRFSS

Figure 35.

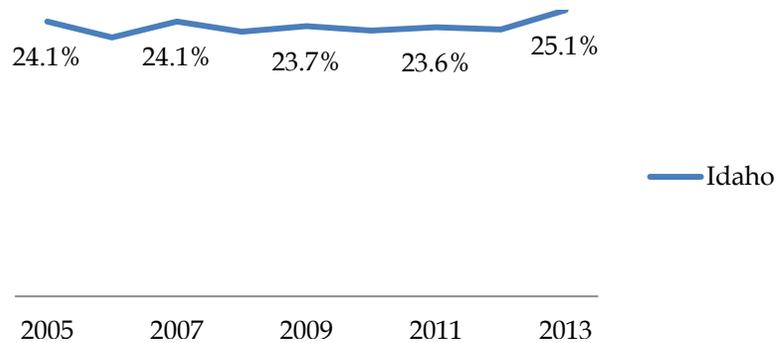
Illicit drug use other than marijuana (percent using in the past 30 days) among adults has been similar to the national rate.



For the previous 5 years, the percentage of people aged 12 and over who have used illicit drugs other than marijuana in the past 30 days has slightly decreased, with the percentage in Idaho typically higher than that of the United States as a whole. The lowest percentage of individuals reporting illicit drug use other than marijuana in Idaho was 2.7% in 2012-2013, and the highest was in 2009-2010 at 3.9%. Nationally, the lowest percentage of people reporting illicit drug other than marijuana was in 2010-2011 at 3.1%, and highest at 3.6% also in 2009-2010.

Figure 36.

Illicit drug use (percent using in their lifetimes) among adults has been consistent over the years.



Between 2011 and 2013, the percentage of adults who have ever used illicit drugs has stayed fairly consistent. **In 2011, the BRFSS, which is a telephone-based survey, included cell phone numbers. Prior to 2011, younger adults, among other populations, were not accurately represented; therefore, data prior to 2011 cannot be compared to data after 2011.** From 2011 to 2013, the lowest percentage of adults ever using illicit drugs in Idaho was 23.4% in 2012, and the highest in 2013 at 25.1%.

Other Drug Crime

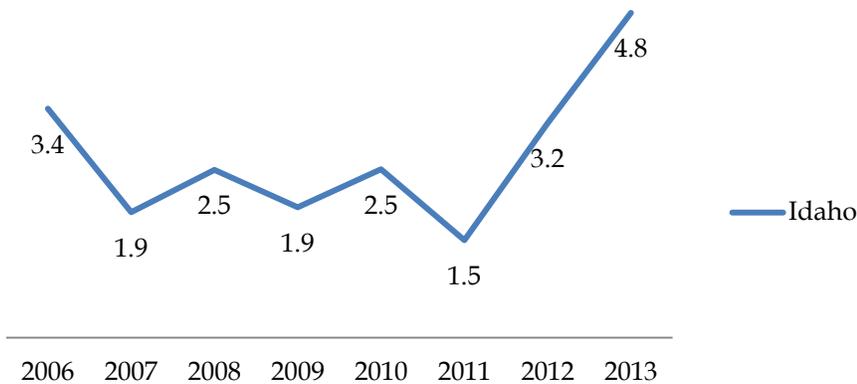
Table 13: Crime Related to Other Drugs Construct

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

Other drugs are considered all illicit drugs other than prescription medication and marijuana.

Figure 37.

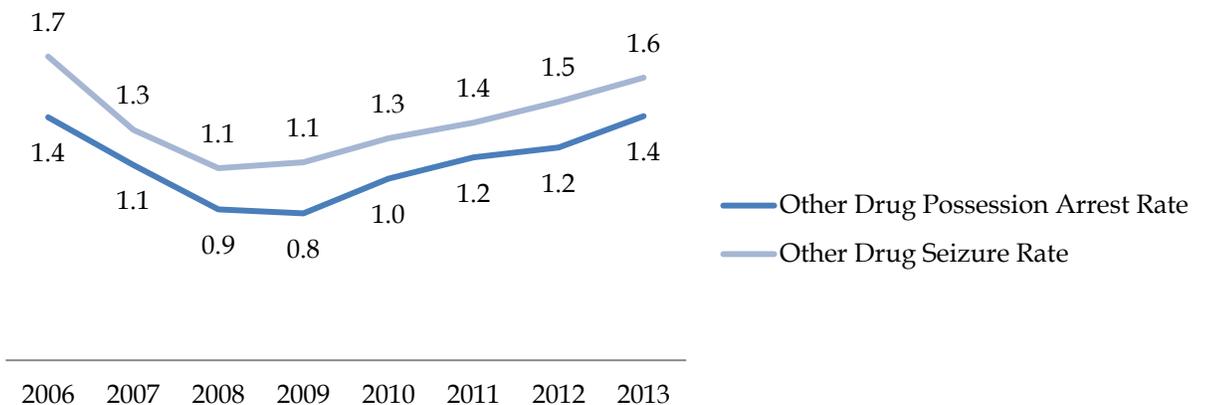
Other drug trafficking (arrest rate per 100,000 population) has increased over the years.



Between 2006 and 2013, the lowest other drug trafficking arrest rate was 1.5 per 100,000 population in 2011, and the highest in 2013 at 4.8 per 100,000 population.

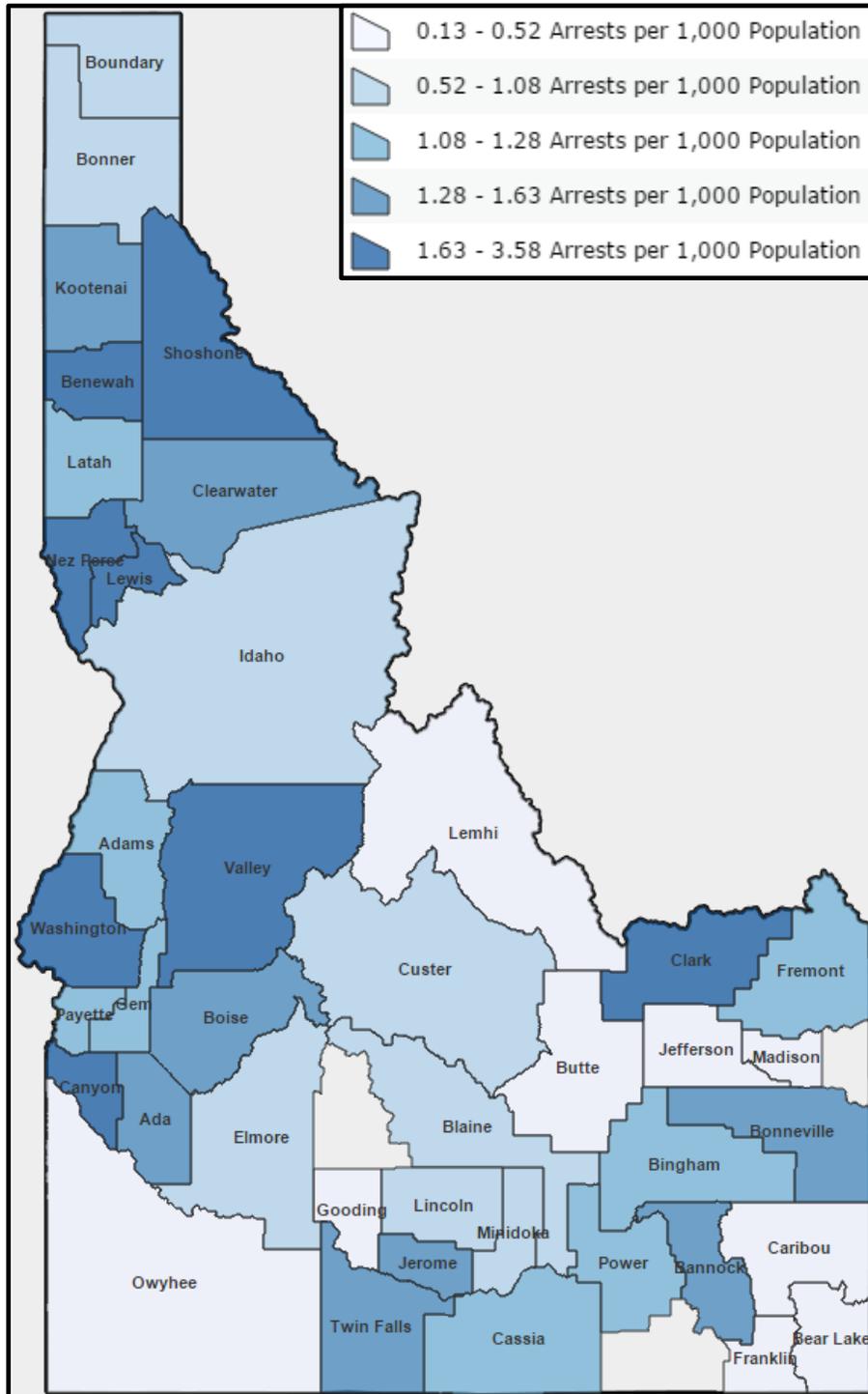
Figure 38.

Other drug possession arrests and seizures (rate per 1,000 population) have increased over the years.



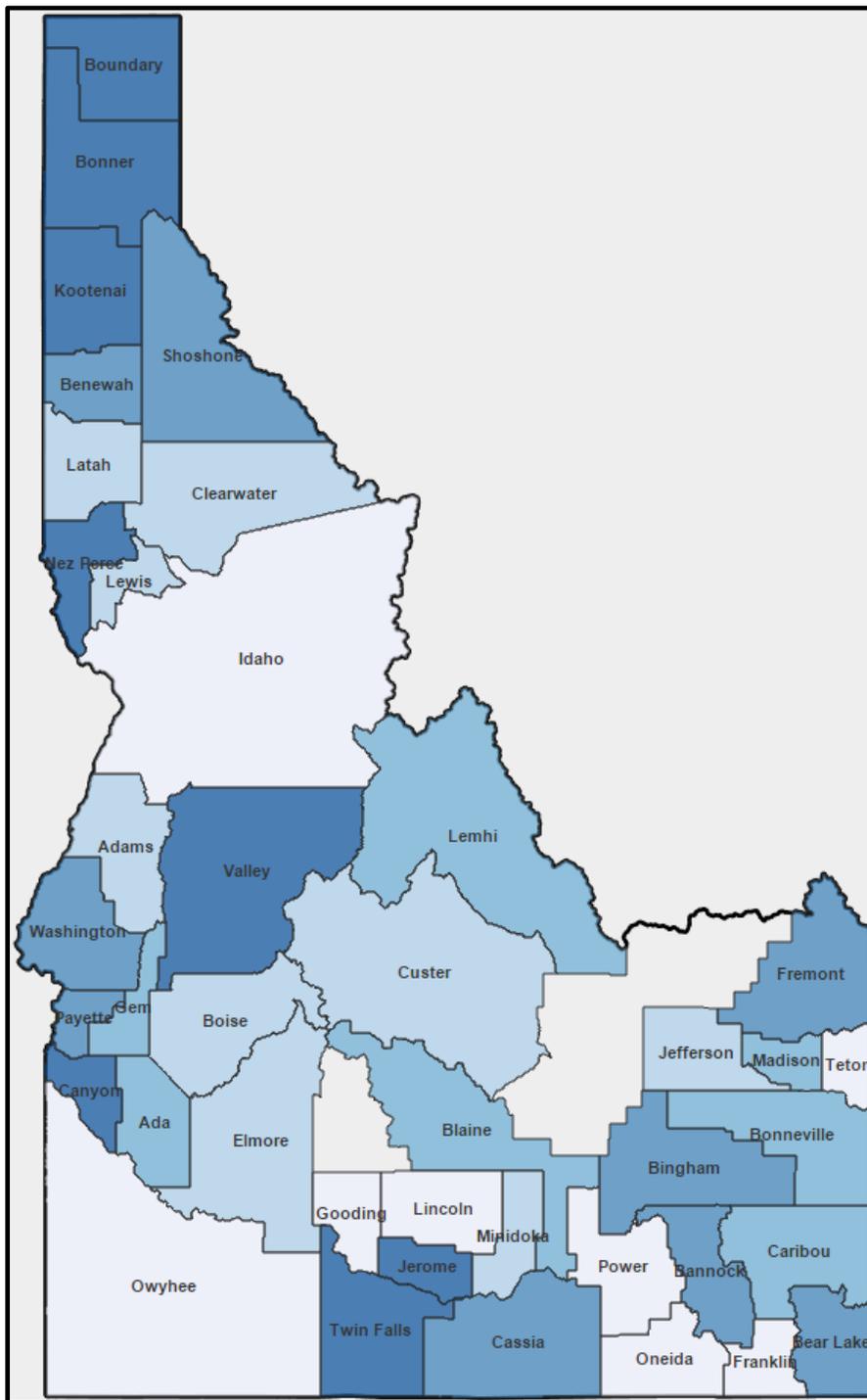
After a decline, other drug possession arrests and other drug seizures have increased. The lowest rate of other drug seizures was 1.1 per 1,000 population in 2008, and the highest was in 2006 at 1.75 arrests per 1,000 population. The lowest rate of other drug possession arrests was 0.84 per 1,000 population in 2009, and the highest was in 2013 at 1.40 arrests per 1,000 population.

Figure 39: Drug Equipment Violations Arrest Rate per 1,000 population: 2013



According to the Idaho Statistical Analysis Center, the drug equipment arrest rate for Idaho in 2013 was 1.6 per 1,000 population. Camas County, Teton County, and Oneida County did not have any drug equipment arrests in 2013. The counties with the lowest drug equipment arrest rates per 1,000 population were Lemhi County (0.13), Gooding County (0.20), and Franklin County (0.23). The counties with the highest drug equipment arrest rates per 1,000 population were Clark County (3.58), Lewis County (2.80), and Washington County (2.47). Both Clark County and Lewis County had significantly higher drug equipment arrest rates than state as a whole.

Figure 40: Drug/Narcotic Violations Arrest Rate per 1,000 population: 2013



According to the Idaho Statistical Analysis Center, the drug narcotic arrest rate for Idaho in 2013 was 4.7 per 1,000 population. Camas County, Butte County, and Clark County did not have any drug/narcotic arrests in 2013. The counties with the lowest drug/narcotic arrests rates per 1,000 population were Power County (0.77), Owyhee County (0.96), and Lincoln County (0.96). The counties with the highest drug/narcotic arrest rates per 1,000 population were Kootenai County (6.73), Twin Falls County (6.11), and Valley County (5.99). Kootenai County had a significantly higher drug/narcotic violation arrest rate than state as a whole.

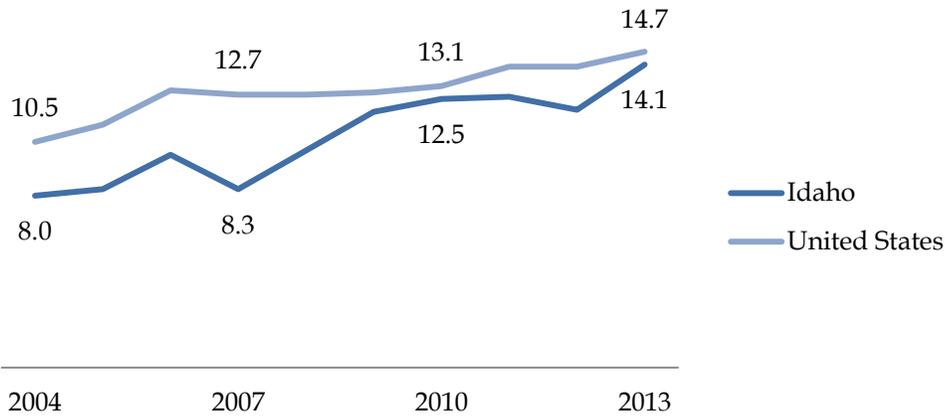
Other Drug Outcomes

Table 14. Other Drug Outcomes

Other Drug Consumption		
Construct	Indicator	Source
Use	Drug-induced mortality rate per 100,000 population	VS
	Primary substance of use upon treatment entry, 2014	TEDS
	Primary substance of use upon treatment entry, 2002-2014	TEDS

Figure 41.

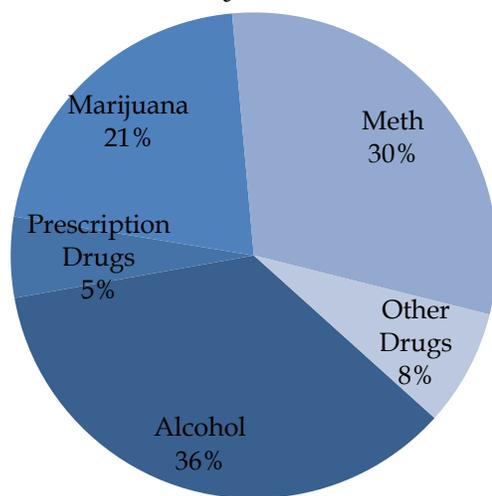
Drug-induced mortality (rate per 100,000 population) is slightly lower than the national rate, but over the years the difference has diminished.



Between 2004 and 2013, the drug-induced mortality rate has increased, with the rate in Idaho consistently lower than that of the United States as a whole. The lowest drug-induced mortality rate in Idaho was 8 per 100,000 population in 2004, and the highest in 2013 at 14.1 per 100,000 population. Nationally, the lowest drug-induced mortality rate was also in 2004 at 10.5 per 100,000 population and highest also in 2013 at 14.7 per 100,000 population.

According to the Idaho Department of Health and Welfare Division of Behavioral

Figure 42. Primary Substance Upon Treatment Entry in Idaho, 2014



Health, there were 7,054 substance abuse treatment admissions in 2014. Alcohol was the single most often reported primary substance of abuse upon treatment entry at 35.5%.

Methamphetamine was reported as the primary substance of abuse for 30.3% of individuals, and marijuana was reported for 21%. "Other drugs" accounted for the remaining 8% of treatment admissions

and included heroin (5.2%), other (0.7%), cocaine/crack (0.5%), not reported (0.4%), other amphetamines (0.4%), club drugs (0.2%), over-the-counter medications (0.1%), other hallucinogens (0.1%), inhalants (0.1%), and non-prescription methadone (0.1%).

The remaining 5% of individuals reported prescription drugs as a primary substance of abuse upon treatment entry and included other opiates/synthetics (4.1%), oxycodone (0.8%), benzodiazepines (0.2%), barbiturates (0.2%), hypnotics/other sedatives (0.1%), other stimulants (<0.1%), and other tranquilizers non-benzodiazepines (<0.1%).

Table 15.

The primary substance reported for treatment admission (rate per 100,000 population) in Idaho has changed throughout the years.

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2014
Alcohol	128	200	202	240	148	189	213	85	121	162	153
Methamphetamine	73	191	201	240	217	131	127	86	89	119	131
Marijuana	65	120	110	142	105	149	148	89	108	126	91
Non-Heroin Opiates	4	13	11	20	17	22	28	25	28	37	21
Cocaine	3	6	6	8	8	8	8	4	2	3	2
Heroin	2	6	4	7	10	8	13	10	9	13	22

Due to the changes in the TEDS data management system, figures from 2014 cannot be reliably compared to data before 2012. Data from 2013 is missing due to the transition in data management systems. The data from 2002 to 2012 were obtained from the TEDS online state reports, whereas the data from 2014 were received from the Department of Health and Welfare Division of Behavioral Health.

In Table 10, non-heroin opiates include codeine, hydrocodone, hydromorphone, meperidine, morphine, opium, oxycodone, pentazocine, propoxyphene, tramadol, and any other drug with morphine-like effects. Non-prescription use of methadone is not included.

Consistently, alcohol, methamphetamine, and marijuana are the three most often reported primary substances of abuse upon treatment entry in Idaho. Despite an increase in non-heroin opiate admissions between 2002 and 2012, it appears that treatment admission for this particular substance has decreased; however, the definition could be slightly different as a result of the transition between data systems. Conversely, heroin as a primary substance of abuse upon treatment entry has increased. In 2014, the rate of heroin admissions surpassed admissions for non-heroin opiates.

Alcohol

Consumption

- ❖ The rate of alcohol consumption among the AI/AN population is not significantly different than their non-AI/AN counterparts in Idaho, according to data from the IYPS and the BRFSS.
- ❖ Although overall alcohol consumption is similar among AI/AN as non-AI/AN populations, AI/AN 6th-12th grade students are more likely to drink liquor when compared to all 6th-12th grade Idaho students, 11.6% versus 8.9%, respectively (IYPS, 2014)
- ❖ AI/AN 6th-12th grade students were no more likely to binge drink when compared to all 6th-12th grade Idaho students (IYPS, 2014).

Perception

- ❖ According to the Idaho Youth Prevention Survey in 2014, a higher percentage of AI/AN youth in grades 6-12 believe there is no risk in drinking alcohol compared all 6th-12th grade Idaho students, 15.3% versus 8.9%, respectively.
- ❖ Additionally, AI/AN youth are significantly more likely to report binge drinking as possessing no risk when compared to all 6th-12th grade Idaho students, 9.5% versus 5.5%, respectively (IYPS, 2014).

Mortality

- ❖ According to the Northwest Portland Area Indian Health Board, among Idaho, Washington, and Oregon between 2006 and 2009, 4.9% of AI/AN died of chronic liver disease and cirrhosis compared to 1.4% of Whites.
- ❖ According to the Idaho Department of Health and Welfare- Bureau of Vital Statistics, between 2009 and 2013, the age adjusted alcohol-induced mortality rate for AI/AN populations in Idaho was 54.8 per 100,000 population, compared to 11.7 for the state as a whole.
- ❖ In Idaho between 2011 and 2013, Native Americans had a higher chronic liver disease and cirrhosis mortality rate (51.1 per 100,000 populations) than Hispanics (10.9) or Whites (10.8) (CDC Health Data Interactive National Vital Statistics System).

Drinking and Driving

- ❖ According to data from the Idaho Statistical Analysis Center (ISAC), between 2009 and 2013, the DUI arrest rate among AI/AN was 908.9 per 100,000 population per year in Idaho compared to 621.8 per 100,000 for the state as a whole.
- ❖ In 2014 in Idaho, AI/AN 6th-12th grade students were the most likely of any racial/ethnic group to ride in a vehicle or motorcycle driven by someone who had been using alcohol or drugs (27.7%) compared to 18.8% of all Idaho students in the same age group (IYPS).
- ❖ In 2014 in Idaho 7.7% of AI/AN 6th-12th grade students reported driving a vehicle or motorcycle after using alcohol or drugs compared to 6% for individuals in the same age group in the state (IYPS).

Marijuana

Consumption

- ❖ In 2014 in Idaho, 11.6% of AI/ AN students in 6th-12th grade smoked marijuana in the past 30 days compared to 8.9% of all 6th-12th grade students in the state (IYPS).

Perception

- ❖ According to the IYPS in 2014, a higher percentage of AI/ AN youth in grades 6-12 in Idaho believe there is no risk in using marijuana compared to the average for all 6th-12th grade students in the state, 22.3% versus 15.5%, respectively.

Prescription Drugs

Consumption

- ❖ In 2014, AI/ AN students in 6th-12th grade in Idaho were significantly more likely to use prescription drugs not prescribed to them such as Ritalin, Adderall, or Xanax in the past 30 days (2.8%) compared all 6th-12th grade students in the state (1.8%) (IYPS).
- ❖ In 2014, AI/ AN students in 6th-12th grade in Idaho were significantly more likely to use prescription painkillers not prescribed to them such as Vicodin, OxyContin, or Percocet in the past 30 days (4%) compared all 6th-12th grade students in the state (2.2%) (IYPS).

Perception

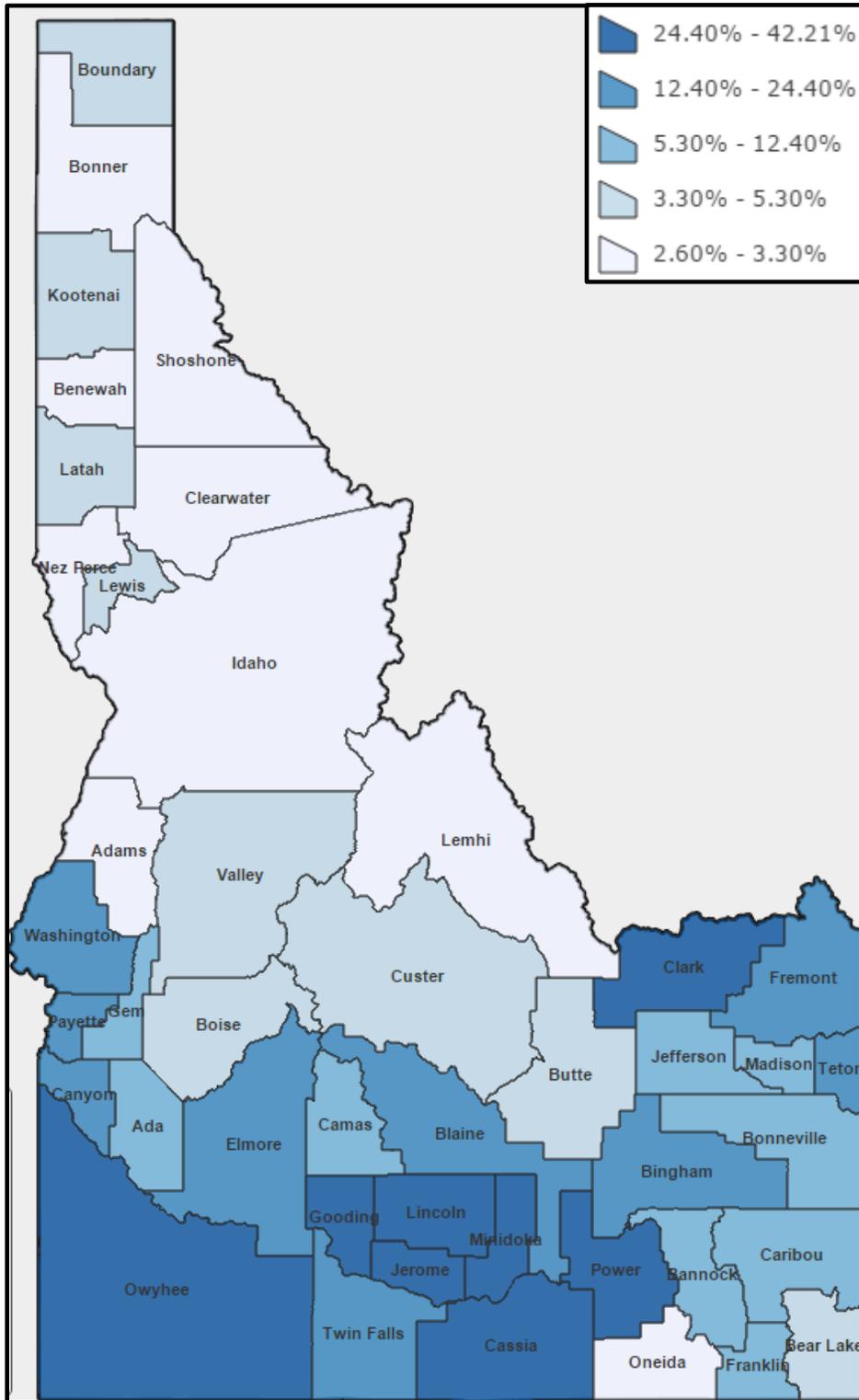
- ❖ According to the IYPS in 2014, a significantly higher percentage of AI/ AN youth in grades 6-12 in Idaho believe there is no risk in using prescription drugs not prescribed to them compared to the average for all 6th-12th grade students in the state, 15.7% versus 9.3%, respectively.

Mortality

- ❖ According to Idaho Department of Health and Welfare- Bureau of Vital Statistics, between 2009 and 2013 in Idaho, the age adjusted drug-induced mortality rate for AI/ AN populations in Idaho was 25.4 per 100,000 population, compared to 13.2 per 100,000 population for the state.
 - Although not all drug-induced mortality is a result of prescription medication, according to the Centers for Disease Control and Prevention in 2011, prescription medication is responsible for more deaths than heroin and cocaine combined.

Hispanic/Latino

Figure 44. Percent Hispanic/Latino, 2013



Population

According to the Census Bureau estimates for 2013, 190,315 Idahoans reported being Hispanic or Latino, making up a 11.8% the population. Approximately 17.1% of United States population report being Hispanic.

Figure 44 shows the percentage of Idaho’s population that reported being Hispanic or Latino in 2013 by county. The counties with the highest percentage of the population being Hispanic or Latino were Clark County (42.2%), Minidoka County (33%), and Power County (31.1%). The counties with the lowest percentage of the population that reported being Hispanic or Latino were Bonner County (2.6%), Lemhi County

(2.9%), and Idaho County (3%). Clark County had a significantly higher percentage of the population reporting being Hispanic or Latino than the state as a whole.

Alcohol

Consumption

- ❖ Hispanic youth in grades 6-12 were significantly more likely than to have drunk alcohol in the past 30 days compared to the average for all 6th-12th grade students in the state, 22.9% versus 18.2%, respectively (IYPS, 2014).
- ❖ According to the YRBS in 2013, Hispanics were significantly more likely to have their first drink of alcohol before age 13 (25%) when compared to White students (13%).
- ❖ According to the IYPS in 2014, Hispanic 6th-12th grade students were significantly more likely to report binge drinking in the previous 30 days when compared to the average for all 6th-12th grade students in the state, 32.8% versus 30%, respectively.
- ❖ Between 2009 and 2013, Hispanics were arrested for drunkenness at a higher rate than Non-Hispanics, 48.1 versus 22.1 per 100,000 population, respectively, according to data from the ISAC.

Perception

- ❖ Hispanic students in grades 6-12 were significantly more likely to report that binge drinking and casual drinking possess no risk, 7.5% and 9.4% respectively, when compared to the average for all 6th-12th grade students in the state, 5.5% and 7%, respectively.

Mortality

- ❖ The alcohol-induced mortality rate for Hispanics/Latinos does not differ from non-Hispanics/Latinos. According to Idaho Department of Health and Welfare-Bureau of Vital Statistics, between 2009 and 2013 in Idaho, the age adjusted alcohol-induced mortality rate for Hispanic/Latino populations was 11.3 per 100,000 population, compared to 11.7 for the state.

Drinking and Driving

- ❖ In 2014 in Idaho, Hispanic 6th-12th grade students were the most likely of any racial/ethnic group to drive a vehicle or motorcycle after using alcohol or drugs (7.8%) compared to 6% of all Idaho students in the same age group (IYPS, 2014).
- ❖ In 2014 in Idaho 24.1% of Hispanic 6th-12th grade students reported riding in a vehicle or motorcycle driven by someone who had been using alcohol or drugs compared to 18.8% for all 6th-12th grade students in the state, on average (IYPS, 2014).

Marijuana

Consumption

- ❖ In 2014 in Idaho, 13.2% of Hispanic students in 6th-12th grade smoked marijuana in the past 30 days compared to 8.9% of all 6th-12th grade students in the state (IYPS).

Perception

- ❖ According to the IYPS in 2014, a higher percentage of Hispanic youth in grades 6-12 in Idaho believe there is no risk in using marijuana compared to the average for all 6th-12th grade students in the state, 19.4% versus 15.5%, respectively.

Prescription Drugs

Consumption

- ❖ In 2014 in Idaho, Hispanic students in 6th-12th grade were no more likely to report using prescription drugs in the past 30 days than other students in Idaho in the same age group (IYPS).

Perception

- ❖ According to the IYPS in 2014, a significantly higher percentage of Hispanic youth in grades 6-12 in Idaho believe there is no risk in using prescription drugs not prescribed to them compared to the average for all 6th-12th grade students in the state, 11.7% versus 9.3%, respectively.

Mortality

- ❖ According to the Bureau of Vital Statistics from 2009-2013, the age adjusted drug-induced mortality rate for Hispanics in Idaho was lower, 6.1 per 100,000 population, than Non-Hispanics in the state, 13.2 per 100,000 population.

Data Gaps & Limitations

Survey Data

Idaho struggles to collect indicators that directly describe and measure substance abuse rather than aspects related to usage. Among other issues, self-report data has often been deemed somewhat unreliable, especially in a state with a demographic as diverse as Idaho's. Statistical modeling assumes a certain degree of homogeneity that simply is not present. This, coupled with low funding levels set aside for assessment, results in small sample sizes with questionable validity. As a result, the SEOW attempted to use capacity measures as a substitute for reliable survey data. However, in the future, efforts may be undertaken to expand the sample sizes on the NSDUH, BRFSS and YRBS to remedy this issue.

Additionally, ODP has added questions to the BRFSS regarding the three priority areas, underage alcohol use, marijuana use, and prescription drug abuse. The questions will be added to the 2015 BRFSS, with data available in 2016. As of 2015, the BRFSS will no longer broadly ask adults about illicit drug usage.

Despite the SEOW's goal of gathering ongoing data using the IYPS to report at the county-level, the sample size fell below the threshold of generalizability. However, state-level and regional-level data is considered representative.

In some cases, issues regarding validity of the data may be remedied by aggregating data by region; however, it creates additional complications. 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. Because only some of Idaho's counties are demographically similar to those counties that adjoin them, mean regional scores can mischaracterize trends occurring in the rural and frontier counties that represent the majority of the state's land mass.

Administrative Data

There are gaps in the administrative data reporting that would provide a more robust analysis of needs in Idaho. Idaho lacks a hospital discharge database. In many states, a discharge database is the major source of morbidity indicators.

Another challenge of administrative databases is that fluctuations in budgets can result in discrepancies in the resulting data. Quite simply, treatment services are underfunded. Similar complications can be found with DUI related data. Often, local authorities will receive extra funds for patrols, leading to a spike in arrests. Therefore, the indicator is not as reflective of a growing DUI problem as one may suspect.

Setting boundaries for administrative databases is a persistent issue. Beyond education, few partner agencies use the same administrative regions. While regions normally do not vary to a large degree, there is enough variance that direct comparisons are cumbersome and often unreliable.

Subpopulations

As earlier noted, Idaho has a relatively small population. Once segmented to any degree by any means geographically or demographically, occurrences are magnified a great deal. Due to the statistical complications small sample sizes create, the SEOW felt compelled to be sensitive to the cultural implications that documenting questionably relevant subpopulation data may create.

Due to a high degree of variance created by small denominators, the determination was made that not all data should be published. From an ethical perspective it would be irresponsible to do so and may only serve to create confusion. The subpopulation data is maintained by the SEOW and may be used on a case-by-case basis with appropriate cultural sensitivity. For the data regarding AI/AN and Hispanic/Latino populations, only differences that were statistically significant at an alpha level of 0.05 were reported, unless otherwise noted.

Due to a lack of surveillance infrastructure regarding sexual orientation, data regarding individuals who identify as lesbian, gay, bisexual, or transgendered (LGBT) are not included in this needs assessment. It has been documented in the literature that LGBT populations may disproportionately suffer from alcohol- and drug-related consequences when compared to non-LGBT populations; however, it is not clear if this is case with the quantitative data sources available in Idaho. In 2015, the BRFSS contained modified, more targeted questions regarding not only gender identity, but also sexual preference, allowing for a more detailed analysis in the future.

Alcohol- and drug-related consequences are difficult to obtain by veteran status. ODP has not received arrests, mortality, or treatment data by veteran status. As with LGBT

populations, it has been documented that veterans are at particular risk for substance use and abuse issues. In the future, it is the hope of the SEOW that more robust data sources may be available.

Conclusion

Many alcohol-related indicators have been generally decreasing or are stable. Alcohol-related motor vehicle crashes and DUI arrest are down, and although, alcohol-related motor vehicle fatalities have been very sporadic over the years, they seem to be decreasing. Despite this, liquor sales per capita and alcohol-related death rates, including alcoholic liver mortality rates, which seem to contribute to most of the alcohol-related deaths in Idaho, are increasing.

All tobacco indicators have been generally decreasing or stable except for lifetime adult smokeless tobacco use rates, which are increasing and continue to be higher than the national average. Despite the progress prevention efforts have made in cigarette smoking in Idaho, e-cigarette use and vaporizing are seemingly prevalent. Currently, Idaho lacks adequate vaping surveillance data. The BRFSS and YRBS have both added questions regarding this issue for 2015.

As stated previously in this report, there is not enough robust data to divide the prescription drug construct into consumption and consequence due to the lack of state-level data. As such, the data regarding prescription drug usage in Idaho is seemingly contradictory. Prescription drug seizures are on increasing, yet past year non-medical use of prescription pain relievers is down for adults. Additionally, according the YRBS, prescription drug abuse among high school students was 20.1% in 2011 and 16.3% in 2013. One potential explanation is that since seizures have increased, the supply has decreased, leading to a decrease in usage over the past few years. Another hypothesis is that heroin usage is replacing prescription drug usage as prevention efforts have become more robust. However, since data sources are limited, these hypotheses cannot be thoroughly investigated. It is the hope that in the future, the BRFSS data regarding prescription medication can shed light on the topic.

Similarly, there is limited data regarding marijuana consumption and consequences in Idaho. With the limited data available in this report, the indicators for marijuana-related consequences have increased, but usage among youth has not, as of 2013. Marijuana possession arrests and seizures have increased, and since 2009, marijuana trafficking arrests have more than quadrupled in the state. With marijuana legalization in neighboring states, Oregon and Washington, Idaho is likely to see an increase in all marijuana-related indicators. To understand the true prevalence in Idaho, ODP has added questions to the BRFSS regarding marijuana use in Idaho.

For other drugs, consumption indicators have stayed relatively constant, yet all consequence indicators have increased. Other drug trafficking arrest rates have increased more than 3.5 times since 2011. Correspondingly, other drug possession arrest rates and seizures have almost doubled since 2009.

Next Steps

Workgroups

Coordinating substance abuse prevention efforts will be Idaho's next step. The Office of Drug Policy has begun organizing regular meetings for workgroups tasked with organizing prevention efforts for each priority area. The Prescription Drug Workgroup, the Alcohol Workgroup, and the Marijuana Workgroup are composed of experts in each respective topic area ranging from law enforcement to physicians.

The first step of the SPF is Assessment, and as such, each workgroup has begun to more deeply assess their respective priority. More detailed information regarding each priority area has become well-defined as each respective workgroup has completed a logic model, documenting problem statements, root causes, and local conditions.

Following the SPF in the coming year, the workgroups will begin assessing capacity, plan, implement, and evaluate their efforts, demonstrating cultural competence and building sustainability throughout.

Emerging Trends

In addition to developing workgroups for our current priority areas, the SEOW will continue to remain vigilant regarding emerging trends. Trends in drug use are continuously changing based on various contributing factors, such as price, regulation, availability, politics, and manufacturing. Unfortunately, administrative data reporting takes time and can be slow to catch up to current circumstances. For that reason, throughout the next year, the SEOW will discuss ways to measure emerging trends in Idaho.

The SEOW will review the process for selecting priorities to confirm appropriate use of resources to combat substance abuse in the state. Preliminary data indicates that heroin use may be emerging as a threat in Idaho, and the SEOW and the Office of Drug Policy plan to remain vigilant.

Appendices

Appendix A: Glossary of Acronyms

ARCOS	Automation of Reports and Consolidated Orders System
ATOD	Alcohol, Tobacco & Other Drugs
BRFSS	Behavioral Risk Factor Surveillance System
CSAP	Center for Substance Abuse Prevention
DHW	Department of Health & Welfare
IBRS	Incident Based Reporting System
ISAC	Idaho Statistical Analysis Center
ISLD	Idaho State Liquor Division
ITD	Idaho Transportation Department
IYPS	Idaho Youth Prevention Survey
NSDUH	National Survey on Drug Use and Health
ODP	Office of Drug Policy
PIRE	Pacific Institute for Research and Evaluation
SEOW	State Epidemiological Outcome Workgroup
SPF	Strategic Prevention Framework
SIG	State Incentive Grant
TEDS	Treatment Episode Data Set
VS	Vital Statistics
YRBS	Youth Risk Behavior Survey

Appendix B: Final Indicator Table

Constructs and Indicators			Criteria					
Constructs	Indicators	Sources	Community or Regional Collection	Five Years of Data Available	Subpopulation 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
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 Consequences								
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

Appendix B: Final Indicator 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 100,000	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 marijuana 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 100,000	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 are readily available to Idaho Supreme Court staff	All convictions of possession and trafficking offenses in Idaho	ISTARS records are not 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. There is a high level of consistency in the way convictions are entered.	1995-Present. Data are readily retrievable from the county databases, and data is entered within days of the conviction	Compares conviction trends by time (years or months) or geography (region or county)	Fluctuations in conviction are not dependent on crime. Shifts in political climate, prosecutorial practices, or statutory changes can influence ISTARS reporting.
RMPDC	Poisonings	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 Database 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) (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% 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	Lung cancer, emphysema, cardiovascular disease, and other 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 - 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.	Death certificates were revised in 2003 and some data prior to 2003 are not comparable with data thereafter

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							
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.	1999-2012 (annual) NCHS defined drug-induced deaths based on ICD-10. The 10th revision of the International Classification of Diseases (ICD-10) took place in 1999.	Changes in mortality rates over time by age group, gender, race and ethnicity.	Drug-induced mortality includes deaths due to natural causes, accidental overdose, suicide, homicide, and undetermined external causes. Drug-induced deaths divided into prescription or non-prescription induced death. Approximately 35% of death certificates do not report type of drug(s) involved in the death. Accidental deaths such as motor vehicle accidents with drugs involved are not included.
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.	1999-2012 (annual) NCHS defined alcohol-induced deaths based on ICD-10. The 10th revision of the International Classification of Diseases (ICD-10) took place in 1999.	Changes in mortality rates over time by age group, gender, race and ethnicity.	Alcohol-induced mortality includes deaths due to natural causes, accidental overdose, suicide, homicide, and undetermined external causes. Accidental deaths such as motor vehicle accidents with alcohol involved are not included.
DHW-VS	Morbidity, oral and lung cancer	Chris Johnson, Cancer Data Registry of Idaho, cjohnson@teamidaho.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)	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 contracted cancer.

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							
BRFSS	Alcohol use, tobacco use, and illicit drug use	Chris Murphy, Behavioral Risk Factor Surveillance System Program Director, murphyc@dhw.idaho.gov . Web: www.healthstatistics.idaho.gov .	Prevalence rates for Idaho adults	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 surveys adults estimate the prevalence of risk factors for major causes of morbidity and mortality in the United States.	New methodology began in 2011 with the inclusion of cell phones in the survey sample. Data after 2011 are not comparable with data prior to 2011.	Trends for 2001-2010 and 2011-2013. Data are available by gender, age group, education, employment, income, and ethnicity	Data is self-reported. Alcohol use is defined as having had at least one drink of alcohol in the past 30 days. Binge drinking is defined as consuming 5+ drinks for males and 4+ drinks for females during one occasion in the past 30 days. Heavy drinking defined as consuming 60+ drinks for males 30+ drinks for females in the past 30 days. Smoking is defined as having smoked at least 100 cigarettes in one's life. Current smoking is defined as having smoked at least one cigarette in the past 30 days. Before 2014, the BRFSS did not distinguish between types of illicit drugs. Youth are not included in the survey.
IBRS	Crime	Idaho Statistical Analysis Center (ISAC) http://www.isp.idaho.gov/CrimeInIdaho2/toQuery.action Idaho State Police Bureau of Criminal Identification (BCI) http://www.isp.idaho.gov/BCI/ucr/crimeinidah2012.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 report to the Idaho State Police repository. ISP provides an online web application by the ISAC and yearly publication by BCI. 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 are not a perfect reflection, but rather notes pill seizures. Also, the data are a reflection of police activity and not a true indicator of consumption or consequences throughout the state.

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							
iCARE	Child welfare	Sarah Siron, Division of Family and Community Services, siron@dhw.idaho.gov	Child welfare workers enter case information into iCARE 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	Compares 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	Violence and discipline in schools	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.
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.

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							
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, which is an online reporting and analysis system for the Idaho Statewide Crash Database. Data are provided to any governmental or non-profit agency. Data is also available on the OHS website at www.itd.idaho.gov/ohs	Reportable crashes include all unintentional motor vehicle crashes that occur on a public roadway and result in an injury or more than \$1,500 in property damage. 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 database was provided to each agency, as per Idaho Statute 49-1307. The crash data have been evaluated and changes were implemented in 1997 and 2011.	1987 to present. As of 2010, all eIMPACT crash reports are transmitted electronically to the OHS upon completion of the crash investigation. The reports are available but incomplete in WebCARS the day after data are received. The information is checked for accuracy before the report is completed in CIRCA. There is a 2-3 month delay in completing the data.	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. Compares crash trends by time (years or months) or geography (regions or counties)	Crashes not meeting the reportable criteria are entered in the database as non-reportable. Data is not checked for accuracy for these reports. There is no consistency to which these reports are transmitted to the OHS.
NSDUH	National Survey on Drug Use and Health	https://nsduhweh.b.rti.org/	The National Survey on Drug Use and Health is an annual nationwide survey 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 from SAMHSA's Center for Behavioral Health Statistics and Quality (CBHSQ).	A 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 in sampling and sampling inconsistencies.

Appendix D: 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						
Tobacco Consumption								
Use	Percent of students in grades 9-12 that smoke 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						

Appendix D: Priority Setting Score Sheet of Final Indicators

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