Millennium Fund Grant Proposal

Prevention/Cessation/Treatment

For the Period July 1, 2016 through June 30, 2017

The Idaho Legislature appropriates funding from the Idaho Millennium Fund to eligible applicants who provide services that help individuals to never start, to quit, or to receive treatment for, tobacco or substance use. This process begins with a submitted application to the Joint Legislative Millennium Fund Committee. Applicants that are awarded a Millennium Fund Grant must then submit an annual report detailing the project, and any outcomes and expenses. Please contact Jared Tatro, Legislative Services Office, with any questions at (208) 334-4740 or email jtatro@lso.idaho.gov.

<Project Title Goes Here>

I. Grant Applicant

Full Legal Organization Name	**<name>**
Address	<address>
City	<city>
State	<state>
Zip Code	<zip>
Website	<website>

Primary Grant Applicant Contact Person

Name	<name>
Title	<title>
Phone	<phone>
Email Address	<email address>

Alternate Grant Applicant Contact Person

Name	<name>
Title	<title>
Phone	<phone>
Email Address	<email address>

Organization's Executive Director

Name	<name>
Title	<title>
Phone	<phone>
Email Address	<email address>

Organizational Description: <replace this with own text>

II. Grant Proposal Summary

Meets One or More of the Following Criteria: *(Indicate Yes Where Applicable)*

1. Tobacco Cessation or Prevention
2. Vaping/E-Cigarette Cessation or Prevention
3. Substance Abuse Cessation or Prevention
4. Tobacco or Substance Abuse Treatment

Purpose of Grant: <replace this with own text>

III. Proposed Budget

<Include a brief budget scenario that describes the total personnel Costs, total Operating Expenditures, and total Capital Outlay costs for the grant. Explain the highlights of the budget and any other important pieces of the budget that you would like to draw attention to.

The Proposed Budget should be completed in the separate Excel file that is provided on the Millennium Fund Website. Please fill in all cells. If your organization does not or will not have expenditures for a specific category, please enter a zero (0) in that cell. You can add additional rows and columns for additional clarity, but do not delete unnecessary rows.

Your budget should include all personnel, operating and capital outlay requested expenditures that relate to the Millennium Fund Grant Application only. In the far right column labeled Organization Total, include all personnel costs, operating expenditures, and capital outlay costs for your organization. Be sure to not double count the Millennium Fund Grant Request.

Budget Notes:

Personnel Costs: *<Replace the following text with summary-level information from your prepared budget. Include all dollars that will be spent on personnel related to the implementation of the Millennium Fund Grant. This includes agency or organization staff that have been, or will be, directly hired by the organization to implement/oversee the grant. This also includes any contracted employees and consultants that are hired to implement or oversee the grant. Be sure to separate out the salary from the benefits and include the number of "bodies" that will be working on the grant in the Number of Staff cells, and include the total estimated hours that staff (directly hired or contract) will be applying toward implementation and oversight of the grant.>*

Operating Expenditures: *<Replace the following text with summary-level information from your prepared budget. Include all dollars that will be spent on expenditures related to the operations of the organization and implementation of the grant not previously listed in Personnel Costs, or to be listed in Capital Outlay Costs. This includes travel costs (hotel, rental cars, airfare, etc.), building rent, utilities, and insurance. Also include a breakdown of marketing and advertising costs related to the Grant and any organization overhead that is included in the grant request, but not counted elsewhere. Include the estimated expenditures related to program evaluations. This can be for internal evaluations or for an outside entity that was hired to evaluate the program; be sure to not double count these costs. Include a listed breakdown of all "other" miscellaneous costs; these costs should not exceed 5% of the total operating budget.>*

Capital Outlay: *<Replace the following text with summary level information from your prepared budget. Capital Outlay and other equipment purchases should be separated out into comparable categories including computers, laptops, printers, cell phones, projectors, furniture, etc. Add rows as needed to meet the needs of your grant application.>*

Transfers & Sub-Grants: *<Replace the following text with summary level information from your prepared budget. Include requested information on the funds that will be contracted out to another entity, as well as any funds that will be sub-granted to another entity. Requested information includes the name of the entity, amount, and how this pass through of funds will meet the intent of the grant award.>*

***Grant Amount Requested (should tie to budget file)*: $<amount>**

IV. Statement of Need

<*Replace with your own text:* The Statement of Need should describe the problem that the proposed project will attempt to address, as well as the population that will be served. It should clearly set forth the rationale, or justification, for what is being proposed. Simply stating "tobacco/alcohol/drugs are bad" will not suffice for a justified statement of need. Further, your approach to address the problem should be established in evidence-based research. In addition, any supportive data and information verifying the magnitude of the problem should be incorporated, and why you require a grant to address this issue. Include literature and scientific references to support your request as described in section IX below. Make sure that the committee understands why this project should be considered.>

V. Project Design

<Describe the project and how you propose to implement it. Identify specific project goal(s) and objectives, how they will be achieved, how success or failure will be measured, and how the evidence-based processes will be incorporated. Include corresponding information on the desired outcome.>

VI. Grant Management

<Provide information on how this project will be generally managed. This may include information on the qualifications, responsibilities, tasks, and time commitments of key personnel associated with the project. It could also include a brief description of the history of your organization, its structure, information about office locations and partnerships that will be utilized in carrying out the activities of the grant proposal, relevant experience and organizational accomplishments, and an explanation of what makes your organization an appropriate grantee. In short, establish your credibility as a grant applicant.>

VII. Evaluation Plan

<Briefly explain what you want to learn about your program goals, outcomes, and process over the grant period. Include information on two or three primary evaluation questions you expect to answer, assessment methods and strategies you will use to answer your evaluation questions, how stakeholders will be involved in the evaluation process, and how you will use this information to improve desired outcomes. Include how you will be evaluating the program (i.e. surveys, phone calls, etc.) and who will

be conducting the evaluation. If an internal evaluation will be conducted then include relevant information on the staff member that demonstrates the ability to conduct the evaluation and what measures/tools will be used to determine success of the program. If an external evaluation is to be conducted, include who will be conducting the evaluation, what the cost of the evaluation will be, and the qualifications of the external entity, and what measures/tools will be used.>

VIII. Sustainability

<Clearly communicate your organization's plan and rationale for sustaining, expanding, replicating, or terminating the project once the grant period ends. **Information should also include a plan of how you will secure future funding to sustain the project over the long-term**. If the Millennium Fund is your organization's long-term plan for finances, then note why you are unable to secure funding (in-kind or direct dollars) from other sources.

IX. Evidence-Based Research

<Provide a maximum of three evidence-based sources that substantiate your methodology of cessation, prevention, or treatment. Sources should be listed in priority order with your strongest source listed as number 1. All sources should be evidence-based, timely, and from reputable sources, preferably medical institutions, accredited universities, or government-funded studies. Sources that simply state how tobacco/substance use is harmful will not be accepted. For purposes of this application you should include a valid web link, the title, author, publication date, and 3-4 sentences summarizing the research of each source. If a link to the study is not feasible, contact Jared Tatro for additional guidance.>

Idaho Millennium Fund Grant Application Budget — Fiscal Year 2017

	Millennium Fund Grant Application				
PERSONNEL COSTS	**Millennium Fund**	**Other Fund Sources**	**Project Total**	**In-Kind Contributions**	**Organization Total**
Organization Hired Staff					
Number of staff			**0.0**		
Est. Hours to be worked			**0.0**		
Salaries			**$0.00**		
Benefits			**$0.00**		
Contract Hired Staff					
Number of staff			**0.0**		
Est. Hours to be worked			**0.0**		
Salaries			**$0.00**		
Benefits			**$0.00**		
TOTAL PERSONNEL STAFF	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
TOTAL PERSONNEL HOURS	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
TOTAL PERSONNEL COSTS	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

OPERATING EXPENDITURES	**Millennium Fund**	**Other Fund Sources**	**Project Total**	**In-Kind Contributions**	**Organization Total**
Program Evaluation (not already counted)			**$0.00**		
Travel			**$0.00**		
Marketing			**$0.00**		
Advertising			**$0.00**		
Insurance			**$0.00**		
Rent/Bldg. Lease			**$0.00**		
Utilities			**$0.00**		
Organization Overhead			**$0.00**		
Lobbying Activities/ Organization Awareness			**$0.00**		
Materials & Supplies			**$0.00**		
Contracts (not already counted)			**$0.00**		
Employee Development/Training			**$0.00**		
Other*			**$0.00**		
* Other: <Include a written description of all "other" costs.>					
TOTAL OPERATING EXPENDITURES	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

EQUIPMENT/CAPITAL OUTLAY COSTS	**Millennium Fund**	**Other Fund Sources**	**Project Total**	**In-Kind Contributions**	**Organization Total**
Computers			**$0.00**		
Printers			**$0.00**		
Projectors			**$0.00**		
Furniture			**$0.00**		
Software			**$0.00**		
Other			**$0.00**		
TOTAL CAPITAL OUTLAY	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

PERSONNEL COSTS	Millennium Fund	Other Fund Sources	Project Total	In-Kind Contributions	Organization Total
TOTAL MILLENNIUM FUND BUDGET REQUEST	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

TRANSFERS TO OTHER ORGANIZATIONS/AGENCIES

<copy/paste new transfer rows as necessary>

Organization Name _____

Amount _____

Purpose <replace with own text, briefly explain why there will be a subgrant and how it will met the mission of prevention/cessation/treatment>

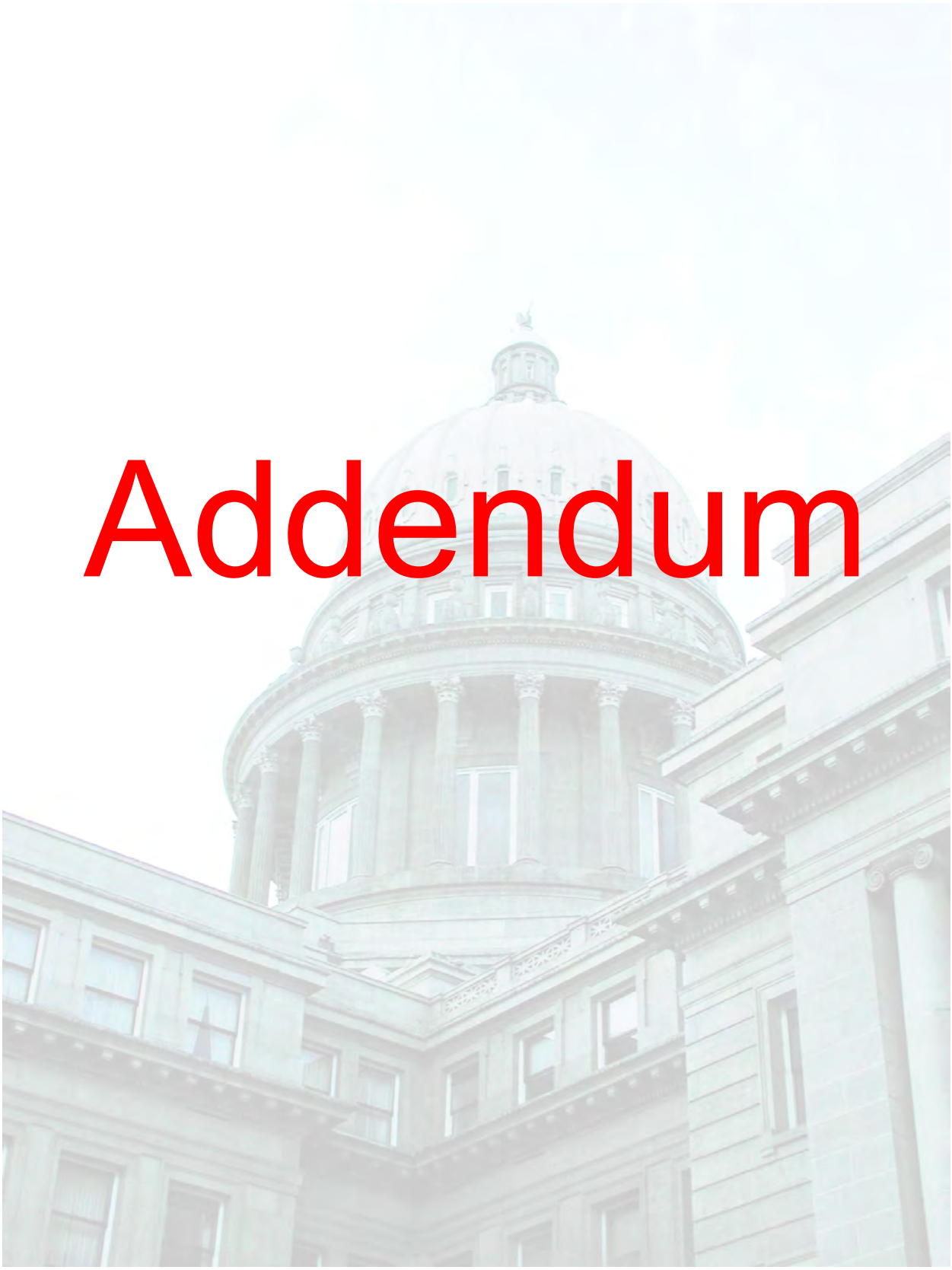
SUBCONTRACTING/SUBGRANTING INFORMATION

<copy/paste new sub-contract/grant rows as necessary>

Organization Name _____

Amount _____

Purpose <replace with own text, briefly explain why there will be a subgrant and how it will met the mission of prevention/cessation/treatment>



Addendum

American Lung Association: Youth Tobacco Prevention, Engagement, and Cessation
Millennium Fund Grant Proposal
For the Period July 1, 2016 through June 30, 2017
ADDENDUM

Regional Board of Directors and Idaho Leadership Council Members

Our regional Board of Directors is comprised of community leaders, business leaders, and medical professionals who meet regularly to provide governance and organizational leadership. They include:

- Mike Fenello, Idaho, Chair-Elect
- Donald Lojek, Idaho
- Patty Ginsburg, Alaska, Board Chair
- Ted Zurcher, Oregon, Immediate Past Board Chair
- John Coefield, Montana
- Anne Etter, Washington
- Virginia Hall, Oregon
- Julie Hasquet, Alaska
- Robert Merchant, M.D., Montana
- Tad Seder, Washington
- Sterling Yee, Hawaii
- Renee Klein, President and CEO, American Lung Association of the Mountain Pacific

Our Idaho ALA Leadership Council is comprised of community leaders who help extend awareness about lung health and expand our programmatic reach. They include:

- Susan Olson, Chair, AmeriBen
- David W. Knotts, Immediate Past Chair, Hawley Troxell Ennis & Hawley
- Kathy Eroschenko, PharmD, University of Idaho
- Rebecca Hupp, Boise Airport
- Robert Low, Holland & Hart
- Amy Ocmand, MD, St. Luke's Health System
- Eugene Ritti, Office Depot Inc.
- Heather Kimmel, Idaho Executive Director, American Lung Association of the Mountain Pacific

Staff Roles, Responsibilities, and Apportioned Time (for Budget Notes and Grant Management):
Staff members responsible for managing the grant and whose time is directly apportioned to it include:

- Idaho Executive Director (.20FTE): Provides oversight of the grant and Lung Health Manager and Marketing Manager; ensures that grant-funded programs meet their stated deliverables on time and within budget; measures progress toward grant goals and reviews with Community Engagement Manager on monthly and quarterly basis; maintains oversight of all grant-related contracts; and ensures program fidelity. Reports to Regional President and CEO.

- Idaho Community Engagement Manager (.80FTE): Maintains primary responsibility for day-to-day grant operations; trains and oversees independent contractor program facilitators; coordinates with schools, community partners, and program facilitators to promote and schedule grant activities; manages interns and volunteers; conducts TATU teen trainings and oversees

presentations; maintains oversight and tracks progress and expenses of STAND grant recipients; coordinates STAND training workshop; schedules, promotes, and conducts NOT facilitator training; ensures collection of evaluation data; and tracks grant expenses on monthly basis. Reports to Idaho Executive Director.

- Marketing Manager (.1FTE): in coordination with Idaho Community Engagement Manager, ensures that grant-funded programs are marketed and advertised appropriately to ensure broad geographic reach and statewide participation. Reports to Idaho Executive Director.

Independent Contract Program Facilitators: individuals experienced in working with youth and in educational and/or community settings who implement TATU in North, Southwest, Central, and Southeast Idaho. All staff, contractors, and interns or key volunteers with a direct role in implementing youth programs are required to pass an Idaho State Police background check, successfully complete program training, and be non-smokers.

Regional staff with a role in overseeing grant management and ensuring successful implementation whose time is not directly apportioned to the grant include:

- Chief Financial Officer: compiles reports of all expenses, including personnel, related to grant; ensures grant revenues and expenses are correctly tracked in accordance with generally accepted accounting principles; prepares monthly and year-end financial statements

- Regional Vice President, Health Initiatives: works with Idaho State Executive Director and national Lung Association health education staff to ensure programs meet and maintain practice standards; assists, supports, and reviews program evaluation and innovation

- Regional Vice President, Advocacy: Provides technical support to Idaho staff with respect to implementation of STAND program; Supports promotion of grant activities including trainings and workshops as needed.

Description of Proposed Programs:

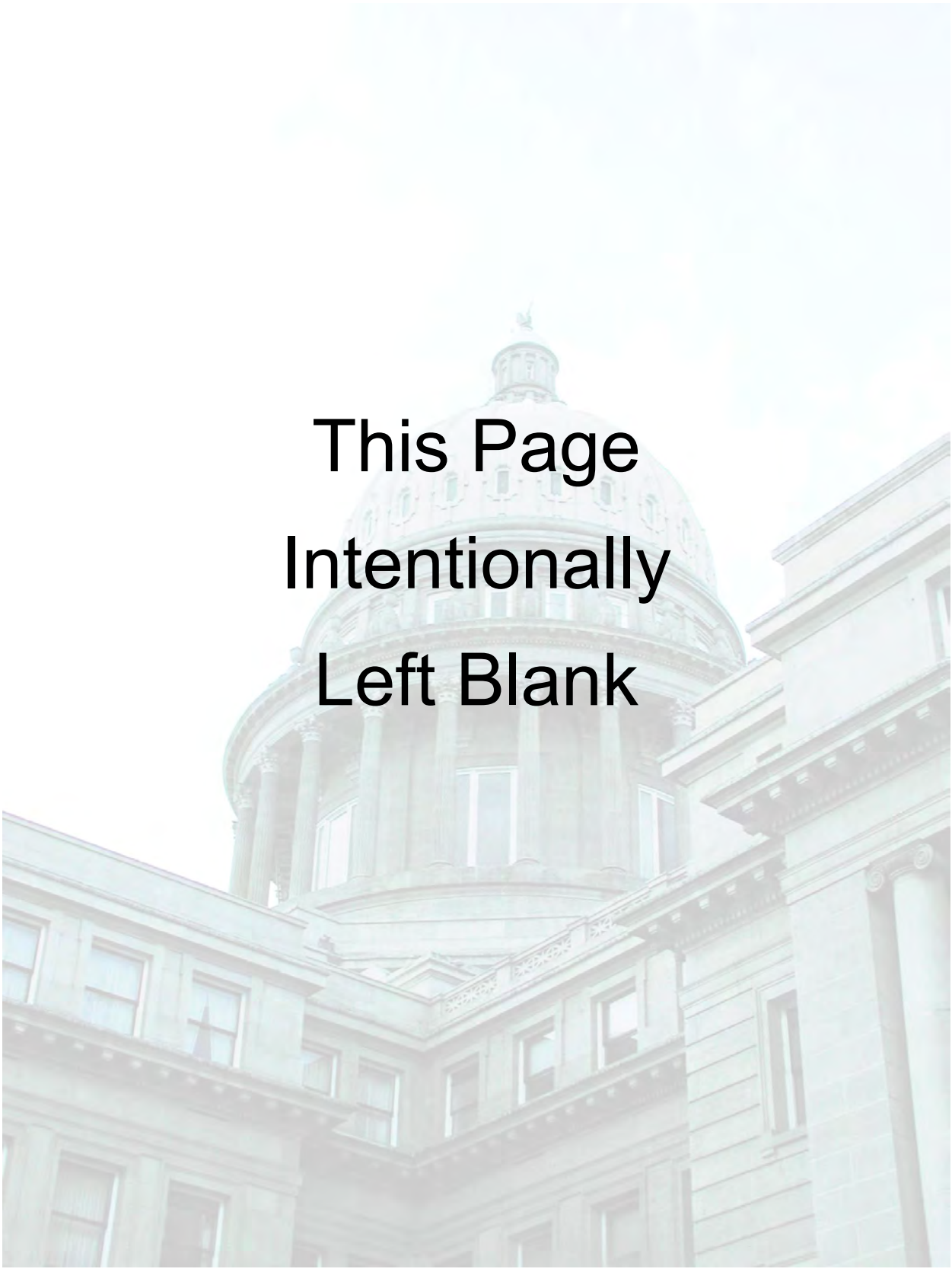
TATU: Teens Against Tobacco Use is an American Lung Association school-based prevention program that has trained more than 5,700 teens to reach more than 100,000 Idaho youth since 2004. American Lung Association in Idaho staff train adult program facilitators and work with them to train teens in high school and community settings. During each one-day training, TATU teen participants learn the information, skills, and demonstration techniques needed to craft creative and engaging presentations for younger students.

The TATU Teen Educators make classroom and community presentations lasting approximately 45 minutes that include a variety of hands-on activities to teach children the threat that tobacco poses to their health, along with awareness of how marketing, movies, social media, and peer pressure work to influence them, and how they can make independent decisions that are in their own best interest. Young students learn life-saving facts and practice refusal skills in a fun and non-threatening setting. TATU educational outreach may also take the form of health fairs and community awareness activities. The American Lung Association provides coordination and technical support to implement TATU

presentations, conducts observations to ensure program fidelity and integrity, and disseminates and collects evaluation forms at each training and presentation to support program evaluation and improvement. Particular effort is made to reach underserved populations that have proportionately higher rates of tobacco use. We experience high demand for TATU in rural areas and small towns, where there is both higher need and less access to tobacco prevention resources.

STAND: The tobacco industry spends over $100,000 per day in Idaho to sell its addictive products, and STAND seeks to counter this messaging. The Centers for Disease Control cites youth advocacy and engagement programs as a best practice tobacco prevention method. STAND has fostered leadership and civic involvement in over thirty youth groups throughout Idaho in the five years we have conducted the program. With American Lung Association training, technical support, and resources provided through $750-$1,000 mini-grants, teens conduct projects to raise awareness in their communities of the consequences of tobacco use while working with and influencing decision makers to make positive policy changes. From advocating for smoke-free parks in Meridian to working with city councils in Post Falls, Coeur d'Alene, and Hayden to pass Idaho's first ordinances prohibiting the sale of electronic cigarettes to minors, to persuading the management of Soldier Mountain Ski Resort to designate smoke-free areas at the resort, these young citizen-leaders have made impressive achievements since the program's inception in 2010. Last year STAND projects included work to create a smoke-free city park in St. Maries, and work with school and community leaders in Marsh Valley and Clark Fork to rewrite the schools' tobacco policy to include all forms of tobacco products including e-cigarettes and to apply the policy to adults on school grounds as well.

NOT: Many teens who are daily smokers report that they wish they had never started and express a desire to quit. Yet programs that are designed for adult smokers often don't fit the social, emotional, and developmental needs of young people. NOT is a nationally recognized smoking cessation program for smokers under the age of 18 that was developed by the American Lung Association to address youth's specific needs. Support from the Millennium Fund allows us to offer no-cost NOT facilitator training to equip adults working with youth to lead cessation classes for teens who want to quit. Designed primarily as a volunteer program, NOT also includes a component that can be used as an alternative to suspension, making it adaptable to the needs of schools and communities. We experience continuing interest and demand for this program from juvenile corrections agencies.



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Bannock County Commissioners

5500 S 5th Avenue, Pocatello, Idaho 83204 Phone (208) 236-7210
Fax (208) 232-2185

HOWARD MANWARING
CHAIRMAN
COMMISSIONER 3RD DISTRICT
POCATELLO, IDAHO

STEVE HADLEY
COMMISSIONER 2ND DISTRICT
POCATELLO, IDAHO

KARL E. ANDERSON
COMMISSIONER 1ST DISTRICT
POCATELLO, IDAHO

September 23, 2016

Daniel Chadwick
Executive Director, IAC
700 W. Washington
Boise, ID 83701

Re: Letter of Support

Dear Dan:

We are writing to express the support for your efforts to seek a Millennium Fund grant to develop additional Recovery Community Centers (RCC) in Eastern Idaho. Eastern Idaho has a critical need for services provided by a Recovery Community Center. RRC's provide resources to persons in addiction recovery within their community. They are staffed with trained volunteers and, therefore, are cost-effective ways of filling a critical recovery need.

Having a RRC in our region would be a positive benefit for our citizens. Bannock County will support the implementation and the sustainability of an RRC were seed money allocated for such a resource by the Millennium Fund.

We respectfully request your serious consideration of this proposal.

Sincerely,

BOARD OF BANNOCK COUNTY COMMISSIONERS

Howard Manwaring, Chairman

Steve Hadley, Member

Karl E. Anderson, Member

nn

Idaho State
UNIVERSITY
Division of Health Sciences

921 South 8th Avenue, Stop 8055 · Pocatello, Idaho 83209-8055

September 15, 2015

Daniel G. Chadwick, Executive Director
The Idaho Association of Counties
P.O. Box 1623
Boise, ID 83701

Dear Mr. Chadwick:

I am writing to express the support of the Division of Health Sciences, at Idaho State University (ISU), for your efforts to seek a Millennium Fund grant to development additional Recovery Community Centers (RCC) in Idaho, including one in Eastern Idaho. The concept of a Recovery Community Center is moving forward in Idaho, thanks to successful Millennium Fund funding, this fiscal year, in western and northern Idaho counties. Eastern Idaho also has a critical need for services provided by a Recovery Community Center. RRC's provide resources to persons in addiction recovery within their community. They are staffed with trained volunteers and, therefore, are cost-effective ways of filling a critical recovery need. When communities do not have RRC's, individuals may not seek the support they need leading to increased costs to the local community and increased hardship on the individual and his/her family.

The Division of Health Sciences is dedicated to providing educational programs across all segments of health care including physical health, oral health, rehabilitation, mental health and wellness. We also provide direct services to the community through our own clinics. As such, we are very aware of the need for more comprehensive services to persons who seek recovery from addiction, some of whom also have mental illness. Our students and faculty are also a source of volunteer staffing for the RCC in the area once it is developed.

Having a RRC in our region would be a positive benefit for our citizens. The Division of Health Sciences at ISU, stands ready to assist with the implementation and the sustainability of an RRC were seed money allocated for such a resource by the Millennium Fund.

Sincerely,

Linda Hatzenbuehler, Ph.D.
Vice Provost & Executive Dean

Gateway Counseling inc.
"Tune ups are not just for cars"

Individual Counseling
Community Based Rehabilitation Services
Mental Health Case Management
Well Balanced, Payee Service
Addictions Treatment

9/16/2015

Daniel Chadwick
Executive Director, Idaho Association of Counties
700 W. Washington
Boise, ID 83701

Dear Mr. Chadwick:

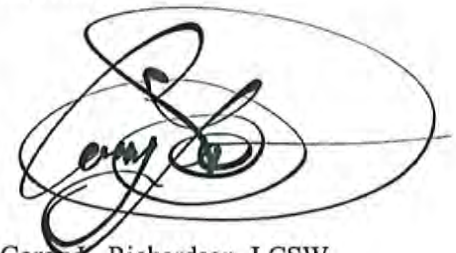
I am writing to express my support for your proposal to establish Recovery Community Centers in Idaho, particularly one here in South East Idaho.

As I read through the proposal I was pleased with the idea of organizing local Recovery Community Centers. I am especially pleased with the idea of providing four separate centers so that recovery can be provided in rural areas of Idaho. It is my experience that without programs that reach out to individual who lack resources they may not seek help or may end up in jail, or crowd our local Emergency Departments.

I spent 5 years working in Portneuf Medical Center's Emergency Department as a Social Worker, and frequently had limited and poor resources. I was frequently frustrated trying to link individuals with support. I wish that we had local Recovery Community Centers when I was working in the Emergency Department. I feel that I would have provided much better support and most likely saved lives if this resource had been available.

Thank you for taking the time and effort to seek this grant. Knowing that we are working to obtain such a resource is a breath of fresh air.

Sincerely,



Corey L. Richardson, LCSW
Gateway Counseling
Clinical Director

224 S. Arthur, Suite 2 - Pocatello Idaho 83204 - Office: 208-242-3771 - Fax: 208-242-3772

Pocatello
A MUNICIPAL CORPORATION OF IDAHO

OFFICE OF THE MAYOR
911 North 7th Avenue
P.O. Box 4169
Pocatello, Idaho 83205

(208) 234-6163
Fax: (208) 234-6297
www.pocatello.us

BRIAN C. BLAD
Mayor

Pocatello City Council:

STEVE BROWN
CRAIG COOPER
W. JAMES JOHNSTON
GARY MOORE
EVA JOHNSON NYE
MICHAEL L. ORR

September 14, 2015

Committee Chairs and Committee Members:

The City of Pocatello is pleased to support a grant request for funding to assist in providing support for recovery community centers.

These centers provide individuals with a place to work toward their recovery goals with the help of volunteers who have personal recovery experience. These centers also provide necessary resources needed to attain long-term recovery.

The proposed budget necessary provides for staffing support, transportation, indirect costs software programs and administrative costs. The centers would be managed and staffed by professionals who can manage operations and coordinate volunteer efforts.

We respectfully request your serious consideration of this proposal

Sincerely,

Brian C. Blad
Mayor

/kk

City of CHUBBUCK IDAHO

Office of the Mayor

Kevin B. England

September 16, 2015

Daniel Chadwick
Executive Director, Idaho Association of Counties
700 W Washington
Boise, ID 83701

Dear Mr. Chadwick:

I am writing to express my support for your proposal to secure Millennium Fund grant dollars to establish Recovery Community Centers around the state.

I believe a Recovery Community Center is a welcome and needed resource. Addiction and mental health issues affect every community, and a Recovery Community Center will provide access to support services to those seeking to recover. Without a Recovery Community Center, individuals who lack resources may not seek help, or end up in the local jail or emergency room. This costs out local community in terms of law enforcement time and money, jail costs, and county indigent funds. It also hurts the people who want to recover, but lack the necessary funds to seek traditional treatment.

With a Recovery Community Center in place, people seeking recovery from addiction or mental health issues can work, free of charge, with peers who volunteer to share their recovery experience. They can establish a support system critical to their maintenance of long-term recovery, and have a place to go or contact when they feel they need additional support. And when they are ready, they can in turn volunteer their experience to help others continue a tradition of healthy recovery.

In addition, the establishment of a local Recovery Community Center would help put a positive face on recovery in our community. The Recovery Community Center and its staff will be able to establish local friendships and partnerships, and include the community in efforts to bring recovery out of the shadows. When our citizens recover, we feel the entire community will benefit.

Having a Recovery Community Center in our Region would be a positive benefit for our citizens in need.

Sincerely,

Kevin B. England

Kevin B. England
Mayor of the City of Chubbuck, Idaho

PO Box 5604 – 5160 Yellowstone Avenue, Chubbuck, ID 83202
208.237.2430 – Fax 208.237.2409
www.cityofchubbuck.us

IDAHO DEPARTMENT OF CORRECTION

To promote a safer Idaho by reducing recidivism

C. L. "BUTCH" OTTER
Governor

KEVIN H. KEMPF
Director

September 14, 2015

Daniel Chadwick
Executive Director, Idaho Association of Counties
700 W Washington
Boise, ID 83701

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In addition, the establishment of a local Recovery Community Center would help put a positive face on recovery in our community. The Recovery Community Center and its staff will be able to establish local friendships and partnerships, and include the community in efforts to bring recovery out of the shadows. When our citizens recover, we feel the entire community will benefit.

Having a Recovery Community Center in our Region would be a positive benefit for our citizens in need.

Sincerely,

Jeff Kirkman
Warden, Pocatello Women's Correctional Center

POCATELLO WOMEN'S CORRECTIONAL CENTER
1451 Fore Road, Pocatello, ID 83205
Phone: (208) 236-6360 * Fax: (208) 236-6362

Pocatello Free Clinic
Our community. Our health.

429 Washington, Pocatello ID 83201 • 208.233.6245 Tel • 208.233.1065 Fax • www.pocatellofreeclinic.com

September 23, 2015

Daniel Chadwick
Executive Director, Idaho Association of Counties
700 W Washington
Boise, ID 83701

Dear Mr. Chadwick:

As the Executive Director of the Pocatello Free Clinic, I am writing to express my support for your proposal to secure Millennium Fund grant dollars to establish Recovery Community Centers around the state. The Pocatello Free Clinic (PFC) is a safety-net healthcare organization which provides healthcare services to low-income, uninsured individuals in Bannock County-a vulnerable population which experiences higher rates of ill health and death when compared to the general population. One third of our patient visits from last month had a primary diagnosis of mental illness. These individuals have very limited resources and I believe a Recovery Community Center is needed.

Addiction and mental health issues affect every community, and a Recovery Community Center will provide access to support services to those seeking to recover. Without a Recovery Community Center, individuals who lack resources may not seek help, or end up in the local jail or emergency room. This costs out local community in terms of law enforcement time and money, jail costs, and county indigent funds. It also hurts the people who want to recover, but lack the necessary funds to seek traditional treatment.

With a Recovery Community Center in place, people seeking recovery from addiction or mental health issues can work, free of charge, with peers who volunteer to share their recovery experience. They can establish a support system critical to their maintenance of long-term recovery, and have a place to go or contact when they feel they need additional support. And when they are ready, they can in turn volunteer their experience to help others continue a tradition of healthy recovery.

In addition, the establishment of a local Recovery Community Center would help put a positive face on recovery in our community. The Recovery Community Center and its staff will be able to establish local friendships and partnerships, and include the community in efforts to bring recovery out of the shadows. When our citizens recover, we feel the entire community will benefit.

Sincerely,

Mindy Hong, Executive Director
Pocatello Free Clinic

Portneuf MEDICAL CENTER Be well.

777 Hospital Way, Pocatello, Idaho 83201
Switchboard: (208) 239-1000
Physician Referrals: (877) 721-6673

September 16, 2015

Daniel Chadwick
Executive Director, Idaho Association of Counties
700 W Washington
Boise, ID 83701

Dear Mr. Chadwick:

I am writing to express my support for your proposal to secure Millennium Fund grant dollars to establish Recovery Community Centers around the state.

I believe a Recovery Community Center is a welcome and needed resource. Addiction and mental health issues affect every community, and a Recovery Community Center will provide access to support services to those seeking to recover. Without a Recovery Community Center, individuals who lack resources may not seek help, or end up in the local jail or emergency room. As a provider of an emergency department, we are well aware of the cost to our local community in terms of law enforcement time, medical funding and county indigent funds. It is often the wrong level of care for persons who are seeking supportive services that could be provided by a recovery center.

With a Recovery Community Center in place, people seeking recovery from addiction or mental health issues can work, free of charge, with peers who volunteer to share their recovery experience. They can establish a support system critical to their maintenance of long-term recovery, and have a place to go or contact when they feel they need additional support. And when they are ready, they can in turn can volunteer their experience to help others continue a tradition of healthy recovery.

In addition, the establishment of a local Recovery Community Center would help put a positive face on recovery in our community and Idaho. The Recovery Community Center and its staff will be able to establish local friendships and partnerships, and include the community in efforts to bring recovery out of the shadows. When our citizens recover, the entire community benefits in so many ways.

Sincerely,

Charles Aasand, RN-BC, MBA
Director, Behavioral Health Services
Portneuf Medical Center

Southeastern Idaho Public Health

September 16, 2015

Daniel Chadwick
Executive Director, Idaho Association of Counties
700 W Washington
Boise, ID 83701

Dear Mr. Chadwick:

I am writing to express Southeastern Idaho Public Health's support for your proposal to secure Millennium Fund grant dollars to establish Recovery Community Centers around the state.

I believe a Recovery Community Center is a welcome and needed resource. Addiction and mental health issues affect every community, and a Recovery Community Center will provide access to support services to those seeking to recover. Without a Recovery Community Center, individuals who lack resources may not seek help, or end up in the local jail or emergency room. This costs our local community in terms of law enforcement time and money, jail costs, and county indigent funds. It also hurts the people who want to recover, but lack the necessary funds to seek traditional treatment.

With a Recovery Community Center in place, people seeking recovery from addiction or mental health issues can work, free of charge, with peers who volunteer to share their recovery experience. They can establish a support system critical to their maintenance of long-term recovery, and have a place to go or contact when they feel they need additional support. And when they are ready, they can in turn volunteer their experience to help others continue a tradition of healthy recovery.

In addition, the establishment of a local Recovery Community Center would help put a positive face on recovery in our community. The Recovery Community Center and its staff will be able to establish local partnerships, and include the community in efforts to bring recovery out of the shadows. When our citizens recover, we believe the entire community will benefit. Having a Recovery Community Center in our region would be a positive benefit for our citizens in need.

Thank you very much for your attention; if you have any questions, please feel free to contact me at (208) 239-5258.

Sincerely,

Maggie Mann

Maggie A. Mann
District Director

1901 Alvin Ricken Dr. • Pocatello, Idaho 83201 • Phone (208) 233-9080 • Fax (208) 234-7169
siphidaho.org • twitter.com/siphidaho • facebook.com/siphidaho

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER – Governor

DIVISION OF BEHAVIORAL HEALTH
Region VI
Michele Osmond- Program Manager
421 Memorial Dr.
Pocatello, ID 83201
PHONE 208-234-7900
FAX 208-236-6328

September 16, 2015

Daniel Chadwick
Executive Director, Idaho Association of Counties
700 W Washington
Boise, ID 83701

Dear Mr. Chadwick:

I am writing to express my support for your proposal to secure Millennium Fund grant dollars to establish Recovery Community Centers around the state.

I believe a Recovery Community Center is a welcome and needed resource. Addiction and mental health issues affect every community, and a Recovery Community Center will provide access to support services to those seeking to recover. Without a Recovery Community Center, individuals who lack resources may not seek help, or end up in the local jail or emergency room. This costs out local community in terms of law enforcement time and money, jail costs, and county indigent funds. It also hurts the people who want to recover, but lack the necessary funds to seek traditional treatment.

With a Recovery Community Center in place, people seeking recovery from addiction or mental health issues can work, free of charge, with peers who volunteer to share their recovery experience. They can establish a support system critical to their maintenance of long-term recovery, and have a place to go or contact when they feel they need additional support. And when they are ready, they can in turn volunteer their experience to help others continue a tradition of healthy recovery.

In addition, the establishment of a local Recovery Community Center would help put a positive face on recovery in our community. The Recovery Community Center and its staff will be able to establish local friendships and partnerships, and include the community in efforts to bring recovery out of the shadows. When our citizens recover, we feel the entire community will benefit.

Having a Recovery Community Center in our Region would be a positive benefit for our citizens in need.

Sincerely,

Michele Osmond

Michele Osmond, LCPC

October 14, 2015

Daniel Chadwick
Executive Director, Idaho Association of Counties
700 W Washington
Boise, ID 83701

Dear Mr. Chadwick:

I am writing to express my support for your proposal to secure Millennium Fund grant dollars to establish Recovery Community Centers around the state.

At Road to Recovery, we believe a Recovery Community Center will be a positive and needed resource. Addiction and mental health issues affect every community, and a Recovery Community Center will provide additional access to support services to those seeking to recover. We are a dedicated treatment center but without support in the community from something such as this Recovery Community Center, individuals who lack resources may not seek help, or end up in the local jail or emergency room.

With a Recovery Community Center in place, people seeking recovery from addiction or mental health issues can work, free of charge, with peers who volunteer to share their recovery experience. They can establish a support system critical to their maintenance of long-term recovery, and have a place to go or contact when they feel they need additional support. We see this as being valuable for helping connect individuals with treatment and as ongoing support after treatment. The Recovery Community Center and its staff will be able to establish local partnerships, and include the community in efforts to bring recovery out of the shadows. When our citizens recover, we feel the entire community will benefit.

Having a Recovery Community Center in our Region would be a positive benefit for our citizens in need.

Sincerely,

Jody Owens, MS, LCPC

Jody Owens, MS, LCPC

Corporate	Pocatello Outpatient	Blackfoot Clinic	Malad/Oneida Clinic
PO BOX 6249	343 East Bonneville	490 N Maple	20 North Main #2 & 10 Court
Pocatello, ID 83205	Pocatello, ID 83201	Blackfoot ID, 83221	Malad, ID 83252
208.233.2492 Ph	208.233.9135 Ph	208.785.6688 Ph	208.317.6300 Ph
208.233.9136 Fax	208.233.9136 Fax	208.785.6720 Fax	208.766.7623 Fax

Aid For Friends

Administration Office (208) 232-0178 / 210 E. Center Suite A, Pocatello, ID 83201
Emergency Shelter (208) 232-5669 / 653 S. 4th, Pocatello, ID 83201
P. O. Box 4233, Pocatello, Idaho 83205

September 29, 2015

Daniel Chadwick
Executive Director, Idaho Association of Counties
700 W Washington
Boise, ID 83701

Dear Mr. Chadwick:

As Executive Director of Aid For Friends in Pocatello, Idaho, I support the proposal to establish a Recovery Community Center in Southeast Idaho. Our agency serves homeless individuals and households whose lives are often impacted by alcohol and substance abuse addiction and many struggle with mental health issues.

The Recovery Center would offer a tangible location to obtain resources and develop a support system critical to maintaining long-term recovery and sense of well being. It would also allow for collaboration and consolidation our community's various services and present a positive approach of recovery within this region.

Currently, those striving for recovery may not have personal funds to seek traditional treatment or know where the resources are within our community to obtain the help they need. With a Recovery Community Center in place, people seeking recovery from addiction or mental health issues can work, free of charge, with peers who volunteer to share their recovery experience. And eventually, the Recover Center may provide a venue to serve as a volunteer for those that first came for guidance.

A Recovery Community Center in our Region would strengthen and augment the work that is being done to promote recovery and healthy lifestyles for hundreds of citizens.

Sincerely,

BJ Stensland
Executive Director

MARK NYE
DISTRICT 29
BANNOCK COUNTY

HOME ADDRESS
P.O. BOX N
POCATELLO, IDAHO 83205
(208) 221-6109
EMAIL: mnye@house.idaho.gov

House of Representatives
State of Idaho

September 15, 2015

Idaho Association of Counties
c/o Dan Chadwick
P.O. Box 1623
700 W. Washington
Boise, Idaho 83701

Re: Grant Application
Recovery Center

Dear Dan and IAC:

This letter is to support the grant application for the Pocatello regional Recovery Center.

The need is one of the greatest in our state and I urge your favorable consideration.

There has been a murder here due to the lack of mental health prevention; the Women's Prison deposits women who have served their time and have been medicated and now have little follow up and help; our area is one of the lower income regions, and more..

Your help will begin what we hope will begin a long needed program of recovery for Idahoans in this area. Again, thank you and I am sure that with your help we can see significant progress and help lives.

Please call anytime with questions and if I can help further, please let me know. Best from Pocatello.

Regards,

Mark Nye

OFFICE OF THE PROSECUTING ATTORNEY
BANNOCK COUNTY
STATE OF IDAHO

STEPHEN F. HERZOG
PROSECUTING ATTORNEY

ZACHARY G. PARRIS
CHIEF DEPUTY

JaNIECE PRICE
ASSISTANT CHIEF DEPUTY

IAN N. SERVICE
CIVIL DEPUTY

BANNOCK COUNTY COURTHOUSE
POST OFFICE BOX P
POCATELLO, ID 83205-0050

(208) 236-7280
FAX (208) 236-7288
Email: sherzog@bannockcounty.us

TERRESA WILSON
VICTIM/WITNESS COORDINATOR

September 14, 2015

Daniel Chadwick
Executive Director, Idaho Association of Counties
700 W Washington
Boise, ID 83701

Dear Mr. Chadwick:

I am writing to express my support for your proposal to secure Millennium Fund grant dollars to establish Recovery Community Centers around the state.

I believe a Recovery Community Center is a welcome and needed resource. Addiction and mental health issues affect every community, and a Recovery Community Center will provide access to support services to those seeking to recover. Without a Recovery Community Center, individuals who lack resources may not seek help, or end up in the local jail or emergency room. This costs local community in terms of law enforcement time and money, jail costs, and county indigent funds. It also hurts the people who want to recover, but lack the necessary funds to seek traditional treatment.

With a Recovery Community Center in place, people seeking recovery from addiction or mental health issues can work, free of charge, with peers who volunteer to share their recovery experience. They can establish a support system critical to their maintenance of long-term recovery, and have a place to go or contact when they feel they need additional support. And when they are ready, they can in turn volunteer their experience to help others continue a tradition of healthy recovery.

Finally, the establishment of a local Recovery Community Center would help put a positive face on recovery in our community. The Recovery Community Center and its staff will be able to establish local friendships and partnerships, and include the community in efforts to

bring recovery out of the shadows. When our citizens recover, we feel the entire community will benefit.

Sincerely,

STEPHEN F. HERZOG
Bannock County Prosecutor

SFH/dh

THE FRIENDSHIP CLUB, INC.
745 SOUTH FIRST AVE
POCATELLO, IDAHO 83201
(208) 232-9565

Daniel Chadwick
Executive Director, Idaho Association of Counties
700 W Washington
Boise, ID 83701

Dear Mr. Chadwick:

I am writing to express my support for your proposal to secure Millennium Fund grant dollars to establish Recovery Community Centers around the state.

The Friendship Club has served Pocatello for over 30 years as a recovery resource. We are a non-profit organization whose mission is to provide a congenial environment where people in recovery may gather for recreation, fellowship and mutual assistance. We provide space for approximately 35 Twelve-Step meetings each week.

Addiction and mental health issues certainly affect every community, and a Recovery Community Center will provide access to support services to those seeking to recover. Without a Recovery Community Center, individuals who lack resources may not seek help, or end up in the local jail or emergency room. This costs out local community in terms of law enforcement time and

money, jail costs, and county indigent funds. It also hurts the people who want to recover but lack the necessary funds to seek traditional treatment.

With a Recovery Community Center in place, people seeking recovery from addiction or mental health issues can work, free of charge, with peers who volunteer to share their recovery experience. They can establish a support system critical to their maintenance of long-term recovery, and have a place to go or contact when they feel they need additional support. And when they are ready, they can in turn volunteer their experience to help others continue a tradition of healthy recovery.

In addition, the establishment of a local Recovery Community Center would help put a positive face on recovery in our community. The Recovery Community Center and its staff will be able to establish local friendships and partnerships, and include the community in efforts to bring recovery out of the shadows. When our citizens recover, we feel the entire community will benefit.

Thus, I believe a Recovery Community Center is a welcome and needed resource. This Center will provide a significant number of additional resources which will complement the role of the Friendship Club in Bannock County.

Sincerely,

Christopher K. Daniels
President, Friendship Club

POST OFFICE BOX 4666
POCATELLO,IDAHO
83205-4666

TELEPHONE
236-7111

LORIN W. NIELSEN
Sheriff

JIM DALLEY
Chief Deputy

September 9, 2015

Dan Chadwick
Executive Director Idaho Association of Counties
700 West Washington
Boise, Idaho 83701

Dear Dan:

I am writing to express my full support for your proposal to secure Millennium Fund grant dollars to establish Community Recovery Centers around the State.

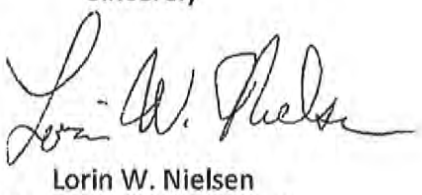
I believe a Community Recovery Center is a missing link in our recovery services and a needed resource. Addiction and mental health issues affect every aspect of our criminal justice system and community services. Without a Community Recovery Center individuals who lack resources will not seek help and/or end up in our Jails or emergency rooms. The cost to our communities in terms of law enforcement, time and money, detention costs and County indigent funds, is extremely high. It also hurts the people who want to recover, but lack the necessary funds to seek traditional treatment.

With a Community Recovery Center in place, people seeking recovery from addiction or mental health issues can work, free of charge, with peers who volunteer to share their recovery experience. They can establish a support system critical to their maintenance of long term recovery and have a place to go or contact when they feel they need additional support. When they are ready, they can in-turn volunteer their experience to help others continue a tradition of healthy recovery.

The establishment of a local Community Recovery Center would help put a positive face on recovery in our community. The Community Recovery Center and its staff will be able to establish partnerships and include the community in efforts to bring recovery out of the shadows. When our citizens recover, I feel that the entire community will benefit.

Having a Community Recovery Center in our Region will be a positive benefit for all of our citizens. We fully support and recommend this effort.

Sincerely



Lorin W. Nielsen
Bannock County Sheriff

BONNEVILLE COUNTY COMMISSIONERS

ROGER S. CHRISTENSEN, CHAIRMAN, DISTRICT #1
DAVE RADFORD, DISTRICT #2
LEE STAKER, DISTRICT #3

Cheryl Matthiesen, Admin. Asst.
Ruby Strong, Admin. Sec.

605 NORTH CAPITAL AVE., SUITE 102
IDAHO FALLS, ID 83402
PHONE: (208) 529-1360
FAX: (208) 524-7932
Email: commsec@co.bonneville.id.us
Website: www.co.bonneville.id.us

September 15, 2015

FY2016 Joint Millennium Fund Committee

Dear Committee Members:

We would like to express our support for the Idaho Falls Center for HOPE. Bonneville County is looking forward to being a partner in this effort.

We are excited to have a center in our community that is run by Peer Specialists and Recovery coaches. We feel it is vital for those in recovery to have somewhere that will offer supportive services and a place to join others to continue to be successful in their recovery. The Center will also help us to create continued recovery opportunities for sustainability once they have left the Crisis Center and Court Programs (Mental Health Court, Drug Courts and the Wood Pilot Project). We also see the need to create a safe place people can go while they are in the Contemplative Stage of their recovery's by putting peers almost immediately into leadership roles to create personal empowerment.

We believe that it is so important, we have offered the adjacent side of the Behavioral Crisis Center building at a substantially reduced rental cost for the Center for HOPE.

The Center for HOPE will be a great asset in addressing the needs of persons who are in Recovery by allowing them access recovery support networks and activities on a voluntary basis. Many individuals and families in the community will benefit from this resource. Your consideration of this proposal is deeply appreciated.

Sincerely,

Roger S Christensen

Roger S. Christensen
Chairman, Board of Bonneville County Commissioners

SULLIVAN
Mental Health Services, LLC
1904 Jennie Lee Drive
Idaho Falls, ID 83404
Telephone: 208-523-1558 Fax: 208-529-4788

October 15, 2015

FY2016 Joint Millennium Fund Committee

Dear Committee Members:

I would like to express my strong support for *The Center for Hope*, a community behavioral health recovery center, in Idaho Falls, ID. My organization is looking forward to being a partner in this effort.

At the present time our area is not able to meet all the needs of persons who are in recovery due to their lack of adequate resources in order to access this support.

The Center for Hope will be a great asset in addressing the needs of persons who are in recovery by allowing them to access recovery support networks and activities in a timely manner, with little to no cost to the client. Many individuals and families in the community will benefit from this resource. Your consideration of this proposal is deeply appreciated.

Sincerely,

Elaine Sullivan, LCPC, LMFT, NCC
Owner/Clinical Director
Sullivan Mental Health Services, LLC

Region VI Behavioral Health Board
150 Shoup Ave. Suite 17
Idaho Falls, ID 83404

October 15, 2015

FY2016 Joint Millennium Fund Committee

Dear Committee Members:

As a Board, we would like to express our strong support for The Center for Hope, a community behavioral health recovery center, in Idaho Falls, ID. Our organization is looking forward to being a partner in this effort much as we have been in the Crisis Center.

As a Board, one of our tasks was to identify gaps and needs within our Region and explore ways to fill these needs. The Center for Hope will certainly fill one of our priority gaps within our Region by providing recovery activities and support to people within the region who due to financial difficulties may not otherwise have access to supportive services.

The Center for Hope will be a great asset in addressing the needs of persons who are in recovery by allowing them to access recovery support networks and activities in a timely manner, with little to no cost to the client. Many individuals and families in our communities will benefit from this resource. Your consideration of this proposal is deeply appreciated.\

Sincerely,

Elaine Sullivan, Chair
Region VI Behavioral Health Board

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER – Governor

RICHARD M. ARMSTRONG – Director

Ross D. Edmunds – Administrator
Randy Rodriquez – Program Manager
DIVISION OF BEHAVIORAL HEALTH
150 Shoup Ave. Ste. 17
Idaho Falls, Idaho 83402
Ph: (208) 528-5700
FAX: (208) 528-5747

October 15, 2015

RE: FY2016 Joint Millennium Fund Committee

Dear Committee Members:

The Department of Health and Welfare, Region VII Behavioral Health is pleased to announce its strong support for *The Center for HOPE* in their application for Millennium funds and their efforts to bring a Recovery Center to our community. We plan to work closely with *The Center for HOPE* as community partner in this effort.

Our agency works with people with behavioral health disorders and it is very apparent to us that we have gaps in our system of care for people with substance and mental health problems. A recovery center would be a much needed resource in our efforts to support individuals in their recovery.

We commend *The Center for HOPE* for their efforts to help people in the recovery process and being a leader to bring a recovery center to Idaho Falls. We unequivocally support *The Center for HOPE* in their amazing efforts.

Sincerely,

RANDY RODRIQUEZ
Program Manager

7TH JUDICIAL DISTRICT
MENTAL HEALTH COURTS
320 "B" Street Suite #110
Idaho Falls, ID. 83402
PH: 208-360-0262
Fax: 208-612-5036
ericolson@qwestoffice.net

Date: October 15, 2015

To Whom It May Concern:

I am writing a letter of support for The Center for HOPE. The Center for HOPE will be such a wonderful addition to our Recovery Community. We are so excited about having this resource in our community to continue to promote recovery and wellness.

Our community has been working for years to promote Recovery. Our problem-solving courts have been very recovery-focused and supportive of recovery concepts that are self-driven and strength-based. We have promoted training and hiring Peer Support Specialists (PSS) and Recovery Coaches and have been thrilled to see this take off in our community and see the benefits; one, the benefit to our participants in having Recovery Coaches and PSS to provide support and services in our Problem Solving Court, and two; the increased recovery, hope, strength, and growth we see in our graduates who are working and providing these services. These programs are truly one the best things I've been involved with in Recovery.

The Center for HOPE would be such a great addition to the community, our PSS and Recovery Coaches, our Problem-Solving Courts, Crisis Center, and all team members in our Recovery Community. Thank you so much for your consideration!

Sincerely,

Eric Olson, LCPC

District Manager, 7th District MH Courts

BONNEVILLE COUNTY
WOOD PILOT PROJECT

Rex Thornley, LCSW
Program Coordinator
rthornley@co.bonneville.id.us
PH: (208)529-1315 ext.5362
FAX: (208) 524-7917
www.co.bonneville.id.us

605 NORTH CAPITAL AVE.
IDAHO FALLS, ID 83402

October 15, 2015
FY2016 Joint Millennium fund Committee

Dear Committee Members:

I would like to express my support for the Idaho Falls Center for HOPE recovery center. The Wood Court is excited to utilize and support the efforts of this center in helping those in Recovery.

The Wood Court along with the District 7 Drug Courts has invested a lot of time and money in training several quality Recovery Coaches in the community of Idaho Falls. This Center will be fundamental in the growth of this effort and offer a place for the numerous trained Recovery Coaches and Peer Support specialists to continue their volunteer activities in giving back to the recovery community.

Sincerely,
Rex Thornley

Bonneville County Wood Court Coordinator

October 15, 2015

To whom it may concern;

I am writing in regard to the Center for Hope Recovery Coaching Organization. The problem solving courts in our area are very supportive and interested in utilizing recovery coaching and having as many opportunities for those in addiction to receive services and support. Center for Hope is another opportunity and the only opportunity to help create and build the recovery coaching community in our area. Currently, we have a few recovery coaches actively involved in our problem solving courts and are anecdotally experiencing great dividends for the service they provide. They are able to support, coach and mentor our participants and bridge the gaps between the participant and the community. We believe that the Center for Hope will be an excellent resource that can further advance the efforts of helping those obtain and maintain sobriety.

Sincerely

Paul Meigio

7th Judicial District Drug Court Manager.

BONNEVILLE COUNTY
SHERIFF

605 N. CAPITAL * IDAHO FALLS, IDAHO 83402
208) 529-1375 FAX (208) 529-1297

PAUL J. WILDE
SHERIFF

SAM HULSE
PATROL CAPTAIN

SID HAMBERLIN
JAIL CAPTAIN

2016 Joint Millennium Fund Committee October15,2015

Dear Committee Members:

I would like to express my support for *The Center for HOPE*, a community behavioral health recovery center, in Idaho Falls. My organization is looking forward to being a partner in this effort.

I have personally seen one of my family member go through drug addiction issues. My Brother was involved in a vehicle accident that almost killed his best friend. He was prosecuted for a DUI. He was placed in Drug court and was the second person to graduate Drug Court in the Bonneville County Courts.

In my 24 years as working for the Bonneville County Sheriff's Office I have seen the issues that relate to addiction. I have seen mental illness after drug use, ladies that sell their bodies for their next high, I have seen violence attributed to drug abuse and so much more.

This facility will help provide an area with support to those that are in the recovery process. This process is not quick or easy. This is why I support the Center for Hope in the Idaho Falls area.

The Center for HOPE will be a great asset in addressing the needs of persons who are in Recovery by allowing them to access recovery support networks and activities in a timely manner, with little to no cost to the client. Many individuals and families in the community will benefit from this resource. Your consideration of this proposal is deeply appreciated.

Sgt. Jeff Edwards
Bonneville County Sheriff's Office
605 N. Capital
Idaho Falls Id, 83402
208 529 1299

Eastern Idaho REGIONAL MEDICAL CENTER

14 October 2015

RE: FY2016 Joint Millennium Fund Committee

Dear Committee Members:

I am writing to extend my strong support for *The Center for HOPE*, a community behavioral health recovery center, in Idaho Falls. I am the Executive Director at EIRMC's Behavioral Health Center (BHC) and we anticipate working very closely with *The Center* and in being their partner in addressing the behavioral health treatment needs of eastern Idaho.

BHC is a 74-bed inpatient facility in Idaho Falls, with 2 acute units (2 adult and 1 adolescent), as well as a youth residential program. We are a major hub of service for meeting behavioral health treatment needs at the more severe end of the spectrum. However, the opportunities for adequate and effective step-down care in our community and region are severely lacking. We partner closely with the agencies and programs already in existence and still find significant gaps in the spectrum of care. When proposals for *The Center for Hope* started moving forward and began to come to fruition, we were deeply supportive and hoped that a recovery center might finally find a home in Idaho Falls.

Following inpatient stays in BHC, our case managers repeatedly have difficulty finding timely follow-up care and sufficient support in the community. Consequently, we see many patients in a revolving door pattern that might easily be resolved with more extensive and frequent peer support to complement their follow-up treatment. *The Center for Hope* would become a key referral for our case managers and the anticipated programming would address this frequent interruption in the continuity of care.

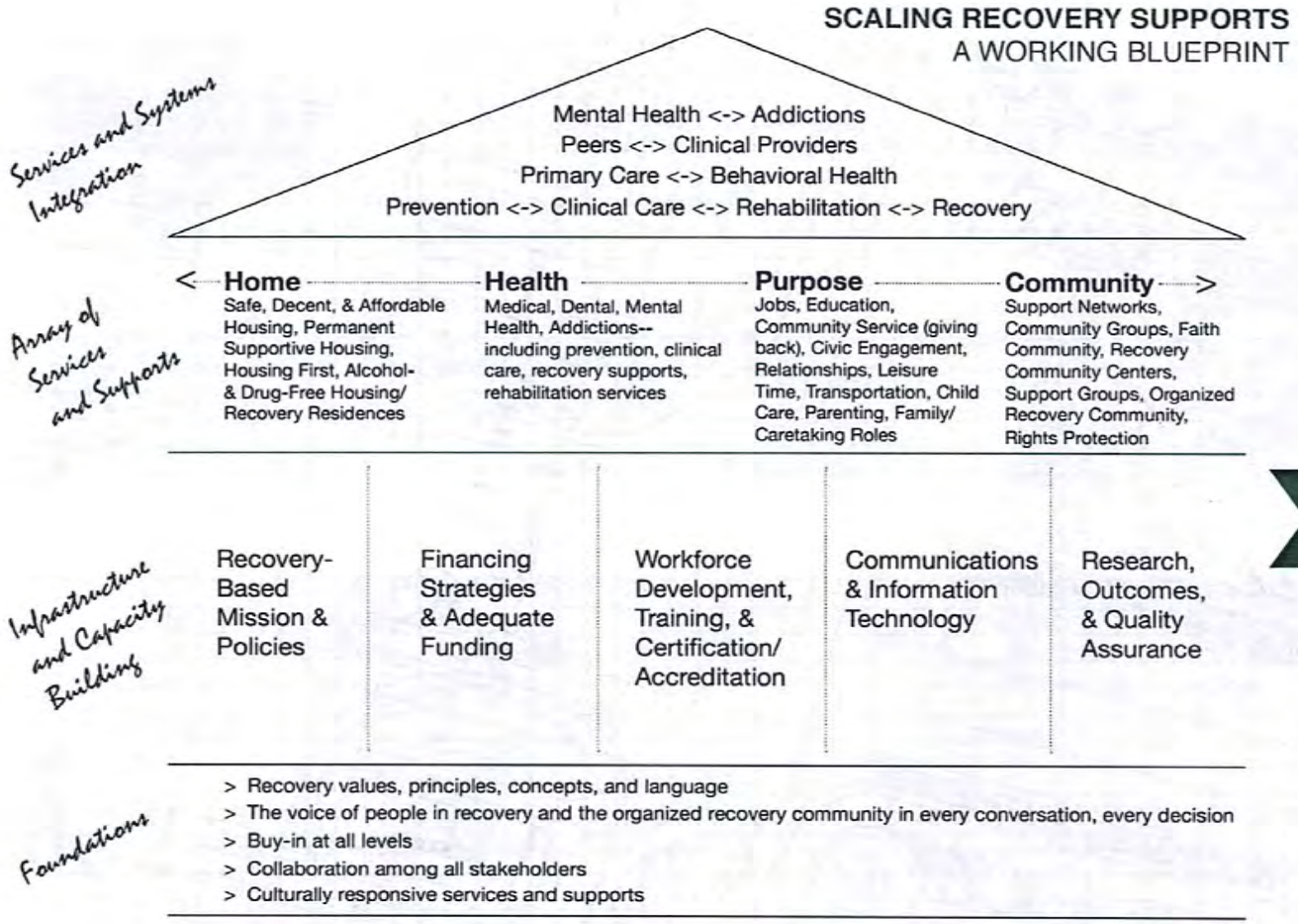
This said, we are enthusiastically supportive of *The Center for Hope* finding the funding and support it needs to succeed and provide Recovery Activities and support to all persons in Recovery in the Idaho Falls area. Co-located with Idaho's first Behavioral Health Crisis Center, I believe *The Center* is primed for success in an area of the state where the need is great. Investing in such a worthwhile asset will provide our community regular access to recovery support networks and activities in a timely manner, with little to no cost to the client. Many individuals and families in the community will benefit, directly and indirectly, from this resource. Your serious consideration of this proposal is deeply appreciated.

Sincerely,

Aaron A. Harris, PhD
Executive Director
Behavioral Health Center (EIRMC)
2280 E. 25th Street
Idaho Falls, ID 83404
Office: (208) 227-2157

2015 BRSS TACS Policy Academy: Individual, Family, and Community Health and Wellness ACTION PLAN

State/Territory: _____



BRSS TACS VISION: We envision open and unrestricted access to sustainable, community-integrated recovery that supports healthy individuals and families.

SWOT Summary

Strengths:	Weaknesses:
1. Grant funding for 4 centers 2. Recovery community 3. Community leaders already on board 4. Collaborative partners	1. Communication disjointed 2. Recovery Idaho's limitation of no staff or budget 3. Optum process 4. Start-up funding is one-time
Opportunities:	**Threats:**
1. Collaboration/coordination 2. SHIP (State Healthcare Innovation Plan) 3. Education/public awareness 4. Starting from the ground up/we get to set the standards	1. Lack of outcome data 2. Lack of awareness in primary healthcare 3. Competing issues 4. Success of first four centers

Priority Areas:

1. Recovery Idaho
2. Current recovery community centers (Latah, Gem, Canyon, Ada)
3. Extending funding opportunities for recovery community centers to additional communities.

Team Objectives:

1. Recovery Idaho has an active board and adequate staffing and resources to support each recovery center in Idaho to the level sought by that center.
2. Each of the four grant-funded recovery community centers is up and running by September 1, 2015.
3. The four initial recovery community centers have established budgets, obtained adequate committed resources and

outcome data to provide support to those in recovery in their communities, as well as the knowledge and information needed to seek new funding for additional services as the need arises.

4. Recovery Idaho creates a recovery community center structure that can be duplicated with adjustment for new communities seeking to establish centers, as well as providing administrative oversight to individual centers, when asked to do so.

Objective 1: *Recovery Idaho has an active board and adequate staffing and resources to support each recovery center in Idaho to the level sought by that center.*

Description: Currently, Recovery Idaho (RI) has an active volunteer board, is incorporated with the State of Idaho and has federal 501(c)(3) tax status. The organization has built the foundation and has a board with the expertise and enthusiasm to support recovery community centers around the state, but without staff, is very limited in its capacity to provide that support.

Inputs	Action Steps	Outcomes
1. RI has an active board that values members with lived experience. 2. Elected officials have been involved in the process to create RI and continue to support it. 3. A number of Idahoans have toured existing recovery centers in other states and are familiar with the benefits they offer. 4. The Idaho Department of Health and Welfare, the Idaho Supreme Court and the Idaho Department of Correction are all supportive of the development of RI and recovery community centers. 5. Current one-time State funding to establish four recovery community centers is flexible enough to also provide options that could help fund RI. 6. The Idaho Association of Counties (IAC) is supportive of RI submitting the next Millennium Fund grant request, making RI a more active and visible partner in creating RSS in Idaho.	1. Activity: Include initial partial funding for RI staff position through BRSS TACS funding. Person Responsible: RI, Division of Behavioral Health (DBH) Timeline: 6/5/2015 $ 2. Activity: Establish support for the ongoing coordination of Idaho's recovery community centers by Recovery Idaho through a meeting, or multiple meetings, with the Idaho Association of Counties, participating recovery center counties, Recovery Idaho board representation, BRSS TACS Idaho policy academy participants, and DBH staff. Determine the level of support organizations and individuals are able to contribute to ensure ongoing recovery community center sustainability. Person Responsible: RI, Idaho Association of Counties (IAC), DBH, and recovery center designees, policy academy participants Timeline: 8/1/2015 $ 3. Activity: Facilitate RI to contract directly with IAC for the operation of the Gem County recovery community center, with a portion of grant funding to support RI costs related to the ongoing sustainability of the recovery community center, development of a toolkit to guide future recovery community centers as they establish in Idaho, and fulfilling the goals of this action plan. Person Responsible: IAC, RI, Board of Gem County Commissioners Timeline: 7/1/2015 $ 4. Activity: Recovery Idaho will work with communities to	1. Initial funding is approved by BRSS TACS to allow RI to hire staff person. 2. IAC and participating counties agree to utilize a portion of existing funding to support RI staff and structure. 3. IAC contracts directly with RI to establish and operate the Gem County recovery community center. RI will also maintain its office in the Gem County recovery community center. 4. Write a successful Millennium Fund grant to include RI funding to cover staff position(s) and other operational costs for additional centers for fiscal year 2017 (7/1/2016-6/30/2017)

	mobilize support for the establishment of additional recovery community centers in coordination with IAC, community members, existing recovery community center officials, and county and state government officials. Recovery Idaho will submit the next application for Millennium Fund grant money to support the establishment of these additional recovery community centers under the coordination of Recovery Idaho.. Person Responsible: RI, IAC, DBH, recovery center designees Timeline: 10/31/2015	

Objective 2: Each of the four grant-funded recovery community centers is up and running by September 1, 2015.

Description: Currently, planning is being done in each of the four counties regarding how the awarded State Millennium Fund money will be dispersed from IAC to the centers for fiscal year 2016. This funding is adequate to initially establish each of the centers, but substantial work must be done to get the doors open for each center. The sustainability of these centers, as well as the funding of additional centers, is absolutely dependent on these centers functioning as represented in the initial grant proposal.

Inputs	Action Plan Steps	Outcomes
1. Awarded one-year funding of $500,000 for the four centers will become available July 1, 2015. 2. Plans are currently in development in each county that should accommodate being open by September 1, 2015. 3. The Regional Behavioral Health Boards with recovery community centers opening in their regions are supportive and involved. 4. There is representation and active participation of the recovery community in the creation of the centers. 5. The centers are being developed with an integrated approach, with peers from the mental health and substance use disorder community involved. 6. There is active awareness and support of elected officials and community leaders for the recovery community centers	1. Activity: Ensure that contracts exist to provide funding to centers in each of the four counties. Person Responsible: IAC, county commissioners Timeline: by 7/1/2015 2. Activity: Identify recovery community centers in other states for potential virtual tours to establish a base-line awareness of potential for centers among staff and stakeholders. Person Responsible: DBH staff, Recovery Idaho Timeline: by 9/1/2015 $ 3. Activity: Create a budget for Year One for each center and secure approval. Person Responsible: IAC, center designees Timeline: 9/15/2015 4. Activity: Verify that recovery community centers in each of the four funded counties are open for business. Person Responsible: IAC, center designees Timeline: by 9/15/2015 5. Activity: Identify, develop and provide role-appropriate and role-specific training and orientation for recovery community center staff and volunteers; Person Responsibility: BRSS TACS TA resources, RI, center designees, Timeline: Initial start of training August 1, 2015 $	1. Contracts for the operation of each of the four centers are signed. 2. Virtual tours have been accomplished and contractors for each of the centers have established what programing will be initially available in their centers. This will also include operating hours, volunteer scheduling, infrastructure needed. 3. Budget for each center has been provided to IAC. 4. Doors are open for business. 5. Recovery Center staff and volunteers demonstrate competency in providing quality services.

Objective 3: The four initial recovery community centers have established budgets, obtained adequate committed resources

and outcome data to provide support to those in recovery in their communities, as well as have the knowledge and information needed to seek new funding for additional services as the need arises.

Description: Each of the centers has one year to demonstrate their success to the communities they operate in, customize this sustainability plan to fit their communities and to achieve committed resources to maintain their facility and services beyond their initial Millennium Fund grant funding.

Inputs	Action Plan Steps	Outcomes
1. Active recovery community involvement in each funded center. 2. State agencies and the Idaho court system aware of benefits of having recovery community centers available to their clients. 3. Decision makers, both in communities and in the Idaho legislature, aware of benefits of recovery community centers. 4. Idaho State Healthcare Innovation Plan (SHIP) may provide opportunities for community-based RSS as part of health home model. 5. Idaho's current Indigence Program has created an awareness of policy makers on the cost of untreated individuals with behavioral health issues. 6. The Millennium Fund grant application established a list of potential services that can be offered and customized to fit the community needs of each recovery community center. Services that may be offered include, but are not limited to: • Peer recovery support • Recovery Coaching • A phone-based support	1. Activity: Adapt BRSS TACS-funded sustainability plan for use in each community with a center in collaboration with RI. Person Responsible: IAC designee for each center Timeline: 11/1/2015 2. Activity: Create a proposed State Fiscal Year 2017 budget and services outline for each recovery community center, listing potential funding sources and a menu of potential community-specific services that will be offered for individuals in recovery in each community. Each center is expected to develop a unique menu of services specific to the goals and needs of its participants and volunteers.. Person Responsible: IAC designee for each center Timeline: 12/1/2015 3. Activity: Establish and secure commitments for on-going funding for each of the centers. Person Responsible: IAC designee for each center Timeline: 3/1/2016 4. Activity: Create outcome working group to establish processes to collect outcome and evaluation data and report by center and aggregate for state. This group may also evaluate and assist in selecting a system that can collect data about recoverees while tracking their recovery progress and outcomes. Person Responsible: RI, IAC designee for each center Timeline: August 1, 2015 and final report for first grant by September 30, 2016 $	1. Adapted plan provided to IAC. 2. Proposed FY 2017 budget with potential funding sources submitted to IAC. 3. Letters of Commitment from funders for FY 2017 to IAC. 4. Work group meets and Outcome and Evaluation data reports delivered. 5. Data collection on recoverees' progress will help bolster requests for ongoing funding in support of existing and future recovery community centers by demonstrating successful outcomes. It will be essential to future Millennium Fund grant requests.

system to reach out to individuals who request peer contact to "check in" on their recovery progress. • Smoking cessation classes (required) • Job skills • Job application tutorials • Parenting classes • Community service • Resume writing • Computer and internet skills • Health eating/cooking • Reading skills • Budgeting/record keeping • Healthy recreation • Paint the Town • Leaf cleanup		

Objective 4: *Recovery Idaho creates a recovery community center structure that can be duplicated with adjustment for new communities seeking to establish centers, as well as providing administrative oversight to individual centers, when asked to do so.*

Description: A plan is currently being created that will provide funding to RI for staffing to carry them through Fiscal Year 2016. In this next year they must become capable of providing an over-all structure to be the submitter of future grant proposals for both the funding of their own organization as well as funding for future recover community centers. They also need to establish themselves as the recognized recovery community organization for Idaho.

Inputs	Action Plan Steps	Outcomes
1. RI's board of directors has wide geographic representation and needed experience to create a solid recovery community center structure that can be replicated	$ 2. Activity: Recovery Idaho works with the Gem County community to recruit volunteers and gather resources necessary to open a Gem County Recovery Community Center with staff	1. 2. The Gem County Recovery Community Center is open. 3. The Idaho Recovery Community Center toolkit is posted to the Recovery Idaho website.

around the state. 2. RI is a 501 (c)(3) which will be an asset in obtaining additional funding. 3. RI has done the work to establish a mission, vision and core values to provide the foundation for current and future recovery community centers. 4. RI has a volunteer state-wide base that will be helpful in establishing largely volunteer-run centers in future communities.	and volunteers available during open hours. Person Responsible: RI Timeline: September 15, 2015 $ 3. Activity: Document all steps of the process for opening the Gem County Recovery Community Center, and collect information from the other recovery community centers, in an Idaho Recovery Community Center Toolkit to be posted to the RI website. Person Responsible: RI Timeline: Toolkit posted to RI website by September 30, 2016 4. Activity: Develop and implement a comprehensive communications plan for recovery community centers in Idaho, including traditional, social, and other media outlets. Person Responsible: RI Timeline: Developed by January 1, 2016 $ 5. Activity: Create a RI website for communication with Idaho's recovery community and built-in collaboration with statewide recovery community centers as the state's Recovery Community Organization. This website will also house the Idaho Recovery Community Center Toolkit upon its completion. Person Responsible: RI Timeline: By November 1, 2015 6. Activity: Train new Recovery Coach trainers to ensure training accessibility across the state as new centers are established. Person Responsible: RI Timeline: November 1, 2015 $	4. Comprehensive communications plan developed and implemented. 5. A Recovery Idaho website up and running. 6. New Recovery Coach trainers are trained and accessible around the state.

September 18, 2015

Millennium Fund Committee
Budget& Policy Analysis
Legislative Services Office – 3rd Floor
700 W. Jefferson
Boise, ID 83720

Dear Millennium Fund Committee,

Please consider this letter as a request to secure funding for a Recovery Center in Kootenai County. Recovery centers provide a meeting place for those in recovery from mental illness, alcohol and /or drug addiction and act as a face for recovery to the community as a whole. Idaho is seventh in the nation for suicide. 90% of individuals who die from suicide have a diagnosis of substance abuse and mental illness. The Region 1- Kootenai Recovery Center Committee is a volunteer group of individuals committed to ensuring the behavior health need of our citizens and community are met; our goal is to promote healing and wellness. That is why we have taken up the great task in organizing and addressing the recovery needs for our area.

Our Center would focus on a model of positive recovery knowing that there are many pathways to recovery. All will be welcome here. Recovery emerges from hope and involves personal responsibility. We believe it is possible to live a full meaningful life regardless of the challenges that we might need to overcome. We all know that mental health and substance abuse issues affect each person differently as well as their families, co-workers and community connections. It will be our intention to have support groups and other educational activities for individuals and family members.

Making change is hard. Individuals who suffer from mental illness or addiction often run into obstacles and require a safe place to access care. Our goal is to provide support for people seeking to initiate or maintain long term recovery from substance use or co – occurring behavioral health disorders. When our citizens recover, the entire community will benefit. Please feel free to contact us if you have any questions or need further information.

Regards,

Kootenai Recovery Center Committee

Bonner County
Board of Commissioners

Cary Kelly Glen Bailey Todd Sudick

September 15, 2015

Millennium Fund Committee
Budget & Policy Analysis
Legislative Services Office – 3rd Floor
700 W. Jefferson
Boise, ID 83720

Dear Millennium Fund Committee,

As Bonner County Commissioners, we ask that Millennium Fund grant dollars be approved to help establish a Recovery and Resource Center in Coeur d'Alene Idaho. By creating this center, our northern communities will have a recovery and support oriented resource for the five northern counties.

This center will provide access to recovery and support services needed by those in our communities who struggle with their recovery. Such individuals often end-up in our emergency rooms or jail facilities. This is a tremendous cost for our medical care and justice systems not to mention our hard-earned tax payer dollars. Obviously these consequences hugely impact those who seek recovery but lack the knowledge or skills to find services and support.

This center will help develop a support system for those in need and their families by promoting long-term recovery, developing contacts for additional support, and hopefully such beneficiaries can "pay it forward" by volunteering their time and energy to a program of healthy recovery.

BONNER COUNTY BOARD OF COMMISSIONERS

Cary Kelly, Chairman

Glen Bailey, Commissioner

Todd Sudick, Commissioner

cc - Ron Beecher
Joyce Broadsword

1500 Highway 2, Ste. 308 Sandpoint, ID 83864 (208) 265-1438 Fax: (208) 265-1460

Heritage Health

Family Support Services of North Idaho, LLC

An Integrative Approach to Individual, Family and Community Services

September 18, 2015

Millennium Fund Committee
c/o Angela Palmer

Please accept this correspondence as support for the funding of a Recovery Center for our North Idaho community. While it may seem we have an abundance of mental health and substance abuse resources available to those in need, there remain significant gaps in our system of care that hinder recovery for those who are ready to embark on the journey.

Recovery is possible, but only with the development and sustainability of personal and natural supports. A Recovery Center would both promote and provide this necessary support. It would serve as a resource for individuals in need as well as for their families. Those of us in the field, understand the need for a holistic approach to health and wellness. Having a resource where people can go to address their needs with full acceptance and without judgment, is critical.

That the Recovery Center will be volunteer-led, lends to the real development of sustainable, natural supports. It also means the investment of time and energy is directly linked to a desire of members of the community to assist those in need. Our community, like many others across our country, is in need of the development of community-sustaining support systems that augment and enhance the current, provider-driven system of care.

It is my sincere hope that the Recovery Center for North Idaho/Coeur d'Alene is funded. I know of many individuals who could directly benefit, either as recipients or as volunteers.

Thank you for your consideration.

Jodi Smith, CPRP, LPC
Clinic Director
Heritage Health/Family Support Services of North Idaho

KootenaiHealth

2003 Kootenai Health Way
Coeur d'Alene, ID 83814
208.666.2000 tel
kootenaihealth.org

September 15, 2015

Dear Members of the Millennium Fund Committee:

I am writing to support a Recovery Community Center for the Coeur d'Alene area. Idaho has the 26th highest drug overdose mortality rate in the United States, with 11.8 per 100,000 people suffering drug overdose fatalities, according to the *Prescription Drug Abuse: Strategies to Stop the Epidemic in 2013*. In addition, methamphetamine and alcohol addictions continue to be a considerable concern in the region.

As Director of Behavioral Health at Kootenai Health, the second largest behavioral health service line in the state, I witness the suffering of addicted individuals on a daily basis. The lack of services in the state and the region compound the issue on an individual and community level. A Recovery Community Center would provide a support system for individuals with addictions that is vital to ongoing recovery and would most likely be very instrumental in preventing relapses which result in the use of expensive higher levels of care.

I hope that you will support a Recovery Community Center for the Coeur d'Alene area. This type of center will provide the opportunity for individuals with substance use disorders the support and hope that they need for ongoing sobriety.

Sincerely,

Claudia Miewald, M.S.N., PMHCNS-BC
Director of Kootenai Behavioral Health

IDAHO DEPARTMENT OF CORRECTION

To promote a safer Idaho by reducing recidivism

C. L. "BUTCH" OTTER
Governor

KEVIN H. KEMPF
Director

From: Greg Willey, Sr. Probation and Parole Officer
Jenifer Carter, Probation and Parole Officer
DATE: September 16, 2015
REF: Letter of support for the Recovery Community Center

To whom it may concern;

P.O. Jenifer Carter and myself currently supervise the mental health caseload in Coeur d'Alene, Idaho. Together, we supervise an average of 100 criminal offenders who have severe and persistent mental illness. One of the issues we struggle with is having community support for people who struggle with co-occurring disorders (housing, clothing, food, treatment, medication, etc.). The Recovery Community Center that is being considered for the Coeur d'Alene, Idaho area is a perfect resource for people with co-occurring disorders. Therefore, we are writing to express our support for your proposal to secure millennium fund grant dollars to establish a Recovery Community Center in our area. We feel it would greatly impact our community in the most positive way.

Respectfully submitted,

Greg Willey
Sr. Probation & Parole Officer
202 E. Anton, #100
Coeur d'Alene, Id. 83854
1-208-769-1444 ext. 254

Jenifer Carter
Probation & Parole Officer
1-208-769-1444 ext. 258

Approved by: Steve Veare, District One Manager, Idaho Department of Correction (via email)

Kootenai County Specialty Courts
P.O. Box 9000 • Coeur d'Alene, ID 83816-9000
501 N Government Way • 1st Floor
Fax: (208) 446-1224

September 16, 2015

Idaho Joint Legislative Millennium Fund Committee
700 W. Jefferson
Boise, ID 83720

RE: Kootenai County Recovery Community Center

Dear Idaho Joint Legislative Millennium Fund Committee:

I am writing to express my support for the proposal to secure Millennium Fund grant dollars to establish a Recovery Community Center in Kootenai County, Idaho. As the Court Coordinator for the Kootenai County Mental Health Court, I see on a daily basis how a center like this would benefit those attempting to be in recovery from drugs and/or alcohol addiction, as well as those who are working on becoming stable in their mental illness. Many of the people in our program could use a place to continue to work on improving their life, and the lives of those around them. This Recovery Community Center would be a place for community members to safely access care for addiction and mental illness. It would be a place of hope, healing and help.

I look forward to this project coming to fruition, and strongly support the use of Millennium Fund grant dollars to ensure that it does.

Sincerely,

Mary E. Wolfinger

Mary E. Wolfinger, MPA
Court Coordinator
Kootenai County Mental Health Court

Tanya L. Reynolds
Drug Court Coordinator
(208) 446-1220
treynolds@kcgov.us

Mary E. Wolfinger
Mental Health Court Coordinator
(208) 446-1219
mwolfinger@kcgov.us

Rita Wickham
DUI Court Coordinator
(208) 446-1218
rwickham@kcgov.us

TRINITY GROUP HOMES, INC.

P.O. Box 1861
Coeur D'Alene, ID 83816-1861
(208) 667-9607 ~ Fax (208) 765-2732
www.trinitygrouphomes.net

September 17, 2015

Ref: Recovery Community Center in Coeur d'Alene Idaho.

To the Millennium Fund Committee:

I am writing to express my support for a Recovery Community Center to be established in Coeur d'Alene Idaho. Our agency has been given the opportunity to gain insight into the need and justification for a Recovery Community Center in this community from our residents, area agencies, and from our attendance at the Region 1 Behavioral Health Board monthly meetings. As you may know, I serve as Executive Director for Trinity Group Homes, Inc. Our mission is to provide caring, community-supported housing for adults with mental illness with programs that teach life skills to our residents. Our goal is to ensure that adults with a severe and persistent mental illness have safe affordable housing in a supportive environment. We were founded in 1979 by local individuals to provide drug and alcohol free homes in which individuals can learn to live independent lives with their mental illness. We were registered as a non-profit organization in Idaho on November 24, 1980. (IRS Tax Determination Letter: 82-0379313).

As you realize, housing for those with mental illness is extremely critical to insure recovery and continued stability for individuals with mental illness. The issue we constantly face with some residents is when their mental illness begins to challenge them, they need more attention than our small staff can provide. Having a Recovery Community Center in this community would be a huge help for our residents. Residents that attend our weekly Life Skills classes have a higher success rate during and after their residency at Trinity than those who choose not to attend these groups. A Recovery center would provide residents with many more weekly classes than our small staff can provide. Our residents would also benefit from the added support and built-in socialization that the Recovery Center will provide. Without sufficient activities to keep them busy, many of our residents often slip into a pattern of isolation that is adverse to mental health and/or substance use recovery.

We all realize that the proposed Recovery Community Center is a key component to the overall health and wellbeing of individuals with a diagnosis of severe and persistent mental illness. It is a missing service link in this community for individuals with mental illness to move with some degree of success ~ towards recovery. Feel free to call with any questions about our agency. I've attach some details about Trinity Group Homes, Inc.'s services. Please feel free to use this information.

Sincerely;

Robert S. Runkle
Executive Director, Trinity Group Homes, Inc.

ACES
COMMUNITY SERVICES

Because a Healthy Mind Matters

Millennium Fund Committee,

I am writing to express our support for your proposal to secure Millennium Fund grant dollars to establish a Recovery Community Centers in Kootenai County, Idaho.

As a Private Provider of Behavioral Health Services in the 3 Northern Counties of Kootenai, Shoshone, and Benewah, we support establishing a Recovery Center in Kootenai County. We believe it would be a benefit to our community because we see the need for these types of supports every day. The recovery center would save dollars by offering preventative services rather than spending the money on the back end.

We would work as a partner to the Center and would offer whatever support they would need. We truly have confidence in this effort for the affected individuals, families and to better the community as a whole.

Amika Taniguchi

ACES Community Services

1700 E Schneidmiller

Post Falls, ID 83854

RECOVERY IDAHO

October 12, 2015

Dear Millennium Fund Committee:

I am writing this letter on behalf of Recovery Idaho, Inc. and in support of the Idaho Association of Counties (IAC) in their efforts to secure a Millennium Fund grant to help establish four new Recovery Community Centers in Nez Perce, Kootenai, Bannock, and Bonneville Counties. Recovery Idaho, Inc. serves as an umbrella organization for support, training, and fundraising for four existing Recovery Community Centers that were supported in the last Millennium Fund cycle, located in Ada, Canyon, Gem, and Latah Counties.

The existing centers are all experiencing a great deal of success in serving recoverees and meeting the needs of their communities. Each Center is at a different stage of the opening process, but all are receiving enormous community support. As the Centers gather additional data regarding the recoverees they serve and their quality of life, Recovery Idaho is confident that lives will be changed and funds will be saved in each community.

The services and support offered at Recovery Community Centers directly benefit the counties and local law enforcement by helping individuals seeking long-term recovery from addictions or co-occurring behavioral health disorders. If left unaddressed, these behavioral health issues can lead to encounters with law enforcement and/or trips to the emergency room with nothing to cover the cost but taxpayer-backed county indigent funds. This Millennium Fund proposal is a way to enhance what counties do in support of their community members who suffer from Behavioral Health issues.

Thank you for your continued support in recovery efforts and for considering the IAC's request for additional funding for these four new Centers across Idaho.

Sincerely,

Tammie Rice
Executive Director, Recovery Idaho

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NEZ PERCE COUNTY
BOARD OF COUNTY COMMISSIONERS

1225 Idaho Street
P.O. Box 896
Lewiston, Idaho 83501-0896
(208) 799-3090
FAX (208) 799-3149

August 11, 2015

Nez Perce County Recovery and Resource Steering Committee
Attn: Eric K. Peterson, Acting Chair Steering Committee
904 7th Avenue
Lewiston, Idaho 83501

Dear Mr. Peterson,

Nez Perce County would like to express our support for Millennium Fund grant dollars to establish a Nez Perce Recovery and Resource Center (The Center) in Lewiston. By creating The Center, our community can put a face on recovery and provide a recovery and support oriented sanctuary for Nez Perce, Lewis, and Asotin Counties.

The Center will provide a gateway and access to recovery and support services needed by those in every community who struggle with their recovery. Such individuals often seek help or otherwise end-up in a local emergency room or jail facilities costing the communities in terms of law enforcement time and money, jail costs, and indigent funds. These outcomes hurt our residents who seek recovery but lack the knowledge or ability to find funds, services, and support.

The Center will help develop a support system critical to maintaining long-term recovery, find contacts for additional support, and when ready may pay it forward by volunteering to continue a tradition of healthy recovery for others.

BOARD OF COUNTY COMMISSIONERS

DOUGLAS W. HAVENS, Chairman

ROBERT H. TIPPETT, Member

DOUGLAS A. ZENNER, Member

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REGION II
Behavioral Health Board

Appointed Members:

Co. Commissioner/Designee (3)
John Allen-Clearwater
Tom Lamar-Latah
Teresa Wolf-Nez Perce

Dept of Health & Welfare (2)
Joyce Lyons
Laura Thayer

Court Appointed Judiciary (1)
Lisa Martin

Law Enforcement (1)
Sheriff Chris Goetz

Adult Correction System (1)
Scott Douglass

Juvenile Justice (1)
VACANT

Physician (1):
Dr. Glenn Jefferson

Hospital Representative (1)
Elizabeth Patzer

School District (1)
Mary Evans

Mental Health Private Provider(1):
Tammy Everson

SUD Private Provider (1):
Beverly Fowler

Mental Health Advocate (1)
Jim Rehder

SUD Advocate (1)
Cathlin Stewart

Parent of Child –MH (1)
Jennifer Griffis

Parent of Child –SUD (1)
Lori Blackmon

Family Member- MH Adult (1)
Deborah Lind

Family Member-SUD Adult (1)
Eleanor Downey

Adult MH Consumer Rep. (1)
Marsha Wilson

Adult SUD Consumer Rep. (1)
Mike Kingsley

August 13, 2015

Daniel Chadwick, Executive Director
Idaho Association of Counties
700 W. Washington
Boise, Idaho 83701

Dan,
The Region II Behavioral Health Board (BHB) supports the Idaho Association of Counties (IAC) to secure Millennium Fund Grant to establish start up funding for Recovery Community Centers (RCC).

Region II BHB actively seeks resources to address recovery for those with Substance Use Disorders (SUD) and Mental Illness. RCC's have proven to be very helpful in mitigating the loss of productivity for those afflicted and saves tax dollars in treatment, incarceration and emergency room visits.

Our Board unanimously supports the establishment of an RCC in Nez Perce County with start-up funding from the Millennium Fund. The Latah County RCC, approved last year, has overwhelming community support and is scheduled to open in September. Nez Perce County has strong community support for an RCC to assist individuals with addictions and mental illness.

The RCC grant process from the Millennium Fund has proven to be an innovative approach to divert those in need to a path of recovery and regaining purpose and productivity in their lives and the lives of their families.

We well know the affects of untreated addictions and mental illness. These situations carry high monetary cost to our local communities in law enforcement, incarceration, hospitals and county indigent funding. More importantly, they carry a high personal cost to the families of those with addiction and mental illness. Additionally, it is estimated that $1 spent on prevention saves more than $5 of treatment.

Please feel free to contact us for further support in securing a RCC for Nez Perce County.

Sincerely,

Jim Rehder, Chair
Region II Behavioral Health Board

Region II Behavioral Health Board•C/O Darrell Keim CRDS,
1350 Troy HWY #2, Moscow, ID 83843
Phone: 208-882-6932

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Nez Perce County Sheriff's Office

1150 Wall Street • Lewiston, Idaho 83501

Joe Rodriguez
Sheriff

Scot Gleason
Chief Deputy

Sheriff's Office
Administration
(208) 799-3130

Detention Center
Administration
(208) 799-3139

Dispatch
(208) 799-3131

Detention Center
(208) 799-3132

Records
(208) 799-3137

Civil
(208) 799-3134

Driver's License
(208) 799-3138

Sheriff's Fax
(208) 799-3101

Detention Fax
(208) 799-3144

August 24, 2015

Nez Perce County Recovery and Resource Steering Committee
Attn: Eric Peterson, Acting Chair Steering Committee
904 7th Avenue
Lewiston, ID 83501

Dear Mr. Peterson;

I would like to express my support for the Millennium Fund grant dollars in order to establish a Nez Perce County Recovery and Resource Center in Lewiston.

From my professional perspective a recovery center would provide an invaluable resource for those who struggle with addictions. These are community members that I and my staff contact every day, people for whom addiction has led to a downward life spiral that not only affects the individual involved, but their families and the community as a whole.

The proposed Nez Perce County Recovery and Resource Center would be an invaluable tool to those who are seeking long-term recovery. The Center would greatly mitigate inmate recidivism and the burden now existing on many other county, state and federal systems by providing a place of refuge, support and advocacy.

The Center's efforts would transfer back to the community, helping to create strong, productive citizens who will break the addiction cycle and pass those values on to their children, ending forever that downward life spiral so many of us in law enforcement have seen go from one generation to the next.

Sincerely,

Joe Rodriguez, Sheriff

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Nez Perce County

OFFICE OF THE PROSECUTING ATTORNEY

1221 F Street, P.O. Box 1267, Lewiston, ID 83501-1267, Phone: (208) 799-3073, Fax: (208) 799-3080

Daniel L. Spickler
Prosecutor
e-mail:
danspickler@co.nezperce.id.us

Sandra K. Dickerson
Chief Deputy

Nance Ceccarelli
Civil Deputy

Joyce G. Kaufman
Victim/Witness Coordinator

August 18, 2015

Nez Perce Recovery and Resource Steering Committee
Attn: Eric K. Peterson, Acting Chair
904 7th Avenue
Lewiston, Idaho 83501

Dear Mr. Peterson:

We at the Nez Perce County Prosecutor's Office are writing to express our support for Millennium Fund grant dollars to establish a Nez Perce Recovery and Resource Center (The Center) in Lewiston. By creating The Center our community can put a face on recovery and provide a recovery and support oriented sanctuary for Nez Perce, Lewis and Asotin counties (those areas served by our regional transit system).

We believe such a Center is a welcome and needed resource. The Center will provide a gateway and access to recovery and support services needed by those in every community who struggle with their recovery. Such individuals often seek help or otherwise end-up in a local emergency room or jail facility costing the communities in terms of law enforcement time and money, jail costs, and indigent funds. These outcomes hurt our residents who seek recovery but lack the knowledge or ability to find funds, services, and support.

With such a recovery and support center in place, those seeking recovery help with their issues can work free of charge with peers and volunteers who share their experiences. They can develop a support system critical to maintaining their long-term recovery, find contacts for additional support, and when ready may pay it forward by volunteering to continue a tradition of healthy recovery for others.

The Center will help put a positive face on recovery and support in our counties' communities. The Center, its staff, and volunteers will help establish local friendships and partnerships which include the communities in efforts to bring recovery and support out of the shadows. When our citizens recover, we feel our communities benefit.

Sincerely,

Daniel L. Spickler

DANIEL L. SPICKLER
Prosecuting Attorney

DLS:mk

17

P.O. Box 586
Orofino, ID 83544
Phone: (208) 476-3615
Fax: (208) 476-3127

Clearwater County Commissioners

August 24, 2015

Nez Perce County Recovery and Resource Steering Committee
Attn: Eric K. Peterson, Acting Chair Steering Committee
904 7th Avenue
Lewiston, Idaho 83501

Dear Mr. Peterson;

Clearwater County would like to express our support for Millennium Fund grant dollars to establish a Nez Perce Recovery and Resource Center (The Center) in Lewiston. By creating The Center, our community can put a face on recovery and provide a recovery and support oriented sanctuary for Nez Perce, Lewis, and Asotin Counties.

The Center will provide a gateway and access to recovery and support services needed by those in every community who struggle with their recovery. Such individuals often seek help or otherwise end-up in a local emergency room or jail facilities costing the communities in terms of law enforcement time and money, jail costs, and indigent funds. These outcomes hurt our residents who seek recovery but lack the knowledge or ability to find funds, services, and support.

The Center will help develop a support system critical to maintaining long-term recovery, find contacts for additional support, and when ready may pay it forward by volunteering to continue a tradition of healthy recovery for others.

BOARD OF COUNTY COMMISSIONERS

DON EBERT, CHAIRMAN

JOHN ALLEN, COMMISSIONER

absent

JOHN SMITH, COMMISSIONER

14

quality behavioral health

T: 509.758.3341 F: 509.758.8009
900 Seventh Street, Clarkston, WA 99403

T: 509.843.3791 F: 509.843.3548
856 Main Street, Pomeroy, WA 99347
www.qualitybehavioralhealth.com

August 4, 2015

Nez Perce County Recovery & Resource Steering Committee
ATTN: Eric K. Peterson, Acting Chair Steering Committee
904 7th Avenue
Lewiston, ID 83501

Dear Mr. Peterson,

The Chemical Dependency Program at Quality Behavioral Health is writing to express our support for Millennium Fund grant dollars to establish a Nez Perce County Recovery and Resource Center (The Center) in Lewiston, Idaho. By creating The Center, our community can put a face on recovery and provide a recovery and support oriented sanctuary for Nez Perce, Lewis, and Asotin Counties (areas served by our regional transit system).

We believe such a center is welcome and a needed resource to our area. The Center will provide a gateway and access to recovery and support services needed by those in every community who struggle with their recovery. Such individuals often seek help or otherwise end-up in our local emergency room or jail facilities which, in turn, cost the communities' time and money in terms of law enforcement time, jail costs, and indigent funds. These outcomes hurt our residents who seek recovery but lack the knowledge or ability to find funds, services, and support.

With such a recovery and support center in place, those seeking recovery-help can work, free of charge, with peers and volunteers who share their experiences. They can develop a support system critical to maintaining their long-term recovery, find contacts for additional support, and when ready, may pay-it-forward by volunteering in order to continue a tradition of healthy recovery for others.

The Center will help put a positive face on recovery and support in our counties' communities. The Center, its staff, and volunteers will help establish local friendships and partnerships which include the communities' efforts to bring recovery and support out of the shadows. When our citizens recover and stigma towards addiction is reduced, we feel our communities benefit.

Sincerely,

Thea Skalicky, MS, CDP, NCACI
CD Program Manager/Clinical Supervisor

15

quality behavioral health

T: 509.758.3341 F: 509.758.8009
900 Seventh Street, Clarkston, WA 99403

T: 509.843.3791 F: 509.843.3568
856 Main Street, Pomeroy, WA 99347
www.qualitybehavioralhealth.com

August 8, 2015

Nez Perce County Recovery & Resource Steering Committee
Attn: Eric K. Peterson, Acting Chair Steering Committee
904 7th Avenue
Lewiston, Id 83501

Dear Mr. Peterson:

It is my pleasure to write a letter in support for the Nez Perce County Recovery and Resource Center (The Center) to seek and receive support from the Idaho Associations of Counties for the IAC Millennium Fund grant.

QBH is a strong supporter of peer service support systems as it provides a healthy system of care as well as growth for those who participate as peer support volunteers and for those who seek services. Peer-run services, such as The Center proposes, provide peer to peer wellness and support, recovery learning, and skill-building. These programs serve to provide a safe and trustworthy community-based connection to services. In addition, peer mentors can teach coping skills that emphasize physical wellness such as getting and maintaining proper sleep and nutrition, reducing or managing stress, and building positive social supports; all necessary elements linked to recovery.

As a provider in the area, Quality Behavioral Health (QBH) is aware that there is a need for additional support for those in recovery and wishes to aid in that endeavor by lending support for this project. QBH believes that such a center will serve as a gateway for those individuals who seek recovery but lack the knowledge or ability to find funds, services or support. Thank you for your consideration.

Sincerely,

Gail A. Price, Ph.D., LMHC, LCPC, BCPC
Executive & Clinical Director of
Quality Behavioral Health

16

quality behavioral health

T: 509.758.3341 F: 509.758.8009
900 Seventh Street, Clarkston, WA 99403

T: 509.843.3791 F: 509.843.3548
856 Main Street, Pomeroy, WA 99347
www.qualitybehavioralhealth.com

August 8, 2015

Nez Perce County Recovery & Resource Steering Committee
Attn: Eric K. Peterson, Acting Chair Steering Committee
904 7th Avenue
Lewiston, Id 83501

Dear Mr. Peterson:

Thank you for contacting me regarding this endeavor. It is my pleasure to write a letter in support for the Nez Perce County Recovery and Resource Center (The Center) to seek and receive support from the Idaho Associations of Counties for the IAC Millennium Fund grant.

I am the sole physician for QBHS, and am well aware of the lack of resources for those in recovery in our Valley. I think this would be a big step in improving access to recovery and to help coordinate other resources available to those in need. I would welcome and support this project and will be active in promoting it's success if approved.

Sincerely,

Allen M. Ernster M.D.
Staff Physician for Quality Behavioral Health

17

Tri-State
Memorial Hospital & Medical Campus

August 6, 2016

Nez Perce County Recovery and Resource Steering Committee
Attn: Eric K. Peterson, Steering Committee Chair
904 7th Avenue
Lewiston, Idaho 83501

Dear Mr. Peterson:

Tri-State Memorial Hospital and Medical Clinic is writing to express our support for Millennium Fund grant dollars to establish a Nez Perce County Recovery and Resource Center in the Lewis-Clark Valley. By creating this Center our community can put a face on recovery and provide a recovery and support oriented sanctuary for Nez Perce and Asotin counties, as well as Lewis County (those areas served by our regional transit system).

We believe such a Center is a welcome and needed resource. The Center will provide a gateway and access to recovery and support services needed by those in every community who struggle with their recovery. Such individuals often seek help or otherwise end-up in our emergency room, where we are not able to meet their needs most of the time. These outcomes hurt our residents who seek recovery but lack the knowledge or ability to find funds, services, and support.

With such a recovery and support center in place, those seeking recovery help with their issues can work, free of charge, with peers and volunteers who share their experiences. They can develop a support system critical to maintaining their long-term recovery, find contacts for additional support, and when ready may pay it forward by volunteering to continue a tradition of healthy recovery for others.

The Center will help put a positive face on recovery and support in our counties' communities. The Center, its staff, and volunteers will help establish local friendships and partnerships which include the communities in efforts to bring recovery and support out of the shadows. When our citizens recover, we feel our communities benefit.

Sincerely,

Don Wee

Don Wee, CEO

DW/ra

1221 Highland Avenue | PO Box 189 | Clarkston, WA 99403 | 509.758.5511 | 1.866.814.3412 | FAX 509.758.3566
www.TriStateHospital.org

18

BRIAN SHINN
COMMISSIONER, FIRST DISTRICT

JIM JEFFORDS
COMMISSIONER, THIRD DISTRICT

ASOTIN COUNTY
STATE CORNERSTONE

JIM FULLER
COMMISSIONER, SECOND DISTRICT

VIVIAN BLY
CLERK OF THE BOARD/BENEFITS

P.O. BOX 250
ASOTIN, WASHINGTON 99402-0250
PHONE (509) 243-2060
FAX (509) 243-2005

August 31, 2015

Nez Perce County Recovery & Resource Steering Committee
Attn: Eric K. Peterson, Acting Chair Steering Committee
904 7th Avenue
Lewiston, Id 83501

Dear Mr. Peterson:

The Asotin County Board of Commissioners strongly endorses and supports the efforts of the (The Center) Nez Perce County Recovery and Resource Center's efforts to secure funding through the Idaho Association of Counties' IAC Millennium Fund grant program to establish itself as a local resource center.

Asotin County recognizes the growing problems of drug and alcohol abuse and the mental health issues that both contribute to and result from this abuse. We also recognize the need of a local center able to facilitate people in recovery, family members and organizations dedicated to promoting healthy communities. We support the center's goal of providing recovery and resource support services that promote recovery through advocacy, education and service for the residents of Nez Perce, Lewis and Asotin Counties.

The Center will help develop a support system essential for long-term recovery for citizens and help them progress as participating and productive members of society. Asotin County supports these goals.

Sincerely,
ASOTIN COUNTY BOARD OF COMMISSIONERS

James R. Jeffords
Jim Jeffords, Chairman

Brian Shinn
Brian Shinn, Vice Chair

Jim Fuller
Jim Fuller, Member

BS/vb

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Nez Perce

TRIBAL EXECUTIVE COMMITTEE
Office of Legal Counsel
P.O. BOX 305 • LAPWAI, IDAHO 83540-0305 • (208) 843-7355
FAX (208) 843-7377

August 24, 2015

Nez Perce Recovery and Resource Steering Committee
Attn: Eric K. Peterson, Acting Chair
904 7th Ave.
Lewiston, ID 83501

Dear Mr. Peterson:

The Nez Perce Tribe Office of Legal Counsel supports and encourages the granting of Millennium Fund dollars to establish a Nez Perce Recovery and Resource Center in the City of Lewiston. Creating a recovery and support oriented sanctuary for the areas served by the transit system, which the Nez Perce Tribe is involved with, will reduce the number of incidents that erupt into police involvement.

The State of Idaho has concurrent jurisdiction over "insanities and mental illness" on the Nez Perce reservation as per Idaho Code Section 67-5101. This State responsibility adds to the already heavy burden of dealing with other State residents who seek mental health assistance help. If establishing this local Center can save the time and money of police officers, the costs of emergency room services or the cost of jail stays, it seems there should be no question that it should be funded. Clearly, having a safe local center available to individuals, including tribal individuals, who are struggling with their mental health can save the State money in the long-term. But it also can save lives by providing early intervention to a person who may need urgent help.

It is my understanding that this Center will be staffed with many volunteers and only a few paid employees, so again, this would be an effective and less expensive way to provide support to persons experiencing crises or relapses in their road to stable mental health. This is a goal worth supporting, so on behalf of the Tribe's in-house legal office, I send my strong encouragement in your effort to establish a Nez Perce Recovery and Resource Center in Lewiston, Idaho.

Sincerely,

Julie Sobotta Kane

Julie Sobotta Kane
Managing Attorney

20

City of Clarkston

City Hall: (509) 758-5541 • Police: (509) 758-1680 • Fire: (509) 758-8681 • Fax: (509) 769-6018

829 5th Street • Clarkston, WA 99403 • www.clarkston-wa.com

September 2, 2015

Nez Perce Recovery and Resource Steering Committee
Attn: Eric K. Peterson, acting chair Steering Committee
904 7th Avenue
Lewiston, Idaho 83501

Dear Mr. Peterson,

We, The City Council of the City of Clarkston, are writing to express our support for Millennium Fund grant dollars to establish a Nez Perce Recovery and Resource Center (The Center) in Lewiston. By creating The Center our community can put a face on recovery and provide a recovery and support oriented sanctuary for Nez Perce, Clearwater, Lewis, and Asotin Counties (those areas served by our regional transit system).

We believe such a Center is a welcome and needed resource. The Center will provide a gateway and access to recovery and support services needed by those in every community who struggle with their recovery. Such individuals often seek help or otherwise end-up in a local emergency room or jail facilities costing the communities in terms of law enforcement time and money, jail costs, and indigent funds. These outcomes hurt our residents who seek recovery but lack the knowledge or ability to find funds, services, and support.

With such a recovery and support center in place, those seeking recovery help with their issues can work, free of charge, with peers and volunteers who share their experiences. They can develop a support system critical to maintaining their long-term recovery, find contacts for additional support, and when ready may pay it forward by volunteering to continue a tradition of healthy recovery for others.

The Center will help put a positive face on recovery and support in our counties' communities. The Center, its staff, and volunteers will help establish local friendships and partnerships which include the communities in efforts to bring recovery and support out of the shadows. When our citizens recover, we feel our communities benefit.

Sincerely,

Kathleen A Warren

Kathleen A. Warren
Mayor, City of Clarkston

TREE CITY USA.

21

Clearwater Valley
Hospital and Clinics | Orofino, Idaho

301 Cedar Street * Orofino, ID 83544 (208) 476-4555 (hospital) 476-5777 (clinic)

Nez Perce Recovery and Resource Steering Committee
904 7th Avenue
Lewiston, Idaho 83501

From: Lenne Bonner, Chief Administrative Officer
Clearwater Valley Hospital and Clinics
St. Mary's Hospital and Clinics

Date: September 1, 2015

Nez Perce Recovery and Resource Steering Committee
Attn: Eric K. Peterson, acting chair Steering Committee
904 7th Avenue
Lewiston, Idaho 83501

Dear Mr. Peterson,

We, Clearwater Valley Hospital and Clinics, are writing to express our support for Millennium Fund grant dollars to establish a Nez Perce Recovery and Resource Center (The Center) in Lewiston. By creating The Center our community can put a face on recovery and provide a recovery and support oriented sanctuary for Nez Perce, Lewis, Clearwater and Asotin counties and the Nez Perce Tribal Reservation (those areas served by our regional transit system).

We believe such a Center is a welcome and needed resource. The Center will provide a gateway and access to recovery and support services needed by those in every community who struggle with their recovery. Such individuals often seek help or otherwise end-up in a local emergency room or jail facilities costing the communities in terms of law enforcement time and money, jail costs, and indigent funds. These outcomes hurt our residents who seek recovery but lack the knowledge or ability to find funds, services, and support.

With such a recovery and support center in place, those seeking recovery help with their issues can work, free of charge, with peers and volunteers who share their experiences. They can develop a support system critical to maintaining their long-term recovery, find contacts for additional support, and when ready may pay it forward by volunteering to continue a tradition of healthy recovery for others.

The Center will help put a positive face on recovery and support in our counties' communities. The Center, its staff, and volunteers will help establish local friendships and partnerships which include the communities in efforts to bring recovery and support out of the shadows. When our citizens recover, we feel our communities benefit.

Sincerely,

Lenne J Bonner

Lenne Bonner
Chief Administrative Officer

Nez Perce

TRIBAL EXECUTIVE COMMITTEE
P.O. BOX 305 • LAPWAI, IDAHO 83540 • (208) 843-2253

September 23, 2015

Eric K. Peterson, Acting Chair
Nez Perce Recovery and Resource Steering Committee
907 7th Avenue
Lewiston, ID 83501

Dear Mr. Peterson:

Thank you for approaching the Nez Perce Tribe with your plans for the Nez Perce Recovery and Resource Center in conjunction with Recovery Idaho, Inc., an Idaho 501 (c) (3) nonprofit. The Nez Perce Tribe supportd the use of a Millennium Fund grant to establish this much needed center.

We are grateful that you have included our communities in your planning for services much needed for those who have addiction issues as well as mental/behavioral health problems. We laud your efforts in reaching out to the Behavioral Health Department of Nimiipuu Health.

We anticipate that the services will be well received. We also hope that those who benefit will become a part of the volunterr work force that will validate this project.

Sincerely,

Anthony D. Johnson
Chairman

ST. JOSEPH
Regional Medical Center

23

September 11, 2015
Nez Perce County Recovery and Resource Steering Committee
Attn: Eric K. Peterson, Acting Chair Steering Committee
904 7th Avenue
Lewiston, Idaho 83501

Dear Mr. Peterson,

I am writing to express the support of St. Joseph Regional Medical Center for the establishment of a Nez Perce County Recovery and Resource Center in Lewiston. We support the use of a Millennium Fund grant to help with the creation of the Resource Center. Behavioral Health is a significantly unmet need in Nez Perce County. People requiring help with recovery from substance abuse are a substantial part of this unmet need. A resource such as the Center will provide an important access point for services that will make successful and sustained recovery more realistic for these patients. Alternatives such as jail or Emergency Room visits clearly do not help these individuals overcome their problem. The Recovery Center will help remove the negative stigma associated with behavioral health problems in our society. St. Joe's endorses this concept and this project.

Sincerely,

Michael Rooney, M.D.

Michael Rooney, M.D.
Interim CEO

Asotin County Sheriff

P.O. Box 130
Asotin, WA 99402
Phone: (509) 243-4717
Fax: (509) 243-4719

24

September 2, 2015

Nez Perce Recovery and Resource Steering Committee
Attn: Eric K. Peterson, acting chair Steering Committee
904 7th Avenue
Lewiston, Idaho 83501

Dear Mr. Peterson,

Thank you for the visit. I found the information you presented quite informative. The Recovery and Resource Center you and your organization are proposing will be a very welcome and much needed resource for this community.

Since taking over as Asotin County Sheriff, I have seen the need for a facility such as this. We have experienced a large amount of people in our community that struggle with mental health and addiction issues. This will provide a service to everyone in the community that is touched by this problem. I would like to ensure that Asotin County will remain partnered by this endeavor and I wish you much success. Again, thank you for allowing Asotin County to be a part of this process.

Sincerley,

John Hilderbrand
Asotin County Sheriff

25

Lewis-Clark
STATE
COLLEGE
Connecting Learning to Life

September 14, 2015

Nez Perce County Recovery and Resource Steering Committee
Eric Peterson, Chair
904 7th Avenue
Lewiston ID 83501

Dear Mr. Peterson,

Lewis-Clark State College is pleased to write in support of a Millennium Fund grant to establish the Nez Perce County Recovery and Resource Center. The Center will enable those seeking help to work free of charge with peers and volunteers who share their experiences, developing a support system critical to maintaining long-term recovery for themselves and others.

LCSC believes that access to recovery services for those afflicted with addiction and mental health issues will make our communities stronger.

Sincerely,

J. Anthony Fernandez
President

BRIAN SHINN
COMMISSIONER, FIRST DISTRICT

JIM JEFFORDS
COMMISSIONER, THIRD DISTRICT

ASOTIN COUNTY
STATE CORNERSTONE

JIM FULLER
COMMISSIONER, SECOND DISTRICT

VIVIAN BLY
CLERK OF THE BOARD/BENEFITS

P.O. BOX 250
ASOTIN, WASHINGTON 99402-0250
PHONE (509) 243-2060
FAX (509) 243-2005

August 31, 2015

Nez Perce County Recovery & Resource Steering Committee
Attn: Eric K. Peterson, Acting Chair Steering Committee
904 7th Avenue
Lewiston, Id 83501

Dear Mr. Peterson:

The Asotin County Board of Commissioners strongly endorses and supports the efforts of the (The Center) Nez Perce County Recovery and Resource Center's efforts to secure funding through the Idaho Association of Counties' IAC Millennium Fund grant program to establish itself as a local resource center.

Asotin County recognizes the growing problems of drug and alcohol abuse and the mental health issues that both contribute to and result from this abuse. We also recognize the need of a local center able to facilitate people in recovery, family members and organizations dedicated to promoting healthy communities. We support the center's goal of providing recovery and resource support services that promote recovery through advocacy, education and service for the residents of Nez Perce, Lewis and Asotin Counties.

The Center will help develop a support system essential for long-term recovery for citizens and help them progress as participating and productive members of society. Asotin County supports these goals.

Sincerely,
ASOTIN COUNTY BOARD OF COMMISSIONERS

James K. Jeffords
Jim Jeffords, Chairman

Brian Shinn
Brian Shinn, Vice Chair

Jim Fuller
Jim Fuller, Member

BS/vb

Latah County
BOARD OF COUNTY COMMISSIONERS

P.O. Box 8068 ♦ 522 South Adams ♦ Moscow, Idaho 83843
(208) 883-7208 ♦ fax (208) 883-2280 ♦ e-mail bocc@latah.id.us
Richard Walser ♦ ***David McGraw*** ♦ ***Thomas C. Lamar***

September 25, 2015

Caitlyn Rusche
Idaho Association of Counties
PO Box 1623
Boise, ID 83701

Dear Ms. Rusche,

The Latah County Board of County Commissioners understands that the current IAC request before the Idaho Millennium Fund seeks funding for additional Recovery Centers in the state of Idaho, including one in Nez Perce County. Our Board wishes to express our support for this proposal that would help establish a Nez Perce Recovery Center.

Thanks to last year's IAC proposal to the Millennium Fund, Latah County has had a very successful opening of our Recovery Center, with the first client being assisted within the first hour of operation. We believe that we will continue to see a very successful use of this resource during this year, and are actively seeking funds to maintain this center in our County seat for years to come.

The current IAC proposal to establish additional centers (including one in Nez Perce County) helps to meet the vision of providing a network of recovery centers that can address addictive behavior within our state. We encourage you to include in your request funding for Recovery Idaho to help the local centers better administer their work, and provide uniform Idaho-based training to the various centers. Recovery Idaho serves as the hub of the network, and is in the perfect position to strengthen this work throughout the state.

We believe Recovery Centers are welcome and needed resources. They provide gateways and access to recovery and support services needed by those in every community who struggle with their recovery. Such individuals often seek help or otherwise end-up in a local emergency room or jail facilities costing the communities in terms of law enforcement time and money, jail costs, and indigent funds.

Thank you for your work to seek positive solutions for the Counties of Idaho.

Sincerely,

Richard Walser
Chair

David McGraw
Commissioner

Thomas C. Lamar
Commissioner

PEER WELLNESS CENTER, INC.

963 S. ORCHARD STREET – SUITE 102 BOISE, ID 83705

10/15/2015

Dear Millennium Fund Committee,

I'd like to express the full support of PEER Wellness Center for the Idaho Association of Counties' application to the Millennium Fund to support the start-up funds for Recovery Community Centers in Bannock, Bonneville, Kootenai, and Nez Perce counties.

In the short time since PEER Wellness Center officially opened our doors on June 25, 2015, we have already seen not only the need for recovery support services but the positive effect on over 1000 individual's lives as they find the support that they need to be successful. Each Recovery Community Center puts a face on the often stigmatized recovery process for the community as a whole, demonstrating that people can not only recover from addiction and mental illness, but that they can be true assets to their community as well. In addition to the recovery support services and tobacco cessation classes offered by each center, each recoveree has the opportunity to volunteer their time to help peers who may be struggling, which is a valuable experience for anyone navigating recovery. Recoverees are encouraged to be active members of their community and have the opportunity to learn from others, including peer recovery coaches and peer specialists, the tools they need to live a successful life in recovery, regardless of their pathway to achieving it. We believe that peer-based recovery support services should be available in every community across the state of Idaho.

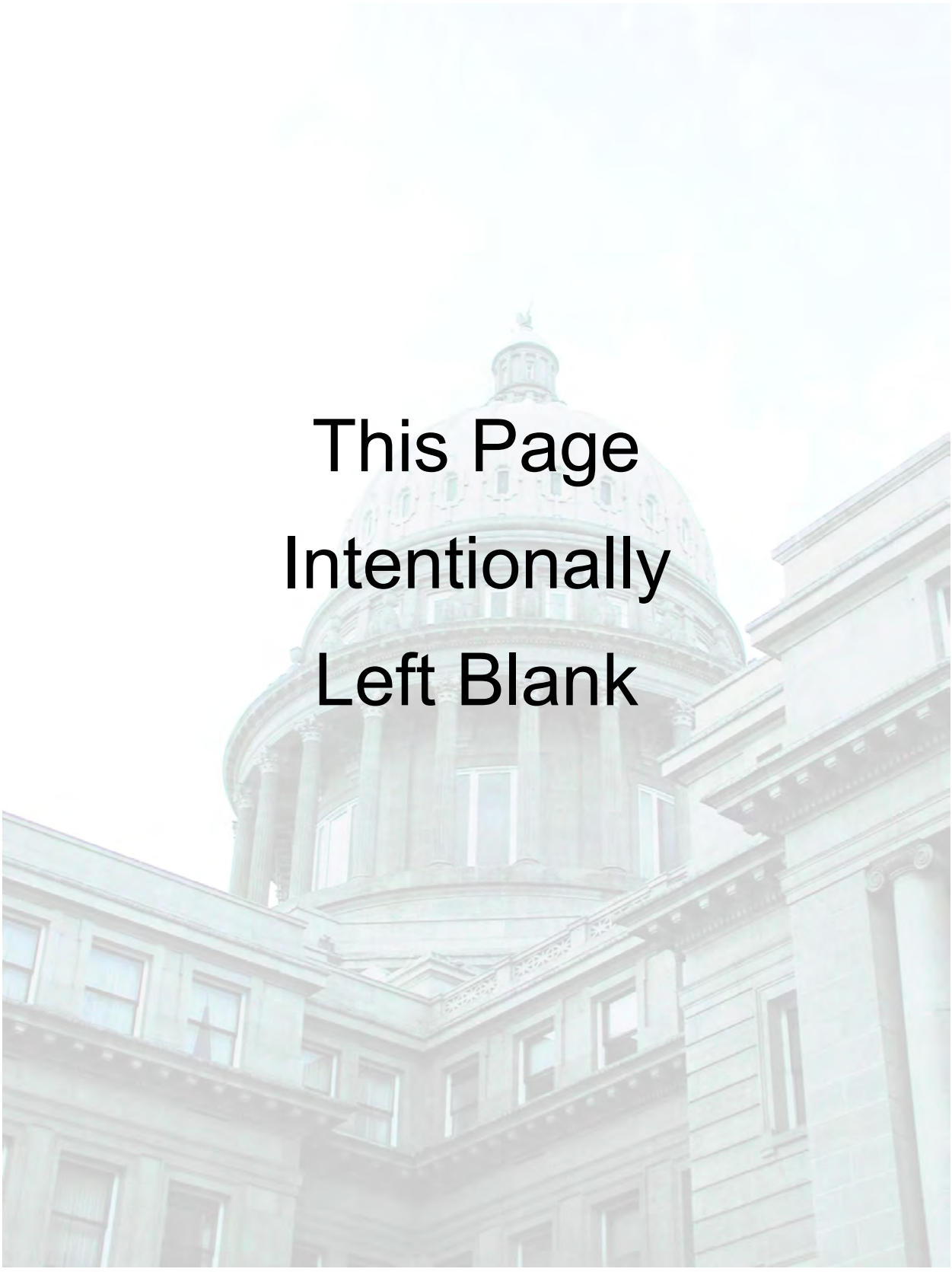
Untreated or unsupported Behavioral Health problems lead to crisis which can include criminal justice system involvement, emergency room visits, and acute hospitalizations. For every dollar that we invest in preventative support we will realize a savings of six to seven dollars in taxpayer resources.

Thank you for your continued support of recovery efforts and for considering the Idaho Association of Counties request for funding for these new centers.

Sincerely,

Monica Forbes

Monica Forbes
Executive Director
PEER Wellness Center, Inc.



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IDAHO ASSOCIATION OF COUNTIES

700 W. Washington Street
P.O. Box 1623, Boise, Idaho 83701
Phone (208) 345-9126 - FAX: (208) 345-0379

October 15th,2015

Dear Millennium Fund Committee,

I'd like to express the full support of the Idaho Association of Counties for Recovery Idaho, Inc.'s application to the Millennium Fund to support the ongoing operation of four Recovery Community Centers in Ada, Canyon, Gem and Latah counties.

In the short time since these facilities each received $125,000 from the Millennium Fund's last grant cycle on July 1, 2015, they've already shown that they are deeply needed by those seeking long-term addiction and behavioral health recovery in their communities. Each Recovery Community Center puts a face on the often stigmatized recovery process for the community as a whole, demonstrating that people can not only recover from addiction and mental illness, but that they can be true assets to their community as well. In addition to the recovery support services and tobacco cessation classes offered by each center, each recoveree has the opportunity to volunteer their time to help peers who may be struggling, which is a valuable experience for anyone navigating recovery. Recoverees are encouraged to be active members of their community and have the opportunity to learn from others, including peer recovery coaches and peer specialists, the tools they need to live a successful life in recovery, regardless of their pathway to achieving it.

Additionally, each Recovery Community Center has the potential to save money for the communities and counties near where it is located. In addition to the stigma surrounding behavioral health issues, lack of money or available treatment options can also result in Behavioral Health problems going unaddressed until they lead to crisis. This can lead to encounters with law enforcement or costly trips to the emergency room that may have been avoided if the individuals had easy access to a safe place to seek free help with their recovery. These Recovery Community Centers offer that safe place along with supportive volunteers who have navigated recovery themselves.

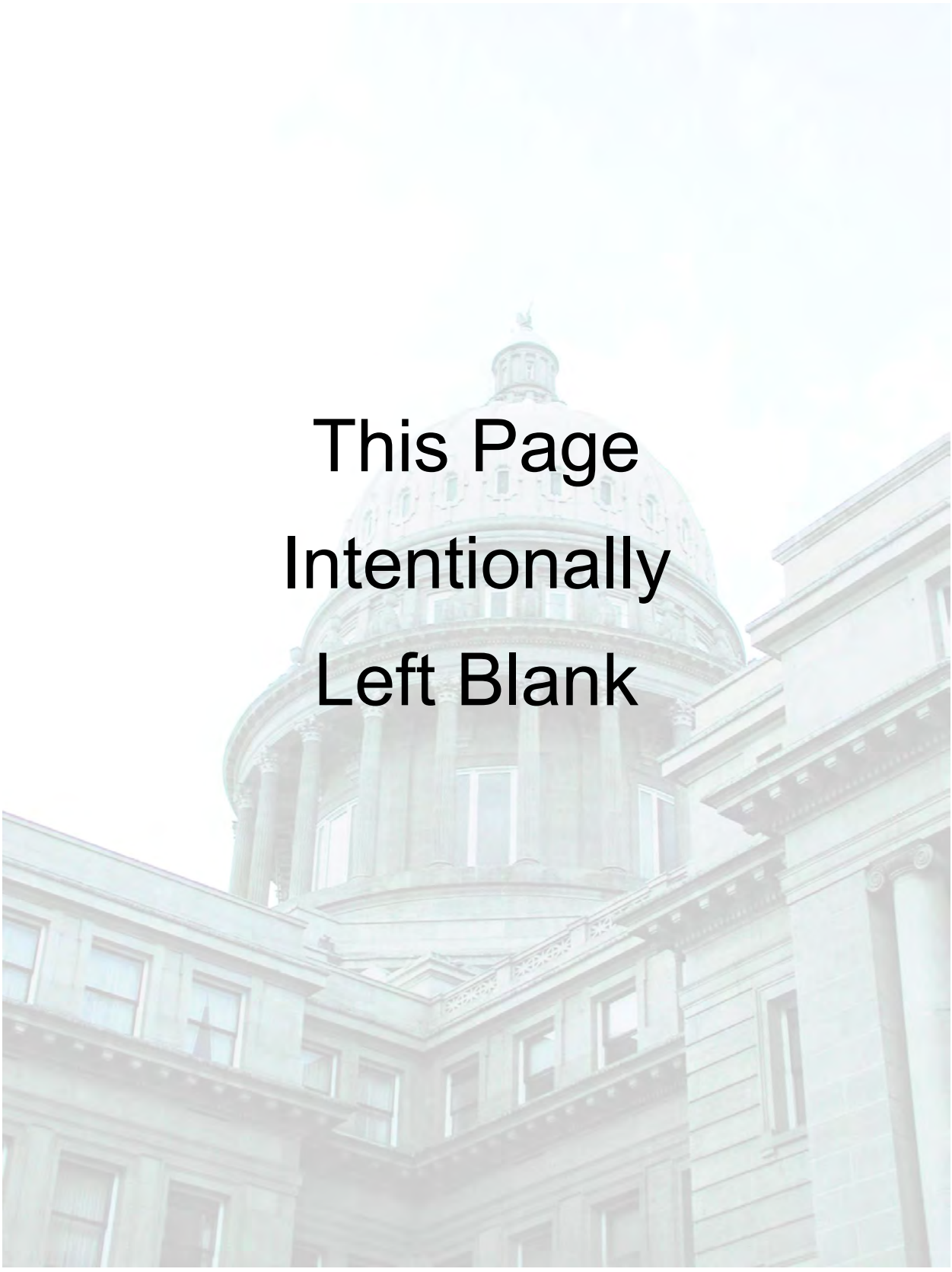
Each Recovery Community Center is at a different point in the process of mobilizing to meet the needs of its community. Each center aims to become self-sustaining with the help of community support and ongoing grant writing and fundraising. The Idaho Association of Counties understands the challenge each center has faced in working to open the doors and simultaneously seeking ongoing funds for operation. We encourage you to support the Millennium Fund application by Recovery Idaho, Inc. to give these vital facilities the opportunities they need to serve their communities in the most beneficial way possible.

Thank you for your continued support of recovery efforts and for considering Recovery Idaho's request for additional funding.

Sincerely,

Daniel G. Chadwick

Daniel G. Chadwick
Executive Director



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Valley County Board of County Commissioners

P.O. Box 1350 • 219 N. Main Street
Cascade, Idaho 83611-1350

Phone (208) 382-7100
Facsimile (208) 382-7107

GORDON L. CRUICKSHANK
Chairman of the Board
gcruickshank@co.valley.id.us

BILL WILLEY
Commissioner
bwilley@co.valley.id.us

ELTING G. HASBROUCK
Commissioner
ehasbrouck@co.valley.id.us

DOUGLAS A. MILLER
Clerk
dmiller@co.valley.id.us

Daniel Chadwick
Executive Director, Idaho Association of Counties
P.O. Box 1623
Boise, ID 83701

October 13, 2015

Dear Mr. Chadwick:

The Valley County Commissioners heard a presentation on Tuesday October 13th on securing Millennium Fund grant dollars to establish Recovery Community Centers around the state. Valley County would like to support PEER Wellness Center providing a satellite peer-based recovery support center in Valley County.

A Recovery Community Center located in Valley County would serve our region and is a welcome and needed resource. Addiction and mental health issues affect every community, and a Recovery Community Center in our region will provide access to support services to those seeking to recover. Without a Recovery Community Center, individuals who lack resources may not seek help, or end up in the local jail or emergency room. Our local community is impacted in terms of law enforcement time and money, jail costs, and county indigent funds. A Recovery Community Center will aid the people who want to recover, but lack the necessary funds to seek traditional treatment.

With a Recovery Community Center in place, people seeking recovery from addiction or mental health issues can work, free of charge, with peers who volunteer to share their recovery experience. They can establish a support system critical to their maintenance of long-term recovery, and have a place to go when they feel additional support is needed. When they are ready, they can in turn volunteer their experience to help others continue a tradition of healthy recovery.

The Recovery Community Center and its staff would be able to establish local friendships and partnerships, and include the community in efforts to bring recovery out of the shadows. This would provide our citizens recovery needs and the commissioners feel the entire community will benefit.

Having a Recovery Community Center in our Central Idaho Region would be a positive benefit for our citizens in need.

Sincerely,

Gordon L. Cruickshank
Chairman

Bill Willey
Commissioner

Elt Hasbrouck
Commissioner

IDAHO
ASSOCIATION OF
COUNTIES

700 W. Washington Street
P.O. Box 1623, Boise, Idaho 83701
Phone (208) 345-9126 - FAX: (208) 345-0379

th
October 15' 2015

Dear Millennium Fund Committee,

I'd like to express the full support of the Idaho Association of Counties for Peer Wellness Center's application to the Millennium Fund to support the start-up funds for Recovery Community Center satellite offices in Boise, Elmore, and Valley counties.

In the short time since the initial four facilities each received $125,000 from the Millennium Fund's last grant cycle on July 1, 2015, they've already shown that they are deeply needed by those seeking long-term addiction and behavioral health recovery in their communities. Each Recovery Community Center puts a face on the often stigmatized recovery process for the community as a whole, demonstrating that people can not only recover from addiction and mental illness, but that they can be true assets to their community as well. In addition to the recovery support services and tobacco cessation classes offered by each center, each recoveree has the opportunity to volunteer their time to help peers who may be struggling, which is a valuable experience for anyone navigating recovery. Recoverees are encouraged to be active members of their community and have the opportunity to learn from others, including peer recovery coaches and peer specialists, the tools they need to live a successful life in recovery, regardless of their pathway to achieving it.

Additionally, each Recovery Community Center has the potential to save money for the communities and counties near where it is located. In addition to the stigma surrounding behavioral health issues, lack of money or available treatment options can also result in Behavioral Health problems going unaddressed until they lead to crisis. This can lead to encounters with law enforcement or costly trips to the emergency room that may have been avoided if the individuals had easy access to a safe place to seek free help with their recovery. These Recovery Community Centers offer that safe place along with supportive volunteers who have navigated recovery themselves.

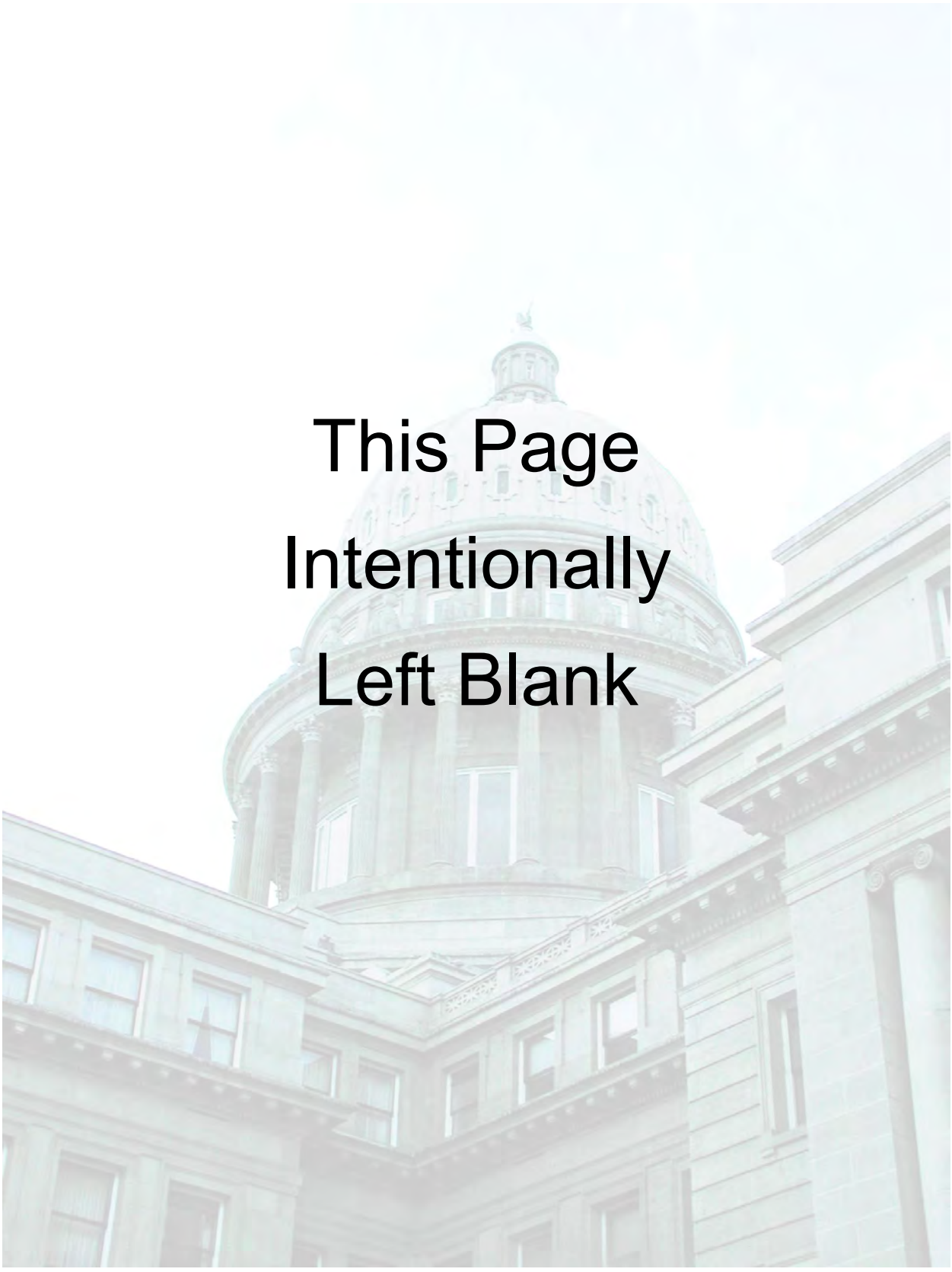
Each Recovery Community Center is at a different point in the process of mobilizing to meet the needs of its community.
Each center aims to become self-sustaining with the help of community support and ongoing grant writing and fundraising. The Idaho Association of Counties understands the challenge each center has faced in working to open the doors and simultaneously seeking ongoing funds for operation. We encourage you to support the Millennium Fund application by Recovery Idaho, Inc. to give these vital facilities the opportunities they need to serve their communities in the most beneficial way possible.

Thank you for your continued support of recovery efforts and for considering the Peer Wellness Center's request for funding for these new satellite centers.

Sincerely,

Sincerely,

Daniel G. Chadwick
Executive Director



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IDAHO ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR IDAHO

777 N. RAYMOND, SUITE 100 BOISE, IDAHO 83704 • PHONE (208) 323-1156 • FAX (208) 323-9661

September 30, 2015

Joint Millennium Fund Committee
State Capitol
Building
PO Box 83720
Boise, ID 83720

Dear Members of the Joint Millennium Fund Committee;

On behalf of the members of Idaho Academy of Family Physicians (IAFP), I am pleased to submit this letter of support for the Idaho Public Health Districts' FY17 Millennium Fund request to prevent prescription drug abuse through a prescription monitoring program awareness project.

The IAFP is the largest medical specialty society in Idaho and provides education and resources to our members on a variety of medical relevant topics. The use of prescription drugs for non-medical use has become an epidemic in the United States. Idaho is ranked 4th highest and it is critical to implement a comprehensive approach to preventing opioid overdose and deaths.

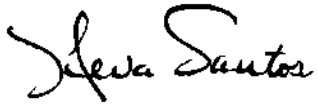
State prescription drug monitoring programs have emerged as a key strategy for addressing the misuse and abuse of prescription opioids and thus preventing opioid overdoses and deaths. Through prescription drug monitoring program databases, prescribers can check to determine whether a patient is filling the prescriptions provided and/or obtaining prescriptions for the same or similar drugs from multiple prescribers. The IAFP is pleased to partner the health districts in this effort to promote the use of the Idaho prescription drug monitoring program to reduce the amount of prescription opioids.

The IAFP is committed to quality health care, education, and advocacy on behalf of Idaho's family physicians to improve the health of our patients and our communities. The Mission of the IAFP is to support initiatives that improve the health of all Idahoans. The work of this initiative complements the IAFP's duty to support and cultivate continuing medical education and life-long learning with our members throughout Idaho. The IAFP will work with the health districts to educate our members on the importance of the prescription drug monitoring program and its use by family physicians.

We feel this project is an important part of a comprehensive approach to reduce prescription drug abuse. I encourage the Joint Millennium Fund Committee to consider

granting the Idaho Public Health Districts' request for funding to address prescription drug abuse through promotion and increased utilization of Idaho's prescription drug monitoring program.

Sincerely,



Neva Santos, CAE
Executive Director

Idaho State Board of Pharmacy

1199 W Shoreline Lane Ste 303 Boise, Idaho 83702-9103 http://bop.idaho.gov
P.O. Box 83720 Boise, Idaho 83720-0067 208.334.2356 208.334.3536 fax

September 29, 2015

Members of the Joint Millennium Fund Committee
State Capitol Building
PO Box 83720
Boise, ID 83720

Dear Members of the Joint Millennium Fund Committee:

I am pleased to support the Idaho Public Health Districts' FY17 Millennium Fund request to prevent prescription drug abuse through a prescription monitoring program awareness project. We feel this is a much needed effort to further educate Idaho's primary care providers on the harsh realities of prescription drug abuse. As the fastest growing drug problem in the United States -- and with Idaho ranking 4th highest in nonmedical use of prescription medications -- it is critical to implement a comprehensive approach to preventing opioid overdose and deaths.

State prescription monitoring programs (PMPs) have emerged as a key strategy for addressing the misuse and abuse of prescription opioids and thus preventing opioid overdoses and deaths. Through PMP databases, prescribers can check to determine whether a patient is filling the prescriptions provided and/or obtaining prescriptions for the same or similar drugs from multiple prescribers. We are pleased to partner in this community effort to promote use of Idaho's PMP to reduce the amount of prescription opioids being obtained for nonmedical use.

The Idaho State Board of Pharmacy maintains the state's PMP and was among the early pioneers to make this resource available to prescribers and pharmacists across the state. In addition, Idaho's PMP is among the first to participate in a program that shares data across state lines to authorized users, providing a more effective means to monitor drug diversion and drug abuse. Despite the availability of this resource, utilization of PMP prior to the prescribing or dispensing of a controlled substance remains suboptimal.

We feel this project is an important part of a comprehensive approach to reduce prescription drug abuse. I encourage the Joint Millennium Fund to grant the Idaho Public Health Districts' request for funding to address prescription drug abuse through promotion and increased utilization of Idaho's prescription drug monitoring program.

Sincerely,

Alex J. Adams

Alex J. Adams, PharmD, MPH
Executive Director
Idaho State Board of Pharmacy

Idaho State
UNIVERSITY

College of Pharmacy
Office of the Dean
921 South 8th Avenue, Stop 8288 • Pocatello, Idaho 83209-8288
1311 East Central Drive • Meridian, Idaho 83642-7991

September 29, 2015

Members of the Joint Millennium Fund Committee
State Capitol Building
PO Box 83720
Boise, ID 83720

Dear Members of the Joint Millennium Fund Committee:

I am pleased to support the Idaho Public Health Districts' FY17 Millennium Fund request to reduce prescription drug abuse through their prescription monitoring program awareness project. This is a much-needed effort to educate Idaho's primary care providers about tools to reduce prescription drug abuse. Prescription drug abuse is well documented as being the fastest growing drug problem in the United States. Idaho ranks 4th highest in nonmedical use of prescription medications, therefore it is of critical importance to implement a comprehensive approach to prevent drug diversion, addiction, opioid overdose, and deaths.

State prescription drug monitoring programs have emerged as a key strategy for addressing the misuse and abuse of prescription opioids. Through the Idaho Board of Pharmacy's prescription drug monitoring program database, prescribers can check to determine whether a patient obtaining prescriptions for the same or similar drugs from multiple prescribers and pharmacies. Importantly, it provides a tool for pharmacists and prescribers to work together to address this problem at its primary source: the prescription. The Idaho State University College of Pharmacy is excited to partner in this community-based effort to promote use of the prescription drug monitoring program to reduce the amount of prescription opioids being obtained for nonmedical use.

The College and its students understand the gravity of the problem of prescription drug abuse. One of our student organizations, Generation RX, provides education through classroom presentations and community outreach events to increase awareness of prescription drug abuse, especially among adolescents ages 12-18. Further, I fully endorse the College's role in assisting with the development of this program and playing a key role in the evaluation of the project. Two of our faculty, Drs. Cathy Oliphant and Rex Force, are passionate about the issue of prescription drug abuse and will provide the project with outstanding expertise.

I feel this project is an important part of a comprehensive approach to reduce prescription drug abuse. I encourage the Joint Millennium Fund to grant the Idaho Public Health Districts' request for funding to address prescription drug abuse through promotion and increased utilization of Idaho's prescription drug monitoring program.

Sincerely,

Paul S. Cady, Ph.D., R.Ph.
Dean

C.L. "Butch" Otter

Governor

Elisha Figueroa

Administrator

304 N 8th Street, Room 455

Boise, ID 83702

208-854-3042

208-854-3041

State of Idaho

Office of Drug Policy

Executive Office of the Governor

October 1, 2015

Members of the Joint Millennium Fund Committee
State Capitol Building
PO Box 83720
Boise, ID 83720

Dear Members of the Joint Millennium Fund Committee:

I am pleased to support the Idaho Public Health Districts' FY17 Millennium Fund request to prevent prescription drug abuse through a prescription monitoring program awareness project. We feel this is a much needed effort to educate Idaho's primary care providers on the harsh realities of prescription drug abuse. As the fastest growing drug problem in the United States and with Idaho ranking 4th highest in nonmedical use of prescription medications, it is critical to implement a comprehensive approach to preventing opioid overdose and deaths.

State prescription drug monitoring programs have emerged as a key strategy for addressing the misuse and abuse of prescription opioids and thus preventing opioid overdoses and deaths. Through prescription drug monitoring program databases, prescribers can check to determine whether a patient is filling the prescriptions provided and/or obtaining prescriptions for the same or similar drugs from multiple prescribers. We are pleased to partner in this community effort to promote use of the prescription drug monitoring program to reduce the amount of prescription opioids being obtained for nonmedical use.

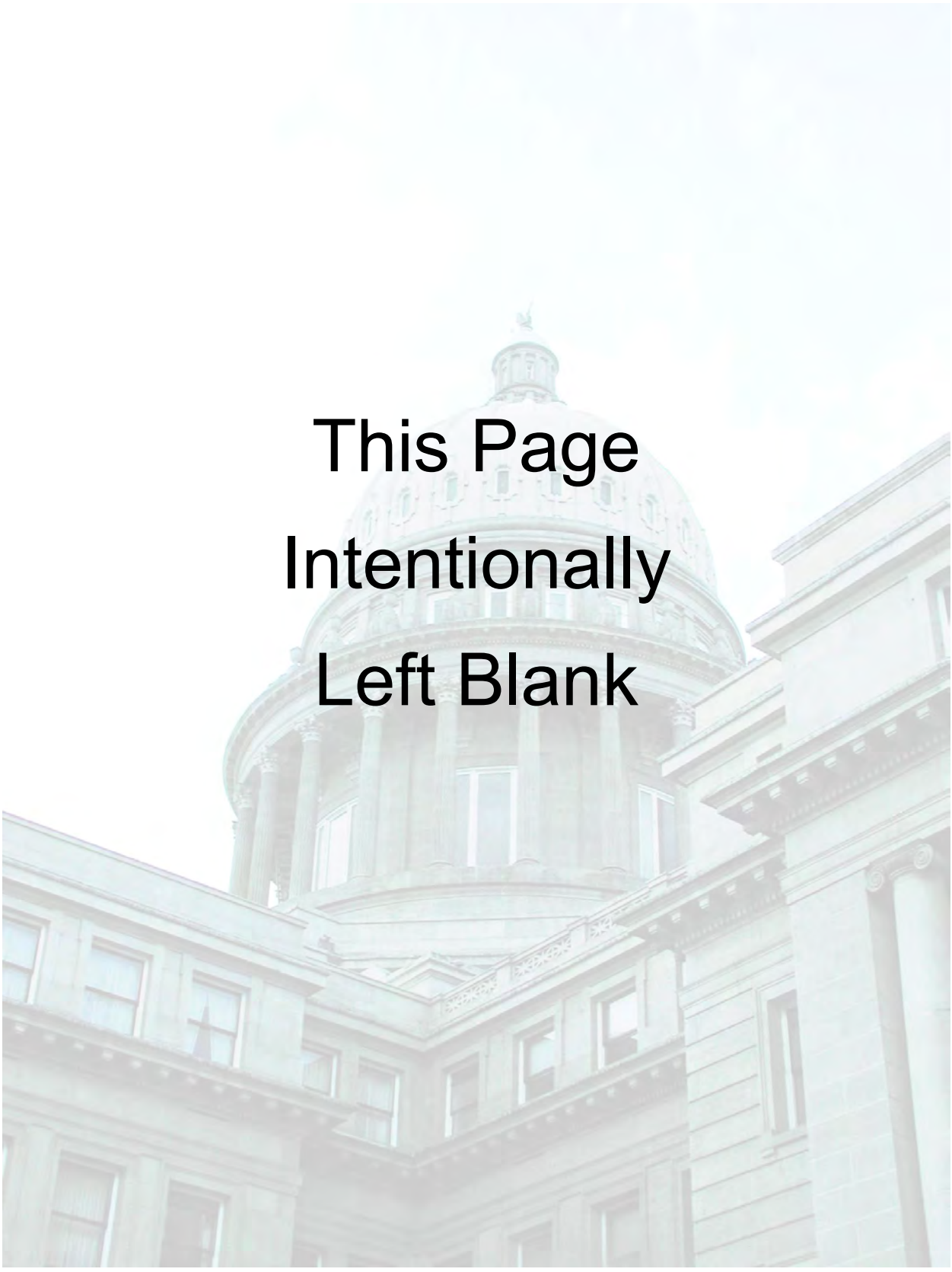
This project works in harmony with two of Idaho's Prescription Drug Workgroup's objectives: 1) increasing the number of prescribers registered for the state's Prescription Monitoring Program (PMP) and, 2) identify and implement methods to educate prescribers in Idaho regarding the proper treatment of pain and the signs, symptoms, and dangers of prescription drug misuse and abuse.

We feel this project is an important part of a comprehensive approach to reduce prescription drug abuse. I encourage the Joint Millennium Fund to grant the Idaho Public Health Districts' request for funding to address prescription drug abuse through promotion and increased utilization of Idaho's prescription drug monitoring program.

Sincerely,

Elisha Figueroa

Elisha Figueroa
Administrator, Office of Drug Policy



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Women's Health Check

Women's Health Check is a breast and cervical cancer screening program that provides FREE mammogram, clinical breast exam, and/or Pap test for eligible women.

Contact a local coordinator to check eligibility and enroll today!

Coordinator	Address	Phone Number	Counties Served
Panhandle Health District	8500 N. Atlas Rd. Hayden, ID 83835	(208) 415-5140	Boundary, Bonner, Kootenai, Benewah, Shoshone
St. Joseph Breast Imaging Center	1630 23rd Ave, Suite 601 Lewiston, ID 83501	(208) 799-6505	Latah, Nez Perce, Lewis, Clearwater, Idaho
Southwest District Health	1008 E. Locust Emmett, ID 83617	(208) 365-6371 Ext 21	Adams, Washington, Payette, Gem, Canyon, Owyhee
Central District Health Department	707 N. Armstrong Pl. Boise, ID 83709	(208) 327-8608	Valley, Boise, Ada, Elmore
South Central Public Health District	1020 Washington St. N. Twin Falls, ID 83301	(208) 737-5935	Camas, Blaine, Gooding, Lincoln, Jerome, Minidoka, Twin Falls, Cassia
Southeastern Idaho Public Health	1901 Alvin Ricken Dr. Pocatello, ID 83201	(208) 239-5290	Butte, Bingham, Power, Bannock, Caribou, Oneida, Franklin, Bear Lake
Eastern Idaho Public Health District	1250 Hollipark Dr. Idaho Falls, ID 83401	(208) 533-3209	Lemhi, Custer, Clark, Fremont, Jefferson, Madison, Teton, Bonneville
Terry Reilly	223 16th Ave. N. Nampa, ID 83653	(208) 466-7869 Ext 3154 or 1223	Canyon, Ada, Owyhee
Family Medicine Residency of Idaho	777 N. Raymond St. Boise, ID 83704	(208) 954-8718	Ada, Elmore
Saint Alphonsus Breast Care Center	6200 W. Emerald St. Boise, ID 83704	(208) 367-8332	Ada, Canyon, Payette, Adams, Owyhee, Boise, Gem, Washington, Valley, Elmore

Visit www.womenshealthcheck.dhw.idaho.gov for more information

Last revised 5/1/2015

Women's Health Check Provider List

A to Z Family Care

Alexander, Debra FNP

Anesthesia Associates of Coeur d Alene

Ashton Medical Clinic

Associates in Family Practice - Gooding

Associates in Family Practice - Hagerman

Associates in Family Practice - Wendell

Baird, Eric G MD

Bear Lake Family Care & OB/GYN

Bear Lake Memorial Hospital

Bear Lake Physician's Clinic

Beckstead, David MD

Benewah Community Hospital

Benewah Medical Center

Bingham Memorial Hospital/Idaho Physicians Clinic

Bingham Memorial Medical Plaza Family Medicine

Bingham Memorial Medical Plaza Women's Center

Bingham Memorial Physicians & Surgeons Center

Blackfoot Medical Clinic

Boise Anesthesia, PA

Boise Pathology Group

Bonner General Hospital

Bonner's Ferry Family Medicine

Boundary Community Hospital

Campanale, Ralph MD

Campbell, Clay MD

Cardinal, DJ Marc MD

Care, LLC

Caribou Mem Hosp/Mtn View & Lake View Med Ctr

Caribou Memorial Hospital

Cedar Creek Family Medical

Central District Health Department - Boise

Central District Health Department - McCall

Central District Health Department - Mountain Home

Challis Area Health Ctr

Chamberlain, David J DO

Christensen, Brian W MD

Columbia Medical Associates

Community Family Clinic

Community Family Clinic - Blackfoot

Crosspointe Family Services

Cushman, Austin MD

Diagnostic Imaging Services of Idaho

Dirne / Heritage Health Centers

Driggs Health Clinic

Eastern Idaho Public Health District - Challis

Eastern Idaho Public Health District - Driggs

Eastern Idaho Public Health District - Dubois

Eastern Idaho Public Health District - Idaho Falls

Eastern Idaho Public Health District - Mud Lake

Eastern Idaho Public Health District - Rexburg

Eastern Idaho Public Health District - Rigby

Women's Health Check Provider List

Eastern Idaho Public Health District - Salmon

Eastern Idaho Public Health District - St Anthony

Eastern Idaho Regional Medical Center and Imaging Center

Eskelson, Lynn MD

Family Health Center

Family Health Services - Buhl

Family Health Services - Burley

Family Health Services - Fairfield

Family Health Services - Jerome

Family Health Services - Kimberly

Family Health Services - Rupert

Family Health Services - Twin Falls

Family Medicine Residency of Idaho

Family Practice Group, PA

Garden Valley Family Medicine

Glenns Ferry Health Center & Desert Sage

Gooding Family Physicians

Grand Peaks Medical

Green Field Family Medicine

Gritman Medical Center

Health West Inc. - Aberdeen

Health West Inc. - American Falls

Health West Inc. - Downey

Health West Inc. - Lava Hot Springs

Health West Inc. - Pocatello Clinic

Health West Inc. - Pocatello Family Medicine

Health West Inc. - Chubbuck Community Health Center

Henneberg & Kim OB/GYN

I-Care Medical Center

Idaho Falls Surgical Specialists

Idaho Gynecology Onology

Imaging Center of Idaho

Inland Imaging, LLC

Integra Imaging

Intermountain Medical Imaging Ctr

Island Park Medical Center

Kaniksu Health Services

Kootenai Clinic Cancer Services - Coeur d Alene

Kootenai Clinic Cancer Services - Post Falls

Kootenai Clinic Cancer Services - Sandpoint

Kootenai Clinic Cancer Services Benewah Community

Kootenai Clinic General Surgery

Kootenai Health

Kootenai Outpatient Surgery

Lakeland Family Medicine, PA

Latah Community Health (CHAS)

Lewis & Clark Health Center (CHAS)

Life Spring Women's Clinic

Lost Rivers Medical Ctr

Madison Women's Clinic

Magic Valley Surgery Clinic

Medical Imaging Association of Idaho Falls, PA

Women's Health Check Provider List

Mini-Cassia Surgical

Minidoka Memorial Hospital

Minimally Invasive Surgery Northwest

Monarch Healthcare

Monroe Anesthesia Services

Mountain Medical Physician Specialists of Idaho

Mountain View Family Medicine

Mountain View Hospital

Nelson, Alan S DO

Nimiipuu Health

North Canyon Medical Center

Northstar Health Care

Northwest Specialty Hospital

Nurse Practitioners Care, LLC

OB/GYN Associates of Idaho Falls

Oneida County Clinic

Ontario Pathology Group

Panhandle Health District - Bonners Ferry

Panhandle Health District - Hayden

Panhandle Health District - Kellogg

Panhandle Health District - Sandpoint

Panhandle Health District - St Marie's

Pathologists Regional Lab

Pend Oreille Radiology

Pend Oreille Surgery Center

Phoenix Radiology, PLLC

Physician Health Clinic - Saunero-Nava

Pocatello Women's Clinic

Portneuf Medical Center

Positive Connections

Power County Family Clinic

Rosemark Womencare Specialists

Saint Alphonsus - Adams County Health Center

Saint Alphonsus - Eagle

Saint Alphonsus - Nampa

Saint Alphonsus - Ontario

Saint Alphonsus - Women's Medical Clinic

Saint Alphonsus BCC/Mobile

Saint Alphonsus Breast Care Center

Saint Alphonsus Pathology Group

Salmon River Clinic

Saltzer Clinics

Sandpoint Family Health Center

Sandpoint Surgical Associates

Schmid, Stephen MD

Seasons Medical

Shelley, Carol E MD

Shoshone Family Medical Center

Shoshone-Bannock Tribal Health

South Central District Health - Bellevue

South Central District Health - Burley

South Central District Health - Jerome

Women's Health Check Provider List

South Central District Health - Twin Falls

Southeastern Idaho Public Health - American Falls

Southeastern Idaho Public Health - Arco-Butte

Southeastern Idaho Public Health - Bear Lake County Health Dept.

Southeastern Idaho Public Health - Blackfoot

Southeastern Idaho Public Health - Malad-Oneida

Southeastern Idaho Public Health - Pocatello

Southeastern Idaho Public Health - Preston-Franklin

Southeastern Idaho Public Health - Soda Springs

Southwest District Health - Caldwell

Southwest District Health - Emmett

Southwest District Health - Nampa

Southwest District Health - Payette

Southwest District Health - Weiser

Specialized Family Medicine, PA

St Anthony Medical Center

St John's Medical Center

St Joseph Breast Imaging Center

St Joseph Regional Med Ctr & Mobile

St Luke's Clinic - McCall, LLC

St Luke's Clinic - Treasure Valley, LLC

St Luke's Clinic - Wood River, LLC

St Luke's Clinic Wood River - Anesthesia

St Luke's Clinic, LLC

St Luke's Elmore Medical Center

St Luke's Elmore Medical Center Physician Group

St Luke's Jerome

St Luke's Jerome Family Medical Center

St Luke's Jerome Family Medicine

St Luke's Magic Valley RMC

St Luke's McCall

St Luke's McCall Physicians

St Luke's Regional Medical Center, Ltd.

St Luke's Trinity Mountain

St Luke's Wood River

St Marie's Family Medicine

St Marie's Family Medicine - Luther

St Mary's Hospital and Clinics

Steele Memorial Medical Center

Terry Reilly Health Services - Boise

Terry Reilly Health Services - Caldwell

Terry Reilly Health Services - Homedale

Terry Reilly Health Services - Marsing

Terry Reilly Health Services - Melba

Terry Reilly Health Services - Middleton

Terry Reilly Health Services - Nampa

Teton Cancer Institute

Teton Radiology Diagnostics

Teton Radiology Madison, LLC

Teton Valley Health Care

Total Family Medicine

Treasure Valley Family Medicine

Twin Falls Healthcare

Two Rivers Medical Clinic

Upper Valley Community Health Services

Upper Valley Family Medicine

Upper Valley Family Practice

Valley Family Health Care

Valley Medical Center, PLL

Valley Pathology Associates

Victor Health Clinic

Weiser Hospital Family Medical Clinic

Weiser Memorial Hospital

West Valley Medical Ctr

West Valley OB/GYN

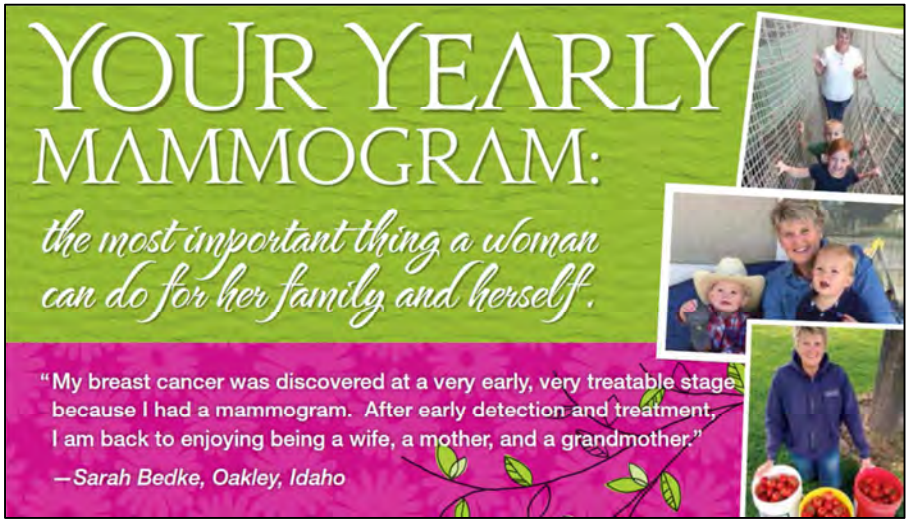
Weyhrich, Darin L MD

Whitmore, James CRNA

Willow Valley Family Medicine

Wolf, James MD

Postcard Mailers for Twin Falls, Minidoka, and Cassia Counties



Educational Brochure

TODAY, PUT YOURSELF FIRST

Get a mammogram for yourself, get a mammogram for your family.

American Cancer Society

Size of tumors found by mammography and breast exam

Average-sized lump found by yearly mammogram*

Average-sized lump found by first mammogram*

Average-sized lump found by regular self-exam*

Average-sized lump found by accident*

Doing breast self-exams is a good way to notice a difference in yourself, but you may be missing something. **Mammograms are able to find abnormalities as small as a pea.**

*American Cancer Society

CARE *for* YOUR FAMILY BY CARING *for* YOURSELF.

You work hard to care for your family and loved ones and they count on you. So make sure you're there for them every day… for years to come.

Put YOUR health first for just one day. Schedule an appointment for a mammogram. It's quick, painless and usually free to you.

"Regular cancer screening is one of the most important things a woman can do for her family and herself. After early detection and treatment, I am back to enjoying my role as a wife, a mother, and a grandmother."

—Sarah Bedke, Oakley, Idaho

HOW TO GET SCREENED: *it's easy!*

Schedule your appointment today!

Mammograms are offered at the locations below.

St Luke's Magic Valley
(208) 814-7210

Cassia Regional Medical Center
(208) 677-6515

Minidoka Memorial Hospital
(208) 436-8143

If you have health insurance, your insurance company will usually cover the cost.

If you don't have health insurance,
your local hospital may offer financial help. Or, call Women's Health Check for other options. They can help you schedule a mammogram and provide financial aid if you need it.

Women's Health Check
(208) 737-5900

WHY GET A MAMMOGRAM? *Here are some facts:*

- **One in eight** women will get breast cancer during their lifetime.
- **Idaho has one of the highest breast cancer mortality rates** in the U.S. The key to success is to catch it early. Yearly screening is the best way to do that.
- It's even **more** important to get regular mammograms if you have a family history of cancer.

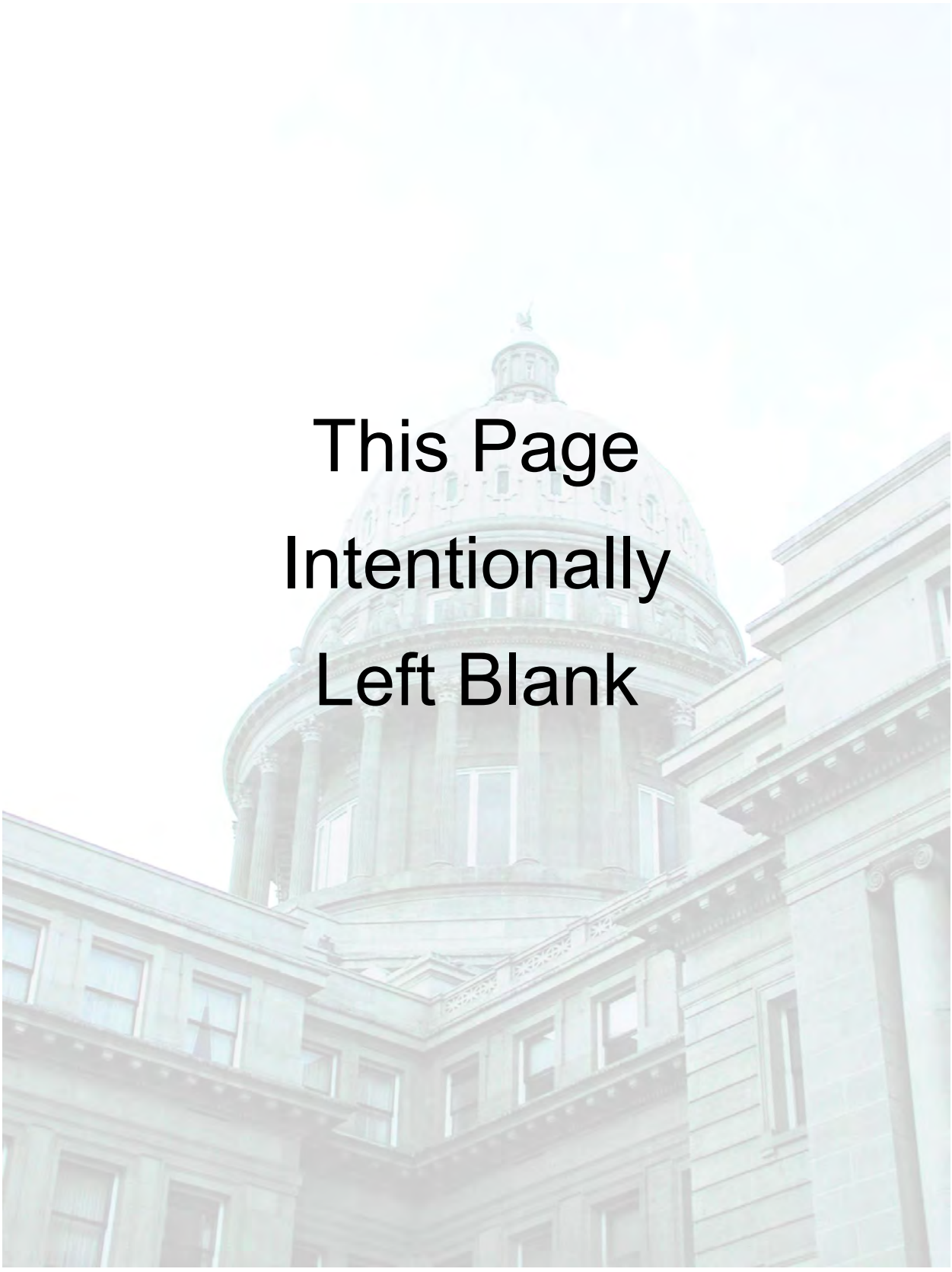
Smoking increases risk for all cancers. Ready to quit? Go to www.ProjectFilter.org.

To learn more, visit www.Cancer.org.

American Cancer Society | Intermountain Cassia Regional Medical Center | St Luke's | Minidoka Memorial Hospital

American Cancer Society: 1-800-227-2345 | www.cancer.org

Project funded by the Idaho Millennium Fund.



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LEWIS-CLARK STATE COLLEGE

Addendum

Glossary of Acronyms

ACHA	American College Health Association
AOD	Alcohol or Other Drug
EUDL	Enforcement of Underage Drinking Laws
ICHC	Idaho College Health Coalition
IHE	Institution of Higher Education
LCSC	Lewis-Clark State College
NCHA	National College Health Assessment
SAMSHA	Substance Abuse and Mental Health Services Administration
SCC	Student Counseling Center
SHS	Student Health Center
SLC	Student Life Committee

References Cited in Narrative

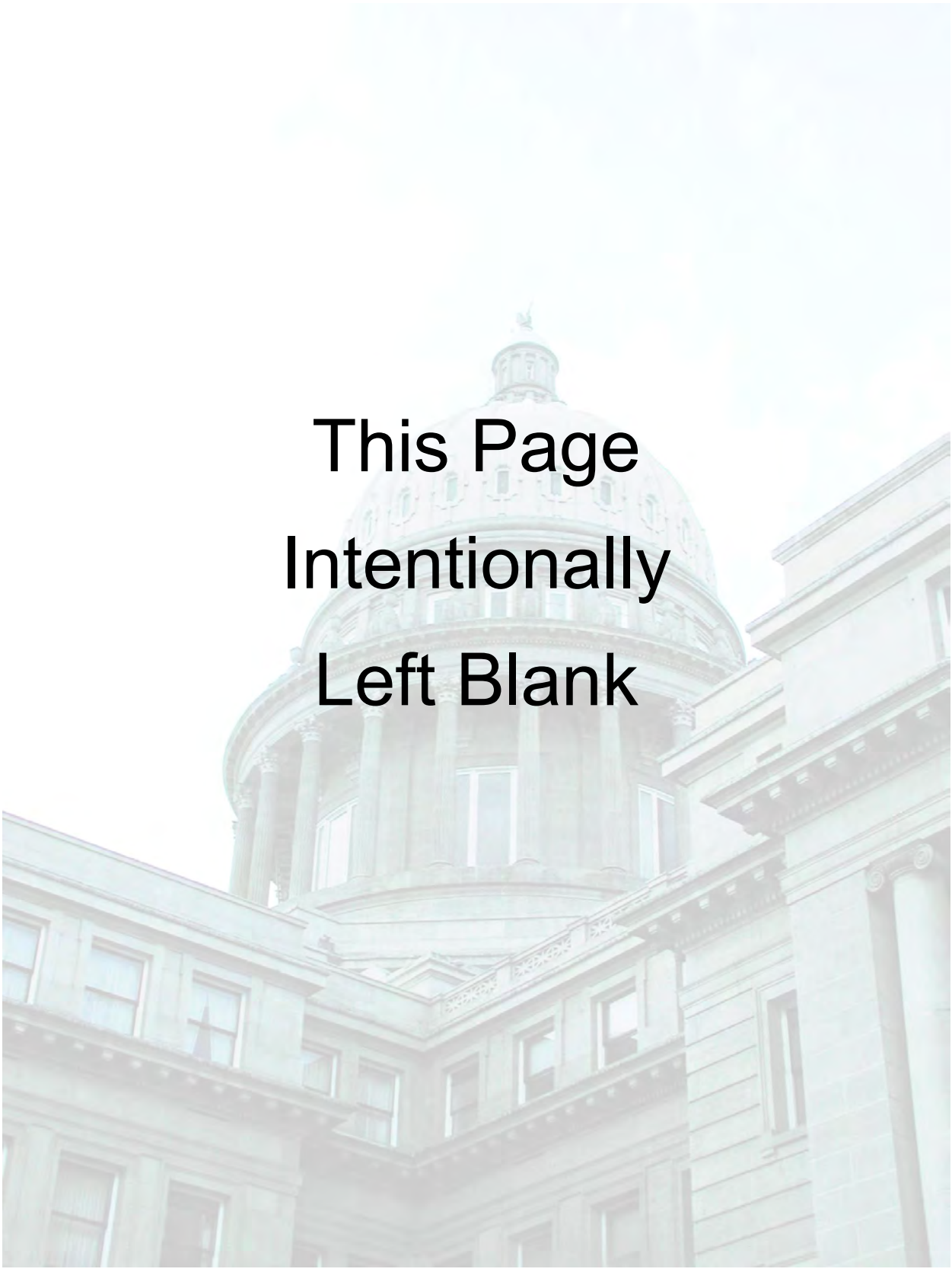
Lewis-Clark State College Executive Summary, Fall 2013 American College Health Association – National College Health Assessment. http://www.lcsc.edu/student-counseling/student-counseling/american-college-health-association-national-college-health-assessment-acha-ncha-ii/

Neinstein, Lawrence (2013) The New Adolescents; An Analysis of Health Conditions, Behaviors, Risks, and Access to Services in the United States compared to California, Among Adolescents (12-17), Emerging Young Adults (18-25) and Young Adults (26-34). http://www.usc.edu/student-affairs/Health_Center/thenewadolescents/doc/TheNewAdolescents_Final_Locked.pdf

Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (August 7, 2014). *The NSDUH Report: Underage Binge Alcohol Use Varies within and across States,* Rockville, MD. http://www.samhsa.gov/data. http://www.samhsa.gov/data/sites/default/files/NSDUH-SR199-UnderageBinge-2014/NSDUH-SR199-UnderageBinge-2014.pdf

LCSC Fact Sheet

http://www.lcsc.edu/media/2824159/fact-sheet-2014-draft1.pdf



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Suicide and Life-Threatening Behavior 37(3) June 2007

An Evaluation of Crisis Hotline Outcomes Part 2: Suicidal Callers

Madelyn S. Gould, PhD, MPH, John Kalafat, PhD,
Jimmie Lou HarrisMunfakh, BA, and Marjorie Kleinman, MS

In this study we evaluated the effectiveness of telephone crisis services/hotlines, examining proximal outcomes as measured by changes in callers' suicide state from the beginning to the end of their calls to eight centers in the U.S. and again within 3 weeks of their calls. Between March 2003 and July 2004, 1,085 suicide callers were assessed during their calls and 380 (35.0%) participated in the follow-up assessment. Several key findings emerged. Seriously suicidal individuals reached out to telephone crisis services. Significant decreases in suicidality were found during the course of the telephone session, with continuing decreases in hopelessness and psychological pain in the following weeks. A caller's intent to die at the end of the call was the most potent predictor of subsequent suicidality. The need to heighten outreach strategies and improve referrals is highlighted.

Crisis hotlines are one of the oldest suicide prevention resources in the United States (Litman, Farberow, Shneidman, Heilig, & Kramer, 1965; Shneidman & Farberow, 1957) and United Kingdom (Day, 1974), and are now ubiquitous sources of help worldwide. One rationale for crisis hotlines (Mishara & Daigle, 2000; Shaffer, Garland, Gould, Fisher, & Trautman, 1988) is that suicidal behavior is often associated with a crisis. The psychological autopsy research generally supports the association of stressful life events, such as interpersonal losses and legal or disciplinary problems, with suicide (Brent et al., 1993; Marttunen, Aro, & Lonnqvist, 1993; Rich, Fowler, Fogarty, & Young, 1988; Gould, Fisher, Parides, Flory, & Shaffer, 1996; Runeson, 1990). Furthermore, suicide is usually contemplated with psychological ambivalence, as evidenced by surviving suicide attempters who often report that the wish to die coexisted with wishes to be rescued and saved (Shaffer et al., 1988). This wish sometimes results in a "cry for help,"

Dr. Gould is a Professor at Columbia University in the Division of Child and Adolescent Psychiatry (College of Physicians & Surgeons) and Department of Epidemiology (School of Public Health), and a Research Scientist at the New York State Psychiatric Institute; Dr. Kalafat is a faculty member of Rutgers Graduate School of Applied and Professional Psychology; Ms. Munfakh and Ms. Kleinman are in the Division of Child and Adolescent Psychiatry and New York State Psychiatric Institute.

Supported by a cooperative agreement from the Substance Abuse and Mental Health Services Administration (SAMHSA), U79SM54128. We gratefully acknowledge Dr. Rachel Strohl and Ms. Rebecca Brent Weinberg for their assistance in data collection and analysis, respectively. While they must remain anonymous, we want to thank the participating centers for their dedication and hard work on the project.

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which can be addressed by those with special training (Litman et al., 1965). Lastly, crisis services may provide relief to an individual who is in the "final common pathway to suicide" (Shaffer et al., 1988) by providing the opportunity for immediate support at these critical times through services that are convenient, accessible, and available outside of usual office hours.

Despite strong theoretical and practical justification as a suicide prevention strategy, hotlines' empirical effectiveness has yet to be demonstrated unequivocally. One measure of the effectiveness of telephone crisis services has been the assessment of suicide rates in communities served by the centers. Studies examining the impact of crisis hotlines on mortality have largely employed ecological designs. These studies have compared the suicide rates in areas with and without a crisis program or in areas before and after the introduction of a crisis program. Several studies (Barraclough & Jennings, 1977; Bridge, Potkin, Zung, & Soldo, 1977; Jennings, Barraclough, & Moss, 1978; Lester, 1973, 1974; Riehl, Marchner, & Moller, 1988; Wiener, 1969), including a meta-analysis (Dew, Bromet, Brent, & Greenhouse, 1987), found no significant effects of hotlines on suicide rates. A significant effect of Samaritan suicide prevention programs in England was found by Bagley (1968), but the results were not replicated by other researchers using more elaborate and accurate statistical techniques (Barraclough & Jennings, 1977; Jennings et al., 1978). These broad measures of community suicide rates did not, however, consider the populations reached by crisis services. Miller, Coombs, Leeper, and Barton (1984) examined race-sex-age–specific suicide rates in U.S. counties with and without, and before and after the introduction of, a suicide prevention program. A significant reduction in the suicide rate in young White females was found, but no evidence of an impact in other population groups emerged. In their paper, the authors also reported a replication of their findings on a second set of counties for a different time span. The findings of Miller et al. are consistent with surveys of hotline users that indicate that young White females are the most frequent callers to hotline services (King, 1977; Litman et al., 1965; Slem & Cotler, 1973). More recently, Lester (1997) conducted a meta-analysis of 14 studies on the relationship of suicide prevention centers on suicide rates. While the results of individual studies did not always reach statistical significance, Lester found a significant overall preventive effect. Finally, Leenaars and Lester (2004) reported two studies on the number of suicide prevention centers in ten Canadian provinces and two territories. The first assessed the relationship between the density of centers in 1985 and age-adjusted rates for 1985–1989 and found no significant preventive impact. The second assessed the relationship between the density of centers in 1994 and age-adjusted rates for 1994–1998 and found negative correlations between presence of centers and change in the suicide rates for 8 of the 12 correlations. That is, the more centers, the lower the suicide rates. When the Yukon and Northwest territories were excluded, the correlation coefficients "approached or reached statistical significance" (p. 67). They concluded that this indicated "a preventive impact, though weak, of suicide prevention centers on suicide in Canada" (p. 67). However, caution is advised against the use of the term *impact* as the authors correctly note that the study was correlational and did not take into account changes in other social variables over the period.

It is difficult to draw conclusions about the effectiveness of crisis centers from studies of the relationship between the presence of suicide prevention/crisis centers and community suicide rates without a consideration of a complementary evaluation of proximal outcomes among crisis center users. One means to evaluate proximal outcomes is through silent monitoring of calls (Mishara & Daigle, 1997). Mishara and Daigle listened to 617 telephone calls from suicidal callers to two Canadian suicide centers. Immediate or proximal effects on the reduction of depres-

sive mood and in suicidal urgency were linked to specific intervention styles, most notably an empathetic Rogerian style, which also included directive components. King, Nurcombe, Bickman, Hides, and Reid (2003) rated 100 taped suicide calls to Kids Help Line in Australia. Significant decreases in suicidality and significant improvements in the mental state of youth were observed during the course of the call (King et al., 2003).

The present study employed the callers' own ratings of their mental state and suicidality, in response to a standardized set of inquiries by the crisis counselors, at the beginning and end of the call to assess the immediate proximal effect of the crisis intervention. Research findings have indicated that individuals' self ratings of their own suicidal states are more predictive of their subsequent suicidality than clinicians' ratings (Joiner, Rudd, & Rajab, 1999). A follow-up assessment, 2 to 4 weeks later, was also conducted in the present study to assess the duration of an effect and the telephone intervention's impact on future suicidal risk and behavior. To our knowledge this is the first evaluation of telephone crisis services to employ such a follow-up assessment, despite a follow-up being considered a critical evaluation strategy (King et al., 2003; Mishara & Daigle, 2000).

The aims of the present study are to determine (1) the extent to which callers to telephone crisis services are seriously suicidal; (2) whether significant decreases in suicidality occur during the call; (3) the extent and predictors of suicidality after the call; (4) the callers' perceptions of the utility of the intervention; and (5) the types of referrals given during the calls, and the extent to which callers follow through with them.

METHODS

A detailed description of the methods of this study has been provided in the accompanying article by Kalafat and colleagues (this issue). With the exception of the variables and sample that are unique to this article, only a brief description of the methods is given. The project was approved by the Institutional Review Boards of New York State Psychiatric Institute/Columbia University and Rutgers Graduate School of Applied and Professional Psychology. A confidentiality certificate was obtained from the Department of Health and Human Service through the Substance Abuse and Mental Health Services Administration (SAMHSA).

Sample

Adult suicidal individuals calling eight telephone crisis services/hotlines across the United States were the targeted population for this study. Between March 2003 and July 2004 telephone crisis counselors conducted assessments with 1,085 suicidal callers (39.4% male and 60.6% female). Individuals who called a center more than once during the data collection period were only assessed during their first contact with the center. The majority (72.0%) of assessed suicide callers called the center's local crisis hotline telephone number, the remaining called 1-800-SUICIDE, a national network of crisis centers. Of the 426 calls received on the 1-800-SUICIDE line, 277 (65%) were suicide calls. There were 654 nonparticipants who were not assessed because crisis counselors, using their own clinical criteria, considered the callers' risk status to be "too high." These callers were in an acute suicidal state, and as such, efforts to moderate their suicidality and/or initiate rescue procedures took precedence over the administration of our standard risk assessment (described in the measures section below). As noted in Kalafat et al. (this issue), other callers were not assessed because call volume was too high, the caller refused/hung up, the counselor thought it not appropriate to assess, or phone problems existed. Among these non-assessed callers, we could not differentiate suicidal from nonsuicidal crisis callers. Thus, we do not have a precise estimate of the total number of suicidal callers; the lower bound of the estimate is 1,739 (1,085 + 654), yielding a 62.4% participation rate (upper bound).

Between April 2003 and August 2004

follow-up assessments were conducted with 380 of the 1,085 suicide callers who completed the baseline assessment (35.3%). Follow-up assessments were conducted between 1 and 52 days from the baseline assessment date, with the average being 13.5 days. For the 380 suicide callers who were followed, 30.3% were male and 69.7% female; their age ranged from 18–72, and the mean was 36.1 years. The ethnic distribution was 66.3% White, 15.2% African American, 10.2% Hispanic, 3.5% Native American, 3.2% Asian, and 1.6% Other. Ethnicity was not coded for six callers.

The reasons for no follow-up assessment for 705 suicidal callers were: 311 (44.1%) callers at baseline refused re-contact; 273 (38.7%) callers at baseline were not asked by the counselors if they wanted to receive a follow-up call; 63 (9.0%) callers gave consent at baseline for follow-up contact but the follow-up interviewers received passive or active refusals at follow up; and 58 (8.2%) callers gave the crisis counselors invalid contact information. Common reasons for counselors not asking for consent for the follow-up call were that the caller had to quickly terminate the call or hung up before the counselor could ask. A significantly greater proportion of suicidal callers (38.7%) compared to crisis callers (8.5%) were not asked for consent at baseline. Suicide callers who did not complete a follow-up assessment were significantly more intent on dying ($F = 15.3$, $p < .001$), more hopeless ($F = 14.2$, $p < .001$), more likely to be rescued ($\chi^2 = 19.9$, $p < .001$), and less likely to be given a referral ($\chi^2 = 24.9$, $p < .001$) at baseline compared to suicide callers who completed the follow-up. However, changes in suicide state (intent to die, hopelessness, and psychological pain) from the beginning to the end of the baseline call did not vary as a function of follow-up participation status.

Measures

Suicide Risk Status. The suicide risk assessment was shaped by Chiles and Strosahl's (1995) book on the assessment, treatment, and case management of suicidal patients, and the chapter on psychiatric and psychological factors in a report by the Institute of Medicine (Goldsmith, Pellmar, Kleinman, & Bunney, 2002), which showed evidence supporting Shneidman's (1993) concept of psychological pain as a contributing factor to suicidal behavior. The assessment was also influenced by the empirical risk factors reviewed by Joiner, Walker, Rudd, and Jobes (1999) and the factor-analytic study of the Modified Scale for Suicidal Ideation (Joiner, Rudd, & Rajab, 1997). Practical considerations as to the feasibility of conducting a risk assessment within the context of a telephone intervention also shaped the suicide risk assessment. This was based on input from the crisis center directors on our advisory board and crisis center counselors who piloted the assessments (described in Kalafat et al., this issue).

Questions assessing callers' risk status included suicidal ideation and behavior, intent to die, hopelessness, and psychological pain. Three questions were asked about the caller's thoughts of suicide (any thoughts, persistence of thoughts, and control over thoughts); one question assessed whether the caller considered suicide the only possible option to solve problems; one question asked about current plans (plus narrative of "how," "when," and "where"); one question asked whether the caller had taken any action or preparatory behavior to kill or harm him/herself immediately prior to the call; and three questions assessed past attempts (lifetime occurrence, number of attempts, and whether treatment was required). These questions were asked at the beginning of the call. Suicidal thoughts, plans, and attempts since the call to the center were reassessed at the follow-up assessment. Three *a priori* scales—*intent to die*, *hopelessness*, and *psychological pain*—were the three major outcomes of the study, and were asked at the beginning of the call to the center and repeated at the end of the call and at the follow-up. These outcomes were chosen in collaboration with our advisory board, with particular input from the crisis center directors (see details in Kala-

fat et al., this issue). These outcomes were considered to be appropriate targets for an intervention plan and their attenuation during a crisis call was deemed to be critical. The items within the intent to die, hopelessness, and psychological pain domains were each rated on a 5-point scale and averaged to derive each scale score. Higher scores indicated more of the particular domain. *Intent to die* was assessed by two questions, "How much do you really want to die?" and "How likely are you to carry out your thoughts/plans to kill yourself?" The correlation of the items was 0.43. *Hopelessness* was comprised of two questions; callers were asked how hopeful they felt about the future and whether they felt they could go on (correlation = 0.32). *Psychological pain* consisted of two items assessing current hurt, anguish, and misery (not physical pain) and whether callers could tolerate the way they felt if their current situation did not change (correlation = 0.47). The correlations of the scales at the beginning of the call were 0.52 (intent to die and hopelessness), 0.38 (intent to die and psychological pain), and 0.43 (hopelessness and psychological pain). (The remaining measures are also described in Kalafat et al., this issue).

Client Feedback on Call. The client feedback questions were asked at the follow-up assessment. Two open-ended questions about what was or was not helpful about the call initiated the assessment: "Thinking back to the call you placed to the crisis line, can you tell me how the call was helpful to you?" "Can you tell me what was not helpful about the call?" Twenty-one close-ended questions followed the open-ended assessment and provided ratings in three areas: helper interventions, emotion regulation, and overall effectiveness, but the responses to the close-ended questions will be the focus of a future paper.

Plan of Action and Compliance. This set of questions assessed whether callers remembered, agreed with, and followed through with plans of actions developed by the crisis counselors with the callers. These questions were asked at the follow-up assessment.

Service Utilization and Compliance. These questions included the type of referral (emergency services, mental health services, social services, and information and referral services) and the extent of follow through. Information on the type of referral was obtained from the crisis counselors at baseline and the referral follow through questions were asked of the callers at the follow-up assessment.

Procedures

Baseline assessments (Time 1) were conducted by center counselors near the beginning of calls, prior to providing intervention services to callers. The suicide risk assessment was conducted with callers if they had any thoughts about killing themselves. The suicidal crisis was either self-defined by the caller or identified by the crisis worker after an assessment of risk. Not all counselors felt comfortable initiating a suicide risk assessment without some clinical indicator, such as depression, or some veiled threat. Because we tried to minimize interference with the usual interactions between the counselors and the callers, we did not require the centers' counselors to routinely initiate the risk assessment. Upon completing the intervention, counselors then conducted another assessment at the end of the call (Time 2), which included a subset of the initial questions to determine whether the intervention reduced callers' suicidal status. Local data coordinators reviewed the centers' call records on an ongoing basis and compared them to completed assessments to assure that all eligible callers were being assessed. If assessments were not conducted with potentially eligible callers, the coordinators reviewed the call records for these callers with the crisis counselors. Immediately preceding the end of the calls, counselors used a standardized script to ask callers if the research team could contact them in 1 to 2 weeks to see if they were interested in participating in the follow-up assessment. The follow-up assessments were conducted by independent research interviewers

who had prior training and experience as telephone crisis counselors. The training, quality control procedures, and consent procedures are described in detail in the article by Kalafat and colleagues (this issue); only safety procedures, specific to suicide callers, will be described here. In the beginning of the risk assessment during the call to the center, suicide callers were asked if they had done anything, including preparatory behavior, to hurt or kill themselves before they called the crisis center. If a caller was in imminent danger, the crisis center stopped the interview and initiated their standard rescue procedures. The assessment was only continued if it was helpful to keep the caller engaged while waiting for emergency rescue services to arrive.

The follow-up assessment included criteria to be used by our interviewers to determine whether callers needed intervention at follow-up. The need for intervention was defined by a past plan or actual attempt at self-injury since speaking with the center, or a serious intent to die at the time of the follow-up interview. The method for getting help to callers consisted of follow-up interviewers re-connecting callers back to the center they had initially phoned. If callers were unable to participate in a call-back to the center immediately after completing their interviews, follow-up interviewers obtained callers' consent for the center to contact the callers. In this last instance, the follow-up interviewer contacted the center and gave them the caller's contact information and details as to why the caller needed intervention.

Analytic Strategy

The primary sampling unit of the study was crisis center, and the secondary sampling unit was caller within center. Thus, we examined the extent of within-center clustering in order to determine whether this clustering variable warranted inclusion in the analyses. The sample clusters (center) had little impact on outcomes (intent to die, psychological pain, and hopelessness) as indicated by the intraclass correlation coefficients, which were all close to zero (ranging from .004 to .05). Therefore, the use of mixed-effects linear models to account for the clustering variable of center was unnecessary. Center was included as a covariate in the analyses.

A repeated measures design was employed to examine changes over time, always employing center as the between subjects factor. The measures were assessed at three points: near the beginning of the call (Time 1), at the end of the call (Time 2), and at follow-up (Time 3). The repeated measures for the suicide callers were intent to die, psychological pain, and hopelessness. These repeated measures were also examined as a function of the suicide risk elements (i.e., whether the caller had a suicide plan, had made a preparatory or actual action to harm/kill self prior to the call, or had an attempt history).

A series of logistic regression analyses were conducted to determine the baseline predictors of any suicidality (thoughts, plans, or attempts) following the crisis call. The independent variables included in separate models were intent to die, psychological pain, and hopelessness (each at the beginning and end of the baseline call), persistence of suicide thoughts, control over thoughts, considering suicide as the only solution to problems, plans to kill self, actions or preparatory behavior before the call, and a history of an attempt. Age and gender were included in all models. All significant predictors in the initial models were entered simultaneously as independent variables in a final multivariate analysis.

Those callers followed up were compared to those who were not followed up on baseline measures at the beginning of the call (as previously described) by means of univariate analyses of variance. Interactions between follow-up status and changes from Time 1 to Time 2 were examined using two-way analyses of variance.

The statistical analyses were con-

ducted with SPSS statistical software (version 12.0). Given the number of comparisons, results were considered significant at $\alpha < .001$, but results at $\alpha < .01$ are presented in the tables.

RESULTS

Presenting Problems

Suicide callers contacted the centers with a variety of problems ranging from abuse/violence (10.0%), physical health problems (16.1%), work problems (12.8%), addictions (17.9%), base needs (25.9%), mental health problems (54.7%), and interpersonal problems (58.4%), along with their suicidal crises. Gender differences were significantly related to only one type of problem: males (24.8%) had significantly more addiction problems than females (13.5%) ($\chi^2 = 21.4$, $p < .001$).

Risk Profile

Of all the suicide callers who completed the baseline assessment (1,085 callers), over half (585 callers) had a suicide plan when they called the crisis center and 8.1% (88 callers) had taken some action to harm or kill themselves immediately before calling the center. More than half (57.5%, 624 callers) had made prior suicide attempts, of which 53.2% (332 callers) had made multiple attempts and 44.1% (275 callers) had made single attempts. There were 17 callers (2.7% of those who had prior attempts) for whom the number of prior suicide attempts was not coded. Only 22.2% of the suicidal callers had no current plans, actions, or a history of suicidal behavior; 5.7% had all three suicide risks. Of those with current suicide plans, 366 (62.6%) had a history of past attempts. Of those who had taken some action to harm/kill themselves immediately before their call, 63 (71.6%) had a history of past attempts. The suicide risk profile of males and females was similar with the exception of a significantly higher rate of previous suicide attempts among the females (64.8% versus 49.3%) ($\chi^2 = 24.5$, $p < .001$). There was no significant difference in the risk profile of callers to the centers' regular line and to 1-800-SUICIDE.

Rescues

Counselors reported initiating rescue procedures with 136 (12.6%) of the callers who participated in the baseline assessment. Rescue procedures were significantly more likely to be initiated for the callers who had engaged in preparatory behavior or had done something to hurt/kill themselves (37.9%) than for callers who had not taken these actions (10.8%) ($\chi^2 = 49.2$, $p < .001$). Of the suicidal callers who had taken some action to hurt/kill themselves and had not initiated rescue ($n = 54$), eight had been unable to have a rescue initiated because the center was unable to identify the caller's telephone number or the caller refused or hung up prematurely. Rescues were initiated significantly more often for callers who had a current plan to hurt/kill themselves (19.2%) than for those without a plan (4.9%) ($\chi^2 = 45.3$, $p < .001$). Rescues were also initiated more often for callers who had a history of previous suicide attempts (15.2%) than for those with no such history (8.5%) ($\chi^2 = 10.0$, $p < .01$).

Referrals

Out of the 1,085 callers who participated in the baseline assessment, 506 (46.6%) were given a new referral, of which 284 (56.1%) were to mental health resources. An additional 116 (10.7%) callers were referred back to their current therapist or services. Of the 380 callers who participated in the follow-up, 221 (58.2%) were given a new referral at baseline, of which 151 (68.3%) were to mental health resources. An additional 52 (13.7%) callers were referred back to their current therapist or services. The overall referral rate for those who participated in the baseline was 57.3% and the rate of referral for those who participated in the follow-up was 71.8%.

Overall, the rate of referrals was some-

what *lower* for callers with more serious suicide risk profiles compared to other callers. Callers who had current plans to hurt/kill themselves received *fewer* referrals (44.2%) than callers who had no current plans (53.0%) ($\chi^2 = 7.4$, $p < .01$). Callers who had taken action to hurt/kill themselves also received fewer referrals (34.5%) than callers who had not taken any action (49.3%) ($\chi^2 = 6.5$, $p = .01$). Callers who had at least one previous suicide attempt were given the same rate of referrals (46.7%) as callers who did not have at least one previous attempt (51.2%) ($\chi^2 = 1.8$, $p > .05$). This referral pattern may reflect the significantly greater propensity of counselors to initiate rescues among callers with higher risk profiles, thus precluding any other follow-up recommendations.

Immediate Outcomes

For the 1,085 callers who completed the baseline assessment, there was a significant reduction in suicide status from the beginning of the call (Time 1), to the end of the call (Time 2) on intent to die ($F = 130.8$, $p < .001$), hopelessness ($F = 112.8$, $p < .001$), and psychological pain ($F = 181.4$, $p < .001$) (Table 1). The extent to which the immediate outcomes were modified by the suicide risk profile factors (plans, actions, and prior attempts) was examined (Table 2). Despite the considerable overlap among the risk factors, as previously noted, each was examined separately as a potential modifier. This analytic strategy allowed the clinical import of each factor to be highlighted. While callers who had a suicide plan, who had taken actions to hurt/kill themselves, or who had a history of suicide attempts had higher scores on psychological pain and were significantly more hopeless and intent on dying, there were no significant interactions between the suicide risk profile factors and time. In other words, changes from Time 1 to Time 2 were not modified by the suicide risk profile.

Intermediate Outcomes

There were significant reductions in callers' psychological pain ($F = 13.1$, $p < .001$) and hopelessness ($F = 17.0$, $p < .001$) from the end of the call (Time 2) to follow-up (Time 3) among the 380 suicide callers who completed a follow-up assessment (Table 3). However, there was no significant reduction in callers' intent to die during this period ($F = 0.19$, $p > 05$). At follow-up, 43.2% (164/380) of callers reported any suicidality (ideation, plan, or attempt) since their call to the center. Of these, 17.1% (28/164; 7.4% of total sample) had made a suicide plan, and 6.7% (11/164; 2.9% of total sample) had made a suicide attempt. Of those who made a suicide attempt after their call to the center, 63.6% (7/11) had made a prior attempt some time before their call. Intent to die at the end of the baseline call (OR = 1.7, 95% CI = 1.2, 2.3, $p < .001$), having made any specific plan to hurt or kill self prior to the call (OR = 1.6, 95% CI = 1.02, 2.4, $p < .04$), and persistent suicidal thoughts at baseline (OR = 1.6, 95% CI = 1.03, 2.4, $p < .04$) were statistically significant predictors of any suicidality (ide-

TABLE 1
Immediate Outcomes from Beginning (Time 1) to End (Time 2) of Call

	Time 1		Time 2		Main Effect of Time	
Outcomes	Mean	(*SD*)	Mean	(*SD*)	*F*	*p*
Intent to Die	2.81	(1.07)	2.31	(1.04)	130.84	.001
Hopelessness	3.41	(0.99)	2.87	(0.97)	112.79	.001
Psych Pain	4.09	(0.92)	3.47	(1.08)	181.37	.001

TABLE 2
Immediate Outcomes by Suicide Risk Profile

	Intent to Die						Hopelessness						Psychological Pain					
	Time 1	Time 2	Main Effect of Risk		Interaction Effect of Time by Risk		Time 1	Time 2	Main Effect of Risk		Interaction Effect of Time by Risk		Time 1	Time 2	Main Effect of Risk		Interaction Effect of Time by Risk	
Outcome	Mean (*SD*)	Mean (*SD*)	*F*	*p*	*F*	*p*	Mean (*SD*)	Mean (*SD*)	*F*	*p*	*F*	*p*	Mean (*SD*)	Mean (*SD*)	*F*	*p*	*F*	*p*
Risk Profile																		
Plan	3.15	2.59					3.62	3.03					4.32	3.68				
(*n* = 585)	(1.04)	(1.10)	109.9	0.001	4.13	*ns*	(0.97)	(0.97)	40.26	.001	3.72	*ns*	(0.80)	(1.05)	50.05	.001	0.71	*ns*
No Plan	2.42	1.98					3.16	2.69										
(*n* = 468)	(0.96)	(0.85)					(0.96)	(0.92)										
Action	3.28	2.85					3.72	3.28					4.37	3.79				
(*n* = 88)	(1.15)	(1.30)	19.40	.001	1.14	*ns*	(1.04)	(1.10)	11.34	.001	1.40	*ns*	(0.89)	(1.09)	8.04	.01	0.70	*ns*
No Action	2.77	2.27					3.38	2.84					4.07	3.45				
(*n* = 980)	(1.05)	(1.01)					(0.98)	(0.95)					(0.92)	(1.08)				
Multiple Attempts	3.06	2.50					3.62	2.98					4.22	3.54				
(*n* = 332)	(1.03)	(1.07)	10.97	.001	1.22	*ns*	(0.98)	(1.00)	6.43	.01	3.83	*ns*	(0.83)	(1.07)	1.90	*ns*	1.48	*ns*
Single Attempts	2.76	2.28					3.28	2.82					4.08	3.45				
(*n* = 275)	(1.01)	(0.99)					(0.97)	(0.92)					(0.88)	(1.09)				
No Attempts	2.67	2.20					3.33	2.83					4.02	3.34				
(*n* = 440)	(1.09)	(1.03)					(0.98)	(0.96)					(0.98)	(1.10)				

TABLE 3
Intermediate (Follow-up) Outcomes

	Time 1		Time 2		Time 3		Main Effect of Time		T2–T3 Contrast	
	Mean	(*SD*)	Mean	(*SD*)	Mean	(*SD*)	*F*	*p*	*F*	*p*
Intent to Die	2.80	(0.90)	2.35	(0.90)	2.25	(0.95)	7.57	.01	0.19	*ns*
Hopelessness	3.27	(0.93)	2.72	(0.87)	2.24	(1.09)	47.84	.001	17.03	.001
Psych Pain	4.07	(0.89)	3.42	(1.06)	2.85	(1.22)	52.84	.001	14.13	.001

ation, plan, or attempt) at follow-up (43.2% of the callers) (Table 4). When these three items were entered simultaneously in the logistic regression model, only intent to die at the end of the baseline call remained a significant predictor (OR = 1.7, 95% CI = 1.2, 2.3, $p < .002$).

Caller Feedback. At follow-up, 380 suicide callers provided a total of 668 positive responses and 83 negative responses to the two open-ended questions about what was or was not helpful about the call. There were six positive categories most frequently mentioned by suicide callers: listen and let talk (23.2% of responses; 40.8% of callers), warm and caring etc. (9.7%; 17.1%), options for dealing with concerns (7.5%; 13.2%), available and patient (7.3%; 12.9%), calm down (6.9%; 12.1%), and think clearly/new perspective (6.9%; 12.1%). Notably, 11.6% (*n* =

TABLE 4
Predictors of Suicidality (Thoughts, Plans, or Attempts) Following Telephone Intervention

	Model 1[a]		Model 2[b]	
Suicide Risks	Odds Ratio (CI)	*p*	Odds Ratio (CI)	*p*
Persistent thoughts†	1.6 (1.03–2.4)	.03	1.3 (0.8–2.0)	.30
Control over thoughts†	1.4 (0.9 –2.2)	.16	–	–
Suicide as only possible option†	0.8 (0.5 –1.3)	.29	–	–
Plans†	1.6 (1.02–2.4)	.04	1.4 (0.8–2.0)	.35
Actions/preparatory behavior†	1.1 (0.5 –2.8)	.80	–	–
Prior attempts†	1.4 (0.9 –2.2)	.11	–	–
Intent to die‡—beginning of call	1.0 (0.8 –1.3)	.96	0.9 (0.7–1.2)	.62
—end of call	1.7 (1.2 –2.3)	.001	1.7 (1.2–2.3)	.002
Hopelessness‡—beginning of call	1.1 (0.9 –1.5)	.41	–	–
—end of call	1.3 (0.9 –1.7)	.15	–	–
Psychological pain‡—beginning of call	1.0 (0.8 –1.4)	.87	–	–
—end of call	1.1 (0.9 –1.4)	.52	–	–

Note. Age and gender were included in all models.
†Dichotomous item
‡5-point scale
[a]Each suicide risk variable was entered into separate logistic models, with exception of intent to die, psychological pain, and hopelessness for which the same measure at the beginning and end of call were entered simultaneously.
[b]Suicide risk variables that were statistically significant in model 1 were entered simultaneously in model 2. Intent to die (beginning of call) was entered into model 2 despite not being statistically significant in model 1 in order to account for it when assessing intent to die (end of call).

44) of suicide callers said that the call prevented them from killing or harming themselves.

The most frequent negative feedback concerned problems with the referral (10.8% of responses; 23.7% of callers). Other concerns were raised about unhelpful interventions; such as counselors being condescending, not concerned, or abrupt (16.9% of responses; 3.7% of callers); counselors providing unhelpful solutions/suggestions (12.1%; 2.6%); and counselors not identifying the problem (8.4%; 1.8%). Six respondents stated that the call was too short (7.2%; 1.6%) and six stated that the helper asked too many questions (7.2%; 1.6%).

Action Plan Compliance. Of the 380 suicide callers who participated in the follow-up, counselors developed plans of action with 278 (73.2%) callers. Examples of action plans included having a friend come over to stay with caller; and calling friends and family members. At follow up, 60 (21.6%) of the 278 callers did not recall the plan. Of those recalling the plan, 102 (46.8%) callers completed "all" of the plan, 34 (15.6%) callers completed "most," 28 (12.8%) callers completed "some" of the plan, 24 (11.0%) callers said the plan was still "in process," and 26 (11.9%) callers had not carried out any of the plan. The extent of follow through was not coded for four callers (1.8%).

Follow Through with Referral. Of the 151 follow-up suicidal callers who were given a new mental health referral, 35% had kept or made an appointment with a mental health service in the period between the initial call to the center and the follow-up assessment.

Re-Contact with the Center. Of the 380 suicide callers who participated in the follow-up, 107 (28.2%) callers had another contact with the crisis center after their initial call. Of these callers, 59 (55.1%) callers had one additional contact, 19 (17.8%) callers had two contacts, 9 (8.4%) callers had three contacts, 4 (3.7%) callers had four contacts, 10 (9.3%) callers had between 5 and 30 contacts, and 6 (5.6%) callers did not remember the number of times. Fifty-two percent ($n = 56$) of the 107 callers had received a new referral or referral back to a mental health resource, yet only 15.8% (17) had either completed or set up an appointment.

DISCUSSION

Several studies have suggested that telephone crisis services do not reach individuals at high risk for suicide but instead attract lower-risk suicidal individuals who are more likely to attempt than complete suicide (Clum, Patsiokas, & Luscomb, 1979; Greaves, 1973; Lester, 1972; Maris, 1969; Sawyer, Sudak, & Hall, 1972). The higher proportion of females who call telephone crisis services is consistent with this conjecture (Miller et al., 1984; Mishara & Diagle, 2000). Although our study also found that females were more likely than males to call crisis services, the profile of the suicide callers indicated substantial levels of risk. Over half of the suicidal callers had current plans to harm themselves when they called the crisis service and nearly 10 percent had taken some action to hurt or kill themselves immediately prior to their call. Furthermore, nearly 60 percent of the suicidal callers had made previous suicide attempts, one of the strongest predictors of completed suicide (Gould, Greenberg, Velting, & Shaffer, 2003; Groholt, Ekeberg, Wickstrom, & Hadorsen, 1997; Reinherz et al., 1995). Notably, the suicide risk exhibited by our sample of suicide callers is probably underestimated, given the substantial proportion of callers who were not assessed as part of our research protocol at baseline ($n = 654$) because they were deemed at too high a risk of suicide by the telephone counselors. Thus, our study empirically supports an earlier impression that seriously suicidal individuals are reaching out to telephone crisis services (Dew et al., 1987).

The clinical effectiveness of the crisis intervention is consistent with the significant decreases in suicidality, specifically, intent to die, hopelessness and psychological pain, found

during the course of the telephone session, similar to a recent evaluation of telephone counseling services (King et al., 2003). The immediate suicidality outcomes were not modified by the suicide risk status of the callers. This suggests that the reductions in suicidality were not simply a function of "regression to the mean," which would have been more consistent with greater decreases among higher risk individuals. In light of these positive proximal outcomes, the relatively weak, albeit positive, preventive impact of suicide prevention centers on community suicide rates (Leenaars & Lester, 2004; Lester, 1997) suggests that greater efforts are needed to attract a greater proportion of suicidal individuals in the community.

In the weeks following the crisis intervention, callers' hopelessness and psychological pain continued to lessen but the intensity of their intent to die did not continue to diminish. Moreover, a substantial proportion (43.2%) of the callers continued to express suicidal ideation a few weeks after the initial call and nearly 3 percent had made a suicide attempt after their call. The callers' intent to die score at the end of the crisis intervention was the only significant independent predictor of suicidality following the call; although having made any specific plan to hurt or kill self prior to the call and persistent suicidal thoughts at baseline were also significant, albeit not independent, predictors of any suicidality (ideation, plan, or attempt). Our findings suggest that outreach strategies, such as follow-up calls, may need to be heightened, particularly for suicidal callers with a high level of intent to die and for callers with a history of suicide attempts, who were significantly overrepresented among those who reattempted shortly after their call to the center. Moreover, outreach efforts during the course of the call may also need to be expanded in light of our findings that a rescue procedure was initiated for only 40 percent of suicidal callers who had engaged in either preparatory behavior or an actual action to hurt or kill themselves immediately prior to calling the center.

A sizable minority, nearly 30 percent, of suicidal callers had another contact with the crisis center after their initial call. This is consistent with reported rates of repeated use of telephone crisis services (Apsler & Hoople, 1976; Mishara & Daigle, 2000; Murphy, Wetzel, Swallow, & McClure, 1969; Speer, 1971; Wold, 1973). This finding is difficult to interpret; it may indicate that the caller found the initial intervention to be useful or may merely indicate that the callers are inappropriately relying on the crisis hotline rather than getting the mental health services they need. The latter is suggested by our finding that only 16 percent of the repeat callers followed through with a mental health referral after their initial call to the centers. The need to improve referrals to mental health services by telephone crisis services is also highlighted by several findings in the present study: over half of suicidal callers presented with mental health problems at the time of the call; only about a third of the suicidal callers were given a new referral to a mental health resource or a referral back to such a service; only a third of suicide callers had followed through with the referral; and, the most frequent negative feedback by suicidal callers was about problems with referrals. While callers' follow through with referrals is a function of many factors, including caller motivation (Stein & Lambert, 1984), it appears that steps need to be taken by crisis centers and counselors to address the factors under their control; for example, increasing their knowledge of community resources, matching caller needs with appropriate services, and fostering connectedness to support services (De Leo, Buono, & Dwyer, 2002).

Limitations

The study has important limitations, as described in Kalafat et al. (this issue), which also apply to the current article. A particularly important limitation is that the study was uncontrolled, and the lack of a control condition makes it difficult to definitively attribute the reduction in suicidality to the cri-

sis intervention. However, ethical concerns about compromising the clinical services provided to callers in crisis precluded the inclusion of a control condition. Another limitation specific to this article was the low participation rate at follow-up, reflecting the difficulty of implementing outreach procedures with suicidal callers. One major obstacle was the crisis counselor's reluctance to ask for the caller's consent for re-contact. This is an area that needs to be addressed in the training of crisis counselors. The substantial differences observed between the suicidal callers who were followed and those who were lost to follow-up are problematic. Those who participated in the follow-up were significantly less suicidal than the nonparticipants; however, changes in suicide state from the beginning to the end of the call did not vary as a function of follow-up participation status; thus, we are reassured that the findings generally apply to most callers in a suicidal crisis. The results may indeed underestimate the impact of the intervention on suicidality because rescue procedures were initiated significantly more often for the suicidal callers who were not followed and were most likely initiated for a substantial proportion of the high risk individuals who were not assessed at baseline.

Conclusions

Our study provides empirical evidence that seriously suicidal individuals are reaching out to telephone crisis services. The clinical effectiveness of the crisis intervention is consistent with the significant decreases in suicidality found during the course of the telephone session, and the continuing decrease in callers' hopelessness and psychological pain in the weeks following the crisis intervention. Without a control group, however, these effects cannot be definitively attributed to the crisis intervention. Our findings also suggest that follow-up outreach strategies may need to be heightened, particularly for suicidal callers with a history of suicide attempts, who were significantly overrepresented among those who reattempted shortly after their call to the center. The need to improve referrals to mental health services by telephone crisis services is also highlighted. Lastly, any suicide risk assessment should include a re-evaluation of the caller's intent to die at the end of the call, in light of its predictiveness of subsequent suicidality.

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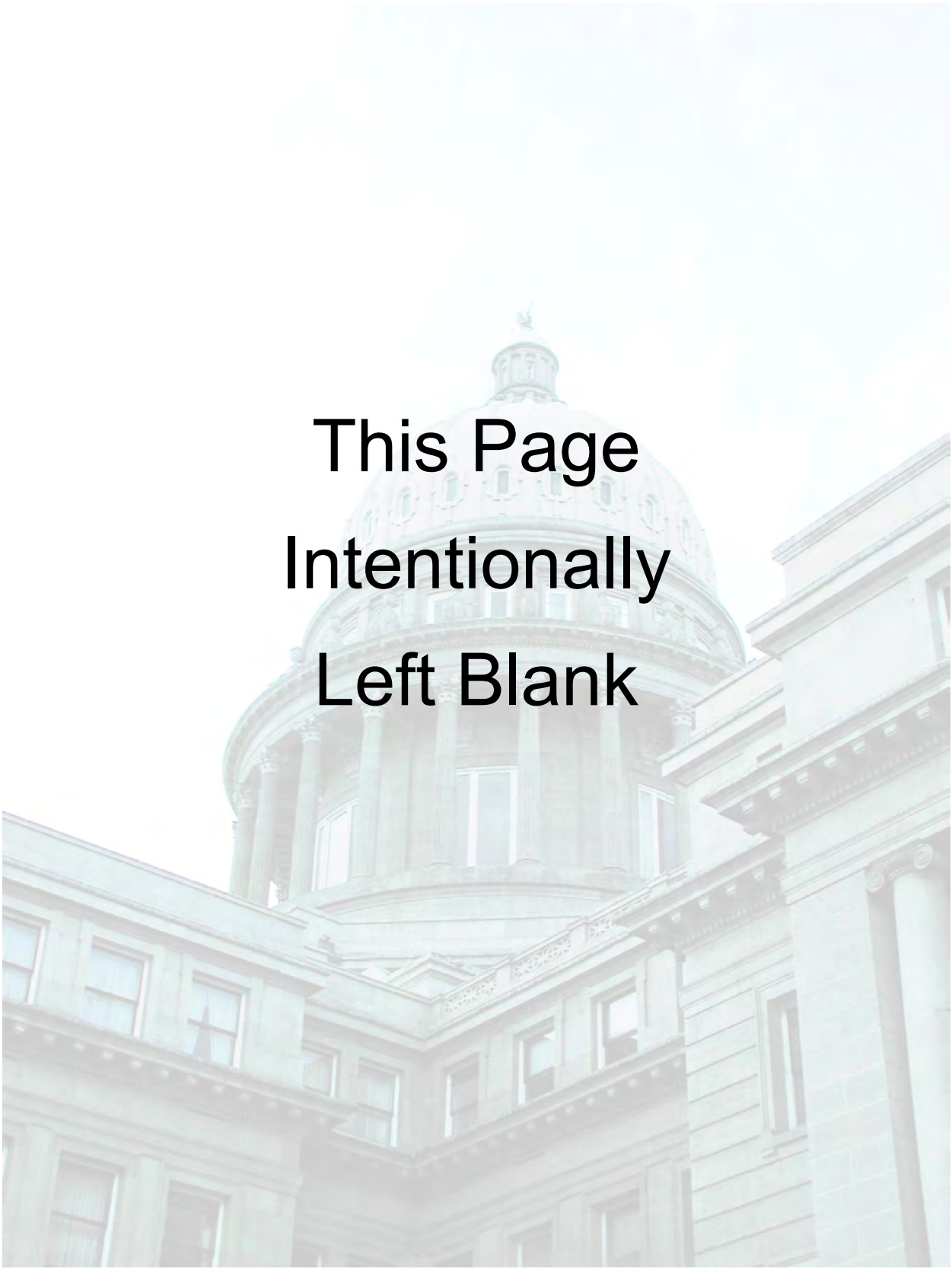

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Year One Assessment of the Idaho Department of Juvenile Corrections' REsponsible Actions and Decisions by Youth (READY) Program

Prepared for the Idaho

Department of Juvenile Corrections

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Executive Summary

In fiscal year 2015 (FY15), the Millennium Fund (MF) programs previously overseen by the Idaho Supreme Court (ISC) were shifted to the oversight of the Idaho Department of Juvenile Corrections (IDJC). These programs primarily serve youth who have come into contact with the justice system because of a status offense. Youth who commit status offenses are often in need of brief interventions for noncriminal behavior and therefore represent a unique subset of the youthful population IDJC serves.

The 26 grantees that received a FY15 MF grant offer programs that are based on the philosophy of restorative justice, focus on reducing the use of tobacco, alcohol, and other substances, and also concentrate on skill-building. Thirteen of these programs were inherited from ISC and 13 were newly awarded grants in FY15.

Year 1 Evaluation Approach

Because this set of MF grantees had never participated in a systematic evaluation before, we focused our attention on developing a sustainable, uniform strategy to collect and analyze data. As part of this effort, we received data from ISC's case management system (ISTARS) and also collected data from each of the grantees by way of quarterly reports. These reports included program-level outputs and participant-level data points. The participant level data points included demographics, program entrance and exit information, the results of a short screener focused on mental health, substance use, and criminality, and a set of questions about tobacco use. Additionally, we asked each grantee to submit a logic model that delineated their program's goals and objectives, among other items.

Year 1 Evaluation Results

We quickly learned that statewide data on status offenders do exist, albeit inconsistently. ISTARS contains some data on status offenses and such data is also tracked by varying degrees at the county and/or program level. Because such data can be found in many systems (or, in some instances, no system) and because the programs supported by an MF grant are diverse, developing a set of data points to collect and analyze that were applicable to and appropriate for every program, while also maintaining the integrity of the grant funding guidelines, was challenging. The effort included, for many grantees, considerable changes to their current processes and systems. After working through these types of challenges in the first quarter of FY15, we were able to establish a set of data points to collect from every program for the remaining quarters of the fiscal year. To their credit, the grantees made notable improvement over the course of the year in how they submitted the required data.

ISTARS Data

Using ISTARS data from fiscal years 2012, 2013, and 2014 (FY12, FY13, and FY14), we found that the total number of status offenses filed in court has decreased since FY12. Additionally:

- Although the number of alcohol citations decreased over the course of the three fiscal years, the number of tobacco citations increased
- In all three years, alcohol and tobacco citations made up over half of all status offense charges and counts filed
- In all three years, tobacco citations were the most common status offense
- Generally speaking, roughly half of all charges and counts were found to be true and the other half of all charges and counts were dismissed by the court

Data Submitted by the Grantees

Data is included in this Year 1 evaluation report, on some level, for a total of 980 MF program participants. For a number of reasons detailed in the body of the main report, the data submitted by the grantees contained, at times, rather large amounts of missing data points.

Participant Demographics

- The average age was 15 years old
- Most participants were male (65%)
- Most participants were Caucasian (73%)
- Most participants were first-time offenders (85%)

Offense Type

- Offenses that can be categorized broadly as substance use offenses were the most common (351 total offenses): alcohol (105 offenses), tobacco (201 offenses), and possession or paraphernalia (45 offenses)
- Truancy was the next most common offense (195 offenses)
- Runaway/beyond control/incorrigible (108 offenses)

Program Length

- The average (mean) number of days between the date of referral and the program start date was 24.0 days
    - 266 participants (36%) of 746 youth included in this analysis started their programs within a week of referral for their offense
- The average (mean) number of days spent participating in a program was 106.8 days
    - 195 participants (40%) of 487 youth included in this analysis participated in their program for more than 90 days

Program Completion

- 83% of the 603 participants included in this analysis successfully completed their program
- 101 participants were reported as having failed or not completed their program
    - 64% were referred back to court
- The most commonly reported reasons for program failures was a new charge/offense and/or some type of non-compliance

GAIN-SS

At our request, the grantees implemented use of the Global Appraisal of Individual Needs – Short Screener (GAIN-SS) to screen participants in their programs. This screener consists of four domains that screen for various types of mental health disorders, substance use disorders, and crime and violence behaviors.

- Among the 416 screened participants that were included in our analysis, 83.4% could benefit from a lengthier assessment because of symptoms reported in the past month
- The most commonly reported symptoms were found on the two mental health domains as opposed to the substance use or crime and violence domains:
    - Had a hard time paying attention at school, work, or home (44%)
    - Had a hard time listening to instructions at school, work, or home (38%)
    - Sleep trouble, such as bad dreams, sleeping restlessly, or falling asleep during the day (36%)
    - Lied or conned to get things you wanted or to avoid having to do something (33%)
    - Becoming very distressed and upset when something reminded you of the past (31%)
    - Feeling very anxious, nervous, tense, scared, panicked, or like something bad was going to happen (31%)
    - Feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future (29%)

Tobacco Use

- 201 youth served by an MF program committed a tobacco offense and 343 youth reported they are either currently using tobacco or, if they are not currently using, admitted to ever having tried tobacco
    - 243 participants (71%) used cigarettes
    - 171 participants (50%) used electronic or e-cigarettes
- The average age of first use was 13 years old

Year 1 Evaluation Findings and Year 2 Approach

In this section, we outline our most important findings and, as a result of those findings, the action steps we plan to take in the Year 2 evaluation.

Year 1 Finding

Perhaps the most important (or, at least, most common) outcome discussed in national literature as it relates to effective interventions for status-offending youth is to reduce the number of these cases that are processed formally in court.

- We collected data on 980 youth diverted from a formal court process by MF programs in FY15
- ISTARS contained information for 2,698 charges or counts for status offenses in FY14
- Approximately half of all charges or counts in FY12 and FY13 were ultimately dismissed

Year 2 Approach

Now that we have established a baseline in this Year 1 evaluation, in Year 2, we will monitor the number of cases processed formally in court.

- Continue to track the number of diverted youth
- Continue to track the number of petitioned charges and counts in ISTARS
- Continue to track the number of petitioned dismissed charges and counts in ISTARS

Year 1 Finding

Nearly 85% of MF program participants were first-time offenders and approximately 15% of MF program participants have had a previous offense.

Year 2 Approach

Devise a method to collect a youth's intervention history and use that information to assess what interventions have already been tried.

Year 1 Finding

The literature documents that juvenile justice system resources should be spent on high-risk youth and that interventions for low-risk youth should be minimal. Unnecessarily long interventions have the potential to create negative consequences, including increasing a youth's risk of reoffending.

- Start of services: 36% of youth began their intervention within one week of being referred for an offense, yet 23% of youth did not start their MF program for more than four weeks after being referred for an offense
- Program length: The programs implemented by the MF grantees are intended to serve low-risk youth and, therefore, "need" only a brief intervention, yet 40% of youth participate in an MF program for more than 90 days

Year 2 Approach

A program length of 90 or more days may not align with the literature's assertion that low-risk youth only need a brief intervention. Therefore, we plan to work with the MF grantees to learn more about the characteristics of youth who are involved in the system for relatively longer periods of time than others.

- Examine which factors contribute to delays in getting youth started in their MF programs
- Explore the types of factors that contribute to youth being involved in lengthier interventions

Year 1 Finding

The goal of an overall program completion rate of 90% was not met. However, the data necessary to complete this calculation was missing for 38% of youth participants. For those youth we could include in the analysis, the completion rate was 83%.

- The MF grantees indicated that, overall, 101 youth failed to complete their program. Of those, 64% were referred back to court.

Year 2 Approach

Continue to work with the grantees on data collection and submission strategies to ensure we receive program exit information.

- Further investigate the processes the MF grantees undertake after a youth fails to complete the program
- Explore the option of tracking the number of youth who are offered more than one diversion option before referring the case back to court

Year 1 Finding:

Based on symptoms identified in the past month, 83.2% of youth who received a GAIN-SS should receive a lengthier assessment. Given the characteristics of the youth eligible for participation in MF programs, this statistic seems rather high. That said, we learned that the symptoms identified most often by youth who received a GAIN-SS are those that most youth likely face as a normal part of adolescent development.

- 44% reported having a hard time paying attention at school, work, or home
- 38% reported having a hard time listening to instructions at school, work, or home
- 36% reported sleep trouble, such as bad dreams, sleeping restlessly, or falling asleep during the day

Year 2 Approach

Because the most commonly identified symptoms are those that many youth experience, including youth that have not committed a status offense, we plan to discuss with the MF grantees to what extent program administrators (or other staff) review and use the GAIN-SS results.

- Survey program administrators to ascertain how the results of the GAIN-SS affect service delivery and the type of intervention offered

Year 1 Finding

In addition to diverting these youth away from or out of the formal judicial system, the program goals of the MF grantees also include reducing the risk for ongoing or continued use of tobacco and other substances. Tobacco and other types of substance use offenses were the most common offense types among MF program participants. Therefore, a continued focus on the behaviors associated with these offenses seems warranted. However, because some of these behaviors can be considered socially normative, determining the appropriate response (i.e., type of intervention) is critical.

Year 2 Approach

We made suggestions for continuous quality improvement for each grantee. Given that this evaluation is in its first year, these suggestions tend to focus on data collection and submission. In the Year 2 evaluation, we hope to shift our focus away from data integrity and towards helping the grantees measure positive youth outcomes.

Acknowledgements

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Introduction

The Idaho Department of Juvenile Corrections' (IDJC) fiscal year 2015 Millennium Fund (MF) grant application outlined IDJC's and the Idaho Supreme Court's (ISC) plan to transition MF programs previously overseen by ISC to IDJC. The application also described IDJC's intention to award new grants for programs proposing to use restorative justice practices with status offenders.[1] Among other types of offenses, citations for tobacco and alcohol are accurately categorized as status offenses.
Although the delinquent behavior of youth who receive citations for tobacco or alcohol use (or commit other types status offenses) does not necessarily warrant involvement in the juvenile justice system, current research supports the notion that status-offending youth require attention and may need intervention (Salsich & Trone, 2013). In Idaho, youth who commit status offenses present unique needs for preventative and early intervention services (including, for example, substance use education), but often do not qualify for state-funded intervention services (e.g., substance use treatment). Therefore, the purpose of IDJC's focus on status offenders is to enhance the continuum of care that serves youthful offenders throughout Idaho and provide brief intervention services.

Fiscal Year 2015 Grantees

The programs included in this evaluation primarily focus on cessation and prevention of tobacco, alcohol, and substance use among status offenders and diverting those offenders out of and away from the formal justice system. Throughout the state, MF dollars support 26 programs that serve youth facing first-time alcohol and tobacco citations, other types of status offenses, and some other low-level offenses: 13 of these programs are continuations of those previously overseen by ISC and 13 are new grantees in fiscal year 2015. A list of the grantees may be seen in Appendix A. The type of interventions implemented by the grantees range from youth courts to education classes to counseling to restorative justice conferences. Despite their varied approaches, all of the grantees share the common goal of providing early intervention services to youth who have been brought to the attention of the justice system for a status offense or other type of low-level offense.

[1] Restorative justice practices seek to help repair the harm done by an offender and offer healing to the offender, the victim, and the community (McCold & Wachtel, 2003). Status offenses are acts that would otherwise be legal if not for the person's age such as consumption of alcohol, tobacco use, truancy, running away, incorrigibility, and curfew violations (National Center for Juvenile Justice, 2014).

- Of the 13 new grantees:
  - Eight sought to implement restorative justice practices[2]
  - Four implemented school-based interventions[3]
  - Two implemented a life skills program[4]
  - One implemented a family-based program[5]
  - One implemented a diversion board[6]
  - One implemented a youth court[7]

- Of the 13 inherited programs:
  - Three operate youth courts[8]
  - Two operate attendance or truancy courts[9]
  - Two provide clinical or counseling services[10]
  - Two provide status offender services[11]
  - Two have implemented a program based on Towards No Drug Abuse (TND)[12]
  - One has implemented NOT on Tobacco (NOT)[13]
  - One has implemented Thinking for a Change (TFAC)[14]
  - One receives funds for a program coordinator position[15]

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[2] Boundary County Youth Accountability Board, Nez Perce County Restorative Justice, Canyon County Restorative Justice, Boise County Restorative Justice, Bannock County Restorative Justice, School District #25 Restorative Justice, Teton County Restorative Victim Awareness, and Kuna School-based Referrals Project

[3] Boise County Restorative Justice, Post Falls Teen Court and Service Learning, School District #25 Restorative Justice, and Kuna School-based Referrals Project.

[4] Learning Life Company and Ada County Tobacco Alcohol Program each planned to implement Botvin Life Skills.

[5] Volunteers of America Crosswalk North Idaho implemented Active Parenting of Teens: Families in Action.

[6] Jerome County Status Offender Diversion Board.

[7] Post Falls Teen Court and Service Learning.

[8] 3rd District Youth Court, Bannock County Youth Court, and Bingham County Youth Court.

[9] 5th District Truancy Court and Bannock County Truancy Court.

[10] Nez Perce County Clinical Services and Ada County Diversion Counseling.

[11] 5th District Status Offender Services and Teton County Status Offender Program.

[12] 5th District Tobacco Alcohol Platform and Bingham County Youth Court.

[13] Madison County NOT.

[14] Fremont County TFAC.

[15] Bonneville County.

Current Evaluation

The first goal outlined in IDJC's application to the MF outlines the primary purpose of this evaluation: to evaluate whether and to what extent the funded programs help prevent and reduce tobacco, alcohol, and substance use by status offenders. This goal is further delineated by the following objectives:

- Develop responsible decision-making and refusal skills in youth served
- Support at least eight evidence-based restorative justice projects focused on status offenders
- Achieve a 90% program completion rate for youth served
- Document a reduction in risk for tobacco, alcohol, and/or substance use among youth served

The main focus of this first year of evaluation was to develop an effective data collection and analysis strategy, primarily through the identification and selection of an instrument that will create a baseline by which to accurately describe the type of youth served by the programs. Such a baseline in Year 1 will help us produce data-driven, outcome-focused reports for the Year 2 evaluation and beyond.

In addition to a statewide summary, this Year 1 evaluation provides program-specific briefs included as an addendum to the report. The program briefs focus on program-level outputs and outcomes, program fidelity, and continuous quality improvement (CQI). The statewide summary compiles the data submitted by each MF grantee and particularly focuses on the results of screens completed by program participants.

Methodology

Literature Review

We conducted a review of the current and most salient research on: (1) status-offending youth and their patterns of substance and tobacco use; (2) restorative justice practices and their role in providing services to status offenders; and (3) screening and assessment best practices for youth referred to the formal justice system for a status offense. We relied heavily on a 2013 Vera Institute report that focuses specifically on services for status offenders and provides a framework within which those services should be provided.[16] We summarize the report below.

Services for Status Offenders

In a 2013 report published by the Vera Institute, Salsich and Trone distill the research on the "right response" to status offenses by identifying five hallmarks: (1) diversion from court and the juvenile justice system; (2) an immediate response; (3) a triage, screening, and assessment process; (4) services that are accessible, effective, and involve the entire family; and (5) internal assessment and monitoring of outcomes. These hallmarks nicely summarize and mirror the findings of other recent reports on how to build an effective, community-based system that is well-positioned to respond appropriately to status offenders.[17]

Diversion from Court

Status offenses often either reflect unmet, noncriminal needs that do not represent public safety issues per se or represent socially normative adolescent behavior (Coalition for Juvenile Justice, 2013; Salsich & Trone, 2013). As such, national literature discusses the importance of diverting all status offenders away from the formal juvenile justice system and instead resolving all status offenses through voluntary diversion (Kendall, 2007).

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[16] The Status Offense Reform Center is supported by the MacArthur Foundation as part of its Models for Change Resource Center Partnership.

[17] For example: Coalition for Juvenile Justice. *National Standards for the Care of Youth Charged with Status Offenses*. (2013). Safety, Opportunity, and Success Project: Standards of Care for Non-delinquent Youth; Seigle, E., Walsh, N., & Weber, J. (2014). *Core Principles for Reducing Recidivism and Improving Other Outcomes for Youth in the Juvenile Justice System*. Council of State Governments Justice Center; Louisiana Models for Change (2011). *Summary of National Models, Policies, and Practices of Service Needs of Status Offending Youth*.

Research demonstrates that court intervention can exacerbate any underlying issues instead of addressing the root causes of the youth's behavior (Lambie & Randell, 2013). In such cases, a court response that involves penalties and sanctions unrelated to the root cause of the behavior is not an appropriate intervention. Therefore, diverting all first-time status offenders and then providing graduated responses is a best practice. Likewise, introducing court involvement only after thoroughly exploring and exhausting all other options is also a best practice. Diverted youth should not "fail" immediately and/or automatically be referred back to court as a response to such a "failure" if the first intervention does not work (Coalition for Juvenile Justice, 2013; Seigle, Walsh, & Weber, 2014).

An Immediate Response

Literature published from the Models for Change Initiative in Louisiana states that all youth, without exception, should receive an immediate response that includes triage and referral, crisis intervention, screening and referral for assessment, and brief strategic intervention (Phillipi, Koch, Bolin, & DePrato, 2011).

A Triage Process

National literature advises using a screening tool at intake to quickly identify the service needs of status offenders. We discuss this idea in greater detail in an upcoming section of this report. Of importance to highlight here, however, is that such a "triage process" lends itself to the best practice of tailoring services to meet the individualized needs of different youth. As discussed in the Coalition for Juvenile Justice's 2013 report, *National Standards for the Care of Youth Charged with Status Offenses*, "often a categorical array of services are offered or mandated that do not meet the youth and family's individualized needs. Treatment plans for youth and families can become prescriptive and coercive, with no real buy-in from the child or family"—a situation that can lead to poor outcomes (Coalition for Juvenile Justice, p. 103).

Accessible, Effective, Family-focused Services

National literature stresses the importance of services that are family- and community-centric (Seigle et al., 2014). The Coalition for Juvenile Justice's report on national standards summarizes why: "given the nature of behaviors labeled status offenses, and the underlying reasons for the behaviors, the family team approach is a perfect fit for status offense interventions and cases" (Coalition for Juvenile Justice, 2013, p. 104). Although services should focus on the family, research also cautions against interventions that perversely disengage, disempower, or confuse the role of the youth's family, particularly the youth's parents. Court intervention should not replace the role of the parents as the entity responsible for meeting the youth's needs nor should court intervention become increasingly punitive; instead, the court should strive to empower the youth's family to engage in services (Coalition for Juvenile Justice, 2013).

Internal Assessment and Outcome Monitoring

Making decisions about how to assess the effectiveness of programs that serve status offenders and how to monitor those programs' outcomes is challenging. National literature suggests a focus on positive youth development, rather than solely focusing on recidivism (Mansoor, 2014).

Data Collection and Analysis

We used five primary sources of data for the Year 1 evaluation: (1) ISC's data system (ISTARS); (2) program logic models; (3) quarterly program data reports; (4) a program participant short screener; and (5) communication with the MF grantees.

ISTARS Data

ISC staff provided us with data from their case management system, ISTARS, for fiscal years 2012, 2013, and 2014. Specifically, ISC staff compiled a report on all juvenile offender cases (excluding 18-20 year olds) filed in court in those three years. We then filtered the results by charge description to arrive at those charges that can be appropriately categorized as status offenses. The youth included in this set of data may have participated in an MF program, but not necessarily. Unfortunately, we are not able to make this distinction given the data available. We discuss data limitation issues further in the Results section of this report.

Program Logic Models

We asked the MF grantees to submit a logic model that defined each program's inputs, activities/strategies, outputs, and outcomes.[18] Logic models map the processes each program undertakes from the point of program conception to its implementation and subsequent results. As such, they bring into better focus the goals and objectives of the program and the steps necessary to achieve those goals and objectives. For the purposes of the Year 1 evaluation, the logic models served as process maps that not only reflected the programmatic differences among the MF grantees, but also helped us measure program fidelity and make suggestions for continuous quality improvement (CQI).

Quarterly Reports

Overall, national models for status offender programs emphasize having a data collection system that accomplishes two primary goals: 1) describing the population being served and 2) evaluating the success of the program (Louisiana Models for Change, 2011). We developed, in concert with IDJC staff, a set of consistent data measures to be collected by each MF grantee and submitted to us. We distributed the initial set of measures to the grantees prior to an Idaho Juvenile Justice Association (IJJA) workshop that all of the grantees attended in September 2014. We then refined the data points with each grantee in November and December 2014. The final set of data points are described in Appendix B. The data points include demographics, responses to program intake and exit questions, responses to a short screener, plus responses to a set of questions about tobacco use. The grantees submitted data quarterly beginning with fiscal year 2015, quarter 2 (FY15Qtr2). As part of our data inputting process, we cleaned and coded all data submissions to allow us to efficiently and effectively analyze the aggregate data.

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[18] Inputs: resources needed to implement the program or intervention. Strategies/activities: methods used to implement the program or intervention, designed to achieve intended outcomes. Outputs: direct results of implemented strategies/activities. Outcomes: impact of the program or intervention (W.K. Kellogg Foundation, 1998).

The Global Appraisal of Individual Needs Short Screener

Selecting a short screener appropriate for the type of youth the MF grantees target to participate in their programs was challenging. Certainly the use of a common screening tool promotes consistent data collection and reporting across the state; however, although many popular tools are in use, there is not yet a best practice for a specific screening or assessment tool for status offenders (Meyer, Ananthakrishnan, & Salsich, 2014). After some brief discussions with the MF grantees and weighing the advantages and disadvantages of various tools, we asked the grantees to screen each program participant using the Global Appraisal of Individual Needs Short Screener (GAIN-SS).[19] A copy of the GAIN-SS is included in Appendix C.

The GAIN-SS is designed to quickly screen members of the general population in four different behavioral health domains: internalizing disorders, externalizing disorders, substance use disorders, and a crime and violence screener.[20] There are a total of 23 symptoms on the screener and items in each domain include issues (symptoms) a youth may have experienced. The response choices allow youth to indicate whether they experienced the issue during the past month, 2-3 months ago, 4-12 months ago, more than a year ago, or never. For our purposes, the GAIN-SS helped us: 1) describe and understand the MF program participants and the symptoms they faced prior to their involvement in the justice system; 2) initiate the best practice of screening all status offenders; and 3) collect consistent data from all grantees.

To score the GAIN-SS, the number of responses within each time frame are counted separately (i.e., the number of times a youth indicates that he or she had an issue during the past month, 2-3 months ago, 4-12 months ago, or more than a year ago). If a youth identifies more than three past-year issues, the youth is considered High Severity; 1-2 past-year issues is considered Moderate Severity, and zero past-year issues is Low Severity.[21] These severity levels are applicable within each domain (each domain receives a score) and across all domains (the total score of all domains).

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[19] Examples of the types of pros and cons we considered include cost of administration and training, whether the tool could be self-administered or required specialized staff, time to complete, and number and type of domains covered.

[20] Examples of internalizing disorders include depression, anxiety, and trauma. Examples of externalizing disorders include attention deficits, impulsivity, and conduct problems.

[21] High severity: high probabilities of a diagnosis and need for services; likely to need a formal assessment and intervention; Moderate severity: possible diagnosis and possibly in need of services; likely to benefit from brief assessment and brief intervention; Low severity: unlikely to have a diagnosis or need services.

Communication with the MF Grantees

Beginning with our introduction to the MF grantees at the IJJA conference in September 2014, and throughout the Year 1 evaluation, we attempted to maintain consistent communication with the MF grantees without being unduly disruptive or intrusive. We accepted requests for in-person and/or on-site interviews and meetings for grantees located in close proximity to Boise (i.e., within the Treasure Valley) and also participated in conference calls with numerous MF grantees to answer questions about the evaluation process, particularly as it relates to data collection.[22] Primarily however, we corresponded with the MF grantees over the phone and through email.

As part of our CQI effort and to ensure we receive consistent, accurate, and complete data from the MF grantees, after we received the first set of data for FY15Qtr2, we corresponded with each grantee to clarify expectations, work through technical issues, and refine data collection and submission strategies.

[22] As part of our Year 2 evaluation, we intend to travel to other parts of the state to visit with MF grantees located outside of the surrounding area.

Analyses and Results: ISTARS Data

Our analyses and results are presented in two main sections: statewide data from ISTARS and participant data as reported by the MF grantees. The ISTARS data provides a much-needed baseline for approximately how many status offenses are filed in court each year and also provides context and, to some extent justification, for whether the MF programs are needed.
As identified by the Vera Institute status offender system toolkit (2013), the first step in designing the types of services needed by status offenders is to define and understand the scope of the problem:

- How many youth commit status offenses each year?
- Which type of status offense is most common?
- What are the characteristics of youth who commit status offenses?
- Are status offenders using alcohol, tobacco, or other substances?

In this section, we present the data available on status offenders but first identify the limitations of those data.

Challenges, Limitations, and Considerations

Data pertaining to the delinquent behavior of youth in Idaho who commit status offenses may be found in many systems or not be tracked in a formal system at all. Some status offenders will not enter the justice system in an official capacity; others will have their cases processed formally in either the juvenile justice system or adult criminal court.[23] Particularly because juvenile justice professionals throughout the state often make specific efforts to keep status offenders out of the formal justice system, tracking youth who may be introduced to the system but not formally enter it presents a major challenge.

- As previously mentioned, if a case is filed in court, the case management system known as ISTARS tracks the case.[24] Not every juvenile arrest or referral to the justice system, including arrests or referrals for status offenses, result in a court filing. Therefore, status offenders may or may not appear in ISTARS.
- Counties also track juvenile offender data using the Idaho Juvenile Offender System (IJOS). However, not every county uses IJOS, and those that do may not use the system in the same way. Data for some youth participating in a diversion-type program may (or may not) be entered into IJOS. Therefore, status offenders may or may not appear in IJOS.

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[23] Idaho Code 20-505(4) provides that alcohol and tobacco citations be processed in adult criminal court rather than the juvenile justice system, although the case can be waived to juvenile court.

[24] Sometimes a status offender's case is not formally filed in court and is instead handled through a diversion program (e.g., an MF program). This practice happens in counties across the state to avoid creating a court record for the juvenile, but the methods by which this occurs vary greatly across counties.

A second major challenge is that not all status offenders participate in an MF program. Although the target population of the MF programs can mostly be categorized under the umbrella of status offenses, the specific population each program intends to serve varies and, therefore, the inclusion (and exclusion) criteria for participation in the MF programs vary. Additionally, most MF programs (and other types of diversion programs) include an "opt-in" clause; in other words, a youth may refuse an offer to participate in such a program.

Finally, other considerations specific to the ISTARS data we used to conduct some of our analyses should be mentioned:

- To arrive at the number of status offenses filed in court within a given fiscal year, we conducted our analyses at the charge- or count-level and not the case-level. In some instances, there are multiple charges in a single case or multiple counts of the same charge in a single case. We counted every charge and every count; therefore, the numbers we present in our findings do not represent the number of cases or the number of youth.
- Some charges and counts in the original dataset were categorized as "transferred." We removed all charges or counts categorized this way, because we can reasonably conclude that the transfers reflect actual cases that transferred to and processed in another court and are therefore reflected elsewhere in the data.

ISTARS Data and Findings

Number of Status Offenses

Tables 1, 2, and 3 display the number of status offenses filed in court and, therefore, tracked in ISTARS for fiscal years 2012-2014 (FY12, FY13, FY14). Overall, the total number of status offenses filed decreased between FY12 and FY14. Although the number of alcohol citations followed this downward trend, the number of tobacco citations has increased each year since FY12. In all three years, alcohol and tobacco citations made up the majority of cases—a combined 56.2% of charges and counts filed in FY12, 57.9% of charges and counts filed in FY13, and 58.7% of charges and counts filed in FY14.

Table 1: Status Offense Charges or Counts, FY12

Offense Type	Number of Charges or Counts
Alcohol citation	834 (27.5%)
Curfew violation	264 (8.7%)
Runaway/beyond control/incorrigible	607 (20.0%)
Status offense (not specified)	195 (6.4 %)
Tobacco citation	**871 (28.7%)**
Truancy or attendance citation	267 (8.8 %)
TOTAL	3,038

Note. Percentages are rounded so the total percentage may not equal 100. The highest percentage is in bold. The count of alcohol citations does not include charges of driving under the influence (DUI).

Table 2: Status Offense Charges or Counts, FY13

Offense Type	Number of Charges or Counts
Alcohol citation	762 (26.3 %)
Curfew violation	282 (9.7%)
Runaway/beyond control/incorrigible	551 (19.0%)
Status offense (not specified)	123 (4.3 %)
Tobacco citation	**914 (31.6 %)**
Truancy or attendance citation	262 (9.1%)
TOTAL	2,894

Note. Percentages are rounded so the total percentage may not equal 100. The highest percentage is in bold. The count of alcohol citations does not include charges of driving under the influence (DUI).

Table 3: Status Offense Charges or Counts, FY14

Offense Type	Number of Charges or Counts
Alcohol citation	593 (22.0%)
Curfew violation	211 (7.8%)
Runaway/beyond control/incorrigible	487 (18.1%)
Status offense (not specified)	210 (7.8%)
Tobacco citation	**990 (36.7%)**
Truancy or attendance citation	207 (7.7%)
TOTAL	2,698

Note. Percentages are rounded so the total percentage may not equal 100. The highest percentage is in bold. The count of alcohol citations does not include charges of driving under the influence (DUI).

Offense by County.

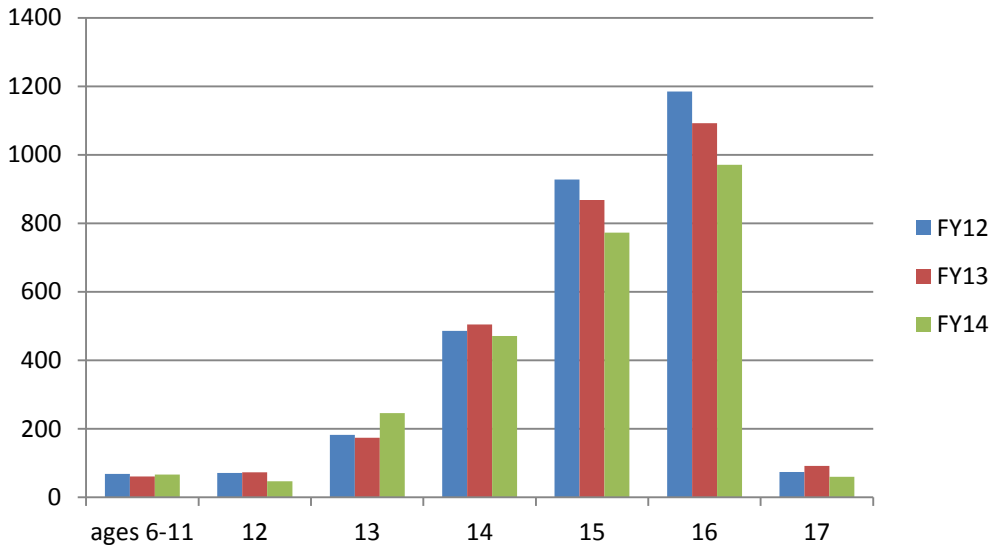
Appendix D includes the total number of status offense charges or counts filed in court in FY12, FY13, and FY14. In the table, we only included those counties served by an MF grantee in FY15 (21 counties).[25]

[25] We included every county in the 5th District although not all counties necessarily access the programs funded by an MF grant.

Ages of Youth

Figure 1 shows that greater than two-thirds of all status offense charges or counts were against youth ages 15 or 16.

Figure 1: Ages of Youth, FY12-14



Findings of the Court

Tables 4, 5, and 6 depict the findings of the court. In FY12, 49.4% of the status offenses represented in this dataset were found to be true and 48.3% were dismissed. In FY13, 49.2% were found to be true and 47.7% were dismissed. In FY14, 52.4% were found to be true and 35.5% were dismissed.

Table 4: Findings of the Court, FY12

Offense Type	Number of Charges or Counts	True	Dismissed	Other
Alcohol citation	834	**427 (51.2%)**	381 (45.7%)	26 (3.1%)
Curfew violation	264	108 (40.9%)	**154 (58.3%)**	2 (0.8%)
Runaway/beyond control/incorrigible	605	216 (35.6%)	**387 (63.8%)**	2 (0.3%)
Status offense (not specified)	195	**112 (57.4%)**	78 (40.0%)	5 (2.6%)
Tobacco citation	870	**503 (57.7%)**	342 (39.3%)	25 (2.9%)
Truant or attendance citation	267	**135 (50.6%)**	125 (46.8%)	7 (2.6%)
TOTAL	3,035	**1,501 (49.4%)**	1,467 (48.3%)	67 (2.2%)

Note. Percentages are rounded so the total percentage may not equal 100. The highest percentage in each row is in bold. A finding of "True" includes any charges or counts that were diverted or informally adjusted. A finding of "Other" also includes charges or counts categorized as "none" which means those charges or counts had not yet been disposed at the time of this analysis. The number of charges or counts does not necessarily match the number reported in Table 4 because for very few charges or counts, no finding of the court was included in the data (i.e., the data was missing).

Table 5: Findings of the Court, FY13

Offense Type	Number of Charges or Counts	True	Dismissed	Other
Alcohol citation	762	**371 (48.7%)**	342 (44.9%)	49 (6.4%)
Curfew violation	282	130 (46.1%)	**144 (51.1%)**	8 (2.8%)
Runaway, beyond control, incorrigible	551	213 (38.7%)	**337 (61.2%)**	1 (0.2%)
Status offense (not specified)	123	**77 (62.6%)**	44 (35.8%)	2 (1.6%)
Tobacco citation	914	**504 (55.1%)**	386 (42.2%)	24 (2.6%)
Truant or attendance citation	262	**130 (49.6%)**	126 (48.1%)	6 (2.3%)
TOTAL	2,894	**1,425 (49.2%)**	1,379 (47.7%)	90 (3.1%)

Note. Percentages are rounded so the total percentage may not equal 100. The highest percentage in each row is in bold. A finding of "True" includes any charges or counts that were diverted or informally adjusted. A finding of "Other" also includes charges or counts categorized as "none" which means those charges or counts had not yet been disposed at the time of this analysis. The number of charges or counts does not necessarily match the number reported in Table 5 because for very few charges or counts, no finding of the court was included in the data (i.e., the data was missing).

Table 6: Findings of the Court, FY14

Offense Type	Number of Charges or Counts	True	Dismissed	Other
Alcohol citation	593	**324 (54.6%)**	192 (32.4%)	77 (13.0%)
Curfew violation	211	**104 (49.3%)**	83 (39.3%)	24 (11.4%)
Runaway, beyond control, incorrigible	487	197 (40.5%)	**223 (45.8%)**	67 (13.8%)
Status offense (not specified)	210	**117 (55.7%)**	76 (36.2%)	17 (8.1%)
Tobacco citation	990	**549 (55.5%)**	310 (31.3%)	131 (13.2%)
Truant or attendance citation	207	**122 (58.9%)**	73 (35.3%)	12 (5.8%)
TOTAL	2,698	**1,413 (52.4%)**	957 (35.5%)	328 (12.2%)

Note. Percentages are rounded so the total percentage may not equal 100. The highest percentage in each row is in bold. A finding of "True" includes any charges or counts that were diverted or informally adjusted. A finding of "Other" also includes charges or counts categorized as "none" which means those charges or counts had not yet been disposed at the time of this analysis. The number of charges or counts does not necessarily match the number reported in Table 6 because for very few charges or counts, no finding of the court was included in the data (i.e., the data was missing).

Analyses and Results: Millennium Fund Program Data

With an understanding of how many charges or counts are filed in court, we present in this section the data we collected from the MF grantees that helps illustrate their role in keeping status offenders out of the adult criminal system and/or formal juvenile justice system. As previously discussed in greater detail, the five hallmarks of an effectively-designed system to serve status offenders, as identified by Salsich and Trone (2013), can be quickly summarized by the following: (1) diversion; (2) an immediate response; (3) a triage process; (4) services that are accessible, effective, and involve the entire family; and (5) evaluation of program performance.

By design, all of the programs implemented by the MF grantees divert youth away from court and the formal juvenile justice system (although the methods used to do so vary greatly) and, to their credit, all programs agreed to engage in our assessment of program performance and outcomes. Below (after first describing some challenges and limitations) we present information and analyses related to whether and to what extent the MF programs also provide an immediate response, a triage process, and services that are accessible, effective, and include the youth's family.

Challenges, Limitations, and Considerations

- With good reason, the first quarter of the grant period (FY15) was dedicated to pre-implementation planning activities, and the second quarter served as a period of CQI for data collection and program implementation. The third and fourth quarters of FY15 offer the most complete data. Conclusions drawn should be interpreted with that context in mind.
- Thirteen MF grantees transitioned their already-existing programs from ISC grant supervision to IDJC. As such, we required these 13 grantees to adjust their data collection strategies to meet the expectations of IDJC and a new evaluation plan.
- Further, because these 13 grantees were combined with 13 new grantees, establishing a set of uniform data points to collect from each grantee proved difficult; the target populations among the grantees differ and the programs and intervention strategies also varied. For example, in this cohort of MF grantees, youth who have a first-time alcohol or tobacco offense may participate in a youth court, in a life skills course, in a Toward No Drug Abuse curriculum, in a NOT on Tobacco class, some combination thereof, etc. Applying a single evaluation (and data collection) strategy or technique to more than one target population and multiple programs is challenging and potentially problematic.
- Technically, three of the MF grantees (the District 7 program manager, Bannock County Truancy Court, and the 5th District Truancy Court) did not implement the GAIN-SS. Both of the truancy court programs function as part of or alongside larger programs that have established triage processes, as is called for in the literature. Bannock County was already using a different assessment (the YLS-I) and the 5th District already had a protocol in place that includes referring youth to the formal diversion program if the initial intervention (i.e., the truancy court response) was unsuccessful.

- Determining an exact total number of participants or youth served by the MF grantees proved difficult for a number of reasons: (1) A small number of youth (about 15 participants from Bannock County) are included in the dataset more than once because they were served in more than one program; (2) not all grantees reported every youth served if the intervention provided (i.e., restorative justice circles) was too brief to justify extensive data collection; and (3) youth served by the 5th District Truancy Court youth are not included in our dataset; instead, the 5th District Truancy court provided summary statistics on the total number of youth served.[26]
- Across analyses, the total number of cases included in each type of analysis varied. In some instances, the variation is due to missing data. In other cases, the variation is also caused by inaccurate data or errors in the data that we then purposely excluded.
- Data collection techniques varied among the MF grantees and much of the data the grantees collected from participants was self-reported. There were instances in which we noticed inconsistencies in the data that the nature of self-reported data can explain. For example, a youth may have participated in an MF program because of a tobacco citation, yet report no tobacco use. It is also possible that youth may under- (or over-) report issues screened for on the GAIN-SS. We discuss sensitivity (screening "in" too many) and specificity (screening "out" too many) issues with the GAIN-SS later in this report.

Fiscal Year 2015 Quarter 1

Evaluation activities in the first quarter of FY15 mostly consisted of pre-implementation planning activities. IDJC awarded grants and we made our initial communication and contact with each of the grantees. In early September, we attended the IJJA conference and hosted a session (alongside IDJC) for all of the MF grantees to discuss the evaluation process and expectations, including those related to data collection.

The MF grantees submitted the first draft of their logic models toward the end of the quarter. As needed, we then worked with each grantee to make any necessary changes that could help clarify the components of their program design and better define goals and objectives.

Fiscal Year 2015 Quarter 2

The first quarter for which the MF grantees submitted data was the second quarter of FY15 (FY15Qtr2). Because all of the grantees were becoming familiar with the new data submission guidelines and procedures, we used FY15Qtr2 as a period of CQI; we worked with the grantees to identify areas for improvement in how they collect, track, and submit program- and participant-level data.

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[26] Youth participating in the 5th District Truancy Court that are not successful are often referred "upstream" to the 5th District Status Offender Services program. These youth are included in our dataset.

After (1) receiving the FY15Qtr2 reports from each of the grantees along with feedback regarding the data collection process and (2) conducting some preliminary data analyses, we made select revisions. Namely, we deleted a question that asked about the child welfare background of each participant and we revised the tobacco questions to ask whether participants had ever used tobacco (instead of whether they were currently using tobacco).

In addition to participant data, the grantees also submitted program outputs which are detailed in the Report Addendum. These outputs help explain the grantees' activities during the quarter:

- Eight grantees trained 143 people as facilitators/coordinators of various types of restorative justice practices to include conferences, circles, and family group decision making meetings.[27] Bannock County, Boise County, and School District #25 each trained at least 30 people.
- Seven grantees held a total of 148 restorative justice practice events: 39 conferences, 49 family group decision making meetings, and 60 circles.[28] Boise County performed all 60 circles.
- Sixteen grantees reported screening 182 youth using the GAIN-SS. Ten grantees did not screen any youth using the GAIN-SS.[29]
- Seven grantees reported completion of a total of 53 service learning projects; 44 of those projects were completed by participants in Bingham County's Youth Court.[30]
- Eight grantees reported that participants were assigned and/or completed a total of 1,304 hours of community service. Bannock County programs accounted for the greatest number of completed community service hours (531 hours).[31]

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[27] Boundary County Youth Accountability Board, Nez Perce County, Canyon County, Boise County, Bannock County, 5th District TAP, and School District #25.

[28] Nez Perce County, Canyon County, Bannock County, Boise County, Ada County Diversion Counseling, and Post Falls Teen Court and Service Learning.

[29] Of the 10 that did not use the GAIN-SS in FY15Qtr2, three grantees (the District 7 program manager, Bannock County Truancy Court, and 5th District Truancy Court) have no plans to use the GAIN-SS, six grantees (Learning Life Company, Jerome County Diversion Board, School District #25, Teton County Restorative Justice, Teton County Forward Thinking, and Ada County TAP) expressed their intention to use the GAIN-SS but did not serve participants in this quarter, and one grantee (5th District Status Offender Services) did serve participants but had not yet implemented the GAIN-SS.

[30] Nez Perce County, 3rd District Youth Court, Boundary County Youth Accountability Board, Volunteers of America-Crosswalk North Idaho, Bingham County Youth Court, Post Falls Teen Court and Service Learning and 5th District TAP.

[31] Boundary County Youth Accountability Board, Volunteers of America-Crosswalk North Idaho, Bingham County Youth Court, Bannock County Youth Court, Bannock County Status Offender Program, Post Falls Teen Court and Service Learning, 5th District Status Offender Services, and 5th District TAP.

Fiscal Year 2015 Quarters 3 and 4

Although we essentially dedicated half of the Year 1 evaluation to MF program and evaluation planning and pre-implementation activities, we are able to report on some results and outcomes using some FY15Qtr2 data, as well as the data submitted in FY15Qtr3 and FY15Qtr4 by each of the MF grantees.

As in FY15Qtr2, the grantees submitted program-level outputs for FY15Qtr3 and FY15Qtr4. We present some of the most commonly reported outputs for each quarter below.

FY15Qtr3 Outputs

- All of the grantees (with one exception) that intend to use the GAIN-SS to screen program participants started using it in FY15Qtr3, if they had not already done so.[32] Not all of the grantees reported the number of screens in their program-level outputs; however, they did submit GAIN-SS data as part of their participant-level data report.
- Six grantees reported training 224 people in restorative justice practices; 184 of these people were teachers from School District #25.[33]
- Nine grantees reported conducting 75 restorative justice practice events, including 43 conferences, 23 circles, 10 family group decision making meetings, and three mediation services.[34]
- Five grantees reported completing a total of 48.5 service learning projects; 42 of those projects were completed by participants in Bingham County's Youth Court.[35]
- Eight grantees reported that participants' were assigned and/or completed a total of 1,450 hours of community service.[36] Bannock County programs accounted for the greatest number of completed community service hours (562 hours).

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[32] The exception is Teton County's Forward Thinking Program which was not implemented yet.

[33] Boise County, Bannock County Restorative Conferencing and Family Group Decision Making, Learning Life Company, Nez Perce County, Post Falls Teen Court and Service Learning, and School District #25.

[34] Boise County, Bannock County Restorative Conferencing and Family Group Decision Making, Boundary County Youth Accountability Board, Canyon County, Kuna School-Based Referrals Project, Learning Life Company, Post Falls Teen Court and Service Learning, and Nez Perce County.

[35] 3rd District Youth Court, 5th District TAP, Bingham County Youth Court, Learning Life Company, and Post Falls Teen Court and Service Learning.

[36] 3rd District Youth Court, 5th District Status Offender Services, 5th District TAP, Bannock County Status Offender Program, Bannock County Youth Court, Boundary County Youth Accountability Board, Bingham County Youth Court, and Post Falls Teen Court and Service Learning.

FY15Qtr4 Outputs

- Four grantees reported training a total of 96 people in restorative justice practices; 70 of these people were from School District #25.[37]
- Six grantees reported conducting a total of 74 restorative justice practice events, including 28 conferences, 22 circles, 22 family group decision making meetings, and two wraparound sessions.[38]
- Five grantees reported completing a total of 60 service learning projects; 43 of those projects were completed by participants in Bingham County's Youth Court.[39]
- Five grantees reported that participants were assigned and/or completed a total of 1,230 hours of community service. Bannock County programs accounted for the greatest number of assigned and/or completed community service hours (644 hours).[40]

Participant Data

Demographics provide important information about the type of youth participating in MF programs. Such information can be used to help inform the type and dose of services needed, especially if we find that a considerable number of participants share certain characteristics, yet participate in services that vary by type and dosage.

At least some data is included in our dataset for a total of 980 participants through the end of FY15Qtr4. For those participants that an age was reported for, the average age was 15.0 years old. Likewise, after only including those participants that gender, race, and offense history was reported for, more participants were male (64.8%) than female (35.2%), most participants were Caucasian (72.9%), and the vast majority of participants were first-time offenders (84.7%).[41] The following tables and figures provide detailed demographic information.

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[37] Bannock County Restorative Conferences and Family Group Decision Making, School District #25, Canyon County, and Nez Perce County.

[38] Bannock County Restorative Conferences and Family Group Decision Making, Post Falls Teen Court and Service Learning, School District #25, Boise County, Boundary County Youth Accountability Board and Canyon County.

[39] Bingham County Youth Court, Canyon County, Jerome County Diversion Board, Post Falls Teen Court and Service Learning, and 5th District TAP.

[40] Bannock County Status Offender Program, Bingham County Youth Court, Boundary County Youth Accountability Board, Post Falls Teen Court and Service Learning, and 5th District TAP.

[41] A large amount of data was missing for age and gender, particularly: 390 participants were missing data for age and 392 participants were missing data for gender. The percentages reported do not reflect the missing data.

Figure 2: Age

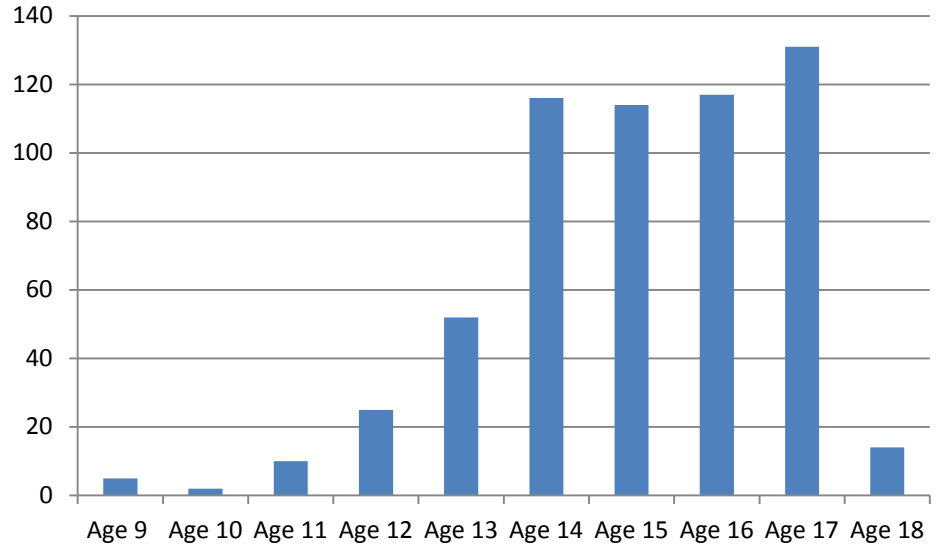


Table 7: Gender

	Number (%)
Female	207 (35.2%)
Male	**381 (64.8%)**
TOTAL	587

Note. Percentages are rounded so the total percentage may not equal 100. The highest percentage is in bold. Gender information was missing for 392 participants.

Table 8: Race

	Number (%)
African American	3 (0.3%)
American Indian or Alaska Native	5 (0.5%)
Hispanic	181 (20.0%)
Native American	25 (2.7%)
Other	29 (3.2%)
Caucasian	**660 (72.9%)**
TOTAL	905

Note. Percentages are rounded so the total percentage may not equal 100. The highest percentage is in bold. Race information was missing for 75 participants.

Table 9: First Time Offenders

	Number (%)
Yes	**771 (84.5%)**
No	139* (15.2%)
Unknown	2 (0.2%)
TOTAL	912

Note. Percentages are rounded so the total percentage may not equal 100. The highest percentage is in bold. Offense history was missing for 62 participants. The figures provided in this table also exclude the data for six youth who participated in a MF program in Teton County but did not commit an offense.

*The most common types of offenses committed by youth who were not first time offenders and who had previously reported offenses were substance use offenses (25 offenses), offenses for battery/assault/fighting (19 offenses), truancy citations (16 offenses), and theft (11 offenses). The remaining offenses had fewer than 10 occurrences each.

Table 10 below does not represent all of the offenses but instead shows the most commonly reported offenses committed by youth participating in an MF program. Offenses that can be categorized broadly as substance use offenses were the most common (351 total offenses), followed by truancy (195 total offenses), and runaway/beyond control/incorrigible (108 total offenses).[42]

Table 10: Most Common Offenses

	Number
Alcohol	105
Battery/assault/fighting	24
Conflict misdemeanor*	20
Curfew	25
Disorderly conduct/disturbing the peace/public nuisance	19
Possession or paraphernalia	45
Runaway/beyond control/incorrigible	**135**
Tobacco	**201**
Theft	56
Trespassing	10
Truancy	**195**

Note. We did not include every offense in this table and therefore, do not include a total. The offenses included here only include those that had 10 or more occurrences. Also, some participants were charged with more than one offense; we counted every offense separately. We bolded the three most common types of offenses.

*Conflict misdemeanor was reported by one grantee (Bannock County) and is a category of offense that covers battery or disorderly conduct.

[42] We counted all alcohol, tobacco, and possession or paraphernalia-related offenses as substance use offenses.

Referral and Program Start Data

We asked the MF grantees to report two different types of referral sources: the referral source for the offense itself and also the source that referred the youth to the MF program. Referral protocols differed greatly across the MF grantees; therefore, the source of the referrals also varied. The most common referral source for offenses was law enforcement (260 youth) followed by schools (174 youth), the court (171 youth), and then prosecutors specifically (132 youth). The most common sources for referral to the MF program were the court (281 youth), law enforcement (198 youth), schools (114 youth), and probation (114 youth).[43]

Regardless of who makes the referral, the VERA Institute status offender system toolkit (2013) states specifically that "timely responses to referrals, a key feature of effective community-based approaches, can help de-escalate crises, while delayed responses can exacerbate problems" (Meyer, Ananthakrishnan, & Salsich, 2013, p. 14). Likewise, Models for Change literature asserts that all youth need an immediate response and that such a response should include triage and referral, crisis intervention, screening and referral for assessment, and a brief strategic intervention. Some youth would then "go on" to need a community-based intervention (to include assessment, mental health services, substance use services, or family-based therapies) (Louisiana Models for Change, 2011).

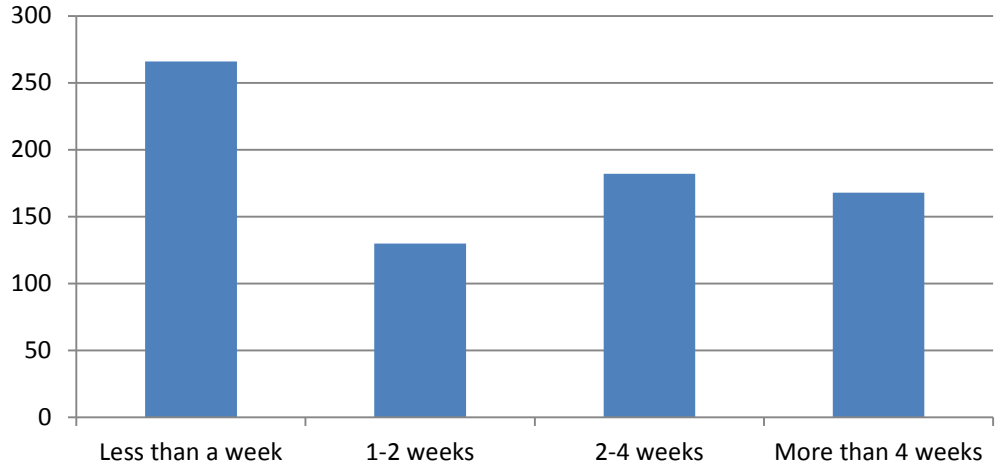
We calculated the average (mean) number of days between the date of referral (i.e., the date the offense presumably occurred and/or the date the youth was brought to the attention of the justice system and/or an MF grantee) and the date the participant entered the program to be 24.0 days.[44]

Figure 3 demonstrates that 266 participants (35.7%) of 746 participants included in this analysis started their programs within a week of referral for their offense.

[43] Prosecutors also referred 74 youth to MF programs.

[44] The median number of days between the date of referral and date of the offense was 13.0 days.

Figure 3: Number of Days Between Referral Date and Program Start Date



Program Length and Exit Data

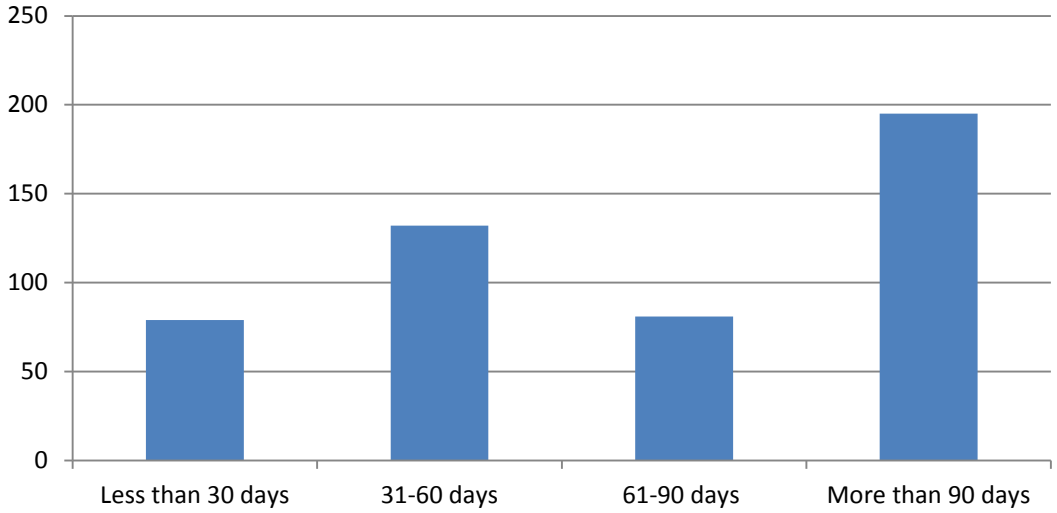
Figure 4 depicts program length. We were only able to include 487 out of 980 participants (49.7%) in the analysis of program length for one of four reasons:

1. The participants failed the program and therefore we did not include them in our calculation of program length (101 youth).
2. The participants have not yet completed the program (i.e., the data has not yet been reported but will be in a future quarter).
3. The data was missing entirely (i.e., the data was not reported and will not be reported in later quarters).
4. The data contained errors so we omitted the associated participant data from this particular analysis.

Of the 487 participants included in the program length analysis, we calculated the average (mean) number of days spent participating in a program as 106.8 days.[45] More specifically, 195 (40.0%) participated for a period of more than 90 days.

[45] The median number of days spent participating in a program was 64.0 days.

Figure 4: Number of Days Between Program Start Date and Date Completed Program



The program completion rate was 83.3% for the 603 participants we were able to include in the analysis. Of the 101 participants reported as having failed or not completed their MF program, 64.4% were referred back to court. The most common reasons provided for program failures were related to a new charge/offense and/or some type of non-compliance. This type of reason was indicated for 79 youth (78.2%).[46]

GAIN-SS Results

With very few exceptions, the MF grantees adopted use of the GAIN-SS to screen program participants.[47] Of the 26 total MF grantees, 23 (88.5%) used the GAIN-SS to screen program participants.

Among those 23 programs, we were able to include the data from 416 participants who were screened using the GAIN-SS (Version 3.0).[48] We combined all three quarters of data and present the results of the GAIN-SS (Version 3.0) in the following tables.

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[46] Eleven youth (10.9%) did not complete their program because the victim was deemed somehow not able to participate in a restorative justice event; seven youth (6.9%) moved; and another type of failure reason was provided for four other youth (4.0%).

[47] Bonneville County received FY15 MF dollars to fund a program manager and, therefore, had no participants for the purposes of this evaluation. Bannock County's diversion unit implemented the GAIN-SS for its Youth Court participants, but did not implement the screen across all programs (although a few Truancy Court participants and a few youth who participate in Family Group Decision Making were screened using the GAIN-SS). The 5th District Truancy Court did not adopt the GAIN-SS.

[48] Some grantees used an older version of the GAIN-SS than Version 3.0. We only scored and interpreted the screens for youth who received Version 3.0 and for whom the screens were completely and correctly administered. The total number of youth who received a version of the GAIN-SS that was *not* Version 3.0 was

The GAIN-SS, by definition, is a short screener. Youth that scored in the High Severity range have high probabilities of some kind of behavioral health diagnosis and a formal assessment and intervention is recommended. Youth that scored in the Moderate Severity range could possibly have a diagnosis and a brief assessment and intervention is recommended. Youth in the Low Severity range are unlikely to have a diagnosis or need services. Table 11 shows a summary of the Total Screener Scores.

Table 11: Total Screener Score, by Number of Youth

	Past month	Past 90 days	Past year	Ever
High Severity	221 (53.1%)	295 (70.9%)	341 (82%)	363 (87.3%)
Moderate Severity	126 (30.3%)	86 (20.7%)	57 (13.7%)	44 (10.6%)
Total (High and Moderate)	347 (83.4%)	381 (91.6%)	398 (95.7%)	407 (97.8%)
Low Severity	69 (16.6%)	35 (8.4%)	18 (4.3%)	9 (2.2%)
TOTAL	416	416	416	416

Note. High severity means that the three or more symptoms were endorsed across all domains. Moderate severity means that one or two symptoms were endorsed across all domains. Low severity means zero symptoms were endorsed across all domains. Percentages are rounded so the total percentage may not equal 100.

Because we are most interested in those significant symptoms that precipitated an offense, our interpretation of the results focuses on those youth that scored in the High Severity (three or more symptoms) and Moderate Severity (one or two symptoms) ranges in the *past month*. Symptoms are considered significant when a youth has them for two or more weeks, when they recur, when they keep a youth from meeting his or her responsibilities, or when they make a youth feel like he or she cannot go on.

As shown in Table 11 above, 347 screened youth (83.4%) could benefit from a lengthier assessment or intervention because of symptoms reported across all domains in the past month: 221 (53.1%) because of three or more symptoms reported in the past month across all domains and 126 (30.3%) because of one or two symptoms reported in the past month across all domains.

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138. Given an estimate of 980 total youth in MF programs, approximately 56.5% of participants received a screen using some version of the GAIN-SS.

The recommended interpretation of the GAIN-SS is to administer a full GAIN assessment for all youth who identify one or more past-year symptoms. If we expanded our focus to include all of the youth who identified more than one past-year symptom, the number of youth recommended for a full assessment would increase to 398 (95.7%). The manual that describes how to interpret and score the GAIN-SS states that one can assume over half of youth who score in the Moderate Severity category and nearly all of those youth who score in the High Severity category would have a diagnosis on the full GAIN assessment.

Domain Screener Scores

The next four tables show the results by domain screener. Youth most commonly identified symptoms included on the internalizing and externalizing disorders screeners. Far fewer youth identified symptoms on the substance use or crime and violence screeners.

Table 12: Internalizing Disorders Screener Score

	Past month	Past 90 days	Past year	Ever
High Severity	87 (20.9%)	139 (33.4%)	197 (47.4%)	256 (61.5%)
Moderate Severity	172 (41.3%)	161 (38.7%)	130 (31.3%)	88 (21.2%)
Total (High and Moderate)	259 (62.3%)	300 (72.1%)	327 (78.6%)	344 (82.7%)
Low Severity	157 (37.7%)	116 (27.9%)	89 (21.4%)	72 (17.3%)
TOTAL	416	416	416	416

Note. High severity means that the three or more symptoms were endorsed within this domain. Moderate severity means that one or two symptoms were endorsed within this domain. Low severity means zero symptoms were endorsed within this domain. Percentages are rounded so the total percentage may not equal 100.

The results displayed in Table 12 above show that 259 (62.3%) of the youth screened would benefit from a lengthier assessment or intervention that focuses on internalizing disorders because of symptoms reported in the past month: 87 (21.0%) because of three or more symptoms reported in the past month and 172 (41.3%) because of one or two symptoms reported in the past month.

Table 13: Externalizing Disorders Screener Score

	Past month	Past 90 days	Past year	Ever
High Severity	96 (23.1%)	155 (37.3%)	217 (52.2%)	281 (67.5%)
Moderate Severity	159 (38.2%)	170 (40.9%)	147 (35.3%)	104 (25%)
Total (High and Moderate)	255 (61.3%)	325 (78.1%)	364 (87.5%)	385 (92.5%)
Low Severity	161 (38.7%)	91 (21.9%)	52 (12.5%)	31 (7.5%)
TOTAL	416	416	416	416

Note. High severity means that the three or more symptoms were endorsed within this domain. Moderate severity means that one or two symptoms were endorsed within this domain. Low severity means zero symptoms were endorsed within this domain. Percentages are rounded so the total percentage may not equal 100.

The results displayed in Table 13 above show that 255 (61.3%) of the youth screened would benefit from a lengthier assessment or intervention that focuses on externalizing disorders because of symptoms reported in the past month: 96 (23.1%) because of three or more symptoms reported in the past month and 159 (38.2%) because of one or two symptoms reported in the past month.

Table 14: Substance Use Screener Score

	Past month	Past 90 days	Past year	Ever
High Severity	12 (2.9%)	36 (8.7%)	70 (16.8%)	87 (20.9%)
Moderate Severity	66 (15.9%)	92 (22.1%)	99 (23.8%)	106 (25.5%)
Total (High and Moderate)	78 (18.8%)	128 (30.8%)	169 (40.6%)	193 (46.4%)
Low Severity	338 (81.2%)	288 (69.2%)	247 (59.4%)	223 (53.6%)
TOTAL	416	416	416	416

Note. High severity means that the three or more symptoms were endorsed within this domain. Moderate severity means that one or two symptoms were endorsed within this domain. Low severity means zero symptoms were endorsed within this domain. Percentages are rounded so the total percentage may not equal 100.

The results displayed in Table 14 above show that 78 (18.8%) of the youth screened would benefit from a lengthier assessment or intervention that focuses on substance use because of symptoms reported in the past month: 12 (2.9%) because of three or more symptoms reported in the past month and 66 (15.9%) because of one or two symptoms reported in the past month.

Table 15: Crime and Violence Screener Score

	Past month	Past 90 days	Past year	Ever
High Severity	1 (0.2%)	8 (1.9%)	31 (7.5%)	74 (17.8%)
Moderate Severity	99 (23.8%)	156 (37.5%)	190 (45.7%)	229 (55%)
Total (High and Moderate)	100 (24%)	164 (39.4%)	221 (53.1%)	303 (72.8%)
Low Severity	316 (76%)	252 (60.6%)	195 (46.9%)	113 (27.2%)
TOTAL	416	416	416	416

Note. High severity means that the three or more symptoms were endorsed within this domain. Moderate severity means that one or two symptoms were endorsed within this domain. Low severity means zero symptoms were endorsed within this domain. Percentages are rounded so the total percentage may not equal 100.

The results displayed in Table 15 above show that 100 (24.0%) of the youth screened would benefit from a lengthier assessment or intervention that focuses on reducing their crime and violence risk because of symptoms reported in the past month: one (0.2%) because of three or more symptoms reported in the past month and 99 (23.8%) because of one or two symptoms reported in the past month.

Responses to Each Symptom or Problem

Youth reported some past-month symptoms much more often than others. The most commonly reported symptoms in the past month were the following:

- Had a hard time paying attention at school, work, or home (44.2%)
- Had a hard time listening to instructions at school, work, or home (37.7%)
- Sleep trouble, such as bad dreams, sleeping restlessly, or falling asleep during the day (36.1%)
- Lied or conned to get things you wanted or to avoid having to do something (32.5%)
- Becoming very distressed and upset when something reminded you of the past (31.3%)
- Feeling very anxious, nervous, tense, scared, panicked, or like something bad was going to happen (31.0%)
- Feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future (29.3%)

Each of the symptoms identified in the bullets above were identified by more than 100 youth and were all symptoms found in either the internalizing or externalizing disorders domain screeners. The next two most common symptoms (in the past month) came from the crime and violence domain screener and the substance use domain screener:

- 17.5% had a disagreement in which the youth pushed, grabbed or shoved someone
- 16.8% used alcohol or other drugs weekly or more often
- Additionally, 5.3% reported thinking about ending their lives or committing suicide

Tables 16-19 display how many youth identified each symptom. Except for four symptoms, the most common response from youth for each symptom was that he or she never experienced the symptom.

Table 16: Internalizing Disorders Screener

When was the last time that you had significant problems with…	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never	Blank: did not answer
Feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?	122 (29.3%)	49 (11.8%)	50 (12%)	36 (8.7%)	158 (38%)	1 (0.2%)
Sleep trouble, such as bad dreams, sleeping restlessly, or falling asleep during the day?	150 (36.1%)	47 (11.3%)	33 (7.9%)	35 (8.4%)	150 (36.1%)	1 (0.2%)
Feeling very anxious, nervous, tense, scared, panicked, or like something bad was going to happen?	129 (31%)	44 (10.6%)	45 (10.8%)	52 (12.5%)	146 (35.1%)	0 (0%)
Becoming very distressed and upset when something reminded you of the past?	130 (31.3%)	49 (11.8%)	44 (10.6%)	37 (8.9%)	156 (37.5%)	0 (0%)
Thinking about ending your life or committing suicide?	22 (5.3%)	27 (6.5%)	30 (7.2%)	51 (12.3%)	285 (68.5%)	1 (0.2%)
Seeing or hearing things that no one else could see or hear or feeling that someone else could read or control your thoughts?	22 (5.3%)	11 (2.6%)	13 (3.1%)	18 (4.3%)	352 (84.6%)	0 (0%)

Note. Percentages are rounded so the total percentage may not equal 100. The highest percentage is in bold.

Table 17: Externalizing Disorders Screener

When was the last time that you did the following things two or more times?	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never	Blank: did not answer
Lied or conned to get things you wanted or to avoid having to do something.	135 (32.5%)	83 (20%)	50 (12%)	50 (12%)	97 (23.3%)	1 (0.2%)
Had a hard time paying attention at school, work, or home.	184 (44.2%)	62 (14.9%)	58 (13.9%)	28 (6.7%)	84 (20.2%)	0 (0%)
Had a hard time listening to instructions at school, work, or home.	157 (37.7%)	53 (12.7%)	46 (11.1%)	46 (11.1%)	113 (27.2%)	1 (0.2%)
Had a hard time waiting for your turn.	54 (13%)	31 (7.5%)	33 (7.9%)	51 (12.3%)	246 (59.1%)	1 (0.2%)
Were a bully or threatened other people.	25 (6%)	18 (4.3%)	23 (5.5%)	62 (14.9%)	285 (68.5%)	3 (0.7%)
Started physical fights with other people.	22 (5.3%)	22 (5.3%)	14 (3.4%)	70 (16.8%)	287 (69%)	1 (0.2%)
Tried to win back your gambling losses by going back another day.	0 (0%)	2 (0.5%)	7 (1.7%)	5 (1.2%)	401 (96.4%)	1 (0.2%)

Note. Percentages are rounded so the total percentage may not equal 100. The highest percentage is in bold.

Table 18: Substance Use Screener

When was the last time that…	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never	Blank: did not answer
you used alcohol or other drugs weekly or more often?	70 (16.8%)	39 (9.4%)	46 (11.1%)	25 (6%)	234 (56.3%)	2 (0.5%)
you spent a lot of time either getting alcohol or other drugs, using alcohol or other drugs, or recovering from the effects of alcohol or other drugs (e.g., feeling sick)?	18 (4.3%)	34 (8.2%)	41 (9.9%)	23 (5.5%)	298 (71.6%)	2 (0.5%)
you kept using alcohol or other drugs even thought it was causing social problems, leading to fights, or getting you into trouble with other people?	16 (3.8%)	29 (7%)	23 (5.5%)	17 (4.1%)	330 (79.3%)	1 (0.2%)
your use of alcohol or other drugs caused you to give up or reduce your involvement in activities at work, school, home, or social events?	9 (2.2%)	22 (5.3%)	24 (5.8%)	13 (3.1%)	347 (83.4%)	1 (0.2%)
you had withdrawal problems from alcohol or other drugs like shaky hands, throwing up, having trouble sitting still or sleeping, or you used any alcohol or other drugs to stop being sick or avoid withdrawal problems?	13 (3.1%)	12 (2.9%)	10 (2.4%)	8 (1.9%)	372 (89.4%)	1 (0.2%)

Note. Percentages are rounded so the total percentage may not equal 100. The highest percentage is in bold.

Table 19: Crime and Violence Screener

When was the last time that you…	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never	Blank: did not answer
had a disagreement in which you pushed, grabbed, or shoved someone?	73 (17.5%)	45 (10.8%)	46 (11.1%)	78 (18.8%)	170 (40.9%)	4 (1%)
took something from a store without paying for it?	15 (3.6%)	22 (5.3%)	35 (8.4%)	76 (18.3%)	263 (63.2%)	5 (1.2%)
sold, distributed, or helped make illegal drugs?	4 (1%)	11 (2.6%)	14 (3.4%)	21 (5%)	362 (87%)	4 (1%)
drove a vehicle while under the influence of alcohol or illegal drugs?	9 (2.2%)	10 (2.4%)	9 (2.2%)	4 (1%)	380 (91.3%)	4 (1%)
purposely damaged or destroyed property that did not belong to you?	21 (5%)	9 (2.2%)	25 (6%)	54 (13%)	302 (72.6%)	5 (1.2%)

Note. Percentages are rounded so the total percentage may not equal 100. The highest percentage is in bold.

Tobacco Use

In Qtr2, 3, and 4 of FY15, MF programs served 201 youth who had committed a tobacco offense. A total of 343 youth reported that they either currently use tobacco or, if they are not currently using, reported they have tried tobacco; 559 youth said they have never tried tobacco.[49] Of those 343 youth that reported ever having used tobacco, 243 of them (70.8%) used cigarettes and 171 (49.9%) used electronic or e-cigarettes. The average age that youth reported they started using tobacco was 13.4 years old.

Figure 5: Age of First Use

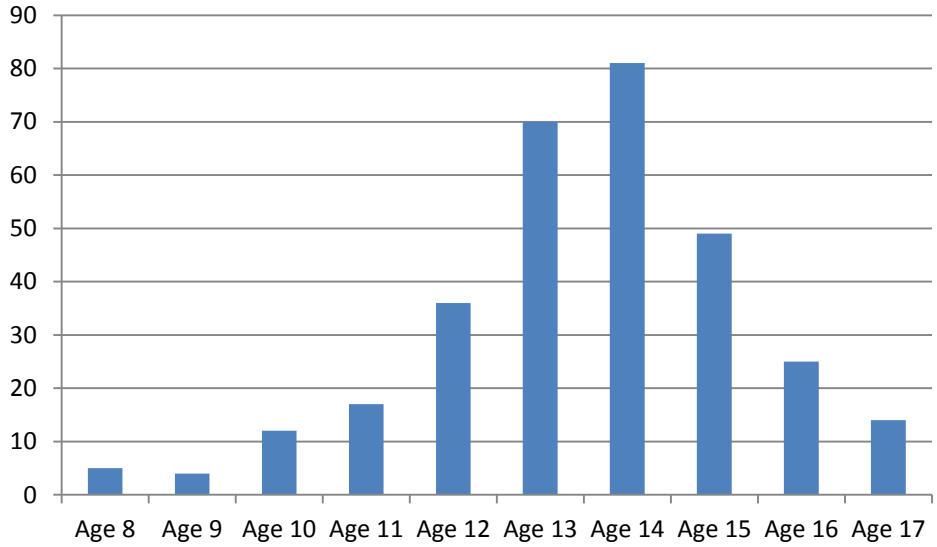

Table 20: Tobacco Use

	Number (%)
Yes	343 (35.0%)
No	**559 (57.0%)**
Blank (Missing)	78 (8.0%)
TOTAL	980

Note. Percentages are rounded so the total percentage may not equal 100. The highest percentage is in bold.

[49] No data was provided for 78 youth.

Table 21: Type of Tobacco Use

	Number (%)
Cigarettes	**243 (70.8%)**
Cigars	34 (9.9%)
Pipes	21 (6.1%)
Chewing tobacco or snuff	46 (13.4%)
Dissolvable tobacco	4 (1.2%)
Electronic or e-cigarettes	171 (49.9%)
Hookah	34 (9.9%)
Other	-

Note. Percentages are rounded so the total percentage may not equal 100. The highest percentage is in bold.

Among those youth who (1) reported ever having used tobacco in the past month and (2) also provided information related to how frequently they used, 89 youth (45.4%) said they used one or two times a week and 75 youth (43.6%) said on the days they used tobacco, they used once a day.

Table 22: Frequency of Tobacco Use by Number of Youth

	1-2 times per week	3-4 times per week	Every day
During the past 30 days, on how many days did you use tobacco? (N=196)	**89 (45.4%)**	42 (21.4%)	65 (33.2%)
	Once a day	**2-3 times throughout the day**	**4 or more times throughout the day**
During the past 30 days, on the days you used tobacco, how many times a day did you use tobacco? (N=172)	**75 (43.6%)**	58 (33.7%)	39 (22.7%)

Note. Percentages are rounded so the total percentage may not equal 100. The highest percentage is in bold.

Discussion

"Successful status offender program models around the country recognize that youth who engage in status offense behaviors come from a variety of backgrounds and are influenced by a wide array of contextual factors. These contextual factors may include having suffered childhood trauma, coming from broken homes, issues with substance use, having unmet or unidentified mental health needs, and/or struggling with unmet education needs. However, the vast majority of status offending youth are simply going through normal developmental immaturity and/or brief crises at home or school. What is needed in these cases is at most brief intervention and time-limited support from an informal, voluntary system" (Phillipi, Koch, Bolin, & DePrato, 2011, p. 1).

Measuring Outcomes

A review of the literature (including several case studies provided through the Vera Institute's Status Offense Reform Center) revealed three common themes for measuring the outcomes for programs that target the status offender population: (1) reduce the number of status offense referrals or petitions to court; (2) decrease the detention rates of status offenders; and (3) monitor case processing times for the courts and community-based programs. These outcomes can be characterized as system-level outcomes and, although these are the most common outcomes, other youth-level outcomes are also tracked. Such youth-level outcomes could include decreased recidivism and increased child/family well-being; deciding upon which outcomes to track is heavily dependent on the goal of the program in question (Models for Change Juvenile Diversion Workgroup, 2011).

The FY15 MF grantees measure the effectiveness of their programs in different ways, with most grantees focusing on some type of recidivism rate as a measure of program success. Generally speaking, the goals of all the MF grantees include keeping youth who have committed tobacco, substance use, and other status offenses out of the formal juvenile justice system, as well as reducing their risk for ongoing or continued use of tobacco and other substances. We discuss these types of outcomes in this section.

Number of Diverted Youth

"While there is limited research focused exclusively on status offenders who go through a traditional court process, there is a robust body of research on youth charged with low-level delinquency offenses from which to draw comparisons. Those studies show that diverting delinquent youth from court and responding with community-based programming is more effective in preventing future crime. If community-based approaches are more effective in delinquency cases, it stands to reason that they are also a better option than court in cases involving young people who are acting out but haven't committed a crime" (Salsich & Trone, 2013, p. 4).

In FY15, we collected data on 980 youth diverted from court by MF programs. In the subsequent years of this evaluation, we will continue to track the number of youth who participate in an MF program rather than having their cases processed formally in court. Additionally, we will continue to track the number of petitioned charges and counts found in ISTARS to measure whether the MF programs are helping to successfully reduce the number of petitioned status offenses. We will also continue to track the number of petitioned charges and counts that are ultimately dismissed; dismissed charges and counts could include youth who participated in and successfully completed an MF program or other type of diversion program.

Offense History

Earlier, we reported that 84.7% of MF program participants were first-time offenders, meaning that roughly 15% of youth who participated in MF programs in FY15 have had previous contact with the justice system. Repeat offenders can appropriately participate in diversion programs such as those provided by the MF grantees. To best serve these types of youth, it would be useful to know which interventions had been tried previously, if any. For example, knowing whether a youth had already participated in an MF program would help us determine if participating in the same intervention would be beneficial or if another type of intervention could be warranted. In our Year 2 evaluation, we will pursue monitoring the intervention history of participating youth and use that information as an indicator of which programs have already been offered to youth that re-offend.

Length of System Involvement

In addition to reducing the case burden of courts, keeping status offenders out of the formal justice system also helps fight against the adverse outcomes of "labeling"—a theory positing that once someone is labeled "delinquent" or as a "law-breaker" due to involvement in the justice system, that person is more likely to internalize that label and act accordingly, leading to future and escalating delinquent acts (Datesman & Aickin, 1984; Jennings, 2011; Kammer, Minor, & Wells, 1997; Ryon et al., 2012). Research clearly documents the importance of reserving the resources of the juvenile justice system for the highest-risk youth and, simultaneously, minimizing intervention for low-risk youth. Unnecessary intervention, although well-intended, could have negative consequences and erroneously justify deeper involvement in the system than is warranted, thereby increasing a youth's risk of reoffending. Therefore, two of our most important findings relate to the amount of time youth are involved in the justice system.

Start of Services

Because it can be difficult to attribute individual and family success to the intervention itself, a common measure of effectiveness is to measure the time between a request for services and service delivery (e.g. Ryon et al., 2012; Status Offense Reform Center, 2013a). As mentioned previously, we found that 35.7% of youth began their intervention within one week of being referred for an offense. However, 22.5% of youth did not start participating in their MF program for more than four weeks after being referred for an offense. In the Year 2 evaluation, we will examine the factors related to delays in youth beginning their MF program "immediately."

Program Length

The programs implemented by the MF grantees are intended to serve youth that need, at most, a brief intervention and are not eligible for extended treatment. We found that 40.0% of youth participate in an MF program for more than 90 days. Seven programs included in our analysis have an average (mean) program length of more than 90 days:

- Bannock County Status Offender Program: 304.2 days
- 5th District Status Offender Services: 247.1 days
- Bannock County Truancy Court: 186.6 days
- Boundary County Youth Accountability Board: 157.6 days
- Bannock County Youth Court: 124.7 days
- Bingham County Youth Court: 101.3 days
- 5th District TAP: 96.3 days

If we exclude the two programs with the longest program lengths from our analysis (Bannock County Status Offender Program and 5th District Status Offender Services), the average (mean) number of days spent in an MF program decreases from 106.8 days to 77.4 days.

A program length of 90 or more days seems to represent a rather extended period of time and quite possibly does not align with the literature's advice to triage first then, if warranted, provide a brief intervention that is informed by the results of a screen for needs and risks. Without evidence that demonstrates increased positive outcomes for youth participating in longer programs, asking or requiring the MF grantees to justify intervention strategies that are lengthy (e.g., 90+ days) may be warranted. In the Year 2 evaluation, we will explore the factors that contribute to status offenders participating in lengthy interventions.

Program Completion

Although the program completion rate could be skewed because of a large amount of missing data, the rate we calculated (83.3%) falls short of IDJC's goal to achieve a 90% program completion rate.[50] In addition to this outcome, we also tracked how many youth were referred back to court after failing to complete their MF program and how many youth were placed in detention at any time while participating in their program. Of the 99 youth that failed to complete their MF program, 64.6% were referred back to court, presumably to have their cases formally petitioned. In the Year 2 evaluation, we plan to further investigate whether all diversion options are exhausted before petitioning a youth's case (a best practice), with the goal of decreasing the number of program failures that are automatically petitioned in court as a consequence of incompletion.

[50] Program completion data was missing for 373 (38.1%) of the MF participants.

Use of the GAIN-SS

Although often used interchangeably, "screening" and "assessment" are not synonymous. Screening has two primary purposes: (1) to identify youth who may require an immediate response or who are actively in crisis and (2) to distinguish between those youth who may have a problem that requires some type of intervention or service versus those youth who do not have such a problem. Screening is a short process that does not require specialized staff. As warranted by a screening, youth identified as potentially having a problem requiring attention should then receive a more comprehensive review (i.e., an assessment) (Vincent, 2011). The Status Offense Reform Center at the Vera Institute for Justice maintains that although screening is appropriate for all status offenders, assessments should be reserved for the subset of the status offender population that screenings identify (Meyer, Ananthakrishnan, & Salsich, 2014).

We selected the GAIN-SS as a screening tool for the MF grantees to use in part because we were lacking data to describe the characteristics of participating youth, but also because screening is an identified best practice. Without a screen that asked about the symptoms and issues that precipitated contact with the justice system, we could only venture guesses or make assumptions about what those symptoms or issues may have been. Nearly all of the MF grantees implemented the GAIN-SS and, as a result, much more detail on MF program participants is now available. However, the results of the screens did not impact the type and dose of services received, as they should per best practice. Participating youth received the same intervention they would have received regardless of whether they were screened using the GAIN-SS.

It is therefore our impression that the GAIN-SS was not used to determine eligibility for an intervention, or the scope and nature of services needed by the youth. Rather, it was used because we required it and, as implemented, one of the drawbacks of that approach was that the screens took place after the youth's acceptance into the program. Ideally, such a screen would occur as part of the initial triage process and would help identify which type of services, if any, may be appropriate or necessary. Implementing this type of best practice, however, would require the availability of multiple types of diversion programs or services by each grantee.

Interpretation of the Results

For the set of youth included in our analysis of the GAIN-SS results, we found that youth most often identified symptoms associated with internalizing and externalizing disorders and were much less likely to identify substance use or crime and violence symptoms. These results seem to demonstrate that the MF programs are diverting and serving the appropriate youth because the issues identified are noncriminal, indicating that these youth do not belong in the justice system.

Despite the noncriminal nature of these youth, if we interpreted the results of the GAIN-SS as recommended, then 95.4 percent would require a lengthier follow-up assessment. This figure seems relatively high given the low-risk nature of the youth the MF programs serve, suggesting that the screening tool, for this particular sample of youth, screened "in" more youth than necessary.

Screening tools such as the GAIN-SS can be overly sensitive in identifying potential problems and thus screen “in” youth who do not have a serious enough problem to warrant a follow-up assessment. They can also lack specificity and screen “out” those youth who do have a problem that may need additional attention. When we reviewed the symptoms that participants identified (i.e., those symptoms that were screening them “in”), the three most common symptoms are those that many “relatively normal” adolescents face:

- 44.2% reported having a hard time paying attention at school, work, or home
- 37.7% reported having a hard time listening to instructions at school, work, or home
- 36.1% reported sleep trouble, such as bad dreams, sleeping restlessly, or falling asleep during the day

We recommend that program administrators or assigned staff review the results of the screen for each participant to assure that the symptoms screening a youth “in” are truly symptoms that warrant additional follow-up. The GAIN-SS notes in a disclaimer that the information provided by the results of the screen are supposed to supplement, not replace, the opinions of trained professionals.

Concluding Comments

A continued focus on early intervention regarding alcohol and tobacco use seems appropriate given that the most common status offenses formally brought before the court are for alcohol and tobacco. The challenge lies in determining the appropriate dose and type of services because, for example, some poor behaviors are socially normative and can appropriately be addressed at home in a familial setting rather than through a justice system intervention. To that effect, the literature tells us that intervening with high-risk youth can lead to a significant reduction in recidivism, but that intervening with low-risk youth not only has a much smaller positive impact, but can also lead to adverse outcomes (Seigle, Walsh, & Weber, 2014).

The CQI suggestions located in the Report Addendum program briefs largely focus on data collection and submission. In the Year 2 evaluation and subsequent years, we hope to shift our focus towards performance measurement and towards ensuring the types of interventions MF programs provide match the risks and needs of participating youth.

In Year 2 (FY16) we plan to initiate other steps in our long-term evaluation plan by conducting interviews and observing programs during site visits. These activities will inform our process evaluation (i.e., how program activities and/or operations are implemented) and will also allow us to engage in a more robust discussion and evaluation of program outcomes. Conducting thorough process evaluations better positions programs to measure and determine whether their intervention strategy led to positive youth outcomes.

As part of our literature review for the Year 1 evaluation, we also began researching how other programs measure performance and which outcomes they track to evaluate program effectiveness. In Appendix E, we list each data collection category recommended by the Louisiana Models for Change initiative and include a note about whether our evaluation collects and evaluates the same categories of data (Childs, Frick, Winfrey, Bascle, & Adams, 2011).

The information in Appendix E, coupled with the findings from literature, indicate that it is appropriate for all grantees to track whether youth who participate in an MF program reoffend. However, Models for Change literature also identifies other ways to evaluate the success of a program beyond using recidivism rates for successful case closures (Louisiana Models for Change, 2011):

- Is there decreased involvement in the juvenile justice system?
- Is there improvement in behavioral, social, family and/or academic functioning?
- Are major stakeholders satisfied?

“Recidivism” is only one of many measures of a program’s performance or impact and may not be the most illustrative, especially for the type of early intervention programs implemented by the MF grantees and the low-risk youth they serve. Instead, the MF grantees should take care to ensure they have articulated specific, measurable performance goals. The focus of our Year 2 evaluation efforts will be working closely with the grantees to make sure such performance measures are in place.

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Appendix A

List of Grantees

District	Organization	Project Name	Award	Year of Funding
1	Boundary County	Youth Accountability Board	$12,800	Year 1 Did not reapply
1	Crosswalk North Idaho/Volunteers of America	Active Parenting of Teens: Families in Action	$20,468	Year 1 Did not reapply
1	Learning Life Company	Life Skills Training	$41,860	Year 1 Did not reapply
1	Post Falls School/Police	Teen Court and Service Learning	$16,732	Year 1
2	Nez Perce County	Restorative Justice	$50,000	Year 1 Did not receive FY16 funds
2	Nez Perce County	Clinical Services	$3,750	Inherited from ISC Did not receive FY16 funds
3	Canyon County	Restorative Justice Conferences	$43,200	Year 1
3	Canyon and Gem Counties	3rd District Youth Court	$22,500	Inherited from ISC Did not receive FY16 funds
4	Boise County	Restorative Justice	$27,602	Year 1

4	Ada County	Kuna School-based Referrals Project	$22,398	Year 1 Did not receive FY16 funds
4	Ada County	Tobacco Alcohol Platform	$18,000	Year 1
4	Ada County	Diversion Counseling	$37,500	Inherited from ISC
5	Jerome County	Status Offender Diversion Board	$27,040	Year 1 Did not receive FY16 funds
5	5th District Court	Status Offender Services	$45,000	Inherited from ISC
5	5th District Court	Tobacco & Alcohol Diversion Platform	$41,250	Inherited from ISC
5	5th District Court	Attendance Court	$1,500	Inherited from ISC Did not reapply
6	Pocatello/Chubbuck School District #25	Restorative Justice	$13,000	Year 1
6	Bannock County	Restorative Justice Conferencing	$35,341	Year 1
6	Bannock County	Truancy Court	$43,630	Inherited from ISC
6	Bannock County	Youth Court	$15,579	Inherited from ISC
7	Teton County	Restorative Justice/Victim Awareness	$8,263	Year 1

7	Teton County	Forward Thinking Program	$1,500	Inherited from ISC Did not receive FY16 funds
7	Madison County	Not On Tobacco	$3,750	Inherited from ISC
7	Fremont County	Thinking for A Change	$1,875	Inherited from ISC Did not reapply
7	Bingham County	Youth Court	-	Inherited from ISC
7	Bonneville County	Program Manager	$11,250	Inherited from ISC Did not reapply

Appendix B

Millennium Fund Quarterly Report Data Points

We developed a set of measures to be collected by each grantee with categories covering participant intake, tobacco use, and program exit.

Participant Intake

Name or Unique Identifier: A name or unique identifier was required to isolate the experience of each youth's MF program participation.

Race: The disproportionate representation of minorities throughout the justice system is of interest to local, state, and national policymakers and stakeholders. By reporting on the distribution of race characteristics, we can make comparisons within and among programs.

Offense: MF grant dollars serve youth who have committed tobacco, alcohol, substance use, and other status offenses. Inclusion of this measure helps us ensure programs served their intended target population and provides important information about the most common types of offenses.

First Time Offense: An understanding of whether a youth has committed a first-time offense or has a previous history with the justice system helps further describe each MF program's target population. Most programs focus on youth who have committed a first-time offense, but some programs allow youth with a previous offense history to also be served.

If second or subsequent offense, indicate most serious previous offense: First-time offenders are not necessarily low-risk offenders. Similarly, a previous offense history does not necessarily equate to high risk. Some explanation of a youth's offense history helps us describe the population served by MF programs.

Referral source for current offense: The source of referral indicates who brought the youth to the attention of the court or MF program administrator for a status offense or other type of citation. This information provides us the opportunity to analyze where referrals for status offenses to the juvenile justice system most commonly originate.

Source of referral to Millennium Fund program: Similar to the referral source discussed above, we asked for this specific source to illustrate where and from whom program referrals originate.

Date of referral: For the purposes of the Year 1 evaluation, the date of referral serves as the date the offense occurred.

Date offered a Millennium Fund program: Depending on the local system, the date of referral and the date offered an MF program may or may not be one in the same. Asking for both dates helps map a youth's path from citation to MF program participation.

Accepted offer to participate in program: In many systems, program participation is a diversion option made available to youth, but is not mandatory. By collecting these data, we intended to compare the number of youth actually served to the number potentially served.

Date entered program/program start date: This date allows us to measure the time between the date of referral and the date the youth started programming.

Tobacco Use

Have you ever used tobacco? Because MF grant dollars serve youth who have committed a variety of first-time or status offenses, inclusion of this measure helps us assess program participants' level of tobacco use, even if the qualifying offense is something other than a tobacco citation.

How old were you the first time you ever used tobacco? Identifying the age at which MF program participants began to use tobacco could help inform prevention and intervention efforts.

What kind of tobacco do you use? Similarly, the type of tobacco used most often by youth helps target prevention and intervention efforts.

During the past 30 days, on how many days did you use tobacco? Determining the number of days a youth used tobacco in the last month helps us draw distinctions among categories of tobacco users (e.g., frequent versus occasional tobacco use).

During the past 30 days, on the days you used tobacco, how many times a day did you use tobacco? In conjunction with the previous variable, an understanding of how often a youth used tobacco on a given day helps us further analyze the degree of substance use.

Program Exit

Date completed program: For the purpose of the Year 1 evaluation, the program completion date provides an end point to measure the length of time a youth participated in an MF program.

Successful completion of program goals: A determination of whether each program participant met the goals of the program upon completion.

Date withdrew/failed program: Similar to the "date completed program" variable, the date a program participant withdrew or failed the program marks a significant end point. Tracking the number of program completers versus non-completers can be used as a measure of program success.

Indicate reason for withdrawing/failing program: Understanding the most common reasons for a participant's non-completion provides an opportunity to improve the program or to address previously unforeseen or untreated participant needs.

Referred to court after withdrawing from or failing program? Determining whether youth who do not successfully complete an MF program are referred to court as a result of their non-completion provides additional context about the scope of resources and services available to address the needs and risks presented by status-offending youth.

Admitted to detention at any point during program? The 1974 Juvenile Justice and Delinquency Prevention Act states that status offenders should not be in secure detention. Tracking the number of youth who participated in an MF program that were admitted to detention offers some indication of whether status offending youth avoid time in detention.

Appendix C

GAIN-SS, Version 3.0

The GAIN was created in 1993 with the intention of meeting the need for a standardized biopsychosocial assessment tool and has evolved into a family of instruments. The GAIN-SS is used for initial screenings and has been found to have good internal consistency and discriminant validity (Dennis, Chan, & Funk, 2006).

Chestnut Health Systems

GAIN
GLOBAL APPRAISAL OF INDIVIDUAL NEEDS
Coordinating Center

GAIN Short Screener (GAIN-SS)

Version [GVER]: GAIN-SS ver. 3.0

What is your name? a._____ b. ____ c. _____
(First name) (M.I.) (Last name)

What is today's date? (MM/DD/YYYY) |__|__| / |__|__| / 20 |__|__|

The following questions are about common psychological, behavioral, and personal problems. These problems are considered **significant** when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on. After each of the following questions, please tell us the last time, if ever, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
	4	3	2	1	0

IDScr 1. **When was the last time** that you had **significant** problems with…

a. feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?	4	3	2	1	0
b. sleep trouble, such as bad dreams, sleeping restlessly, or falling asleep during the day?	4	3	2	1	0
c. feeling very anxious, nervous, tense, scared, panicked, or like something bad was going to happen?	4	3	2	1	0
d. becoming very distressed and upset when something reminded you of the past?	4	3	2	1	0
e. thinking about ending your life or committing suicide?	4	3	2	1	0
f. seeing or hearing things that no one else could see or hear or feeling that someone else could read or control your thoughts?	4	3	2	1	0

EDScr 2. **When was the last time** that you did the following things **two or more times**?

a. Lied or conned to get things you wanted or to avoid having to do something	4	3	2	1	0
b. Had a hard time paying attention at school, work, or home.	4	3	2	1	0
c. Had a hard time listening to instructions at school, work, or home.	4	3	2	1	0
d. Had a hard time waiting for your turn.	4	3	2	1	0
e. Were a bully or threatened other people.	4	3	2	1	0
f. Started physical fights with other people	4	3	2	1	0
g. Tried to win back your gambling losses by going back another day.	4	3	2	1	0

SDScr 3. **When was the last time** that…

a. you used alcohol or other drugs weekly or more often?	4	3	2	1	0
b. you spent a lot of time either getting alcohol or other drugs, using alcohol or other drugs, or recovering from the effects of alcohol or other drugs (e.g., feeling sick)?	4	3	2	1	0
c. you kept using alcohol or other drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people?	4	3	2	1	0
d. your use of alcohol or other drugs caused you to give up or reduce your involvement in activities at work, school, home, or social events?	4	3	2	1	0
e. you had withdrawal problems from alcohol or other drugs like shaky hands, throwing up, having trouble sitting still or sleeping, or you used any alcohol or other drugs to stop being sick or avoid withdrawal problems?	4	3	2	1	0

(Continued) After each of the following questions, please tell us the last time, if ever, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
	4	3	2	1	0

CVScr 4. **When was the last time** that you…

a. had a disagreement in which you pushed, grabbed, or shoved someone?	4	3	2	1	0
b. took something from a store without paying for it?	4	3	2	1	0
c. sold, distributed, or helped to make illegal drugs?	4	3	2	1	0
d. drove a vehicle while under the influence of alcohol or illegal drugs?	4	3	2	1	0
e. purposely damaged or destroyed property that did not belong to you?	4	3	2	1	0

5. Do you have other **significant** psychological, behavioral, or personal problems that you want treatment for or help with? (**Please describe**) ..... Yes 1 No 0

   v1. _____

   _____

6. What is your gender? (If other, please describe below) 1 - Male 2 - Female 99 - Other

   v1. _____

7. How old are you today? |__|__| Age

7a. How many minutes did it take you to complete this survey? |__|__|__| Minutes

Staff Use Only

8. Site ID: _____ Site name v. _____
9. Staff ID: _____ Staff name v. _____
10. Client ID: _____ Comment v. _____
11. Mode: 1 - Administered by staff 2 - Administered by other 3 - Self-administered
13. Referral: MH ____ SA ____ ANG ____ Other ____ 14. Referral codes: _____
15. Referral comments: v1. _____

Scoring

Screener	Items	Past month (4)	Past 90 days (4, 3)	Past year (4, 3, 2)	Ever (4, 3, 2, 1)
IDScr	1a – 1f				
EDScr	2a – 2g				
SDScr	3a – 3e				
CVScr	4a – 4e				
TDScr	1a – 4e				

Appendix D

Appendix D includes the table “Status Offense Charges or Counts Filed In Court, by County, Fiscal Years 2012-2014” which organizes the total number of status offense charges or counts by county. In this table, we only included those counties served by an MF grantee in FY15.

Status Offense Charges or Counts Filed In Court, by County, Fiscal Years 2012-2014

County	Fiscal year	Total	Alcohol citation	Curfew violation	Runaway, beyond control, or incorrigible	Status offense	Tobacco citation	Truancy or attendance citation
Ada	2012	819	170	86	281	3	273	6
	2013	801	152	73	264	1	310	1
	2014	764	130	55	254	7	318	0
Bannock	2012	399	62	27	0	114	47	149
	2013	322	32	13	0	84	54	139
	2014	323	36	15	0	89	59	124
Bingham	2012	150	44	8	42	2	47	7
	2013	128	48	4	22	0	48	6
	2014	114	28	0	20	7	49	10
Blaine	2012	26	14	0	3	1	3	3
	2013	10	2	0	1	0	6	6
	2014	8	6	0	0	0	49	10

Boise	2012	8	5	0	0	0	3	0
	2013	3	1	0	0	0	2	0
	2014	1	1	0	0	0	0	0
Bonneville	2012	193	59	23	3	29	62	17
	2013	222	77	47	6	10	69	13
	2014	250	52	36	0	74	84	4
Boundary	2012	11	6	0	0	1	4	0
	2013	20	5	3	0	1	11	0
	2014	10	2	1	0	0	7	0
Camas	2012	1	1	0	0	0	0	0
	2013	0	0	0	0	0	0	0
	2014	0	0	0	0	0	0	0
Canyon	2012	334	87	23	92	1	115	16
	2013	347	119	34	73	1	99	21
	2014	250	50	40	65	3	86	6

Cassia	2012	9	0	2	0	4	2	1
	2013	26	3	2	0	5	13	3
	2014	42	18	3	0	0	20	1
Fremont	2012	44	19	0	0	3	16	6
	2013	24	10	3	0	2	2	7
	2014	31	4	1	0	8	16	2
Gem	2012	26	7	1	3	0	12	3
	2013	21	6	1	1	0	6	7
	2014	22	5	2	1	0	9	5
Gooding	2012	15	7	3	1	3	1	0
	2013	26	6	7	4	2	7	7
	2014	20	5	0	5	2	6	2
Jerome	2012	57	14	4	20	0	13	6
	2013	50	16	0	1	0	8	11
	2014	82	35	0	17	0	17	13

Kootenai	2012	338	91	28	92	12	96	19
	2013	325	98	26	93	2	81	25
	2014	252	67	27	59	1	86	12
Lincoln	2012	12	4	0	0	0	8	0
	2013	5	4	0	0	0	8	0
	2014	4		0	0	0	4	0
Madison	2012	28	12	2	0	0	14	0
	2013	12	4	0	0	0	8	0
	2014	14		0	0	0	14	0
Minidoka	2012	5	4	1	0	0	0	0
	2013	17	3	2	0	0	12	0
	2014	33	17	0	0	0	16	0
Nez Perce	2012	87	0	0	0	0	0	16
	2013	69	29	0	0	0	36	4
	2014	65	25	0	0	0	35	5

Teton	2012	3	2	0	0	1	0	0
	2013	8	4	0	0	3	1	0
	2014	5	1	0	0	2	2	0
Twin Falls	2012	199	63	28	67	2	4	4
	2013	172	27	12	72	0	56	5
	2014	203	43	10	72	1	73	4

Appendix E

The information included in Appendix E summarizes the data points the Louisiana Models for Change (Childs et al., 2011) recommends collecting and briefly comments on whether our evaluation collected those data. We also include detailed notes on which grantees collect data points that our Year 1 evaluation did not require.

Data Points Tracked by Models for Change

Describing the Target Population

Models for Change	Our Evaluation	Notes
	Youth Information	
Demographics	Yes	We ask for gender, race, and age.
School information	No	
Mental health/substance use	Yes	We use the GAIN-SS to screen for behavioral health disorders and substance use disorders.
Criminal history	Yes, limited	We ask whether the youth is a first-time offender and if not, what the most serious previous offense is.
Previous FINS (Families In Need of Services) involvement	No	We originally asked about previous involvement in the child welfare system but omitted this data point after receiving feedback; in FY16 and beyond, we would like to ask about previous MF program involvement.

Case Information		
Referral	Yes	We ask for the referral source for the offense and the referral source to the MF program. For most programs, these sources are the same. We could consider only asking for the referral to the MF program going forward.
Screening/assessment	Yes	We use the GAIN-SS.
Case acceptance/rejection	No	We attempted to gather this data by asking whether the youth accepted or rejected the offer to participate in an MF program. However, by and large, the youth in our dataset are only those that were offered and accepted the program instead of also capturing rejected cases or youth who rejected an offer to participate. We could omit this data point going forward.
Service Delivery		
FINS service plan agreement	No	We don't require a service plan agreement, nor do we specify what type of case management should take place to manage youth participants.
Case management		

Evaluating Program Effectiveness

Models for Change	Our Evaluation	Notes
	Case Closure Information	
Reason for case closure	Yes	We ask for the reason for program failures (e.g., new offense, moved, etc.).
Referral to the DA	Yes	We ask whether the youth was referred back to court after failing to complete the program.
Client satisfaction survey	No	We did not require the grantees to survey youth or their families about their satisfaction with the provided services. A limited number of grantees (3) reported they are performing surveys akin to a client satisfaction survey.[i]
	Post Program Follow-up	
Referral to court	No	We did not require the grantees to track and report on subsequent referrals to court after completion of an MF program. Some grantees (12) report that they perform system checks (e.g., of ISTARS or IJOS) or

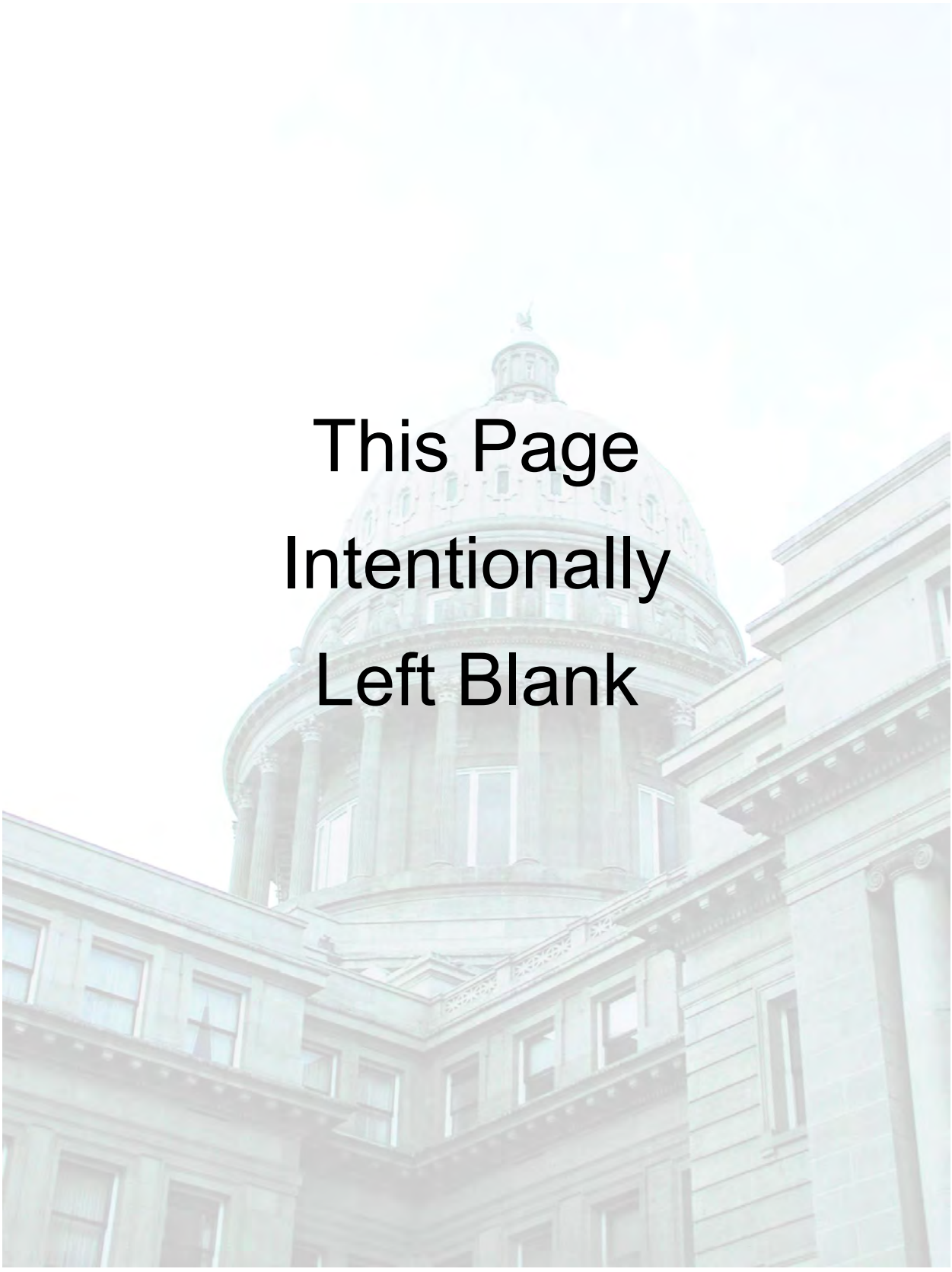
		otherwise conduct some kind of follow-up to determine if youth who have previously participated in an MF program have committed a subsequent offense.[ii] Other grantees (5) are using school records to monitor behavior and other types of outcomes, such as attendance.[iii]
New FINS referrals	No	Same point as above.
New arrests/court involvement	No	Same point as above.
FINS adjudication	No	Same point as above.
Out of home placement (detention and residential)	No	We ask whether youth were placed in detention at any point during their time in the program; however we did not require the grantees to track and report on subsequent out-of-home placements after completion of an MF program.
Change in behavior/environment (based on follow-up survey)	No	Although not required, we know some grantees (10) are using various types of pre- and post-tests to measure increases in knowledge or decreases in symptoms, for example.[iv]

[i] Bonner County Youth Court, Post Falls Teen Court and Service Learning, and 5th District Status Offender Services

[ii] Bonner County Youth Court checks ISTARS monthly ISTARS; Canyon County Restorative Justice checks their Case Management System (CMS) and arrest records monthly; Ada County Diversion checks IJOS yearly three years and also does an optional one-month follow-up, plus a yearly follow-up survey for three years regarding subsequent crimes; Ada County TAP has the ability to check IJOS, ISTARS, and Odyssey; Boise County Restorative Justice checks the sheriff's arrest records and prosecutor petitions; 5th District TAP checks arrest records weekly and reviews citations/petitions with Juvenile Clerk to identify if any youth have already participated in TAP; 5th District SOS conducts monthly, six-month, and one-year reviews of MAGIC, IJOS, ISTARS, and/or Odyssey; (if participants do not show up in these system checks, coordinators make phone calls to families; Bannock County Youth Court checks ISTARS, IJOS, and Bannock County Juvenile Court records during the program and up to one year after; Bannock County Status Offender Services and Truancy Court checks ISTARS, IJOS, Bannock County Juvenile Court records during program and up to one year after; Bannock County Family Group Decision Making checks IJOS, ISTARS, and Bannock County Juvenile Court records; Madison County NOT checks ISTARS and IJOS; Post Falls Teen Court and Service Learning plans to conduct a one year review; Bingham County Youth Court maintains a participant history log and mentioned conducting a recidivism study.

[iii] Post Falls Teen Court and Service Learning checks school attendance; 5th District TAP reviews school attendance and current grades; Bannock County Youth Court checks attendance, grades, and behavioral reports; Bannock County Status Offenders Services and Truancy Court tracks attendance, grades, and behavioral reports; School District #25 monitors incidence reports and student behavior.

[iv] Bonner County Youth Court conducts a post survey on alcohol, tobacco, and drug use; Post Falls Teen Court and Service Learning conducts pre- and post-interviews; Canyon County Restorative Justice conducts pre- and post-tests on tobacco and substance use; Ada County Diversion reports conducting a pre- and post-GAIN-SS; Ada County TAP conducts pre- and post-test knowledge scores; 5th District TAP conducts a TND post-test; 5th District SOS conducts pre- and post-test tobacco and substance use surveys; Bannock County Status Offender Services conducts pre- and post-YLSI's; Bingham County Youth Court conducts post surveys; Madison County NOT uses pre- and post-surveys.



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Attachment B

To: Tyler LaDouceur, DaviesMoore
Casey Suter, Project Filter
Ivie Smart, Project Filter

From: Kara Crohn, EMI Consulting
Danny Molvik, EMI Consulting

Date: June 10, 2015

RE: Project Filter Tobacco Cessation Focus Groups – Research Findings

Introduction

This memo summarizes findings from focus groups from five specific demographic groups conducted in Idaho to understand motivations for using and quitting tobacco and to explore reactions to tobacco cessation print and television messages. The five groups included individuals identified as: (1) American Indian; (2) Hispanic/Latino; (3) lesbian, gay, bisexual, or transgender (LGBT); (4) low socio-economic status (Low-SES) between 25-34 years old; and (5) Low-SES between 35-54 years old.

DaviesMoore develops creative content for Project Filter, a tobacco cessation program funded by the Center for Disease Control, and requested EMI Consulting's service in performing and analyzing results from the focus groups. DaviesMoore and Project Filter intend to use results from these focus groups to inform the development of new creative that addresses themes important to these groups of people while maintaining a broad appeal to the mass audience.

Study Objectives

This study was performed to meet the following objectives:

- Understand motivations for making a quit attempt;
- Identify sources of influence on quitting or continuing use of tobacco;
- Identify sources of information about quitting tobacco and beliefs about those sources; and
- Document themes in reactions to existing tobacco cessation television and print messages.

The following sections include: (1) research methods; (2) trends in tobacco use and quit attempts; (3) key themes across all focus groups; (4) detailed focus group findings; and (5) recommendations.

Research Methods

The research team conducted focus groups between May 18 - 20, 2015 in the afternoon and evening. (See Table 1 in the Appendix.)

Focus Group Structure

Each of the two-hour, audio-recorded, confidential discussions consisted of three sections. The first section began with an explanation of the purpose of the focus groups and included a set of questions about the participants' use of tobacco and experiences with quit attempts. During the second section, the researchers showed four to five messages to the participants, asking participants to discuss their reactions to and the strengths and weaknesses of the message, after each message was shown. The focus group concluded with a discussion across all messages about what stood out the most, what could have been stronger, and what they would include in a commercial if they were asked to create a smoking cessation message. The researchers provided a break to participants between each section. At the end of the focus group, participants handed in consent forms in exchange for $100 in cash.

Sample & Recruiting

The researchers developed recruiting strategies best suited for each focus group. For the Low-SES groups, the researchers used the Boise Idaho Craigslist.com, the Boise online white pages, and in-person recruiting to recruit qualified candidates. The Craigslist.com advertisement directed candidates to complete an online survey to determine if they qualified for the group. The researchers followed up with all eligible recruits by phone to confirm the location, date, and time. The researchers called those identified through the online white pages to screen them for eligibility and desire to participate. Eligible recruits were encouraged to promote the focus group to acquaintances who may also qualify. For the other focus groups, the researchers worked with organizations that conduct outreach to the targeted groups for assistance with recruiting. Interested LGBT candidates called the researchers to confirm eligibility and participation. The organizations that worked with the Boise area Hispanic/Latino population and the Duck Valley Reservation American Indian population, elected to screen and ensure participation on their own. Therefore, the researchers made reminder calls to the Low-SES and LGBT recruits, but not the Hispanic/Latino and American Indian recruits.

Cessation Messages

DaviesMoore identified the video and print messages for which they wanted each focus group to provide feedback. There were four categories of messages, viewed in the following order: (1) positive/encouraging; (2) family-based messaging; (3) negative health consequences; and (4) increased life. (Table 2 in the Appendix describes which ads specific groups viewed.)

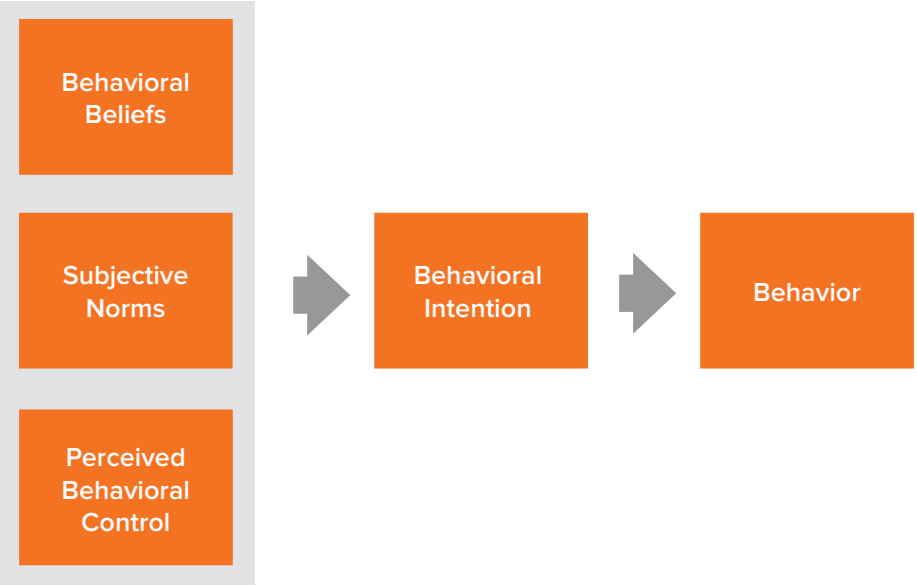
Analysis Framework

In addition to coding data for study objectives and key themes using NVivo (qualitative data analysis software), the researchers used the Theory of Planned Behavior to help organize the analysis of the focus group transcripts. This framework has been widely studied and is highly regarded among social scientists for its ability to consistently predict behavior and behavioral

intention from people's beliefs and perceptions. For this reason, it is frequently used to help design and evaluate behavioral health programs and messages.

To analyze the focus groups, the researchers used a simplified version of this framework as shown below in Figure 1. According to this framework, a person's beliefs about a behavior, the perceived social pressures to engage in that behavior, and their perceived ability to engage in that behavior, predict their intention to engage in that behavior, and ultimately the likelihood that they will actually engage in the behavior.

Figure 1: Theory of Planned Behavior



A central concept in the Theory of Planned Behavior is that behavior is driven by a person's perceptions about a behavior's consequences, the social norms related to it, and their own self-control. These perceptions may align with reality or deviate from it. According to this framework, a person's likelihood to engage in a behavior, like using tobacco, is unrelated to the actual behavioral consequences or actual social norms–only their perceptions of these are important. However, with perceived behavioral control there is a relationship between the real amount of facilitating and impeding factors that exist in the environment, and a person's likelihood to engage in the behavior. In the case of quitting tobacco, for instance, the presence of physical addiction can be a barrier to successfully quitting tobacco regardless of a person's beliefs about their level of addiction (although even in this case, their perception of addiction is still predictive of their likelihood to quit).

Trends in Tobacco Use and Quit Attempts

This section describes findings primarily from the first portion of the focus groups, during which participants discussed sources of influence and reasons why the they started using and continue to use tobacco, motivations for and experiences with quit attempts, opinions about vaping and e-cigarettes, and barriers to quitting. All participants smoked tobacco and only a few used chewing tobacco.

Influences, Reasons for Starting and Continuing to Use Tobacco

The most prevalent reason why participants began smoking was that family members or peers smoked.

Influence of family
Over half reported having parents or siblings who smoked. Some spoke of starting to smoke because they respected their parents and others did it out of rebellion. Some discussed copying a sibling, cousin, or close friend.

- Low-SES 25-34 year old woman: "I stole cigarettes from my step-dad when I was 15 and I liked them. Then I stole cigarettes from gas stations that didn't have the protector thing, and then eventually I bought them."
- Native American man: "When I was younger, a lot of my cousins did it. So I started smoking cigarettes."
- Latino man: "I wanted to be cool like my older brother. He is five years older than me and he always told me, … with a cigarette in his hand … 'Do not be smoking because it is bad for you!' and he would take a drag. I thought that was so cool. I do not know why, I just did … I thought if I smoked, I would look older and feel older. Until my mom caught me and whooped me good–I was hanging around with the wrong group and I started smoking because they were smoking."

Influence of peers
In every group smoking with friends was a theme. While the idea that smoking "looked cool" was an undercurrent associated with peer pressure, the image was explicitly mentioned more by older participants and by the LGBT group. For the LGBT participants, though, smoking was an important way to break into a social group or meet new people.

- Low-SES 35-54 year old woman: "When we started smoking, in our age group, it was the cool thing to do."
- Low-SES 35-54 year old man: "Go to K-Marts with mom and dad and get little candy cigarettes."
- Gay man: "You'd go to a bar and be shy. And if you had a cigarette, someone might come to you and say 'hi' or you could go over there and ask for a light."
- Gay man: "So where people liked each other and they didn't like somebody, right, that somebody didn't have a way to gracefully get into the group for smoking. But now where do we smoke? It's all outside in one designated area. So you can't afford to be cliquish anymore. The people who might feel themselves on the outs get to rub elbows and chitchat and get to know people, and get to be known because they're forced to be with them in the same situation. And that's not a bad thing."

Work breaks
Across all groups, those who worked in hospitality, food service, music industry, manufacturing, industrial warehouses, or retail jobs felt it was a way they could make sure they got a break and some noted that those who don't smoke tend to not take as many breaks.

- Low-SES 34-54 year old man: "The only people that got breaks were the ones that smoked; so I started going out to get a break because you're on your feet so much."

Under the Theory of Planned Behavior framework, these experiences of initiation into tobacco use suggest that the perceived social norms around cigarette use are a major factor in driving people to start smoking. In the language of the framework, the participants who were smokers experienced some combination of: (1) perceived social pressure to smoke from those whose opinions they valued (such as the "cool" friends or older family members mentioned above); (2) a strong willingness to comply with these social pressures; (3) limited social pressure not to start smoking (as in cases where authority figures such as parents smoke themselves); and (4) limited willingness to comply with social pressures not to smoke (for example, among the American Indian participants who recognized the norm of keeping tobacco sacred, but expressed ambivalence about the degree to which they or others felt genuine pressure not to smoke because of this norm).

Quit Attempt Motivations and Experiences

All but five of the 34 participants attempted to quit smoking at least once, and most have tried to quit multiple times or have quit for months or years before starting up again. A few mentioned that they want to quit because they don't get as much pleasure from smoking anymore, but most indicated that they are motivated to quit for family members or significant others.

Parents
Most of the focus group participants who were parents, also wanted to prevent their children from taking up smoking. Among the mothers, many made a point of saying they quit while they were pregnant.

- Latino man: "One day my brother came over and he dropped a cigarette on the porch and stepped on it. My [three year old] son came and said, 'Look dad, I am like you and Tio Rick!' and he had a cigarette in his mouth and that made me twinge. Then my wife saw it and she hit the roof and was, 'Look at what you are teaching him!'... You really do not think about it. That is what he saw me and Tio Rick [doing] and even to this day, he says 'Tio Rick still smokes.' It is something he sees, something they see and I wanted to give him a better example."
- Latino woman: "My daughter will see me going outside for my cigarette and she will pick up a stick and pretend she is smoking it herself. It is just something gross [that] you do not want your child to do; it is not a good example. I have tried plenty of times because of that."
- Pregnant Low-SES 25-34 year old mother, currently having trouble quitting: "I watched an ultrasound of a pregnant mom smoking a cigarette and the baby's reaction inside the womb. I think I try to quit every time I smoke a cigarette. I say, 'I am never going to smoke another cigarette.' I am down to one cigarette in two to three days. I just take a puff of it and put it back out. Because it's sad. I am 5 and a half months pregnant. I don't want my baby to be in the womb trying to fight off the smoke."

Illness, death of family member
A few mentioned having to confront sickness or the death of a family member due to smoking, but not all were motivated to quit by the events.

- Low-SES 35-54 year olds engaged in dialogue about smoking-related illness and death: One woman has interstitial lung disease that is aggravated by smoking and one low-SES couple in the same group watched their 40 year old cousin die of lung cancer after refusing to stop smoking. While these were impactful for them, the medical problems

alone did not seem to be a significant motivator to quit. They discussed how people get cancer after stopping smoking and how "people get cancer without ever even smoking."

- American Indian man: "I have already seen my family members die from smoking. They got cancer. But that did not make me quit. So I really do not know [what would make me quit.]"
- Latino woman: Finding out "grandpop got cancer from smoking cigarettes" and "ended up having to remove his lung" was motivating her to quit again. "Just knowing that happened to somebody in my family is scary and it is more of a motivation to not want to smoke so I do not end up like him. It is something to motivate me to not want to do it."

Vaping, e-Cigarettes, and Nicotine Replacement Therapy

Participants discussed a variety of ways they had tried to quit using the nicotine replacement therapy (NRT) patches and gum or vaping products. Most participants felt that vaping and e-cigarettes were different than smoking cigarettes and not necessarily that much healthier. A few had tried using vaping to wean themselves from smoking, but most participants who had tried vaping did not find it a satisfying substitute for smoking saying, for example, "it just does not give me the same gratification that a cigarette does." Some participants were concerned that inhaling the oils might also be detrimental to their lungs.

Participants experienced a variety of responses to NRT products. Patches and gum worked for some participants to help reduce the nicotine cravings, especially those who used it when in the hospital or recovering from illness. Others said NRT products did not solve the underlying problem, though; the habit of smoking and the oral fixation were difficult to overcome. A few participants said the patches made them feel sick, "lightheaded … dingy" or like they "could not think straight." A few others felt they had allergic reactions to the patches. On the other hand, at least two women used the patches in addition to smoking to get through the day.

Barriers to Quitting

When describing their quit attempts, participants across the focus groups cited a common set of challenges they faced and reasons why they began smoking again. Those who had not been smoking very long or smoked less frequently thought they could quit pretty easily. Those who had smoked for many years knew they had difficulty quitting. Most, but not all, felt that they were addicted to smoking, and noted that the habits were as difficult to replace as the nicotine–as a stress reliever or to relax at certain times of day like the morning coffee, after dinner or dessert, with a beer, and before bed.

Emotional effects

Many experienced grouchiness and feeling bad when trying to quit.

- Latino man: "I am a pretty passive guy, but when I quit smoking I had a really short fuse and I had nightmares."
- Latino woman: Not smoking in morning and at night "just throws off your energy level and you feel like you are dying."

Triggers for restarting smoking

Some tried to quit after being hospitalized, in jail, or in a situation where they could not smoke. Once back in their normal surroundings, though, they were triggered to start smoking again by being around someone else that smokes and the smell of cigarettes, or by a stressful event.

- Transgender woman: "I found that out working graveyard by myself with no cigarettes and I had to take the patch off with eight hours left on my shift. That was a fun night. I was so committed to it. And the first thing I did on the way home from work was stop at the gas station and buy a pack of cigarettes."
- Low-SES 25-34 year old man: "I was going on a road trip. I was going to be away from my family. I was with my uncle who doesn't smoke, so it was really easy….There was none of my regular triggers around. So, I quit really easy. I stayed quit for about 20 days…I found out she was pregnant and I lost it and I went and had a cigarette and I haven't tried to quit ever since."

Feeling left out

Some were concerned about being left out of work conversations during smoking breaks.

- Low-SES 25-34 year old man: "It's like the Friends episode when Rachel gets the modeling/scouting job … and she feels like she wasn't part of the group decision because she wasn't out there smoking a cigarette with the boss. That's the feeling my friends got when they tried to quit. They'd say, 'What did you guys talk about out there?'"

Weight gain

Some individuals, primarily from the LGBT and Low-SES groups, were also concerned about weight gain. For the LGBT men, they were very concerned about their physical appearance and commented on how critical the LGBT community could be about appearance.

- Bisexual woman: "It's that boredom, hand to mouth. You got to be doing something. So if I'm not smoking, I'm going to eat."
- Gay man: "We are very conscious about our looks and weight. And so, if we start putting on pounds we're not accepted. So we want to get rid of that poundage the easiest way possible … If you quit smoking, you put on pounds."

Within the structure of the Theory of Planned Behavior, efforts to quit tobacco were facilitated or impeded by a complex set of factors. Participants expressed mixed attitudes toward the behavior of smoking. On the one hand, participants expressed several negative beliefs about smoking (e.g., smoking makes you smell bad, smoking can lead to sickness or death, smoking is too expensive for me). On the other hand, smoking behaviors' consequences were either seen as unlikely (as with the LGBT participants who did not view illness as an immediate concern) or were outweighed by other, more positive, beliefs about the consequences of smoking (e.g., smoking helps me cope with stress, the smell of cigarette smoke makes me feel nostalgic, or even that cigarettes help me digest my food).

Similarly, conflicting beliefs about social norms hampered many smokers' ability to quit. While the desire to not pass on the norm of smoking to children was an important issue to many participants, many reported that they resumed smoking cigarettes in social situations. Despite their concerns about passing on social norms themselves, these participants fell victim to either perceived social pressures to resume smoking or a lack of social pressure to persist in quitting.

Finally, very few participants expressed any significant degree of confidence that they could control their tobacco use, especially under difficult circumstances. Among the beliefs related to low perceived behavioral control among the participants, was that they were addicted, that tobacco's association with everyday activities would make it very difficult to conduct those activities without smoking, that quitting will lead to them becoming cranky or being unable to deal with stressful situations, and that the smell of cigarette smoke would be too tempting to ignore (especially after drinking alcohol). In addition, seeing family members and friends struggle with quitting seemed to reinforce the beliefs that it is very difficult to control tobacco use.

Key Themes Across All Focus Groups

This section describes themes that occurred across two or more of the focus groups. These themes are divided into strengths and weaknesses of the messages.

Strengths of Messages

Overall, the messages that most often resonated well with the focus group participants were positive messages that described another tobacco user's true story of quitting. They wanted to not only know the "what" but also the reasons "why" and "how" the person quit. Participants resonated best with stories in which they could identify a shared experience or a common situation. The participants also preferred messages with a call to action or an alternative to using tobacco–messages that did not scold but rather presented choices. Some mentioned that they liked seeing the quit line number and the free help. No one expressed a negative reaction toward the Center for Disease Control or other message sponsors. The following quotes provide examples of participants' reactions in their own words:

Personally relate to actors, location

- Low-SES 35-54 year old man: "I think the fact that we're actually showing real, obviously current smokers, putting a cigarette in and then seeing 11 minutes of them having fun. It was kind of an emotional impact."
- Latino man: "We can relate to that…yes. I can relate to that. That was Grandpa. Grandpa used to smoke and he'd laugh…him and my dad used to laugh and he'd hit this certain spot that he couldn't catch his breath anymore and it was due to his smoking. We all knew it."
- Gay man: "It's showing the gay community there. I think that's a very good psychological thing. It's very important as opposed to seeing the basketball star or whatever."
- Native American man: "Don't use it the way people do today and recreational uses. It's like, 'keep it in your ceremony, pray with it.'"

Like a positive reason to try to quit instead of scare tactics

- Low-SES 25-34 year old woman: "I liked the concept and the whole 'add eleven minutes' thing is similar to the, 'You shorten your life,' concept as well. But instead of it being 'Add eleven minutes to your life,' which is what it said but it also is like, 'This is something else that you could be doing for eleven minutes.'"
- Latino woman: "It doesn't force you into anything."

Relate to hearing others' stories

- Low-SES 25-34 year old man: "I know a bunch of dates now. But it would be cool to hear how they quit or what struggles they had so that way people who are quitting don't feel so alone, because it seems so easy for them."
- Latino man: "It is actually showing a real person taking out her real teeth and showing real examples.... A regular person."

Want motivational messages

- Low-SES 25-34 year old woman: "If they can do it, I can too."
- Gay man: "That's a strong thing right there, allowing you to decide and not being told when to quit."

Connect with messages that make you stop and think

- Latino woman: "It is one of those things like...that's me when I get to that age. You don't want to be the hacker because they know who the hacker is."
- Latino man: "She has colon cancer because of smoking and she has a bag she has to change out. It is pretty graphic but it makes you think of what you're really actually doing to yourself."

Possible to respond to calls to action easily and immediately

- Bisexual woman: "It's very informative. It lets you know that there really is a lot of different options for you when you are ready."
- Native American woman: "That was my train of thought [while watching the Quit Date message]. I know that I'm pretty positive that none of those methods [would work] and then I thought "Well, what if I went to the website and then they had other methods of quitting" and I wonder if I should–so those were kind of the thoughts that were going through my mind during the video."

Weaknesses of Messages

Overall, the messages that most often did not resonate well with participants, were those that used actors who did not seem like real smokers or who were not like the participants (e.g., age, ethnicity, lifestyle, location). Participants did not trust over-simplified situations or stories that were missing a key connection between smoking and the person's current condition. Participants also felt disappointed when the messages failed to recommend next steps. They also warned against using silent text on a screen because some people may be listening but not watching the screen or may have limited reading ability and miss the message. The following quotes provide examples of the participants' feedback in their own words:

Did not relate to actors, places they thought were not genuine, similar to them

- Low-SES 25-34 year old man: "These people don't really seem genuine. Those people don't smoke and they did not quit on that day. That's the feeling that I get."
- American Indian woman: "I think people in town and cities relate to stuff more like that because especially around universities and places where they're actually doing that kind of catch marketing. So for people on reservations it's probably not a realistic thing to do but you know around campuses you do see stuff like that pretty frequently."

Did not believe stories that were missing a key aspect

- Low-SES 25-34 year old woman: "I want them to say, 'Yeah it was hard, but I was able to do it. These are the things that I went through,' and then you don't feel so alone. You don't feel like, 'I'm the only one that feels that way for this long, and then goes back to smoking because I feel like it's just me being emotional.'"
- Low-SES 25-34 year old man: "How come there's not more people missing their legs from cigarettes specifically? Tell me specifically why it is, or if it's just more complicated for you because you have amputations."
- Low-SES 35-54 year old man: "Americans dying from smoking, what are the other four out of five dying from and missing moments too? I mean there are all kinds of things that happen in life."

Did not trust overly simplified situations

- Latino woman: "Maybe if they had used less people and let them really talk. 'This is how long I smoked. I went from smoking this many a day to I finally quit on this date.' Make it tell a little bit more of a story and a little bit more of a background on these people rather than… 'Yup, I'm done.' Twenty people…I'm done, but we want to know how and where from."
- Latino woman: "Nobody quits just once. They are probably talking about the last time that they quit."
- Low-SES 25-34 year old woman: "[It] makes me feel like, 'Why aren't I the one that's happy and quitting?' How do they get to that point where they're happy to not be smoking for eleven minutes?"

Thought silent text to read may be a problem

- Low-SES 25-34 year old man: "I didn't have any motivation actually to read it. The only reason I even read it was because I was in here and I felt like I had to. But under normal circumstances I would have ignored the text on the screen."
- Latino man: "I have a hard time reading and understanding stuff. That wasn't enough Spanish for me to really get the hang of it."

Detailed Focus Group Findings

This section includes a bulleted summary of the research team's analysis of group-specific themes. (Tables 3 – 7 in the Appendix provide summaries of comments for each message by focus group.)

American Indians

- Vaping is not viewed as a viable harm-reduction strategy. It is perceived as difficult to obtain and as a poor substitute for cigarettes.
- Participants reported seeing people smoking at Pow Wows, and some even described Pow Wows as venues where they initiated tobacco use. If this is a widespread phenomenon, it may weaken the impact of messages attempting to appeal to subjective norms using Pow Wow scenes.

- Participants reported seeing "very spiritual" older members of their family smoking, even those who espoused beliefs that tobacco is sacred. If this is a frequent occurrence, the norms around keeping tobacco sacred may not provide enough pressure to motivate behavioral change.
- As with other groups, the smell of tobacco smoke was seen as a significant negative social consequence to current smokers, while also being a potential trigger for tobacco cravings among those attempting to quit. The smell of secondhand smoke was universally viewed as a negative consequence.
- Messages involving children were highly emotionally reactive among this group, evoking feelings of guilt. To some participants, this appeared to make them want to disregard the message as a guilt-trip, while others felt that the message was very motivating.

Hispanic/Latino

- Vaping is not viewed as a viable harm-reduction strategy. It is perceived as difficult to obtain and as a poor substitute for cigarettes.
- Participants reported perceiving that people who smoke are able to take longer breaks at work.
- Participants reported that smoking cigarettes is more common among Latino men than among Latino women. Male focus group participants seemed to associate smoking with masculinity and strength. Female focus group participants seemed to view their smoking as an aspect of their identity that distinguished them as a person free from perceived gender norms.
- Cigarettes were seen as a way to reduce anxiety and manage energy levels (e.g., the morning cigarette helps you wake up, the evening cigarette helps you relax). These behavioral beliefs were also cited as potential barriers to quitting tobacco. Participants reported feeling that when they attempt to quit they are cranky, anxious, and unable to cope with stressful situations.

LGBT

- A few participants tried weaning themselves off of cigarettes by vaping, but most viewed vaping and e-cigarettes as quite different than smoking in terms of the way it works, the feel of using an e-cigarette or vapor, and the effect it has on them. Some were concerned about the health consequences of inhaling oils and moist air into their lungs.
- Participants reported similar concerns about the consequences of tobacco use to other groups (e.g., yellow teeth, poor complexion). Participants also believed, though, that smoking cigarettes conferred practical social benefits, such as access to conversations in which other people are smoking or the ability to initiate a conversation after being asked for a light.
- Participants responded very positively to the Quit Date ad and other positive and empowering messages. They expressed distaste for messages that were "preachy" or attempted to "brow beat."
- While the participants felt sorry for the subject of the ad depicting negative health consequences, it did not appear to elicit feelings of personal urgency to change their behavior. Younger participants felt that the subject was older than them and was an extreme case, suggesting that the subject may not have been relatable. These reactions,

seen in other groups as well, may also indicate a desire to dismiss messages depicting negative health consequences altogether. Older participants who were HIV positive explained that when they were younger they had been told many times they only had six months to live, so they did not care about longer-term health. Now many feel differently about their health and could relate more to the older ill woman.

Low-SES (25–34 Years Old)

- Participants viewed vaping as different from smoking cigarettes–as something younger people do because it's hip and flashy. They do not consider it smoking.
- Many in this age group are still defiant and young enough not to have smoking related symptoms. As such, preaching does not connect with them (including use of statistics for some). For some, being told what not to do only encourages them to do the opposite.
- In general, the group preferred the positive messages, such as the 11 minutes message, to the negative ones, but were skeptical that the messages would impact them. Although they did not connect with the people or the date itself, some participants responded positively to the Quit Date ad because it was "not a guilt trip" and offered a free hotline for those who wanted to try to quit. Whereas the message that depicts a child fishing, brought up unwelcomed feelings of guilt and comments that the message was "emotional propaganda" that was "condescending" because "everyone knows that cigarettes kill you."
- Others responded better to the powerful story of long-term health impacts because it was genuine, held their attention, will "make them think again" about it, and they "wanted to know more about this guy." Yet, they questioned the credibility of the message because it did not clearly explain the relationship between smoking and the amputation of toes and legs.
- In general, the group felt they would respond better to factors other than health, such as cost, not being cool or accepted, vanity (e.g., skin, teeth, smell, etc.), and the idea of setting examples for others (e.g., younger siblings, children).

Low-SES (35–54 Years Old)

- Participants viewed vaping as different from smoking. A few participants had tried it and one indicated liking it, but did not see it as a substitute for smoking.
- Messages that provide options and alternatives for the time and financial cost of smoking were viewed positively. As with the other low-SES group, participants viewed the Quit Date message positively for avoiding "scare tactics" and offering a resource and free assistance without being pushy. Participants wanted the message to explain whether "they use[d] these products and [if] it help[ed] them."
- Messages that show impacts to others close to them can be powerful, especially for parents, and must tell a compelling story. Participants enjoyed the 11 minutes message because it made them consider what a difference 11 minutes could make (e.g., spending time with their family). The idea of setting examples for others (e.g., younger siblings, children) was impactful.
- A note of caution about using military personnel in messages: it was effective at stirring emotions, but also may make people feel that the military personnel were being exploited to stir emotions as opposed to telling their story.

- Any stories displaying negative health consequences must make a strong causal connection between smoking and the negative health consequence to be viewed as credible.
- Statistics are not as impactful. Participants questioned the statistics shown. As such, acknowledging alternatives may lend credibility, e.g., if 1 in 5 die from smoking, participants wanted to know is that actually true, and if so, what do the other 4 die from?

Recommendations

Based on the findings from the focus groups, the researchers offer the following recommendations when developing new tobacco cessation messages:

- **Tell a compelling story –** Across the focus groups, many expressed a desire to know more about the people in the ads, which allows them to better connect.
- **Keep it realistic and believable –** Participants emphasized that quitting is difficult and not something that happens in one attempt. The stories in the ads should explain the struggle, not just the success. How did people do it? What helped them quit? How can they develop and maintain self-control under difficult circumstances (e.g., under stress, in social situations, during everyday situations associated with tobacco use)?
- **Provide "next steps" –** Participants wanted to be informed about concrete actions they *should* take next, and positively responded to resources (e.g., websites, phone numbers) and giveaways (e.g., patches). Ideally, these initial next steps should be easy and possible for viewers to implement immediately after viewing the message.
- **Keep the message positive –** Participants desired messages of encouragement and hope that they too could quit; for many, negative messages bring feelings of guilt and lead to feelings of hopelessness and disengagement. However, a few reacted well to negative messages that gave them a "reality check." If negative health consequences are used, it may be beneficial to focus on shorter-term consequences (e.g., yellow teeth, shortness of breath).
- **Focus on the rewards of quitting –** Participants expressed a desire for messages that showed the other positive things they could do with their time with friends/family if they quit smoking, including the positive benefits for those around them.

Possible Messages to Consider

- **Show specific desired short-term behaviors along with their positive consequences –** Many participants expressed frustration with not being able to envision how short-term quitting behaviors (e.g., using NRTs, calling a quit line) would help them ultimately quit. Illustrating the positive consequences associated with these first steps may reinforce beliefs that engaging in these short-term behaviors can lead to long-term success.
- **Show situations that may prompt relapse along with realistic coping mechanisms –** Participants across groups reported specific situations in which they anticipated relapsing into tobacco use during a quit attempt (e.g., during social or stressful situations). While coping strategies and trigger situations vary from person to person, a message showing a person (relatable to the population) appraising their own coping mechanisms or employing coping strategies in difficult, relatable circumstances, may increase viewers' perceived behavioral control over smoking.

APPENDIX

Table 1: Focus Group Time, Location, Participants, and Recruiting Method

Focus Group Name	Time	Location	Number Confirmed	Number Attended	Recruiting Methods
American Indian	May 18, 2015 6-8pm	Duck Valley Reservation Owyhee, NV	8	8	• Johanna Jones, Office of Indian Education • Pete Putra, Health to Healing Wellness Building, Duck Valley Reservation
Low-SES (35-54 Years Old)	May 19, 2015 11:30am – 1:30pm	Main Library Boise, ID	8	7	• Craigslist.com • In-person recruitment • Direct calls to residents based on white page information
LGBT	May 19, 2015 3-5pm	ALPHA Boise, ID	8	7	• Jared Homnick, ALPHA • Joseph Kibbe, The Community Center
Low-SES (25-34 Years Old)	May 20, 2015 3-5pm	Cole & Ustick Library Boise, ID	10	6	• Craigslist.com • In-person recruitment • Direct calls to residents based on white page information
Hispanic/Latino	May 20, 2015 6-8pm	Cole & Ustick Library Boise, ID	6	6	• Margie Gonzalez, Idaho Commission on Hispanic Affairs

Table 2: Messages Viewed by Each Focus Group

Message Type	Low-SES (25-34 Years Old)	Low-SES (35-54 Years Old)	American Indian	Hispanic/Latino	LGBT
Positive/ Encouraging	Quit Date	Quit Date	Quit Date Keep Tobacco Sacred (Print)	Quit Date	Matt and Martini Quit (Print)
Family-based messaging	Little Fisherman	Military Homecoming	Value our Tradition (Print)	Colorado Cowpoke	Honey Maid
Negative Health Consequences	Brandon's Ad	Bill's Ad	Michael's Ad*	Felicita's Ad	Rose's Ad
Increased Life (Positive)	11 More Minutes	11 More Minutes	11 More Minutes	11 More Minutes	11 More Minutes

***Note:** Michael's Ad for the American Indian focus group was not shown because of limited Internet access; two print materials reviewed instead.

Table 3: Comments on Messages by American Indian Focus Group

American Indian	Message	Perceptions of Message
Positive/Encouraging	Quit Date	• Mixed impact – some minimal, others strongly • Involvement & family support provided is motivating • Positive feelings about their success • Weakness is that for some it was too general and they couldn't connect with it
	Keep Tobacco Sacred (Print)	• Stop smoking message is very clear • Visually appealing – good contrast, feather, phone number • Easier to read than "Value our Tradition" print • Feelings – Happy, "I feel good about this" • Phone number and website is a strength • Thoughts of a Pow Wow brought up mixed perceptions
Family-based messaging	Value our Tradition (Print)	• Speaks to the participants • Feelings of guilt for abusing tobacco for more than ceremonial purposes and for what it is "supposed" to be used • "*Simplicity is powerful"* • Relatable – not limited to only a single tribe • Needs a larger text to help with reading
Negative Health Consequences	Michael's Ad*	• Ad not shown – limited Internet access
Increased Life (Positive)	11 More Minutes	• Interesting, and holds your attention • "It makes me think" about options • General consensus that it spoke to them individually • Weakness is that the focus is on large cities, not rural towns

***Note:** Michael's Ad for the American Indian focus group was not shown because of limited Internet access; two print materials reviewed instead.

Table 4: Comments on Messages by Hispanic/Latino Focus Group

Hispanic/Latino	Message	Perceptions of Message
Positive/Encouraging	Quit Date	• Too simple, did not really connect with anyone • Strength is that people were happy and energetic • Gives hope that they too could set a date to quit • Nobody quits just once • Weakness is that it does not address triggers that last many years • Also too many people and not enough back story on each
Family-based messaging	Colorado Cowpoke	• All agreed the commercial spoke to them • Feelings of sadness – "I don't want my grandson seeing me like that" • You get the impression he has been smoking for a long time • Seeing the loving family around the smoker was a strength • You see the cause & effect without showing smoking • No real weaknesses
Negative Health Consequences	Felicita's Ad	• The ad was impactful and an "eye-opener" • Smoking impacts other body parts like teeth, skin, etc. • Could be impactful to a younger generation to discourage starting • A strength was having a clear personal story up front • No weaknesses, tough message was not a scare tactic but a real story
Increased Life (Positive)	11 More Minutes	• Very powerful message – it spoke to everyone • Made them feel that quitting does not have to be negative – "You are trading it in for something better" • "The whole thing is a strength" • It shows that quitting starts with just one, the same way it started • Having a narrator reading the written words would help

Table 5: Comments on Messages by LGBT Focus Group

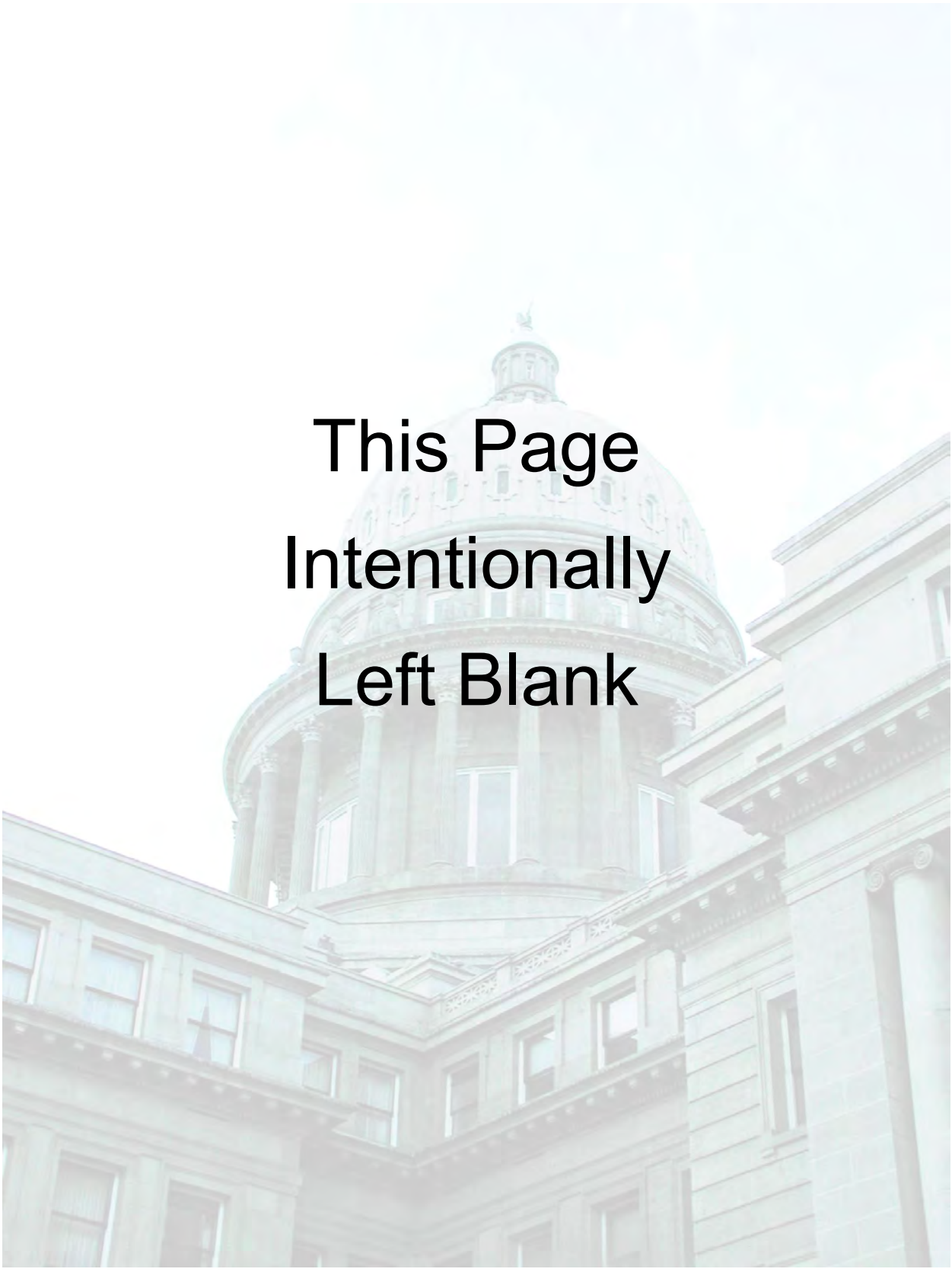
LGBT	Message	Perceptions of Message
Positive/Encouraging	Matt and Martini Quit (Print)	• They knew who Martini was and could relate and connect to the ad • Felt empowered by seeing others in their community who had quit • Were unaware of all of the options for smoking cessation – appreciated that it was a free quit line • Colors and layout were visually appealing • Some felt that the words were too small
Family-based messaging	Honey Maid	• The message of turning something hateful and negative into a positive was really powerful for this group
Negative Health Consequences	Rose's Ad	• Did not like the negativity (“the rod” vs. “the carrot”) • Many felt that the ad’s subject was too old to be relatable • Many did not feel personally connected with ad’s subject • Suggestion to show more immediate consequences (e.g., shortness of breath, yellowing teeth)
Increased Life (Positive)	11 More Minutes	• Very touching and emotional for all • Loved the positive messaging

Table 6: Comments on Messages by Low-SES (25-34 Years Old) Focus Group

Low-SES (25-34 Years Old)	Message	Perceptions of Message
Positive/Encouraging	Quit Date	• Liked that it was positive and not a scare tactic • Hard to connect with, seems like random dates for several and possible that the people don't even smoke • Liked the free offer for smoking cessation products at the end • Bilingual aspect was a strength • A weakness for at least one is that there was no evidence or reference to the struggle of quitting • There also is no reference to the multiple quit attempts many have
Family-based messaging	Little Fisherman	• Liked it better than the "Quit Date" – upbeat, cute, captures attention • Did not relate well with this group – geared more to keep people from starting rather than quitting • Guilty feelings for those that are parents • Several commented that it came across condescending • Would have ignored the text, boring
Negative Health Consequences	Brandon's Ad	• Genuine, but also a spectacle • Engaging, they want to know more about Brandon's story • Showed without telling or lecturing • For one who was resolved to keep smoking – this offered something to think about and internalize – there was a strong impact • Good ad to discourage young kids from starting • Weakness was combining smoking with another disease – too easy to dismiss as not smoking related
Increased Life (Positive)	11 More Minutes	• Original idea and the ad was entertaining, but not something the group felt they connected to – did not seem like a cigarette ad • The statistics were viewed as a weakness for one participant • Another weakness is that quitting is not a happy process

Table 7: Comments on Messages by Low-SES (35-54 Years Old) Focus Group

Low-SES (35-54 Years Old)	Message	Perceptions of Message
Positive/Encouraging	Quit Date	• The 24 hr. line and free offering were seen as a benefits • Felt happy for the people, but did not relate to them (looked like actors and not "real" smokers) • Wanted to know more about what products helped them • Hearing "Idaho" made at least one perk up and pay attention
Family-based messaging	Military Homecoming	• There was a perceived disconnect between smoking and the ad • Hard for several to relate – especially the one who was self-reported "government issued" • The statistics did not help – what are the other 4/5 dying from? • Strength is that it makes you stop and think, especially for those with children
Negative Health Consequences	Bill's Ad	• Some saw it as a scare tactic; others as just hard-hitting • Combining diabetes with smoking loses the impact – "smoking does not cause people to lose a leg" • Sympathy expressed for Bill, but hard to relate if you don't have diabetes – some automatically discredited the commercial • Bill's story was a strength though
Increased Life (Positive)	11 More Minutes	• Very well received – connected well with everyone • Positive message – trade cigarettes for something even better • Makes them think about what they could personally do with 11 min • Only weakness is that there is not a call to action – Who do I call? What do I do?



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C.L. "Butch" Otter

Governor

Elisha Figueroa

Administrator

304 N 8th Street, Room 455

Boise, ID 83702

208-854-3042

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State of Idaho

Office of Drug Policy

Executive Office of the Governor

October 1, 2015

Joint Millennium Fund Committee
Room C305, State Capitol
Boise, Idaho 83720

Dear Committee Members,

I am pleased to lend support to the Community Coalitions of Idaho's (CCI) Millennium Fund request. I have the good fortune of being a past member of CCI and I am keenly aware of the vital work community coalitions do throughout our great state.

If granted, CCI's request will allow them to continue their work in supporting community coalitions throughout the state, as well as developing new coalitions. These organizations are powerful prevention partners and CCI has become an invaluable resource to them. The statewide organization works to educate, support, and provide resources to coalitions, as well as connecting them with each other to collaborate and benefit from shared experiences.

At the Office of Drug Policy (ODP), we know that the type of prevention work done by community coalitions is often the most successful in producing sustainable change. When ODP needs to know what is happening in an individual community, who the relevant stakeholders are, or how we can best work in a community, coalitions are our first contact. Without them, "boots on the ground" prevention work would not get done. Therefore, I encourage the Joint Millennium Fund Committee to grant CCI's request for funding.

Warm regards,

Elisha Figueroa

Elisha Figueroa
Administrator, Office of Drug Policy

Idaho State Police

Service Since 1939

Colonel Ralph W. Powell
Director

C.L. "Butch" Otter
Governor

October 16, 2015

To Whom It May Concern;

For multiple years, the Idaho State Police, Alcohol Beverage Control Bureau has worked closely with the Community Coalitions of Idaho and the Bonneville Youth Development Council. Throughout those years, we have learned they are dedicated, passionate, diligent, and focused on reducing underage drinking, drug abuse, and making our communities a better place to live and raise families. They are strongly involved in local Idaho communities and are a resource, place of assistance and guidance for parents and local youth. They provide service projects, social activities, and other events for youth ages 12 to 18. They are strong advocates in retailer training taught by the Idaho State Police, Alcohol Beverage Control Bureau and share a passion for reducing underage alcohol consumption.

Respectfully,

Captain Russell Wheatley
Idaho State Police
Alcohol Beverage Control Bureau

700 South Stratford Drive, Suite 115 • Meridian, Idaho 83642-6202 • (208) 884-7060

Do Coalitions Work?
Research Support for Coalitions

"Is there research showing that coalitions are effective?"
"Are environmental strategies more effective than programs?"
"Is there research demonstrating that CADCA's approach is effective?"

The answer to all of these questions is a resounding "YES!"

The research described here is a representative sample of the expansive and ever growing research stating that community-based coalitions engaging in comprehensive, environmental strategies is a proven effective approach for creating population level change. While three of these articles are only available with appropriate licensing the other two are available for viewing online as indicated.
If you have any questions about the research support for CADCA's approach or the materials cited here, please contact the CADCA's National Coalition Institute's Evaluation and Research team.
Andrea de la Flor @ (800) 542-2322 ext. 245 or adelaflor@cadca.org.

Summary of Supporting Research

What Works?			How Do I Get It?	
Coalitions	Environmental Strategies	Comprehensive Strategies	Lead Author (Last Name, First Initial)	Year
√	√	√	Hingson et al.	2005
√	√	√	Nargiso, J.	2013
√	√	√	National Research Council	2004
√	√	√	Sorensen, G.	1998
√	√	√	Yang, E.	2012

Hingson R., Heeren, T., Winter M., and Wechsler, H. (2005). Magnitude of Alcohol-Related Mortality and Morbidity Among U.S. College Students 18-24: Changes from 1998 to 2001. Annual Review of Public Health, 26:259-279.

Nargiso, J., et al. (2013). Coalitional Capacities and Environmental Strategies to Prevent Underage Drinking. American Journal of Community Psychology, 51(1/2):222-231.

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COMMUNITY COALITIONS OF IDAHO (CCI)

Mission: Support community coalition's efforts to prevent substance abuse in Idaho
Vision: Safe and healthy Idaho communities free of substance abuse

About Us

Community Coalitions of Idaho (CCI) is a statewide coalition of community coalitions that was organized in early 2009 to strengthen advocacy efforts for substance abuse prevention in Idaho. Participating coalitions represent large and small, urban and rural communities across Idaho. Participating members provide support to one another while sharing ideas, strengths, information, resources and enthusiasm for healthy communities. Working with partners at the local, state and national level, CCI works to facilitate collaboration and encourage cooperation among Idaho community coalitions to affect policy and issues with a united voice.

CCI Purpose

To provide a forum for community coalitions to come together to promote prevention efforts and share ideas; Establish a Strategic Prevention Plan; Develop a state level framework for community coalitions; Seek funding that will accomplish coalition goals; Increase stakeholder involvement of prevention coalitions of Idaho; Increase the number of prevention coalitions in the state; Increase capacity of community coalitions to implement environmental strategies; and Maintain representation of diverse prevention coalitions and partners.

For More Information

If you are a member of a community coalition or substance abuse prevention partner that is not part of CCI, please contact us to learn more:
communitycoalitionsofidaho@gmail.com

Participating Coalitions

Region 1
Benewah Community Coalition
Community Coalition for Substance Abuse Prevention
Kootenai County Substance Abuse Council
Region 2
Campus Community Coalition
Clearwater Youth Alliance
Idaho College Health Coalition (Statewide)
Kamiah Community Partners Coalition
Lapwai Community Care Team
Latah County Youth Advocacy Council
Let's Get It Started
Region 3
Coalition for Drug Free Youth
Middleton United Substance Abuse Coalition
Owyhee County Coalition
Region 4
Drug Free Idaho
Kuna Against Drugs
Meridian Anti-Drug Coalition
Treasure Valley Alcohol & Drug Coalition
Youth Advocacy Coalition
Region 5
Blaine County Community Drug Coalition
Custer County Coalition
Community Coalition for Lincoln County
Region 6
Bannock County Prevention Coalition
Bear Lake County Enough Is Enough
Region 7
Bonneville Youth Development Council
Fremont County Resource & Collaboration Efforts (R.A.C.E.)
Madison Community Council
Pride Committee
Salmon Substance Abuse Prevention Coalition
Teton Valley Mental Health Coalition

Partner Organizations

Boise Police Department
Caldwell Police Department
Elks
Idaho Drug Free Youth (IDFY)
Idaho Dept. of Education
Idaho Dept. of Health & Welfare Community Resource Development Specialists (CRDS)
Idaho Dept. of Health & Welfare
Idaho National Guard, Counterdrug Support Program
Idaho Office of Drug Policy
Idaho State Liquor Division
Idaho State Police
Idaho State Police Alcohol Beverage Control (ABC)
Isaiah's Ranch/Healthy Foundations
Kestrel West Monte Stiles, LLC
Mothers Against Drunk Driving (MADD)
Prevention & Treatment Research (PATR) Workgroup
RADAR
SPAN Idaho

Community Coalitions of Idaho (CCI)
Executive Director & Meeting Information

Mission: Support community coalitions efforts to prevent substance abuse in Idaho
Vision: Safe and healthy Idaho communities free of substance abuse

Executive Director Duties and Responsibilities

CCI Executive Director provides overall management, planning, and leadership of the organization, reports directly to the Board of Directors and works with the Board and committees to further CCI's goals, interprets the organization's purpose, and provides resources, to outside organizations and the public in order to expand and strengthen coalitions and their interconnections, acts as a liaison to other aligned organizations to achieve common objectives, as well as seeks, writes and manages grants to provide organizational sustainability.

Executive Committee

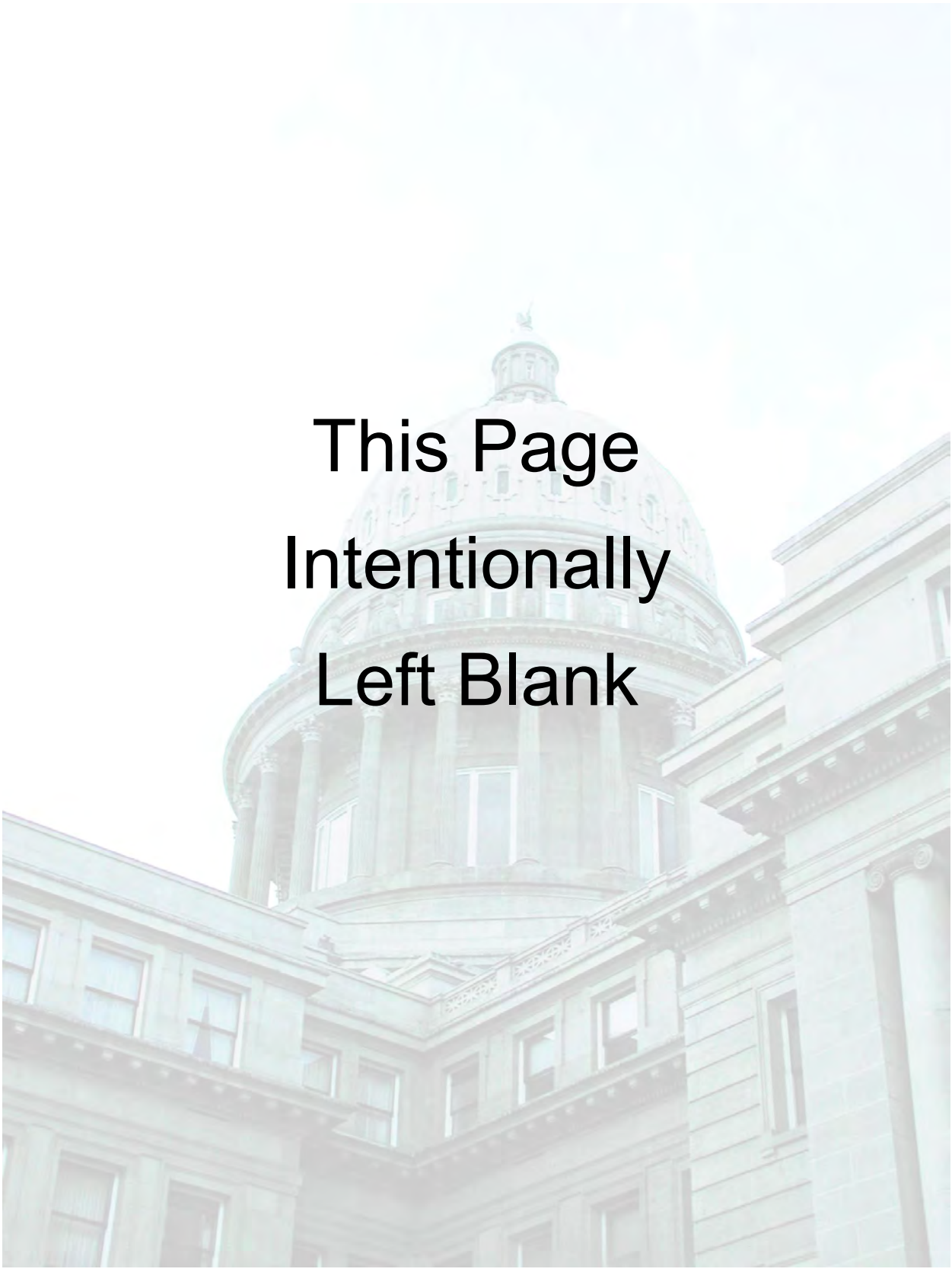
Tammy Rubino, Executive Director
Alisha Passey, Chair and Region 7 Rep.
Kari Clark, Sec/Treas. and Region 1 Rep.
Staci Taylor, Region 2 Representative
Penny Jones, Region 3 Representative
Rob Stevenson, Region 4 Representative
Amber Larna, Region 5 Representative
Marilee Bloxham, Region 6 Representative
Darin Burrell, Capacity Building Committee Chair
Nancy Lopez, Advocacy Committee Chair

Meetings

CCI holds conference calls quarterly on the first Friday and monthly board meeting conference calls the last Friday of the month. In additional, CCI holds three in-person meetings per year. These meetings provide information unique to our state, trainings for coalitions and substance abuse prevention education. The purpose of these meetings is to provide education and training, including a knowledge base for effective prevention strategies and networking and sharing among community coalitions and partners. Many community coalitions do not have funding for training. CCI knows and understands these needs and allows funding for scholarships to our meetings. These scholarships are provided on a first come first serve basis. Expenses are prioritized by first travel expenses, then hotel and then meals based on available funds. Members are asked to car pool and share rooms where appropriate. The CCI Board is very conscious about using our funds very efficiently and yet being flexible to best serve the coalitions.

In-person meeting agendas are set by members and partners based on the needs of our state and local communities, as well as current trends. Also, CCI plans our in-person meetings around other conferences and trainings in an effort to be most effective with our training funds and coalition members and partners time. For example, we partnered with the Idaho Conference on Alcohol and Drug Dependence (ICADD). CCI met the day after the conference and we had a National Speaker from CADCA (Community Anti-Drug Coalitions of America). Because this speaker was already here we only had to pay for an extra night at the hotel and their extra preparation time.

Visit our website and Facebook page at:
http://communitycoalitionsofidaho.org
https://www.facebook.com/communitycoalitionsofidaho



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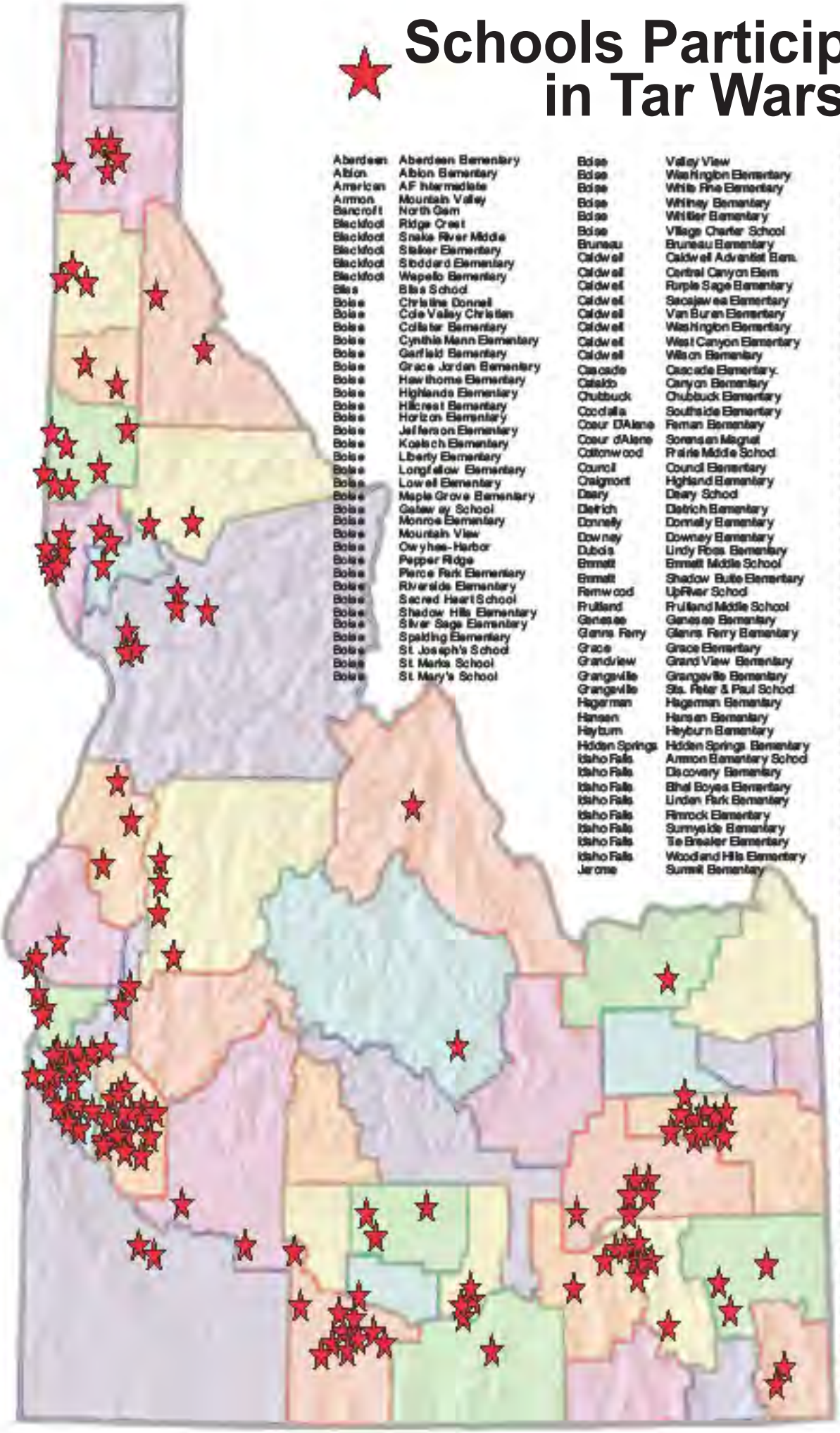
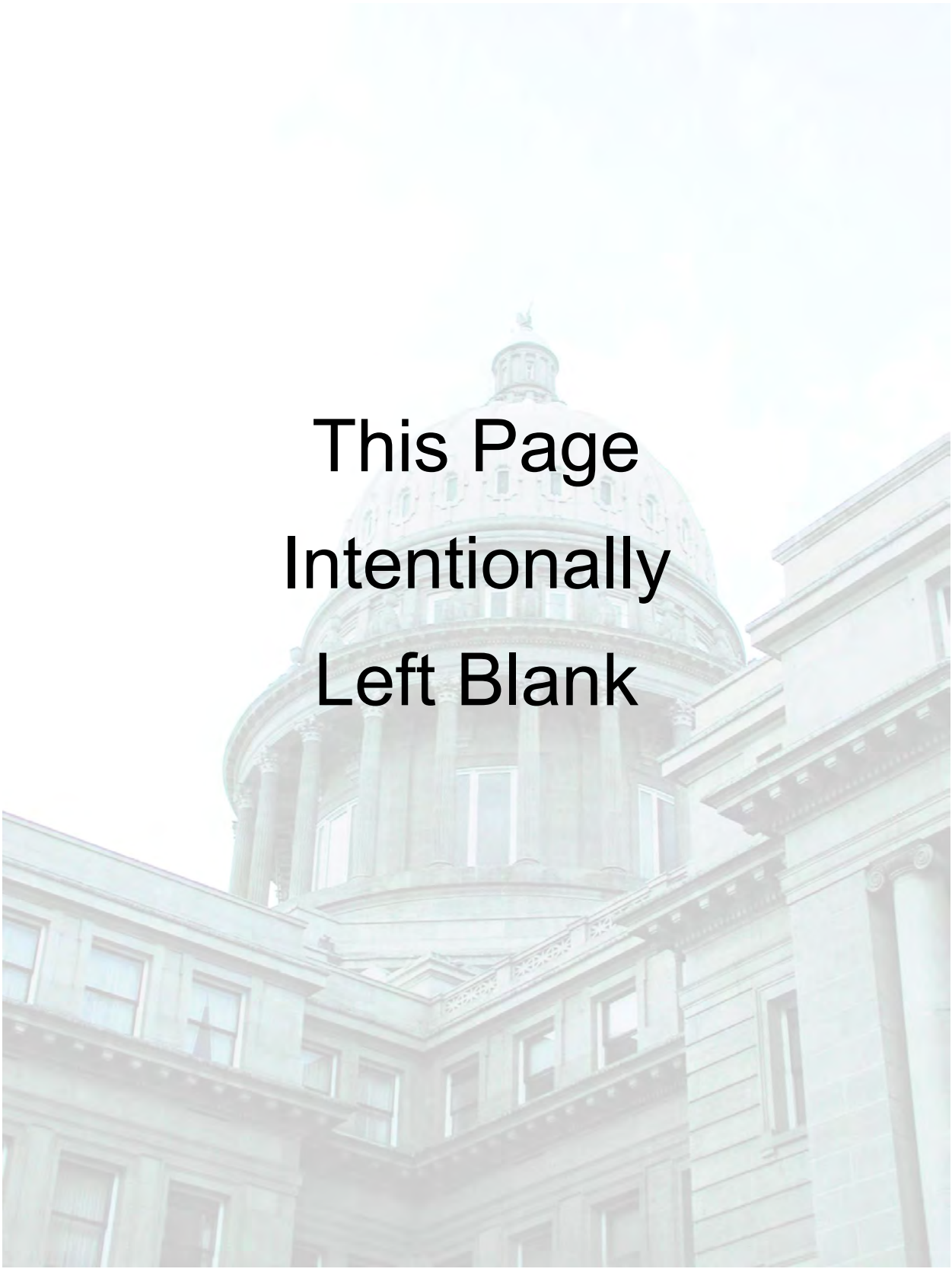
Schools Participating in Tar Wars



Aberdeen	Aberdeen Elementary
Albion	Albion Elementary
American	AF Intermediate
Ammon	Mountain Valley
Bancroft	North Gem
Blackfoot	Ridge Crest
Blackfoot	Snake River Middle
Blackfoot	Stalker Elementary
Blackfoot	Stoddard Elementary
Blackfoot	Wapello Elementary
Bliss	Bliss School
Boise	Christine Donnell
Boise	Cole Valley Christian
Boise	Collister Elementary
Boise	Cynthia Mann Elementary
Boise	Garfield Elementary
Boise	Grace Jordan Elementary
Boise	Hawthorne Elementary
Boise	Highlands Elementary
Boise	Hillcrest Elementary
Boise	Horizon Elementary
Boise	Jefferson Elementary
Boise	Koelsch Elementary
Boise	Liberty Elementary
Boise	Longfellow Elementary
Boise	Lowell Elementary
Boise	Maple Grove Elementary
Boise	Gateway School
Boise	Monroe Elementary
Boise	Mountain View
Boise	Owyhee-Harbor
Boise	Pepper Ridge
Boise	Pierce Park Elementary
Boise	Riverside Elementary
Boise	Sacred Heart School
Boise	Shadow Hills Elementary
Boise	Silver Sage Elementary
Boise	Spalding Elementary
Boise	St. Joseph's School
Boise	St. Marks School
Boise	St. Mary's School
Boise	Valley View
Boise	Washington Elementary
Boise	White Pine Elementary
Boise	Whitney Elementary
Boise	Whittier Elementary
Boise	Village Charter School
Bruneau	Bruneau Elementary
Caldwell	Caldwell Adventist Elem.
Caldwell	Central Canyon Elem.
Caldwell	Purple Sage Elementary
Caldwell	Sacajawea Elementary
Caldwell	Van Buren Elementary
Caldwell	Washington Elementary
Caldwell	West Canyon Elementary
Caldwell	Wilson Elementary
Cascade	Cascade Elementary
Cataldo	Canyon Elementary
Chubbuck	Chubbuck Elementary
Coeur dAlene	Southside Elementary
Coeur DAlene	Fernan Elementary
Coeur dAlene	Sorensen Magnet
Cottonwood	Prairie Middle School
Council	Council Elementary
Craigmont	Highland Elementary
Deary	Deary School
Dietrich	Dietrich Elementary
Donnelly	Donnelly Elementary
Downey	Downey Elementary
Dubois	Lindy Ross Elementary
Emmett	Emmett Middle School
Emmett	Shadow Butte Elementary
Fernwood	UpRiver School
Rutland	Rutland Middle School
Genesee	Genesee Elementary
Glenns Ferry	Glenns Ferry Elementary
Grace	Grace Elementary
Grandview	Grand View Elementary
Grangeville	Grangeville Elementary
Grangeville	Sts. Peter & Paul School
Hagerman	Hagerman Elementary
Hansen	Hansen Elementary
Hayburn	Heyburn Elementary
Hidden Springs	Hidden Springs Elementary
Idaho Falls	Ammon Elementary School
Idaho Falls	Discovery Elementary
Idaho Falls	Ethel Boyes Elementary
Idaho Falls	Linden Park Elementary
Idaho Falls	Rimrock Elementary
Idaho Falls	Sunnyside Elementary
Idaho Falls	Tie Breaker Elementary
Idaho Falls	Woodland Hills Elementary
Jerome	Summit Elementary
Kamiah	Kamiah Middle School
Kellogg	Sunnyside Elementary
Kimberly	Kimberly Elementary
Kooskia	Clearwater Valley
Kootenai	Kootenai Elementary
Kuna	Crimson Point
Lenore	Cavendish-Teakean
Lewiston	Centennial Elementary
Lewiston	McGhee Elementary
Lewiston	McSorley Elementary
Lewiston	Orchards Elementary
Lewiston	Webster Elementary
Lewiston	Whitman Elementary
Mackay	Mackay Elementary
McCall	Barbara Morgan
Menan	Midway Elementary
Meridian	Chaparral Elementary
Meridian	Discovery Elementary
Meridian	Hunter Elementary
Meridian	Barbara Morgan
Meridian	Paramount Elementary
Meridian	River Valley Elementary
Meridian	Siena Elementary
Meridian	Silver Trail Elementary
Middleton	Middleton Heights
Middleton	Mill Creek Elementary
Midvale	Midvale School
Montpelier	AJ Winters Elementary
Moscow	AB McDonald Elementary
Moscow	Moscow Charter School
Mt. Home	Hacker Middle School
Mulan	John Mulan Elementary
Nampa	Centennial Elementary
Nampa	Central Elementary
Nampa	Endeavor Elementary
Nampa	Greenhurst Elementary
Nampa	Idaho Arts Charter
Nampa	Iowa Elementary
Nampa	Lake Ridge Elementary
Nampa	Lakevue Elementary
Nampa	Liberty Charter School
Nampa	Nampa Christian School
Nampa	Owyhee Elementary
Nampa	Park Ridge Elementary
Nampa	Reagan Elementary
Nampa	Roosevelt Elementary
Nampa	Sherman Elementary
Nampa	Snake River Elementary
Nampa	St. Paul's School
Nampa	Willow Creek Elementary
Nampa	Calvary Christian School
New Meadows	Meadows Valley
New Plymouth	New Plymouth Elementary
Nezperce	Nezperce Elementary
Ola	Ola Elementary
Oldtown	Idaho Hill Elementary
Orofino	Orofino Elementary
Paris	Paris Elementary
Paul	Paul Elementary
Payette	Westside Elementary
Peck	Peck Elementary
Pinehurst	Pinehurst Elementary
Plummer	Lakeside Elementary
Pocatello	Edahow Elementary
Pocatello	Fort Hall Elementary
Pocatello	Gate City Elementary
Pocatello	Greenacres Elementary
Pocatello	Jefferson Elementary
Pocatello	Pocatello Comm. Charter
Pocatello	Syringa Elementary
Pocatello	Tyhee Elementary
Pocatello	Washington Elementary
Pocatello	Wilcox Elementary
Pocatello	Holy Spirit Catholic School
Potlatch	Potlatch Elementary
Rathrum	Betty Kiefer Elementary
Richfield	Richfield School
Riggins	Riggins Elementary
Roberts	Roberts Elementary
Rupert	Acequia Elementary
Rupert	Rupert Elementary
Sagle	Sagle Elementary
Salmon	Salmon Middle School
Sandpoint	Washington Elementary
Shoshone	Shoshone Elementary
Soda Springs	Tigert Middle School
St. Maries	Heyburn Elementary
Sweet	Sweet-Montour
Troy	Troy Elementary
Twin Falls	Bickel Elementary
Twin Falls	Harrison Elementary
Twin Falls	Lincoln Elementary
Twin Falls	Morningside Elementary
Twin Falls	Oregon Trail Elementary
Twin Falls	Perrine Elementary
Twin Falls	Sawtooth Elementary
Twin Falls	Immanuel Lutheran School
Twin Falls	St. Edwards Catholic
Weippe	Timberline Elementary
Weiser	Park Intermediate School



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LEWIS-CLARK STATE COLLEGE

Addendum

Sources Cited in Narrative

http://www.cdc.gov/tobacco/campaign/tips/diseases/periodontal-gum-disease.html

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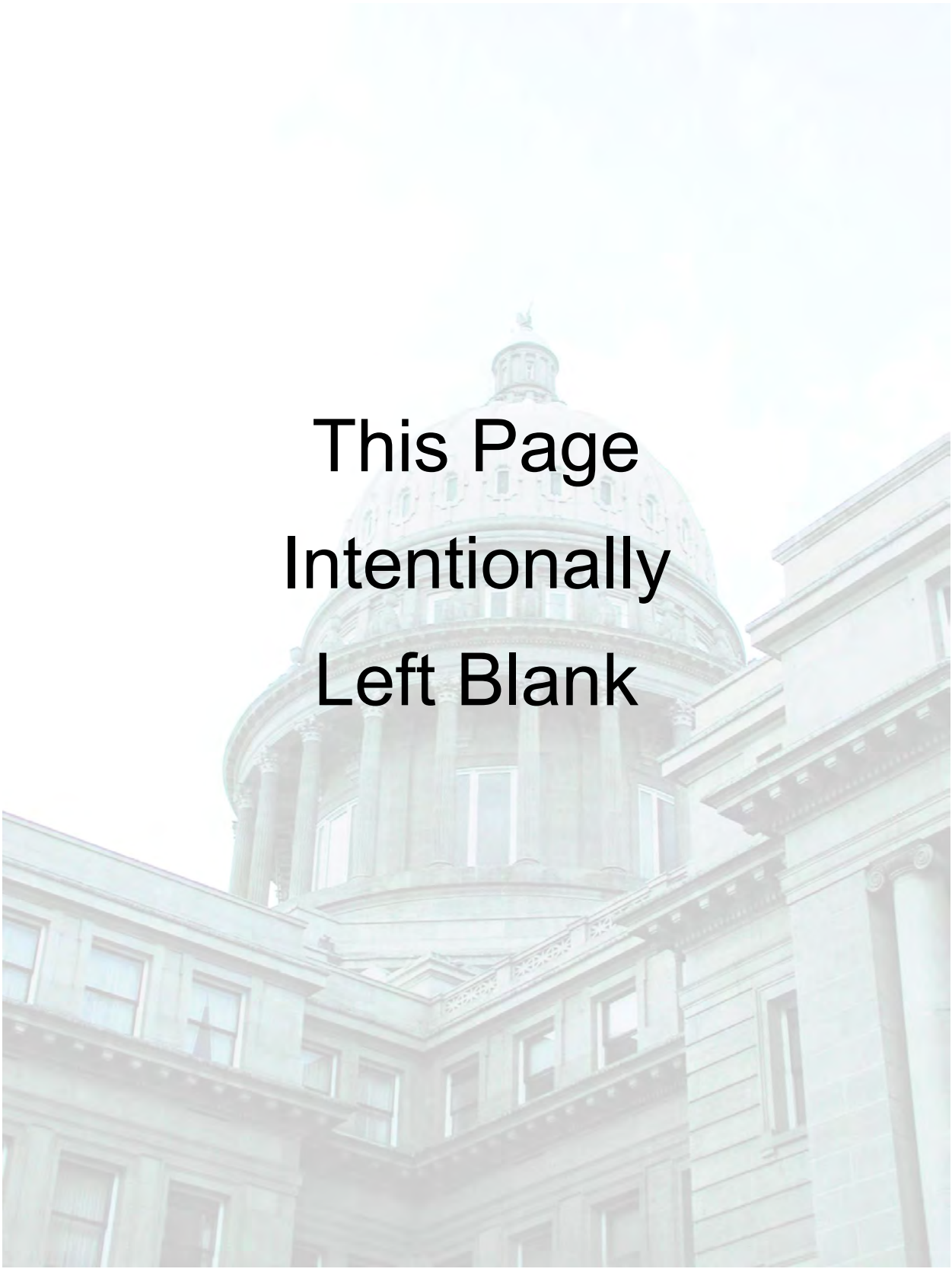
http://www.pewresearch.org/fact-tank/2014/02/07/who-smokes-in-america/

LCSC Fact Sheet

http://www.lcsc.edu/media/2824159/fact-sheet-2014-draft1.pdf



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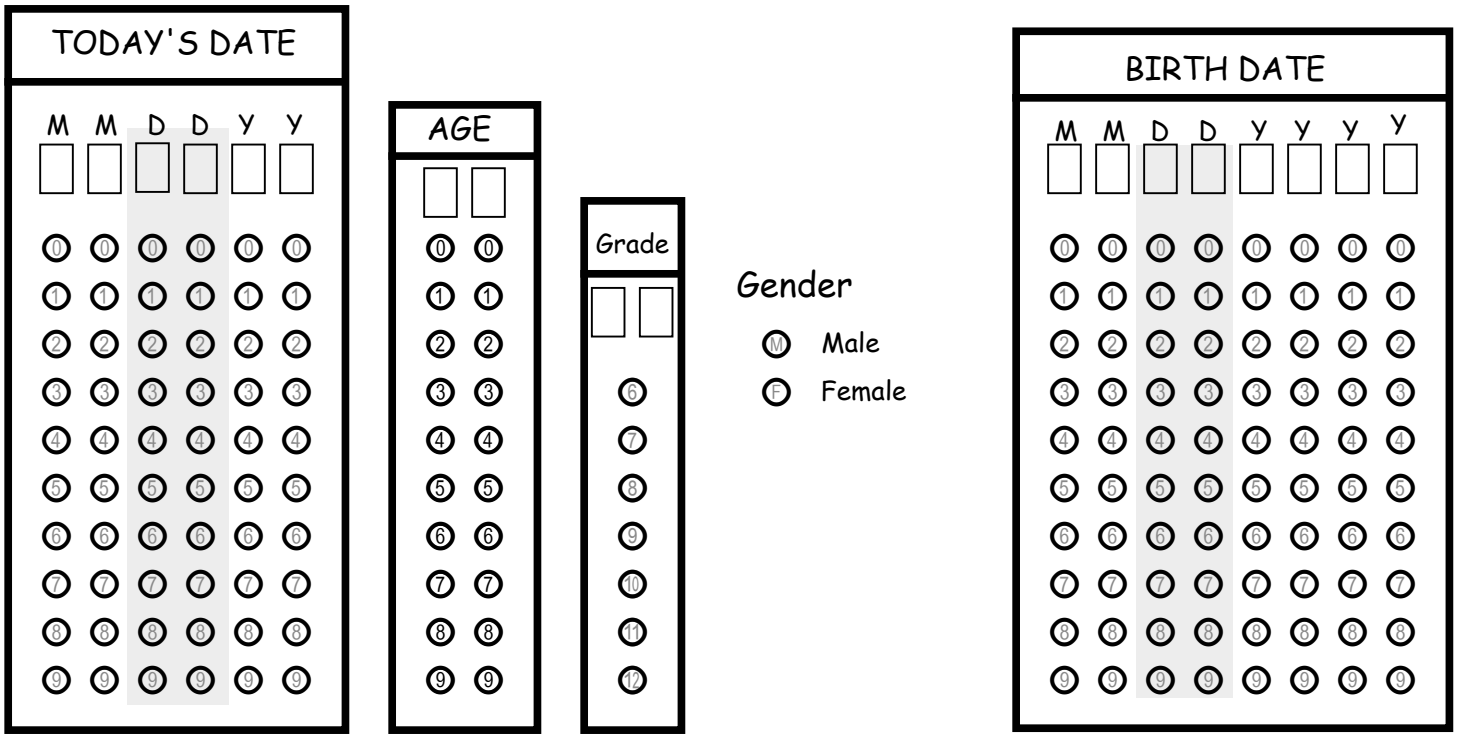
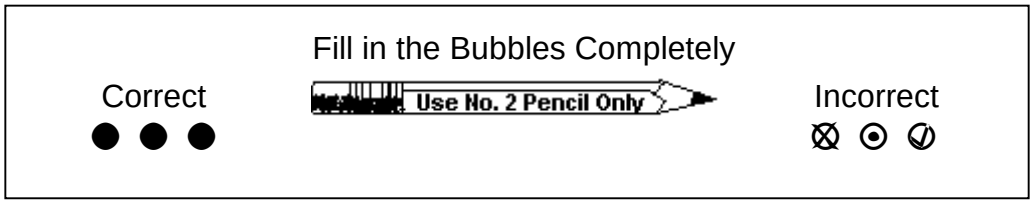
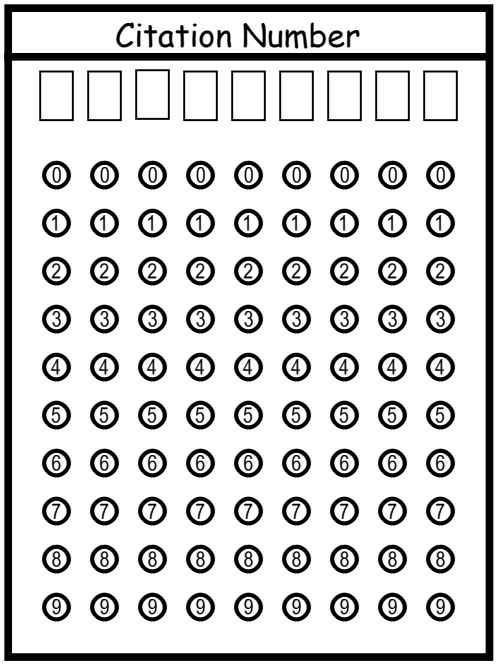
District 5 TND Post-Survey





THINGS TO REMEMBER:

- Read each question carefully.
- Fill in only ONE BUBBLE for each question, unless the question asks for more than one answer.
- Raise your hand when you have questions, or if there are any words you don't understand.
- When you finish this survey, turn it over and sit quietly until the rest of the class finishes.



Comments:

PART I.

1. Who do you live with? (Bubble only ONE)

- ○ Both parents (or stepparents)
- ○ Only with my mother (or stepmother)
- ○ Only with my father (or stepfather)
- ○ Sometimes with my mother (or stepmother) and sometimes with my father (or stepfather)
- ○ Other person(s)
- ○ Alone

2. Which category is your father's main job in? (Bubble only ONE)

- ○ Major Professional (Doctor, Lawyer, Large Business Owner)
- ○ Minor Professional (Teacher, Engineer, Nurse, Pilot, Military Officer)
- ○ Small Business Owner, Manager
- ○ Clerk, Salesperson, Stewardess
- ○ Skilled Laborer (Electrician, Plumber, Tailor, Mechanic, Truck Driver, Military Enlisted)
- ○ Semi-Skilled Laborer (Machine Operator, Cook, Waitress)
- ○ Unskilled Worker
- ○ Unemployed, Welfare
- ○ Househusband

3. Which category is your mother's main job in? (Bubble only ONE)

- ○ Major Professional (Doctor, Lawyer, Large Business Owner)
- ○ Minor Professional (Teacher, Engineer, Nurse, Pilot, Military Officer)
- ○ Small Business Owner, Manager
- ○ Clerk, Salesperson, Stewardess
- ○ Skilled Laborer (Electrician, Plumber, Tailor, Mechanic, Truck Driver, Military Enlisted)
- ○ Semi-Skilled Laborer (Machine Operator, Cook, Waitress)
- ○ Unskilled Worker
- ○ Unemployed, Welfare
- ○ Housewife

4. What is the highest grade completed by your father?(Bubble only ONE)

- ○ Not Completed Elementary School (8Th Grade)
- ○ Not Completed High School (12Th Grade)
- ○ Completed High School (Received A Diploma)
- ○ Some College Or Job Training (1 To 3 Years)
- ○ Completed College (4 Years)
- ○ Completed Graduate School (Doctor, Lawyer)

5. What is the highest grade completed by your mother? (Bubble only ONE)

- ○ Not Completed Elementary School (8Th Grade)
- ○ Not Completed High School (12Th Grade)
- ○ Completed High School (Received A Diploma)
- ○ Some College Or Job Training (1 To 3 Years)
- ○ Completed College (4 Years)
- ○ Completed Graduate School (Doctor, Lawyer)

PART II. **Please answer each of the following questions about drug use.**

6. How many times have you tried each of the drugs below (in your lifetime)?
Fill in the bubble to indicate your answer for each drug.

	0 times	1-10 times	11-20 times	21-30 times	31-40 times	41-50 times	51-60 times	61-70 times	71-80 times	81-90 times	91-100+ times
Cigarettes	○	○	○	○	○	○	○	○	○	○	○
Alcohol	○	○	○	○	○	○	○	○	○	○	○
Marijuana (Weed)	○	○	○	○	○	○	○	○	○	○	○
Cocaine (Crack)	○	○	○	○	○	○	○	○	○	○	○
Hallucinogens (LSD, Acid, Mushrooms)	○	○	○	○	○	○	○	○	○	○	○
Stimulants (Ice, Speed, Amphetamines)	○	○	○	○	○	○	○	○	○	○	○
Inhalants (Rush, Nitrous)	○	○	○	○	○	○	○	○	○	○	○
Other drugs (Depressants, PCP, Steroids, Heroin, etc.)	○	○	○	○	○	○	○	○	○	○	○

7. How many times have you used each of these drugs in the last month (in the last 30 days)? Fill in the bubble to indicate your answer for each drug.

	0 times	1-10 times	11-20 times	21-30 times	31-40 times	41-50 times	51-60 times	61-70 times	71-80 times	81-90 times	91-100+ times
Cigarettes	○	○	○	○	○	○	○	○	○	○	○
Alcohol	○	○	○	○	○	○	○	○	○	○	○
Marijuana (Weed)	○	○	○	○	○	○	○	○	○	○	○
Cocaine (Crack)	○	○	○	○	○	○	○	○	○	○	○
Hallucinogens (LSD, Acid, Mushrooms)	○	○	○	○	○	○	○	○	○	○	○
Stimulants (Ice, Speed, Amphetamines)	○	○	○	○	○	○	○	○	○	○	○
Inhalants (Rush, Nitrous)	○	○	○	○	○	○	○	○	○	○	○
Other drugs (Depressants, PCP, Steroids, Heroin, etc.)	○	○	○	○	○	○	○	○	○	○	○

Below is a list of things that some people do to protect themselves.
How often have you done each of these things in the last <u>year</u> (in the last <u>12</u> <u>months</u>), to feel safer? *Fill in the BUBBLE to indicate your answer for each response below:*

	Never	Rarely	Sometimes	Often	Always
8. Try to talk out the conflict	○	○	○	○	○
9. Yell at people	○	○	○	○	○
10. Carry a knife	○	○	○	○	○
11. Carry a gun	○	○	○	○	○

For each question below, please fill in the "BUBBLE" that indicates how many times that event has happened to you in the last year (last 12 months).

	0 Never	1 time	2 times	3 times	4 times	5 or more times
12. How often has someone injured you on purpose without using a weapon?	○	○	○	○	○	○
13. How often has someone threatened you with a weapon, but not actually injured you?	○	○	○	○	○	○
14. How often has someone injured you with a weapon (like a knife, gun or club)?	○	○	○	○	○	○
15. How often has someone deliberately damaged or stolen your property (your clothing, radio etc.)?	○	○	○	○	○	○

PART III.

Please answer the following questions.
Bubble only ONE answer per question.

16. Which of the following is NOT an effective communication skill?

- ○ Acknowledge what the speaker is saying by nodding, eye-contact, etc
- ○ Make sure verbal and nonverbal messages match
- ○ Look at the speaker and pay attention to what he or she is saying
- ○ Plan your next statement while the speaker is talking

17. An open mind means you are...

- ○ Liberal in your thinking
- ○ Able to express your attitudes
- ○ Willing to listen to other people's view points

18. What percent of students use LSD weekly?

- ○ 1%
- ○ 4%
- ○ 26%

19. What is a self-fulfilling prophecy?

- Becoming what others expect by believing their judgements
- Doing what you want to do
- Finally achieving your goals

20. Which of the following is NOT a myth of drug use?

- Drugs help people establish friendships
- People often argue and fight more when using drugs
- Drug use indicates personal independence

21. "Reinterpretation" of drug use consequences means...

- Making negative drug use consequences seem positive
- Ignoring one's own physical injury from one's drug use
- Blaming others for one's own drug use
- Ignoring how one's drug use affects others

22. Difficulty concentrating, urges, sometimes sweating, irritability and restlessness are signs of what?

- Tolerance
- Denial
- Withdrawal

23. Why might a person in a family affected by drug use feel that he or she must overachieve?

- To mask his/her true feelings
- To prove to the world that his/her family is okay
- To make himself/herself invisible
- To achieve personal goals

24. What is the best thing to do to support someone who has a drug problem?

- Ignore them
- Stop enabling them
- Lecture them
- Turn them in

25. Which of the following areas of your life may suffer due to marijuana abuse?

- Emotional
- Social
- Physical
- All of the above

26. In terms of damage to the lining of your lungs, two joints are equivalent to how many cigarettes?

- 1-5
- 10-15
- 20-25

27. Which of the following is a good way to deal with tobacco use withdrawal symptoms?

- Only take a couple of puffs of a cigarette
- Smoke marijuana instead
- Drink water
- Use snuff or chewing tobacco instead

28. What is the third leading cause of preventable death?

- Accidents
- Passive smoking
- Alcohol use
- Heroin use

29. How many known or suspected cancer-causing substances have been found

- 1-5
- 6-10
- More than 10

30. What does "COPE" stand for?

- Compulsive - obsessive personal evaluation
- Consider lifestyle alternatives, others support, problem solving, esteem building
- Consider pros and cons, be open to options, place values on options, put effort into following through with decisions

31. Does drug use cause stress?

- Yes
- No

32. Laughing at a funeral is an example of…

- Stereotyping
- Being assertive
- Bad timing
- Dealing with stress

33. What are the consequences of having negative thoughts?

- We have negative experiences
- There are no consequences

34. Does drug use lead to negative thinking?

- Yes
- No, negative thinking leads to drug use but not the other way around

35. What does it mean to have a radical view?

- Maintaining the status quo
- Challenging the status quo
- A combination of both (A and B)

36. A traditional view on gun control would be….

- Everyone should have the right to carry any type of gun anytime they want
- Only police officers should be allowed to carry guns
- Guns should be outlawed

37. What is brainstorming?

- Making lists of ideas without judging them
- Comparing the pros and cons of a decision
- When your head is full of ideas and you cannot make a decision
- Cut the message into elements

PART IV. **How likely is it that anything you learn in school this year will help you to...**

38. stay away from, or not increase, use of tobacco, alcohol, or other drugs?

- very likely
- somewhat likely
- not at all likely

39. or reduce use of tobacco, alcohol, or other drugs?

- very likely
- somewhat likely
- not at all likely

40. know about other things you can do with your friends besides using drugs?

- very likely
- somewhat likely
- not at all likely

41. make your household become or stay drug free?

- very likely
- somewhat likely
- not at all likely

41. How likely is it that you will use this drug in the next year (12 months)? Fill in the BUBBLE to indicate your answer for each drug.

41a. Cigarettes

- ○ Definitely Not
- ○ Probably Not
- ○ A Little Likely
- ○ Somewhat Likely
- ○ Very Likely

41b. Alcohol

- ○ Definitely Not
- ○ Probably Not
- ○ A Little Likely
- ○ Somewhat Likely
- ○ Very Likely

41c. Marijuana (Weed)

- ○ Definitely Not
- ○ Probably Not
- ○ A Little Likely
- ○ Somewhat Likely
- ○ Very Likely

41d. Cocaine (Crack)

- ○ Definitely Not
- ○ Probably Not
- ○ A Little Likely
- ○ Somewhat Likely
- ○ Very Likely

41e. Hallucinogens (LSD, Acid, Mushrooms)

- ○ Definitely Not
- ○ Probably Not
- ○ A Little Likely
- ○ Somewhat Likely
- ○ Very Likely

41f. Stimulants (Ice, Speed, Amphetamines)

- ○ Definitely Not
- ○ Probably Not
- ○ A Little Likely
- ○ Somewhat Likely
- ○ Very Likely

41g. Inhalants (Rush, Nitrous)

- ○ Definitely Not
- ○ Probably Not
- ○ A Little Likely
- ○ Somewhat Likely
- ○ Very Likely

41h. Other (Depressants, PCP, Steroids, Heroin, etc.)

- ○ Definitely Not
- ○ Probably Not
- ○ A Little Likely
- ○ Somewhat Likely
- ○ Very Likely

You have just finished a 12-lesson program called Project Towards No Drug Abuse (TND). We would like to know how students feel about the program.

42. Using a scale from 1 (did not like at all) to 10 (liked very much), please write the number that matches how much you liked each TND lesson.

LESSONS

ACTIVE LISTENING AND EFFECTIVE COMMUNICATION

Did not like at all ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Liked very much

STEREOTYPES

Did not like at all ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Liked very much

MYTHS AND DENIAL

Did not like at all ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Liked very much

CHEMICAL DEPENDENCY AND FAMILY ROLES

Did not like at all ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Liked very much

TALK SHOW

Did not like at all ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Liked very much

MARIJUANA PANEL

Did not like at all ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Liked very much

TOBACCO USE CESSATION

Did not like at all ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Liked very much

COPING WITH STRESS

Did not like at all ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Liked very much

SELF-CONTROL

Did not like at all ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Liked very much

POSITIVE AND NEGATIVE THOUGHT AND BEHAVIOR LOOPS

Did not like at all ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Liked very much

PERSPECTIVES

Did not like at all ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Liked very much

DECISION MAKING

Did not like at all ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Liked very much

(Read scenarios, made decisions, saw video, and did commitment sheet.)

PLEASE TAKE A MINUTE TO THINK ABOUT THE PROJECT TND DRUG PREVENTION LESSONS. THINK ABOUT TOPICS AND ACTIVITIES THAT DID EACH DAY. THEN, TRY TO FORM A GENERAL OPINION ABOUT THE CLASS.

42. OVERALL, DID YOU FIND THE TOPICS AND ACTIVITIES IN PROJECT TND….

Believable?
- O Yes
- O Somewhat
- O No, not really
- O Definitely

Enjoyable?
- O Yes
- O Somewhat
- O No, not really
- O Definitely

Helpful?
- O Yes
- O Somewhat
- O No, not really
- O Definitely

Interesting?
- O Yes
- O Somewhat
- O No, not really
- O Definitely

Important?
- O Yes
- O Somewhat
- O No, not really
- O Definitely

Understandable?
- O Yes
- O Somewhat
- O No, not really
- O Definitely

A waste of my time?
- O Yes
- O Somewhat
- O No, not really
- O Definitely

Boring?
- O Yes
- O Somewhat
- O No, not really
- O Definitely

Difficult?
- O Yes
- O Somewhat
- O No, not really
- O Definitely

Well - organized?
- O Yes
- O Somewhat
- O No, not really
- O Definitely

Acceptable?
- O Yes
- O Somewhat
- O No, not really
- O Definitely

(THIS IS THE END OF THE SURVEY THANK YOU VERY MUCH FOR PARTICIPATING)

Post Survery

TWIN FALLS COUNTY
PROSECUTING ATTORNEY

GRANT P. LOEBS

425 SHOSHONE STREET NORTH
P.O. BOX 126
TWIN FALLS, IDAHO 83303-0126

CRIMINAL DIVISION
PHONE 208-736-4020
FAX 208-736-4120

CIVIL DIVISION
PHONE 208-736-4190
FAX 208-736-4157

JUVENILE DIVISION
PHONE 208-733-7699
FAX 208-736-5325

October 13, 2015

TO WHOM IT MAY CONCERN:

MILLENNIUM FUND PREVENTION/CESSATION/TREATMENT GRANT

I am Janice L. Kroeger, Senior Deputy Prosecutor for Twin Falls County Prosecuting Attorney's Juvenile Division. Pursuant to Idaho Code 20-511, the Tobacco and Alcohol Diversion Platform has been utilized by our office since its inception in 2008. The Tobacco & Alcohol Platform has been utilized to provide necessary and appropriate services to first time status offenders that have a charge of possession or consumption of tobacco or alcohol. Prior to 2008 and the Tobacco & Alcohol Platform these youth would come into the adult court system or the formal juvenile court system.

The Tobacco & Alcohol Diversion Platform was developed by retired Judge Jack Varin. Fifth Judicial District piloted this program. It has been successful with youth and their parents in developing and implementing skills that these youth were lacking. The Tobacco & Alcohol Platform has allowed my office the opportunity to address specific behaviors that if left unaddressed could develop into serious social issues. The Tobacco & Alcohol Platform teaches low-risk youth and their parents skills that focus on healthy parenting, the importance of education and holding youth accountable in a very restorative format.

As a prosecutor who works daily with at-risk youth and their parents I have found that the Tobacco & Alcohol Diversion Platform is the best program we have available for youth screened at the education/intervention level. The program addresses the legal, social, educational and health issues that occur when youth engage in these behaviors. As a prosecutor I've seen juveniles as young as six and as old as 18 benefit from this program. I have also routinely had the deputy public defender and other defense counsel ask me to send their clients to this program.

One of the important parts of the Tobacco & Alcohol Diversion Platform is our coordination with law enforcement and the juvenile court. We are able to have youth and their parents meet with a Juvenile Court Judge within one to two weeks of the incident. This timely, formal conversation with the Juvenile Court Judge is critical in introducing the program to both the youth and parents. As the Juvenile Prosecutor I have personally attended the intakes, observed the classes and read and listened to the reviews. I have found that the youth and the parents receive an evidenced based and personalized education.

The Tobacco & Alcohol Diversion Platform has provided many youth and parents in Twin Falls County an opportunity to correct illegal behaviors and replace them with healthy, pro-social, law abiding activities. It also benefits youth residing in surrounding counties that have committed offenses in Twin Falls County. Please consider this program for Millennium Fund Prevention/Cessation/Treatment Grant money. If you have any questions, please contact me at (208) 733-7899.

Respectfully,

J. L. Kroeger

J. L. Kroeger
Sr. Deputy Prosecutor

TWIN FALLS JUVENILE PROBATION
2469 WRIGHT AVE.
TWIN FALLS, IDAHO, 83301
736-4215 EXT. 3117

October 9, 2015

Joint Legislative Millennium Fund Committee:

This letter is written to show our support for the Fifth Judicial District Tobacco and Alcohol Platform. This program has been operating in the 5th District since December, 2008, during which, the program has served approximately 150 youth per year. This program and its coordinator, Nancy Kunau, have been a blessing to our community. Nancy's use of community partners, i.e.; Law Enforcement, Corners Office, Morticians and the South Central Health District, give youth a unique perspective on the negative effects of tobacco, E-cigarettes, vaping, alcohol and overall substance abuse can have on their future.

Dr. Kunau coordinates this program out of the Snake River Youth Center, and because her office is located in our building, we are able to provide administrative assistance to this program keeping program costs down, and serving more with less. Nancy is a wonderful partner, and we consider her one of our own.

The Tobacco and Alcohol Platform in its self is a very informative program, however, I believe its success is directly linked to Dr. Kunau, and her passion to educate youth, and their parents. I have seen a lot of programs come and go in the 20 plus years I have worked in juvenile justice, however, I can say without hesitation, that I have not personally witnessed many individuals with the passion, education and drive that Dr. Kunau possesses.

This program began as a pilot in the Fifth Judicial District funded by a Millennium Grant directed by now retired Judge Jack Varin. Since that time, those funds were moved under the Department of Juvenile Corrections and administered by that Agency. IDJC has informed us that these funds will be reduced each year moving forward, and already administered a reduction in this year's funds. To my knowledge, Twin Falls County is not currently in a position to replace this lost funding, therefore, without assistance; this program will likely dissolve in the coming years. Nancy is a special individual who manages an effective evidence-based program for youth in the 5th District. Youth, parents, and our community will lose a great deal if this program is not funded. I fully support this program and hope it will continue to receive funding. Thank you for your consideration.

Sincerely,

Kevin Sandau
Twin Falls County
Director

October 9, 2015

Joint Legislative Millennium Grant Committee

My name is Todd Hill; I'm a Senior Juvenile Probation Officer for Twin Falls County. I have worked 24 years with juveniles. I have been familiar with the Tobacco & Alcohol Platform in the Fifth Judicial District since its inception in 2008. This prevention/intervention platform was developed with four very direct themes involving parents in every step.

1. Immediate intervention with youth on the charge of possession or consumption of tobacco or alcohol.
2. An evaluation to make sure that the Tobacco & Alcohol Platform is the most appropriate direction to serve the youth and essentially their parents.
3. An educational skill set that is appropriate and measureable.
4. Lastly, these youth and parents were not "mixed" with the general juvenile probation population.

This population prior to 2008 was automatically placed in the general juvenile probation population. I've been an observer of this platform for the past six years; watching and listening to both youth and their parents. I have watched this population to be directly and deliberately served utilizing restorative practices. I have had youth that I have supervised who were also missing skill sets that the Tobacco & Alcohol Platform addressed. I have had low *risk youth* that I have sent to the platform to learn these skills.

The Tobacco & Alcohol Platform in the Fifth Judicial District continues to operate on the very relevant premise that it was developed for. The premise has and continues to hold youth accountable, give clear directives, involve parents and have measureable outcomes. Over the past six years that I have used the Tobacco & Alcohol Platform I have found it to be very youth/parent friendly, always well prepared, organized, provide excellent evidence based instruction and always be outcome focused.

We have learned that the Idaho Department of Juvenile Corrections who is now managing a large portion of the Millennium Grant has reduced all funding for previously funded programs. That is why the Tobacco & Alcohol Platform is looking for funding directly from the Joint Legislative Millennium Funding Committee. I know that approximately 80% of all youth and parents served in the Tobacco & Alcohol Platform are Twin Falls County residence. This platform provides a positive educational foundation for both youth and parents. It encourages youth to pursue a tobacco and alcohol free lifestyle. This platform also encourages parents to model and support a substance free lifestyle.

I would strongly encourage you to fund this very valuable platform. The Millennium Grant was specifically meant to address Prevention/Cessation/Treatment; the Tobacco & Alcohol Platform does just that.

Sincerely,
Todd Hill, Senior Juvenile Probation Officer
Twin Falls County, Probation Office

October 9, 2015

Joint Legislative Millennium Fund Committee:

I'm Jason Wilson, a Juvenile Probation Officer for Twin Falls County. I have the opportunity to work with many youth sent to me from the deputy prosecutor to consider for Diversion. Many of these youth come to us on petty theft charges and often incorrigible charges. After being evaluated some of these youth acknowledge that they use tobacco products and have recently involved themselves in alcohol experimentation. In the past five years we have utilized the skill sets that the Tobacco & Alcohol Platform offers. I have found the platform to be consistent in the information that it offers to both youth and parents. I direct youth that come to our diversion program. All of the youth meet monthly with a Diversion Board that volunteers their time. This board has found the skill sets to be very applicable for these identified youth. The parents have reported many times to the board that the learning experience has been beneficial for both their youth and themselves.

The youth have told me that the skills learned in the Tobacco & Alcohol Platform and the material in the Towards No Drugs Curriculum is relevant. They often say, "We learned that we have the skills, now we need to apply those skills."

The Tobacco & Alcohol Platform has been a benefit for Twin Falls County Juveniles. We know that substance use for all youth is abuse. This platform addresses the importance of parent involvement and parent boundaries. The value of education is one of the top priorities of this platform. As a probation officer who helps to divert youth from the formal court system I have found the Tobacco & Alcohol Platform to serve a very significant role.

The Joint Legislative Millennium Fund Committee would be wise to assist in funding this very valuable platform. The Tobacco & Alcohol Platform is a great fit for your Mission; serving Twin Falls County by supporting a project that addresses health, wellness and health education directed at youth and their parents.

Sincerely, Jason Wils
Jason Wilson, Juvenile Probation Officer
Twin Falls County, Probation Officer

Year 2011

Tobacco & Alcohol Diversion Platform Numbers

Total of 11 Sessions: January 1, 2011—December 31, 2011

Session #1	**Twin Falls**	**Jerome**	**Gooding**	**Lincoln**	**Blaine**	**Minidoka**	**Cassia**
19 Youth	14	2	3				
Session #2							
16 Youth	11	2	3				
Session #3							
19 Youth	10	5	4				
Session #4							
16 Youth	13		1			2	
Session #5							
14 Youth	14						
Session #6							
9 Youth	7	2					
Session #7							
11 Youth	10	1					
Session #8							
8 Youth	3	4	1				
Session #9							
19 Youth	13	3			1	1	1
Session #10							
4 Youth	4						
Session #11							
21 Youth	13	4	3	1			
Session Totals	**Twin Falls**	**Jerome**	**Gooding**	**Lincoln**	**Blaine**	**Minidoka**	**Cassia**
156 Youth	**112**	**23**	**15**	**1**	**1**	**3**	**1**

Year 2012

Tobacco & Alcohol Diversion Platform Numbers

Total of 10 Sessions: January 1, 2012—December 31, 2012

Session #1	**Twin Falls**	**Jerome**	**Gooding**	**Lincoln**	**Blaine**	**Minidoka**	**Cassia**
17 Youth	12	3	2				
Session #2							
10 Youth	1			9			
Session #3							
18 Youth	18						
Session #4							
16 Youth	12		4				
Session #5							
19 Youth	17	1				1	
Session #6							
19Youth	19						
Session #7							
18 Youth	16	2					
Session #8							
16 Youth	14	2					
Session #9							
16 Youth	9	7					
Session #10							
16 Youth	15	1					

Session Totals	**Twin Falls**	**Jerome**	**Gooding**	**Lincoln**	**Blaine**	**Minidoka**	**Cassia**
165 Youth	**133**	**16**	**6**	**9**	**0**	**1**	**0**

Year 2013

Tobacco & Alcohol Diversion Platform Numbers

Total of 7 Sessions: January 1, 2013—December 31, 2013

Session #1	**Twin Falls**	**Jerome**	**Gooding**	**Lincoln**	**Blaine**	**Minidoka**	**Cassia**
18 Youth	16				1	1	
Session #2							
18 Youth	13	2	3				
Session #3							
16 Youth	15	1					
Session #4							
17 Youth	15		2				
Session #5							
10Youth	10						
Session #6							
12Youth	10		1				1
Session #7							
14 Youth	10	1	3				

Session Totals	**Twin Falls**	**Jerome**	**Gooding**	**Lincoln**	**Blaine**	**Minidoka**	**Cassia**
105 Youth	**89**	**4**	**9**	**0**	**1**	**1**	**1**

Year 2014

Tobacco & Alcohol Diversion Platform Numbers

Total of 7 Sessions: January 1, 2014—December 31, 2014

Session #1	**Twin Falls**	**Jerome**	**Gooding**	**Lincoln**	**Blaine**	**Minidoka**
19 Youth	16	3				
Session #2						
23 Youth	22		1			
Session #3						
23 Youth	16	4	1	2		
Session #4						
18 Youth	12	5	1			
Session #5						
14Youth	12		2			
Session #6						
19 Youth	10	6	1			(Nevada 2)
Session #7						
17 Youth	14	1			2	

Session Totals	**Twin Falls**	**Jerome**	**Gooding**	**Lincoln**	**Blaine**	**(Nevada)**
133 Youth	**102**	**19**	**6**	**2**	**2**	**2**

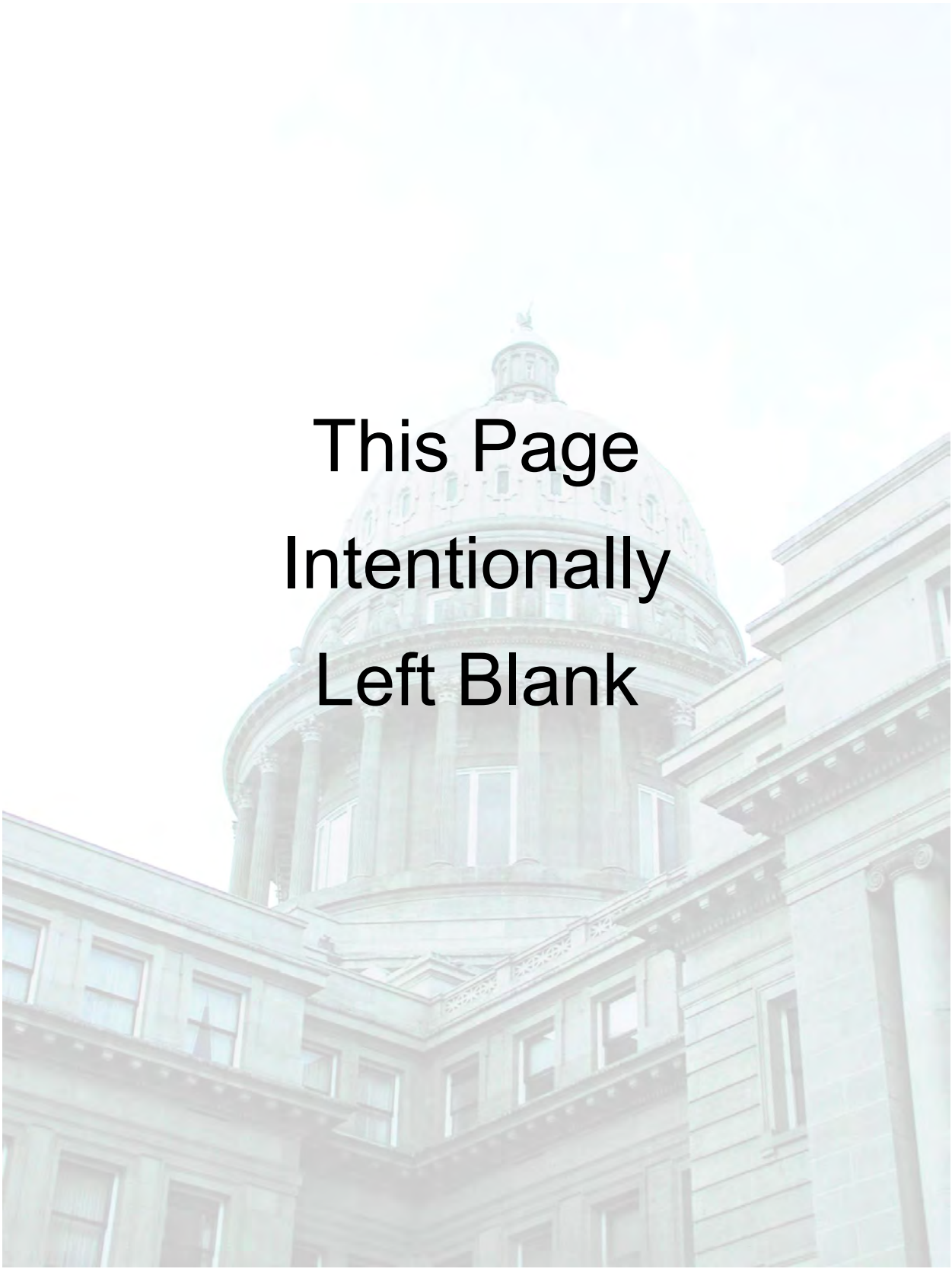
Year 2015

Tobacco & Alcohol Diversion Platform Numbers

Total of 8 Sessions: January 1, 2015—November 30, 2015

Session #1	**Twin Falls**	**Jerome**	**Gooding**	**Lincoln**	**Blaine**	**Minidoka**	**Cassia**
19 Youth	12	6	1				
Session #2							
6 Youth	6						
Session #3							
8 Youth	7		1				
Session #4							
22 Youth	19	2	1				
Session #5							
21Youth	18		1	1		1	
Session #6							
17 Youth	13	2	2				
Session #7							
14 Youth	12		2				
Session #8							
13 Youth	10	1	1			1	

Session Totals	**Twin Falls**	**Jerome**	**Gooding**	**Lincoln**	**Blaine**	**Minidoka**	**Cassia**
120 Youth	**97**	**11**	**9**	**1**	**1**	**1**	**0**



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