

Health Priority: Alcohol and Other Substance Use and Addiction Objective 2: Evidence-Based Prevention Practices for Youth (Template)

Long-term (2010) Subcommittee Outcome Objective:

By 2010, reduce alcohol and other substance abuse among 12-17-year-old youth, using evidence-based practices.

2a. By 2010, reduce the percentage of youth who report binge drinking in the past 30 days to 26.7%.

2b. By 2010, reduce the percentage of youth who report using marijuana in the past 30 days to 20.7%.

2c. By 2010, reduce the percentage of youth who report using tobacco in past 30 days to 22.4%.

2d. By 2010, reduce the percentage of youth who report first use of alcohol prior to age 13 to 24.1%

2e. By 2010, reduce the percentage of youth who report first use of marijuana prior to age 13 to 8.5%.

2f. By 2010, reduce the number of youth under the age of 18 arrested for operating while intoxicated to 641.

2g. By 2010, reduce the number of youth under the age of 18 arrested for liquor law violations to 11,647.

Long-term outcome objective updated as of: November 2004

NOTE: The timeline for this objective is different from all other objectives. This objective is based on the State Incentive Grant Program which goes from 2004 to 2014.

Wisconsin Baseline	Wisconsin Sources and Year
28.2% of youth reported binge drinking in the past 30 days.	2003 Wisconsin Youth Risk Behavior Survey, Department of Public Instruction
25.4% of youth reported their first use of alcohol prior to age 13.	2003 Wisconsin Youth Risk Behavior Survey, Department of Public Instruction
23.6% of youth reported using tobacco in the past 30 days.	2003 Wisconsin Youth Risk Behavior Survey, Department of Public Instruction
21.8% of youth reported using marijuana in the past 30 days.	2003 Wisconsin Youth Risk Behavior Survey, Department of Public Instruction
9% of youth report their first use of marijuana prior to age 13.	2003 Wisconsin Youth Risk Behavior Survey, Department of Public Instruction
675 (0.05%) of youth under the age of 18 were arrested for operating while intoxicated.	2002 FBI
12,260 (0.90%) of youth under the age of 18 were arrested for liquor law violations.	2002 FBI

Federal/National Baseline	Federal/National Sources and Year
23.8% of youth report binge drinking in the past 30 days.	2003 Wisconsin Youth Risk Behavior Survey, Department of Public Instruction
27.8% of youth report first use of alcohol prior to age 13.	2003 Wisconsin Youth Risk Behavior Survey, Department of Public Instruction
21.9% of youth report using tobacco in the past 30 days.	2003 Wisconsin Youth Risk Behavior Survey, Department of Public Instruction
24.4% of youth report using marijuana in the past 30 days.	2003 Wisconsin Youth Risk Behavior Survey, Department of Public Instruction
9.9% of youth report their first use of marijuana prior to age 13.	2003 Wisconsin Youth Risk Behavior Survey, Department of Public Instruction
15,760 (0.02%) of youth under the age of 18 were arrested for operating while intoxicated.	2002 FBI
107,862 (0.15%) of youth under the age of 18 were arrested for liquor law violations.	2002 FBI

Related USDHHS Healthy People 2010 Objectives			
<u>Chapter</u>	<u>Goal</u>	<u>Objective Number</u>	<u>Objective Statement</u>
26 – Substance Abuse	Reduce substance abuse to protect the health, safety, and quality of life for all, especially children.	26-1	Reduce deaths and injuries caused by alcohol and drug-related motor vehicle crashes.
		26-3	Reduce drug-induced deaths.
		26-4	Reduce drug related hospital emergency department visits.
		26-5	(Developmental) Reduce alcohol-related hospital emergency department visits.
		26-6	Reduce the proportion of adolescents who report they have rode, during the previous 30 days, with a driver who had been drinking alcohol.
		26-7	(Developmental) Reduce intentional injuries resulting from alcohol- and illicit drug-related violence.
		26-9	Increase the age and

Related USDHHS Healthy People 2010 Objectives			
<u>Chapter</u>	<u>Goal</u>	<u>Objective Number</u>	<u>Objective Statement</u>
			proportion of adolescents who remain alcohol and drug free.
		26-10	Reduce past-month of illicit substances.
		26-11	Reduce the proportion of persons engaging in binge drinking of alcoholic beverages.
		26-15	Reduce the proportion of adolescents who use inhalants.
		26-16	Increase the proportion of adolescents who disapprove of substance abuse.
		26-17	Increase the proportion of adolescents who perceive great risk associated with substance abuse.
		26-23	(Developmental) Increase the number of communities using partnerships or coalition models to conduct comprehensive substance abuse prevention efforts.
		26-24	Extend administrative license revocation laws, or programs of equal effectiveness, for persons who drive under the influence of intoxicants.
		26-25	Extend legal requirements for maximum blood-alcohol concentration levels of 0.08 percent for motor vehicle drivers aged 21 years and older.
7 – Education and Community-Based Programs	Increase the quality, availability, and effectiveness of education and community-based programs designed to	7-2	Increase the proportion of middle, junior high, and senior high schools that provide school health education to prevent health problems in the following

Related USDHHS Healthy People 2010 Objectives			
<u>Chapter</u>	<u>Goal</u>	<u>Objective Number</u>	<u>Objective Statement</u>
	prevent disease and improve health and quality of life.		areas: unintentional injury; violence; suicide; tobacco use and addiction; alcohol and other drug abuse; unintentional pregnancy, HIV/AIDS, and STD infection; unhealthy dietary patterns; inadequate physical activity; and environmental health.
		7-7	(Developmental) Increase the proportion of health care organizations that provide patient and family education.
		7-12	Increase the proportion of older adults who have participated during the preceding year in at least one organized health promotion activity.
16 – Maternal, Infant, and Child Health	Improve the health and well-being of women, infants, children, and families.	16-17	Increase abstinence from alcohol, cigarettes, and illicit drugs among pregnant women.
		16-18	(Developmental) Reduce the occurrence of fetal alcohol syndrome (FAS).

Definitions	
<u>Term</u>	<u>Definition</u>
Evidence-based prevention approaches	This describes any strategy, program, activity or policy that is research-based with a reasonable expectation of replicating the outcomes of the approach.
Protective factors	Protective factors build resiliency in the same individual, group, or community and increase the likelihood that substance abuse and its related effects can be resisted (CSAP, 2001) or by providing youth with information about identifying the warning signs of violent behavior and how to get help if they recognize these signs in themselves or their peers (CMHS, 1999a).
Risk factors	Risk factors increase the vulnerability of an individual, a group, or a community's vulnerability to substance abuse disorders or untreated conduct disorders can develop into costly adult mental health and societal problems

	such as delinquency, substance abuse and antisocial personality disorder.
Definitions	
<u>Term</u>	<u>Definition</u>
Prevention Framework	A framework is an extensible structure for describing a set of concepts, methods, technologies, and cultural changes necessary for designing and implementing a evidence based substance abuse prevention service delivery infrastructure. It involves the development of a broad overview, outline or skeleton, within which details can be added e.g. CSAP’s Strategic Prevention Framework that sets the context for building a national substance abuse prevention system.
Homegrown Prevention Approaches	Homegrown prevention approaches are those that have been developed locally to meet the needs of local target populations aimed at preventing substance use/abuse among that population. The program or principle has been identified or recognized but there is not sufficient evidence to ensure that the intervention is effective.
Public Health Model	The interactions among the agent, host, and environment. In substance abuse prevention, the agent is alcohol or drugs; or the sources, supplies, and availability of alcohol and drugs. Hosts can be seen as the potential and/or active substance users. The environment is the social climate that encourages and supports the potential and/or actual use of substances. The public health model posits that each of these factors must be addressed together for prevention to be effective.

State Incentive Grant Program

Federal grant funds have been designated to assist states in developing models to coordinate, leverage and redirect substance abuse prevention funds and other resources and to support local science-based substance abuse prevention efforts.

The program calls upon governors to develop and implement a comprehensive substance abuse prevention strategy to optimize the use of all state and federal substance abuse resources.

A Wisconsin State Incentive Grant Advisory Committee was appointed by the Governor whose membership included legislators, state agency representatives, representatives of community-based organizations and faculty/staff representing institutions of higher education. It was charged with the responsibility to develop a comprehensive statewide prevention plan to include recommendations for the improvement of Wisconsin’s network of prevention services, funding and service delivery mechanisms.

The task of this work is driven by the grant goal, objective and outcomes as re-stated below:

Goal 1: Reinvent Wisconsin’s alcohol, tobacco and other drug abuse prevention system to improve prevention programming to eliminate duplication, fill service gaps and coordinate funding.

Objective: Develop a comprehensive, long-range Wisconsin Substance Abuse Prevention Plan to improve system capacity and build sustainable working partnerships and resources that result in the prevention and reduction of alcohol, tobacco and other drug abuse among Wisconsin youth and families.

Anticipated outcomes:

- ♦ Identify the extent and statewide burden of substance abuse problems among Wisconsin citizens, including 12-17-year-old youth and their families.
- ♦ Utilizing variables from statewide substance abuse indicator data and at least one or more variables from the National Household Survey on Drug Abuse, establish outcomes that focus on age of first use of alcohol and/or tobacco, illicit drug use and reducing tobacco use and binge drinking among the 12-17-year-old population.
- ♦ Develop a plan and infrastructure for coordinating the data and information systems necessary for tracking and documenting the State's progress in meeting the targets identified.
- ♦ Develop and implement a sound strategy to identify, coordinate, leverage, and/or redirect, as appropriate and legally permissible, all substance abuse prevention resources (funding streams and programs) within the State that are directed at communities, families, youth (including youth 12 – 17 years of age, schools and workplaces).
- ♦ Develop plan to fill gaps in needed prevention efforts in order to successfully meet targeted substance abuse prevention outcomes.
- ♦ Assess the current prevention system and develop strategies that strengthen, improve and sustain evidence-based approaches to statewide prevention practices.

Rationale:

Prevention programs today must produce tangible results. To achieve this, programs must be developed using substantiated knowledge about what works and what doesn't work. State and federal agencies, local governments, and private foundations are interested in funding programs with the best chance of realizing measurable outcomes. This emphasis on performance means that prevention practitioners must show that the programs they propose will achieve the results predicted. The prevention field now has an empirical knowledge base to assist practitioners in selecting proven approaches for their programs. Using scientifically defensible principles will help practitioners respond to demands for accountability and will simultaneously ensure that program participants receive the most effective services available (Gardner, 2001).

The Wisconsin State Incentive Grant Program develops evidence-based approaches and evaluates the efficacy of prevention programs in reducing or eliminating substance use among 12-17-year-old youth. The program was awarded a three-year grant through the Center for Substance Abuse Prevention at \$3 million per year beginning in Federal Fiscal Year 2002. The program enables Governors to coordinate and leverage all prevention resources in their respective states, resources that can address problem behaviors that may lead to both substance abuse and mental disorders. Local county, tribal, and nonprofit entities began implementing evidence-based programs in State Fiscal Year 2003. Funding to support these local efforts will continue through December 2005. A Governor's State Incentive Grant Advisory Committee was developed in January 2002. This Advisory Committee was formed under the State Council on

Alcohol and Other Drug Abuse and is responsible for developing a long-range comprehensive substance abuse prevention plan that will include recommendations for disseminating and replicating best practices for implementing evidence-based prevention programs/strategies and lessons learned from the 17 local State Incentive Grant programs currently operating under the three-year State Incentive Grant Program.

The most important target population for primary prevention interventions is children and youth (for whom age of first use and misuse of alcohol are important variables). Many public health partners rely on outdated research to base their prevention practices for youth that are affected by substance use and addiction. The use of evidence-based practices will ensure that prevention interventions are valid and reliable. The general population has the expectation that health care interventions be evidence-based; comparable expectations should exist for substance abuse preventative interventions.

Research has disclosed that most illnesses tend to result from the complex interrelationship among biological, psychological, and social factors. For this reason, the Institute of Medicine adopted a classification for disease prevention activities based on the relationship between the risk of an individual getting the disease compared to the costs of the intervention to prevent the disease. When describing prevention programs, prevention professionals often describe preventative interventions in terms of primary, secondary, and tertiary prevention. Primary prevention attempts to decrease the number of new cases of a disorder. Secondary prevention is directed at prevalence and seeks to lower the rate of established cases of a disorder. Tertiary prevention seeks to decrease the amount of disability associated with a disorder (Substance Abuse and Mental Health Service Administration, 2000). The following classification of prevention interventions is adapted widely for both the mental health and substance abuse fields.

In addition, the Institute of Medicine also offers preventative service classification system based on the use of Universal, Selective or Indicated Interventions.

Universal Interventions are offered to an entire population. Examples include prenatal care, smoking prevention, and childhood immunization, or screening of all primary care patients for depression nationwide (Davis, 2002).

Selective Interventions are targeted to groups at greater than average risk of illness than the rest of the population, such as pregnant mothers with an increased incidence of drinking alcohol during pregnancy. The moderate costs are justified by the increased risk of illness. Examples include home visitation to pregnant adolescents, and infant day care for low-birthweight children.

Indicated Interventions are provided to high-risk individuals, their families, and to people experiencing early symptoms of a disorder. Generally, these interventions are more expensive than either universal or selective interventions and are designed either to prevent future development of a health problem or to reduce the duration or severity of an existing health problem. Examples include providing social skills or parent-child interaction training for children who exhibit signs of mental disorders and their families (Substance Abuse and Mental Health Service Administration, 2000), or children who have already started experimenting with drugs but not at a clinically diagnosable level.

Prevention programs are designed specifically to promote the reduction of risk factors and processes and to enhance protective factors and processes (Hawkins and Catalano, 1992). Both risk and protective factors operate in multiple life domains. These include individual, family, school, peer, and community, as well as workplace and society. Further, risk and protective factors vary with the age and developmental stage of the individual.

Prevention programs need to focus on risk and protective factors that are both identifiable and modifiable, recognize schools as central loci for intervention, and provide long-term support (Substance Abuse and Mental Health Service Administration, 2002c; Center for Substance Abuse Prevention, 2000; Davis, 2002; Greenberg, 1999; Olds, 1999; Center for Mental Health Services School Violence Prevention Program, 1999; U.S. National Institute on Drug Abuse, 1997a; General Accounting Office, 1995; Mrazek and Haggerty, 1994). Children and adolescents at risk for co-occurring substance abuse disorders and mental disorders have multiple and complex needs, and they interact with a variety of school, community, and social services agencies. Effective prevention programs must address the multiple domains in the life of a child and the family and promote a consistent message among key agents (e.g., parents, peers, teachers) (Center for Substance Abuse Prevention, 2001; National Institute on Drug Abuse, 1997a). Ideally, prevention programs should be coordinated with systems of treatment to facilitate the best possible outcomes for children and adolescents, and their families (Greenberg, 1999). Prevention programs should be sustained over multiple years (e.g., from kindergarten through 12th grade) (General Accounting Office, 1995), with repeat interventions to reinforce the original prevention goals (National Institute on Drug Abuse, 1997a). After school programs included in Substance Abuse and Mental Health Service Administrations National Registry for Effective Prevention Programs also demonstrate effective prevention strategies.

Researchers have learned that family-focused prevention efforts have a greater impact than strategies that focus on children only or parents only (National Institute on Drug Abuse, 1997a). Further, findings of the Yale Family Study of Co-morbidity of Substance Use Disorders and Psychopathology demonstrate that a family history of substance abuse is one of the most potent risk factors for the development of substance abuse among exposed offspring (Merikangas and Avenevoli, 2000). Both individual and environmental factors contribute to this risk. The study revealed that the other major risk factor for the development of substance abuse disorders is pre-existing psychopathology.

Prevention programs must be developmentally and culturally appropriate and gender specific because youth risk and protection influences differ among population groups (Center for Substance Abuse Prevention, 2001; National Institute on Drug Abuse, 1997c; Substance Abuse and Mental Health Service Administration, 2002c).

Individuals selected to deliver evidence-based prevention programs must be trained in the specific approach used (Center for Substance Abuse Prevention, 2001). Researchers found that effective interventions use individuals known to the students (e.g., peers, parents, teachers, guidance counselors, coaches) to deliver prevention messages (Center for Substance Abuse Prevention, 2001).

“The School Health Education Study conducted during the 1960s identified 10 conceptual areas that have traditionally served as the basis of health education curricula. Subsequently, six categories of behaviors have been identified as responsible for more than 70 percent of illness, disability, and death among adolescents and young adults. These categories, which should be the primary focus of school health education, are injuries (unintentional and intentional), tobacco use, alcohol and illicit drug use, sexual behaviors that cause unintended pregnancies and sexually transmitted diseases, dietary patterns that cause disease, and inadequate physical activity. While unintentional and intentional injuries are grouped together, the prevention program and policy implications for each are distinct given the differences in the risk behaviors and related health outcomes. In addition to the 6 behavior categories, environmental health (recognized influence on personal and community health), mental and emotional health, personal health, and consumer health are among the 10 conceptual areas being added to track the influence of these factors between 2000 and 2010. Text about the contributions school health education can make in achieving objectives can be found in the appropriate Healthy People 2010 focus areas.” (*Healthy People 2010*, page 7-16)

The organizations, agencies and citizens of Wisconsin have worked hard and continue to work hard at preventing substance abuse in this state. Significant resources in human energy, time and money have gone into developing, implementing and refining the current system.

In order for Wisconsin to be successful in reducing substance abuse among youth we must review our current system of services as administrators of state substance abuse prevention funding and resources and develop a plan that takes our system of organizations, agencies and coalitions to the next level, to be stronger, more coordinated and effective.

The impetus for the development of this plan has been the State Incentive Grant awarded to Wisconsin in October 2001 by the Center for Substance Abuse Prevention (CSAP) of the U.S. Department of Health and Human Services.

The award for this \$9 million, three-year cooperative agreement was made to the Office of the Governor. Its broad stated goal is to reduce the use of alcohol, tobacco and other drugs among Wisconsin’s 12 to 17 year old youth. Operational responsibility for the direction and implementation of the project was delegated to the Wisconsin Department of Health and Family Services through its Division of Children and Family Services.

A Wisconsin State Incentive Grant Advisory Committee was subsequently appointed by the Governor. It’s membership included legislators, state agency representatives, representatives of community-based organizations and faculty/staff representing institutions of higher education. Among the Committee’s objectives were:

- To assess Wisconsin’s Alcohol, Tobacco and Other Drug (ATOD) prevention funding streams and resources;
- To develop a comprehensive long-range prevention plan to coordinate and leverage ATOD resources;

- To ensure that a revitalized ATOD prevention system can be sustained for the foreseeable future (i.e. ten years).

The SIG Grant Program (federal level)

The federal funds have been designated to assist states in developing models to coordinate, leverage and redirect substance abuse prevention funds and other resources to support local science-based substance abuse prevention efforts.

The program calls upon governors to develop and implement a comprehensive substance abuse prevention strategy to optimize the use of all state and federal substance abuse resources.

The SIG Grant Program (state level)

The state SIG process has two major segments:

- **Local implementation:** The Division of Children and Family Services issued a Request for Proposal in July 2002. Its intent was to award grants of \$60,000 to \$440,000 (depending on population) to 17 successful applicants from throughout the state.

The funds would be awarded “to fill identified gaps in prevention services targeting an improvement in substance abuse outcomes for youth ages 12 –17 by building upon proven strategies that have worked elsewhere in reaching young people and their families.”

The outcomes would be measured in relation to baseline data previously developed by CSAP. Those grants were subsequently awarded for a planning phase and, upon successful completion, to be followed by an implementation phase.

- On December 17, 2002, the Governor created the SIG Advisory Committee. It was charged with the responsibility to develop a comprehensive statewide prevention plan to include recommendations for the improvement of Wisconsin’s network of prevention services, funding and service delivery mechanisms.

The initial work on goals started with the Goal Attainment Strategies developed by the former State Agency Prevention Coordinating Committee and the State Incentive Grant Advisory Committee Objectives and Recommendations (September 2002).

The Committee developed its framework goals for the plan after extensive discussion, broad consultation and many revisions over numerous meetings. The major goal categories are:

- Evidence-Based Strategies and Best Practices
- Measuring Effectiveness
- Infrastructure Development
- Collaboration and Coordination
- Communication
- Stewardship

Various partners worked to move the system to the next crucial step and through the work of the State Incentive Grant Advisory Committee, a set of Guiding Principles were developed.

Guiding Principles

In order to achieve the outcomes established by the State Incentive Grant, partners will adjust their funding priorities, policies and approaches to prevention services using the following guiding principles:

- 1) State agencies and local affiliates will work together to ensure collaboration in such areas as development, implementation and evaluation of prevention strategies and training plans.
- 2) Prevention resources will include evidence-based research and must reach the intended populations.
- 3) Collection, availability and use of data/research will reach state, regional and local levels.
- 4) Cultural, geographical and environmental issues will be appropriately prioritized throughout the Wisconsin prevention system.
- 5) Consistent standards will be used to set and to measure outcomes.
- 6) A prevention system infrastructure will be designed so that effective prevention strategies will be sustainable.
- 7) The prevention system will actively incorporate the voices of all stakeholders in a systematic, meaningful way in the planning, decision-making and implementation of prevention strategies. This includes youth and marginalized populations.
- 8) Risk and protective factors will be balanced in determining the use of prevention resources. Strategies will be identified that cross the domains of community, individual, family peer and school.

Since the inception of this initiative, the Department has worked with a cross section of staff and community citizens, policy makers, other intra-Department program administrators, and a coalition of seventeen local State Incentive Grant counties/Tribes. In January of 2004, the Department began to investigate how to work with and help sustain the efforts of our local State Incentive Grant partners. These local partners participated in workshops to assist them in building local strategic plans. Education and technical assistance were provided to assist local entities in building strong community coalitions, participate and a needs assessment process to determine service gaps and duplication in services, select target audiences, and select evidence based practices to meet their need. Our local State Incentive Grant partners also began to assess their local prevention systems to assure that local efforts could be sustained. Not only did local program providers benefit from this experience, but also state program staff, administrators and policy makers. As a result, the Department also reconsidered its approach to statewide system

change. The Department established two strategic planning groups to assist in reviewing and prioritize system change characteristics and prioritize the elements that could help to sustain effective substance abuse prevention services. The table below lists system capacity areas, the system characteristics within these areas and the elements for improvement, development or maintenance. From this work, system elements were prioritized, and those identified in bold lettering were identified as priority areas.

**WISCONSIN SYSTEM CHARACTERISTICS
FOR
EFFECTIVE SUBSTANCE ABUSE PREVENTION SERVICES**

System Capacity Area	Characteristic	Elements (Bold reflects priority areas)
<p>1. Delivery of Evidence-Based Services and Best Practices</p>	<p>A. Having uniform standards for programmatic activity, professional and organizational best practices, and evidence-based services</p>	<p>Uniform standards must address:</p> <ol style="list-style-type: none"> 1. Establishing measurable goals and objectives 2. Defining substance abuse prevention and “best practices” 3. Developing procedures and methods for the delivery of substance abuse prevention “best practices”. 4. New efforts and their consideration of evidence-based approaches as first option in the delivery of substance abuse prevention services. 5. Requirements for training of substance abuse prevention service providers. 6. Integrating “best practices” in to agency/organization policies and procedures and contract/grant procedures for delivery of substance abuse prevention services 7. Process for program providers to demonstrate the validity of modifying evidence-based programming prior to implementation.
	<p>B. Providing training, tools and resources to community-based organizations to assist in incorporating and implementing “best practices” and services.</p>	<p>Training, tools and resources must provide for:</p> <ol style="list-style-type: none"> 1. Information dissemination, education and training on evidence-based approaches are provided to Wisconsin’s prevention workforce. 2. Assisting promising homegrown local programs to become accepted as credible evidence-based programs. 3. Mandatory prevention training or orientation for new employees. 4. Selection and supporting programs and strategies to accomplish goals and objectives.

System Capacity Area	Characteristic	Elements (Bold reflects priority areas)
	C. State agencies bring proactive partners in the national dialog related to best practices and services.	<ol style="list-style-type: none"> 1. Having a shared understanding of substance abuse prevention and the value of evidence-based prevention among partner organizations. 2. Involvement in provider coalition who have support from their home organizations. 3. Believe their coalitions' work can make a difference. 4. Personally invested in creating community change.
	D. Reaching consensus between state agencies and local programs on core components of an effective prevention programs and core outcome measures.	<ol style="list-style-type: none"> 1. Deliver both individual and environmental strategies. 2. Arrived at a framework by consensus that guides agencies' prevention activities. 3. Knowledge of the framework is actively disseminated through the community. 4. Consciously attempting to offer programming in one approach that blends with programming in the other approach. 5. Monitor program effectiveness and youth substance abuse.
2. Measuring Effectiveness	A. Measure against decreasing risk factors and increasing protective factors.	<ol style="list-style-type: none"> 1. Agencies must use a risk and protective factor framework that is consistent across agencies. 2. Funded service providers required use of framework.
	B. Use of uniform measuring devices against uniform outcome to measure effectiveness.	<ol style="list-style-type: none"> 1. Established measurable goals and objectives to improve performance. 2. Monitor program effectiveness and youth substance abuse
	C. Use of a uniform needs assessment and analyzed against a consistent set of indicators.	<ol style="list-style-type: none"> 1. Establish common and measurable goals and objectives among agencies. 2. Using evaluation results to improve the performance of prevention.
	D. Providing assistance to local programs in gathering required data.	<ol style="list-style-type: none"> 1. Establish a process for providing technical assistance to prevention providers in planning and implementing outcome measures. 2. Establish protocols for using data to select and support programs and strategies to accomplish goals and objectives.
3. Infrastructure Development	A. Clearly define state and local support mechanisms and resources necessary to support the system needs.	<ol style="list-style-type: none"> 1. Use of state and national prevention technical assistance resources.

System Capacity Area	Characteristic	Elements (Bold reflects priority areas)
		<ol style="list-style-type: none"> 2. Implement a process to make technical assistance needs known to state-level providers. 3. Designate prevention units within State agencies.
	B. An established logical and systematic approach to planning, implementing and evaluating prevention activities.	<ol style="list-style-type: none"> 1. Have a designated logic model for planning, selecting, implementing, and evaluating services that is common across agencies. 2. Actively spread knowledge of the logic model throughout the prevention community
	C. Coordinate prevention activities internally and externally with partner organizations.	<ol style="list-style-type: none"> 1. Maintain clear channels of communication with the providers of prevention technology information.
	D. Implementation of professional and organizational standards to improve competency.	<ol style="list-style-type: none"> 1. Support local capacity to select, implement, and evaluate effective prevention initiatives. 2. Have a process for conflict resolution and decision-making. 3. Knowledgeable about the community system characteristics that affect youth substance abuse prevention
4. Collaboration and Coordination	A. State agencies and local programs develop goals and expectations within the State Plan and propose changes to the State Plan as appropriate.	<ol style="list-style-type: none"> 1. Planning is a collaborative process 2. Establish a state youth substance abuse prevention plan building upon current plans, programs and strategies.
	B. Combine appropriate programs and resources to obtain an outcome that could not be attained alone.	<ol style="list-style-type: none"> 1. Leadership is a shared responsibility 2. Technical assistance is delivered through a team approach.
	C. Sharing local successes and failures and learn from each other leading to collaborative activity.	<ol style="list-style-type: none"> 1. Active participation by all agencies and organizations that have a mandate to delivery substance abuse prevention. 2. Technical assistance providers should use a collaborative planning approach in providing assistance, support and training.
	D. Internally review and coordinate all alcohol, tobacco and other drug abuse activities, policies, funding streams and administrative rules.	<ol style="list-style-type: none"> 1. Funding should be leveraged from multiple sources and used to fill service gaps and avoid duplication through a collective prevention services community plan/approach. 2. Collective reviews of proposals by members of the prevention system. 3. Meetings are on a scheduled, routine basis with records that are maintained and disseminated.

System Capacity Area	Characteristic	Elements (Bold reflects priority areas)
	E. Reaching consensus between state agencies and local programs on core components of an effective prevention programs and core outcome measures.	<ol style="list-style-type: none"> 1. Delivering both individual and environmental strategies. 2. Actively disseminated through the community. 3. Consciously attempts to offer programming in one approach that blends with programming in other approaches.
5. Communication	A. Sharing information and ideas among the prevention partners and with the general public.	1. Open channels of communication with prevention customers.
	B. Informing and involving the public on emerging issues, initiatives, and ongoing activities.	1. Having resources and attention devoted to raising awareness of prevention services and activities.
	C. Informing and involving state agencies on prevention policies, programs initiatives and emerging issues.	1. Informing key decision-makers of the existence of the prevention system.
	D. Collecting and disseminating prevention related information, including, but not limited to, statewide performance indicators.	1. Agencies and organizations agreeing on a database for determining outcomes based on a shared approach or plan and reflects lessons learned from research.
	E. Communicating the State Plan to partner organizations and the public.	1. State Plan disseminated to decision-makers.
6. Stewardship	A. Using public resources to deliver services and strategies that are likely to achieve their desired outcomes.	<ol style="list-style-type: none"> 1. Having a collective prevention services community plan/approach that is supported by efforts to leverage funding from multiple sources. 2. Strengthen and build upon current support systems.
	B. Accountability mechanisms directed at both state agency and local program levels.	1. Guidelines for funding being reviewed by other agencies and organizations prior to release.
	C. Resource decisions being consistent with State Plan.	<ol style="list-style-type: none"> 1. The use of state or national prevention technical assistance resources. 2. Funded program provider recipients required to use the State Plan framework.
	D. All citizens having access to local programs.	<ol style="list-style-type: none"> 1. Believe that state collaborative efforts have adequate representation. 2. Open channels of communication with prevention customers.

System Capacity Area	Characteristic	Elements (Bold reflects priority areas)
		3. Colleges and universities that offer courses on substance abuse prevention.
	E. Maintaining a comprehensive and strategic interagency plan that enhances state/local partnerships in the provision of services	1. Having a process to identify which prevention initiatives are work sustaining. 2. Develop sustainability plans for key efforts, and include other agencies and organizations in sustainability planning 3. Use of common sustainability techniques. 4. Dedicating meeting time to discussing sustainability.
	F. Applying uniform criteria for setting budget and funding priorities for prevention programming.	1. Prevention funding receiving priority in agency/organization budgets.
	G. Appropriate levels of support provided to state agencies resulting in the effective oversight and management of statewide prevention efforts.	1. Guidelines for funding being reviewed by other agencies and organizations prior to release.
	H. Having the capacity to implement evidence-based strategies to develop untried strategies that have promise to produce measurable results, and to meet the cultural and geographic needs of the target populations.	1. Having criteria for defining evidence-based prevention that is consistent across agencies and the same as the state uses 2. Model cultural diversity and inclusion and require program models to be culturally appropriate. 3. Develop a definition and written policy regarding cultural competency that is shared across agencies.
	I. Leverage state and local resources to find new funding sources.	1. Having a collective prevention services community plan/approach that is supported by efforts to leverage funding from multiple sources.

Outcomes:

Short-term Outcome Objectives

- By _____, evidence-based prevention practices will have been defined that focus on the 12 –17 year old population.
- By _____, collaboration will have taken place with partners to assure infrastructure support.
- By _____, current use of evidence-based practices will have been established, existing partners will have been determined, and the partnership base itself will have been broadened.
- By _____, a comprehensive prevention plan, created by the State Incentive Grant Advisory Committee, will be delivered to the Governor.
- By _____, State Incentive Grant sites will use evidence-based prevention practices.
- By _____, simple outcome measures will have been determined within the context of cultural, gender, age, and disability sensitivity.
- By _____, an inventory of evidence-based prevention program models will be made available on the DHFS website.
- By _____, counties will be provided information on best practices for implementing and sustaining evidence-based prevention programs.

Process Objective:

- By _____, an oversight committee to assure the process and assign accountability in accomplishing this objective (e.g., State Council on Alcohol and Other Drug Abuse, State Incentive Grant Advisory Committee) will have been convened.

Medium-term Outcome Objectives

- By _____, an ongoing update of the knowledge base of such practices will be undertaken.
- By _____, additional prevention practitioner partners will use evidence-based prevention practices; and at year’s end, partners identified as using these strategies will be recognized.

Long-term Outcome Objectives:

- By _____, an ongoing update of the knowledge base of such practices will be undertaken.
- By _____, additional prevention practitioner partners will use evidence-based prevention practices; at year’s end, partners identified as using these strategies will be recognized.
- By _____, based upon evaluations of existing evidence-based prevention programs or statewide data, to document a significant decline in illicit drug use, age of first use, and binge drinking among Wisconsin’s children and youth.

Definitions	
Term	Definition
Evidence-Based Practice	Evidenced-based practice means adopting or integrating substance abuse prevention approaches that are based upon credible research and consensus among experts. The following indicator will be used for purposes of measurement: The practice has to have been subject to quantitative

Definitions	
Term	Definition
	<p>analysis (research) and the results have been published in several peer-reviewed journals indicating that it has shown consistent positive results across settings and populations and the practice has received the endorsement of the federal Center for Substance Abuse Prevention.</p> <p>For further details regarding evidence-based prevention practices go to the internet at: http://modelprograms.samhsa.gov and http://www.northeastcapt.org/resources/csap/papers/gardner-cover2.html</p> <p>(Federal Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration)</p>
Protective factors	<p>Protective factors build resiliency in the same individual, group, or community and increase the likelihood that substance abuse and its related effects can be resisted (Center for Substance Abuse Prevention, 2001) or by providing youth with information about identifying the warning signs of violent behavior and how to get help if they recognize these signs in themselves or their peers (Center for Mental Health Services, 1999a).</p>
Risk factors	<p>Risk factors increase the vulnerability of an individual, a group, or a community's vulnerability to substance abuse disorders or untreated conduct disorders can develop into costly adult mental health and societal problems such as delinquency, substance abuse and antisocial personality disorder.</p>

Definitions	
Term	Definition
Public Health Model	The interactions among the agent, host, and environment. In substance abuse prevention, the agent is alcohol or drugs; or the sources, supplies, and availability of alcohol and drugs. Hosts can be seen as the potential and/or active substance users. The environment is the social climate that encourages and supports the potential and/or actual use of substances. The public health model posits that each of these factors must be addressed together for prevention to be effective.
Alcohol and Other Drug Abuse Provider	Any government, public, private, non-profit or voluntary service entity who uses Federal or State aid or grants to provide services aimed at preventing or reducing the use and/or abuse of alcohol, tobacco or other drugs of abuse.