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| **DEPARTMENT OF HEALTH SERVICES**Division of Care and Treatment ServicesF-00659 (08/2025)  | **STATE OF WISCONSIN** |
| **Substance Abuse Block Grant Prevention Program / Practice Approval** |

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| Completion of this form is voluntary, but is required for any prevention programs funded by the Substance Abuse Prevention and Treatment Block Grant that do not appear in one of the approved implementation lists found in DCTS memo 2012-08. Submit completed form to the Division of Care and Treatment Services, Allison Weber, 201 E. Washington Ave., Madison, WI 53703, fax: 608-266-1533, email: allison.weber@wisconsin.gov  |
| 1. Name of Primary Prevention Program / Practice      |
| 2. Brief Program / Practice Description      |
| 3. Community Prevention Need Addressed by the Program / Practice      |
| 4. Goal Addressed by the Program / Practice      |
| 5. Program / Practice Objectives or Outcomes      |
| 6. Primary Targeted Population of the Program / Practice (select one) |
| [ ]  Abuse victims[ ]  Already using substances[ ]  Children of substance abusers[ ]  Drop-outs[ ]  General Population | [ ]  Homeless and/or runaway youth[ ]  Mental health problems[ ]  Physically disabled[ ]  Pregnant women/teens[ ]  Violent or delinquent behavior |
| 7. Institute of Medicine (IOM) Strategy Type (select one) |
| [ ]  Universal Indirect[ ]  Universal Direct | [ ]  Selective[ ]  Indicated |
| 8. Risk and Protective Factors Addressed |
|  | **Domain** | **Risk Factor(s)** | **Protective Factor(s)** |  |
|  | Community |       |       |  |
|  | Family |       |       |  |
|  | Peer |       |       |  |
|  | School |       |       |  |
|  | Individual |       |       |  |
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| 9. Personnel Required for the Program / Practice      |
| 10. Key Elements of the Program / Practice      |
| 11. Evaluation      |
| 12. Contact Person for Agency Providing the Program |
|  | Name |       |  |
|  | Telephone |       |  |
|  | Email |       |  |

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| **Substance Abuse Block Grant Prevention Program / Practice Approval - INSTRUCTIONS** |

1. **Name of Primary Prevention Program/Practice**

Provide the name of the program or practice for which you are requesting approval to spend Substance Abuse Prevention and Treatment Block Grant (SAPTBG) Prevention funding. If the program/practice is used in other parts of the state, a common name should be used.

1. **Brief Program/Practice Description**

The brief description should cover the critical elements of the practice: it is a summary of items 4-12 including the goal, intended outcome, and target population. The description should include the rationale for choosing this program or practice as opposed to one that is found on the evidence-based list of strategies currently approved for implementation with SAPTBG funding.

1. **Community Prevention Need Addressed by the Program/Practice**

Primary prevention programs and practices should address an identified community need. Describe the need that was identified in the community that justifies the use of this program or practice. For example, a county may choose to place permanent prescription drug drop-off boxes because they have identified an increase in access to prescription drugs as a contributing factor to an observed rise in prescription drug misuse and abuse.

1. **Goal Addressed by the Program/Practice**

Goals provide general purpose and direction. They are the end result of ultimate accomplishment toward which an effort is directed. They generally should reflect perceived present and future need. They must be capable of being effectively pursued. The goal is the one, broadly stated purpose of the program. A goal may be stated as reducing a specific behavioral health problem or as improving health and thriving in some particular way. Specific areas of improvement – the intended outcomes – should be described in item five. The goal should be stated more broadly than the intended outcomes. For example:

* Reduce underage drinking
* Increase overall community health
* Reduce alcohol use among pregnant women
1. **Program/Practice Objectives or Outcomes:**

An objective is a concrete statement describing what the project is trying to achieve. The objective should be written so that it can be easily evaluated at the conclusion of a project to see whether it was achieved or not. A well worded objective will be specific, measurable, attainable/achievable, realistic, and time bound (S.M.A.R.T.).

1. **Primary Targeted Population of the Program/Practice (select one)**

Select the single primary population that the program/practice is targeting. Many programs may serve several of the listed groups. If program participants are not chosen or targeted for a particular reason or identified need, then general population should be selected. For example, a substance abuse prevention program run at a community center may include drop-out and runaway youth participants. However, since these participants are being served due to the program setting (community center) rather than as an identified at-need group, they would be considered participating as part of the general population of the center.

1. **Institute of Medicine (IOM) Strategy Type (select one)**

The Institute of Medicine (IOM) provides the following definitions for the four IOM strategy Types.

 **Indicated:** Indicated prevention interventions support individual-based programs and strategies. Strategies are designed to prevent the onset of substance abuse in individuals who do not meet DSM-IV criteria for addiction, but who are showing early danger signs, such as falling grades and consumption of alcohol and other gateway drugs. The mission of indicated prevention is to identify individuals who are exhibiting early signs of substance abuse and other problem behaviors associated with substance abuse and to target them with special programs. The individuals are exhibiting substance abuse-like behavior, but at a sub-clinical level (IOM 1994). Indicated prevention interventions are used for individuals who may or may not be abusing substances, but exhibit risk factors that increase their chances of developing a drug abuse problem. They address risk factors associated with the individual, such as conduct disorders, and alienation from parents, school, and positive peer groups. Less emphasis is placed on assessing or addressing environmental influences, such as community values. The aim of indicated prevention interventions is not only the reduction in first-time substance abuse, but also reduction in the length of time the signs continue, delay of onset of substance abuse, and/or reduction in the severity of substance abuse. Individuals can be referred to indicate prevention interventions by parents, teachers, school counselors, school nurses, youth workers, friends, or the courts. Young people may volunteer to participate in indicated prevention programs. [NOTE: In the majority of cases, indicated strategies would be the most appropriate strategies for youth already involved with the juvenile justice system.]

**Selective**: Interventions support individual-based programs and strategies. Selective prevention interventions target subsets of the total population that are deemed to be at risk for substance abuse by virtue of their membership in a particular population segment--for example, children of adult alcoholics, dropouts, or students who are failing academically. Risk groups may be identified on the basis of biological, psychological, social, or environmental risk factors known to be associated with substance abuse (IOM 1994), and targeted subgroups may be defined by age, gender, family history, place of residence such as high drug-use or low-income neighborhoods, and victimization by physical and/or sexual abuse. Selective prevention targets the entire subgroup regardless of the degree of risk of any individual within the group. One individual in the subgroup may not be at personal risk for substance abuse, while another person in the same subgroup may be abusing substances. The selective prevention program is presented to the entire subgroup because the subgroup as a whole is at higher risk for substance abuse than the general population. An individual's personal risk is not specifically assessed or identified and is based solely on a presumption given his or her membership in the at-risk subgroup.

**Universal:** Prevention strategies address the entire population (national, local, community, school, neighborhood), with messages and programs aimed at prevention or delaying the abuse of alcohol, tobacco and other drugs. For example, it would include the general population and subgroups such as pregnant women, children, adolescents, and the elderly. The mission of universal prevention is to deter the onset of substance abuse by providing all individuals the information and skills necessary to prevent the problem. All members of the population share the same general risk for substance abuse, although the risk may vary greatly among individuals. Universal prevention programs are delivered to large groups without any prior screening for substance abuse risk. The entire population is assessed as at-risk for substance abuse and capable of benefiting from prevention programs. There are two sub-categories for this intervention classification.

* **Universal Direct:** Interventions support individual-based programs and strategies. Activities directly serve an identifiable group of participants who have not been identified on the basis of individual risk (e.g., school curriculum, after school program, parenting class). This could also include interventions involving interpersonal and ongoing/repeated contact (e.g., coalitions).
* **Universal Indirect**: Interventions support population-based programs and strategies. Universal Indirect interventions include planned and deliberate goal-oriented practices, procedures, processes, or activities that have identifiable outcomes achieved with a sequence of steps subject to monitoring and modification. Included within this definition are environmental strategies (which establish or change written and unwritten community standards, codes, laws and attitudes, thereby influencing incidence and prevalence of substance abuse in the general population), one-time or single events (such as a health fair, a school assembly, or the distribution of material), and other activities intended to impact a broad population.

(Adapted from the Institute of Medicine Model of Prevention).

1. **Risk and Protective Factors Addressed**

The ultimate goal of a program/practice is reached by addressing some mediating or moderating conditions that increase or decrease the likelihood of a substance abuse problem. “Risk Factors” increase the likelihood of substance abuse problems; “Protective Factors,” “Developmental Assets,” and “Resiliency” decrease the likelihood of substance abuse problems. On a day to day basis the program/practice is operationally focused on one or more of these risk or protective factors.

The concept of risk and protective factors[[1]](#footnote-1) is very strong in behavioral health and public health programs, especially prevention and public health. The idea is that a program/practice can indirectly achieve an ultimate outcome by changing the factors which modify or mediate it – the risk factors which induce or exacerbate problems and the protective factors which prevent or counteract substance abuse problems.

**Risk Factors:** Risk factors include those individual or social factors associated with an increased likelihood of a negative outcome. Risk Factors can be related to biological, behavioral, and social/environmental characteristics. They include characteristics such as family history, depression or residence in neighborhoods where substance abuse is tolerated. Research supports the idea that the more factors that place the child at risk for substance abuse, the more likely it is she or he will experience substance use.

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| **Family Relationships*** Family History of high-risk behavior
* Family management problems
* Family conflict and domestic violence
* Parental attitudes and involvement in the problem behavior
* Social isolation of family
* Ambiguous, lax or inconsistent rules and sanctions regarding drug use
* Poor child supervision and discipline
* Unrealistic expectations for development
 | **School Environment*** Early and persistent antisocial behavior
* Academic failure beginning in elementary school
* Low commitment to school
* Ambiguous, lax or inconsistent rules and sanctions regarding drug use and student conduct
* Availability of dangerous substances on school property
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| **Individual / Peer Relationships*** Rebelliousness
* Friends who engage in the problem behavior
* Favorable attitudes about the problem behavior
* Early initiation of the problem behavior
* Negative relationships with adults
* Risk-taking propensity/impulsivity
* Association with delinquent peers who use or value dangerous substances
* Association with peers who reject mainstreams activities and pursuit
* Susceptibility to negative peer pressure
* Easily influenced by peers
* Lack of self-control, assertiveness and peer refusal skills
* Early antisocial behavior such as lying, stealing and aggression, often combined with hyperactivity
 | **Community Environment*** Availability of drugs
* Community laws, norms favorable toward drug use
* Extreme economic and social deprivation
* Transition and mobility
* Low neighborhood attachment and community disorganization
* Impoverishment
* Unemployment and underemployment
* Discrimination
* Pro-drug use messages in the media
* Community disorganization
* Lack of cultural pride
* Inadequate youth services and opportunities for pro-social involvement
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**Protective Factors:** Protective factors appear to balance and buffer the negative impact of existing risk factors. Protective factors, such as solid family bonds and the capacity to succeed in school, help safeguard youth from substance abuse. In other words, building up a child's protective factors may decrease their likelihood of substance use, even if risk factors are present. Conversely, decreasing a child's risk factors can substantially lower their likelihood of future substance abuse.

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| **Family Relationships*** Bonding (positive attachments)
* Healthy beliefs and clear standards for behavior
* High parental expectations
* A sense of basic trust
* Positive family dynamic
 | **School Environment*** Opportunities for pro-social involvement
* Rewards/recognition for pro-social involvement
* Healthy beliefs and clear standards for behavior
* Caring and support from teachers and staff
* Positive instructional climate
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| **Individual / Peer Relationships*** Opportunities for pro-social involvement
* Rewards/recognition for pro-social involvement
* Healthy beliefs and clear standards for behavior
* Positive sense of self
* Negative attitudes about drugs
* Positive relationship with adult
* Association with peers who are involved in school, recreation, service, religion, or other organized activities
* Resistance to peer pressure, especially negative
* Not easily influenced by peers
 | **Community Environment*** Opportunities for participation as active members of the community
* Decreasing substance accessibility
* Cultural norms that set high expectations for youth
* Social networks and support systems with the community
* Media Literacy (resistance to pro-use messages)
* Decreased accessibility
* Increased pricing though taxation
* Raised purchasing age and enforcement
* Stricter driving-while-under-the-influence laws
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1. **Personnel Required for the Program/Practice**

Identify the personnel required to implement the program, including any specific knowledge, skill, training or certifications required. This may include paid or un-paid personnel.

1. **Key Elements of the Program/Practice**

A concrete and specific description of the elements that constitute a program or practice can be called a “staff/operations/instruction manual,” “guidebook,” “blueprint,” etc. It can be a work plan, action plan, or any other reasonably concrete and specific description of what the program is. This plan may be very lengthy. For the purposes of this application, it is only necessary to list the key elements that are instrumental in the success of the program/practice.

1. **Evaluation**

Describe any evaluation that has been conducted of the program/practice. This should include results that show favorable results related to the risk and protective factors identified. If no evaluation has been conducted on the program/practice, provide a plan for how the program/practice will be evaluated moving forward.

1. **Contact Person for Agency Providing the Program**

Provide the contact information for the individual responsible for and knowledgeable about the program/practice whom DCTS could contact for further information**.**

1. Hawkings JD, Catalano RF et al., as cited in Hogan JA, Gabrielsen KR, Luna N, Grothaus D. (2003). Substance Abuse Prevention. Boston, MA: Allyn & Bacon. p 15-25. [↑](#footnote-ref-1)