February 12, 2020.

European Society for Prevention Research (EUSPR), a position paper on the Icelandic Prevention Model titled: “The Icelandic model; is the hype justified?”.

Reaction.

We thank the EUSPR for highlighting the recent success of the Icelandic Prevention Model (IPM) and are happy to engage in a discussion about model components. We would first like to take this opportunity to react more formally to the Position Paper by EUSPR on the IPM.

There appears to be a considerable misunderstanding about several of IPM’s prerequisites. First, the Icelandic Prevention Model (IPM) is not “a new way to prevent alcohol and drug use among young people” (pp.1). The underlying elements of the IPM were initiated via practice-based need in the mid-1990s and the model has been in development since, please see here. Second, the IPM is not a for-profit commercial entity. Surely, conducting the work behind the model costs money, but the model is a not-for-profit operation with an administrative home at Planet Youth (www.planetyouth.org) which is run by the Icelandic Center for Social Research and Analysis at Reykjavik University.

Further, the IPM is not “an intervention”. Most likely, interventions may be created and run as results of local and global screening of risk and protective factors and outcomes become available via the systematic local assessment and dissemination that are two important hallmarks of the IPM. But the IPM itself is more appropriately defined as a practice-oriented process-structure to collaboration, that is rooted in classic social theories of deviance. A newly published paper on the 5 Guiding Principles of the IPM can be found here and a description of 10 steps to its implementation can be found here.

A list of so called “Key elements” is presented (pp.2). This list mostly includes various types and levels of interventions that may or may not have been enacted in reaction to survey assessment and are not direct parts of the model. In other words, the IPM does not highlight or suggest certain interventions. The model points towards the importance of rigorous local assessment of practice-based data of risk and protective factors that have been known to predict substance use among youth, and a quick and efficient system of dissemination and local translation of findings for local teams to utilize in goal setting and intervention planning. The items on this list that can rightfully be labelled formal parts of the model include “Making a local diagnosis of problems with youth surveys”, and “Coalitions of local stakeholders in the identification of important factors and activities to be implemented”, the latter rightfully stated by the authors “…a key component of several other well published and researched prevention strategies”.

The section on the strengths of the model is largely a correct interpretation, however, the common misunderstanding of mentioning certain interventions (e.g., curfew) as central parts of the model, is incorrect. Again, the IPM is a process-structure to collaboration where researchers, policy makers and administrative leaders, and practitioners join forces and use efficient data diagnosis to set local goals and pick strategies that may work well in their environment. Whether those include a curfew, stricter access to alcohol outlets, improved opportunities for participation in organized leisure activities, local

policy change, or other interventions, is a goal set by the local collaborative on each occasion, none are unmissable elements of the IPM.

We thank the authors for the nice words on the impact of the IPM in popular media outlets in promoting holistic and environmentally-focused prevention work.

We acknowledge and welcome the Review Board of the EMCDDA's Xchange registry's call for further evaluation studies and tests into the impact and effectiveness of the IPM and are happy to report that we are presently engaging in several such studies with our collaborators in various parts of the world, including several European Countries, Latin America, and the USA.

With reference to the challenges of implementing the IPM in other country settings, the authors appear to misunderstand the prerequisites of the Model. Strong alcohol policy is not a baseline requirement of the IPM. The authors are correct that goal setting and strategy selection comes after initial baseline data is collected in the sequence of model steps. This sequence; data collection and processing > dissemination > local goal setting > strategy selection and follow-up, is then revisited with next round of data along with an assessment of change over time based on the previous set of goals and strategies. Again, certain goals, strategies and interventions are not mandated by the model, merely the process and local leadership to select them. Table 2 in this paper includes many goals and strategies that have commonly been used in Iceland and are presently being considered in several other areas or countries that are utilizing the model, but they do not exclude other interventions that may be preferred by locals, or their own approach to enacting interventions that may have worked well in Iceland. The proponents of the IPM fully realize that interventions that may have worked well in Iceland will most likely need tailoring and adapting in other settings.

We concur with the brief social description of Iceland by the authors and agree that the Icelandic Prevention Model cannot simply be adopted in other contexts, as defined and described by the authors. This is because the authors describe the model largely, but not exclusively, as an adoption of certain intervention activities and not as the Process-Structure that it is.

We also agree, which is not debated, that the decline in youth alcohol use in several parts of Europe follows a secular trend. Iceland is one part of that trend. However, when looking closer at the comparative alcohol data for youth in Europe, one can also identify that the decline in Iceland has been steeper than elsewhere, and considerably so.

We agree that a challenge to scientific validity of the IPM is warranted and are presently working towards further studies to that end. The authors of the position paper, however, did not reference a quasi-experimental evaluation study that we published previously which would have been helpful, and decided to simply refer to a trend-analyses paper. However, it is important to note that holistic environmental approaches to primary prevention do not easily lend themselves to rigorous individual-level evaluation, and collaborative approaches such as the IPM even less so. This presents a challenge for primary prevention more generally and is important for the future of prevention work overall.

The criticism of the lack of clarity concerning model components should be alleviated by reviewing the latest "how to" publications that can be found here and discussed above.

It is correct that the commercial entity of the IPM is operated and run by ICSRA via the Planet Youth platform. However, it is not correct that the data that is collected by local communities, cities or countries is owned by ICSRA. The Center collaborators resume ownership of their own information and can share data and run their own analyses at their own will.

On page 7 the authors state: “Furthermore, there seems to be considerable freedom about which components must be implemented to earn the label “Icelandic model”. Anecdotal evidence suggests that current interpretations of the model allow authoritarian decision makers to skip all incentive elements (e.g. leisure time vouchers for all youth) and focus only on curfew hours and parental control, whereas in other, European implementations the curfew hours and promotion of parenting monitoring have silently been dropped because they were considered a cultural no-go” (pp.7).

The above statement is largely correct and represents an area of concern for the proponents of the IPM. In particular, we realize that the IPM is a process-structure to collaboration and hence relies heavily on the composition, commitment and capability of each local team to utilize the model for the well-being of their youth in collaboration with researchers, policy makers and practitioners. For example, if the practice-based research component is conducted as desired; on time, with high local response rates, and quick dissemination, but local goal setting, strategy and intervention selection is not followed through with the necessary resources and implementation, the impact is likely to be minimal. This collaborative nature goes to the heart of the IPM. We realize that long-term change will require long-term commitment. The Planet Youth team has recently engaged in strategic planning with the aim of defining collaborative commitment inputs more clearly, to maximize the odds of impact beyond mere data collection and dissemination. That process is presently in its final stages.

Finally, in relevance to the concluding paragraphs: Unfortunately, Planet Youth or ICSRA cannot be held responsible for all media coverage and attention the model has received in recent years. Hype or political uproar is not aligned with the goals of our work. We have never stated that the model has been “successfully implemented” (pp.8) in countries or settings where we are merely starting the work. Time can only tell if this collaborative approach can be effective outside of Iceland, but the process has begun. Presently the ICSRA team is collaborating with both practitioners and researchers in several countries to evaluate the evidence base behind the model.

Sincerely,

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