Community Matters:
Fundamentals of the Icelandic Prevention Approach

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Of Mt. Esja (Reykjavik capital area)

Selected facts about Iceland

- One of the Nordic countries
- Not as cold as Greenland
- Size: 103,000 km^2
- Population: ~350,000
- Capital: Reykjavik (ca.65% of population in greater area)
- Language: Icelandic
- Currency: Krona
- Most people beleive elves exist and should be taken seriously

Today:
- Philosophy, theory, assumptions, model and processes

Tomorrow:
- Results, evaluation

Conference heading: **Community Matters**

Why does community matter?

Sample profile – social risks

- Youth 1
  - Lives in a deprived area with relatively high crime rates
  - Parents separated, mother works two minimum wage jobs
  - Attends a chronically under-performing and underfunded public school
  - Peers commonly subject to substance abuse at home
  - Has limited opportunities for participation in organized recreational and extracurricular activities at school and in the community
- Youth 2
  - Lives in a middle-class area with low crime rates
  - Parents cohabitating, both full time working professionals
  - Attends an average performing and average funded public school
  - Peers unlikely to be subject to substance abuse at home
  - Has opportunities for participation in a variety of organized recreational and extracurricular activities in the school and community

Neighborhoods/areas and health outcomes

TheUpshot

Detailed New National Maps Show How Neighborhoods Shape Children for Life

Some places lift children out of poverty. Others trap them there. Now cities are trying to do something about the difference.

By Emily Badger and Quoctrung Bui

Oct. 1, 2018

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How does youth substance use begin?

Icelandic Model: Theoretical base

- classic sociology of deviance, criminology

= > views children/youth as social products

Icelandic Model Assumption:

Behavior change is notoriously difficult to accomplish

= > let's not change behavior…

…let's prevent it!

Icelandic Model Assumption:

Substance use prevention:
There are no quick fixes or simple solutions

Prevention utopia?

- Cut all supply?
  - Hardly realistic or achievable
- Cut the demand?
  - More likely

Cut the demand – where to begin

- Appropriately treat/support people that currently battle with addiction (tertiary prevention, immediate)
- Change the direction of current use (secondary prevention, intermediate)
- <u>Prevent or delay recruitment of new users (primary prevention, long-term)</u>
  - Why primary prevention?

1. Early initiation most likely to escalate into serious addiction problems
2. Cost-benefit analyses show the best return on investment is through primary prevention
3. Common sense

But isn’t substance abuse initiation random in the population?

No!

Do we know anything about who is likely to begin using drugs or not?

Yes!!

Icelandic Model: Three pillars

Not a program

Collaboration is key

Everything is data driven

How is that different

- Abundance of quick fix approaches, most are non-evaluated
- Not a focus on “individual choices”. Children and youth are viewed as social products
- It takes a village to raise a child

Social Ecological Model: Multiple layers of impact

Sallis et al. 2006. Ann Rev Public Health

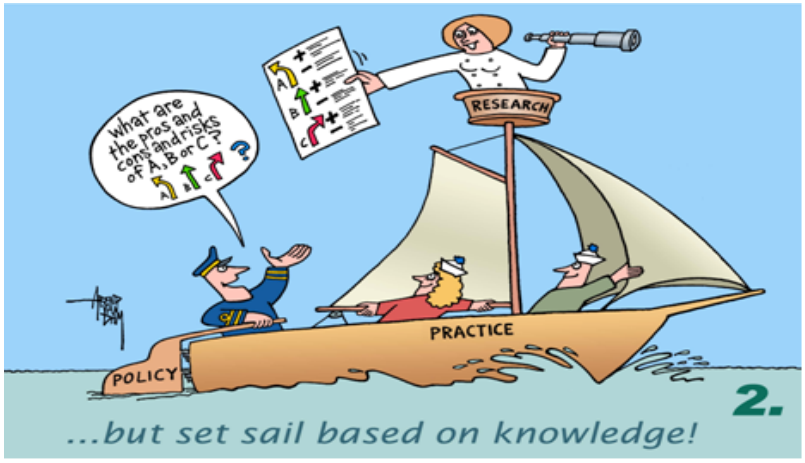
Icelandic Model approach: In a nutshell, to speed-up and integrate..

Aims: What unfortunately often tends to happen:

Research ⟶ Policy ⟶ Practice

Aims: What we would like to see happen:

Research ⇄ Policy ⇄ Practice



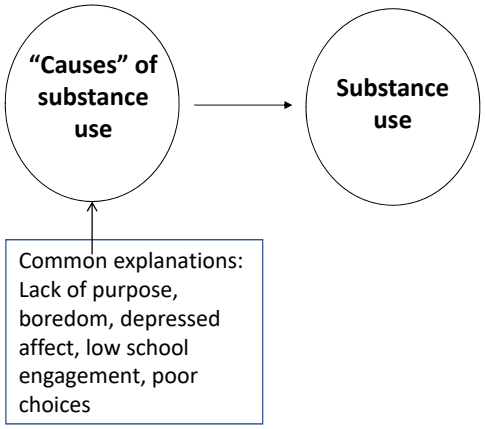
....repeatedly and consistently over time

Important!

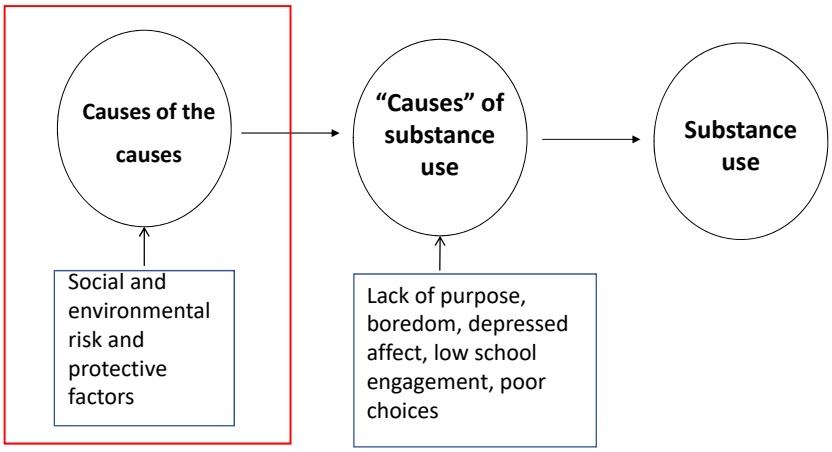
Long term population changes will require long-term, population level, interventions

Short term, individual level interventions are appropriate to achieve short term, individual level, changes

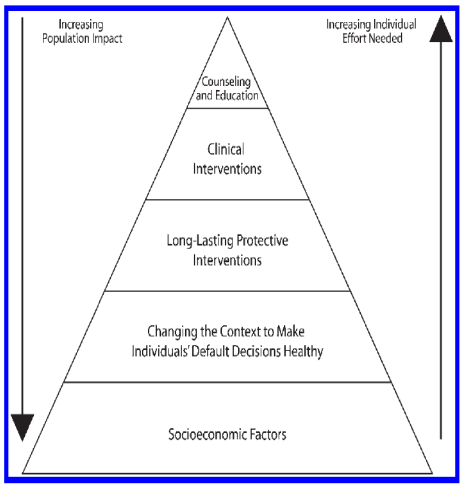
Prevention viewpoint 1. Individual responsibility:
the causes of substance use



Prevention viewpoint 2: Community responsibility.
the "causes of the causes" of substance use



Frieden, T. (2010). A framework for Public Health Action: The Health Impact Pyramid. *Am J Public Health*, 100(4), 590 - 595



- Less individual effort = greater population impact
- More individual effort = less long-term impact

- "Personal life-style is socially conditioned… Individuals are unlikely to eat very differently from the rest of their families and social circle… It makes little sense to expect individuals to behave differently than their peers; it is more appropriate to seek a general change in behavioral norms and in the circumstances which facilitate their adoption"

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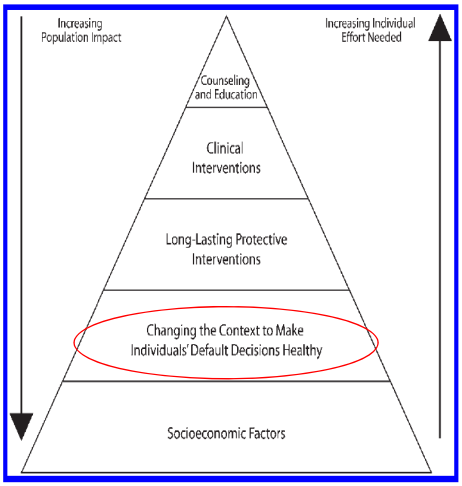

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Public Health Asks of Systems Science: To Advance Our Evidence-Based Practice, Can You Help Us Get More Practice-Based Evidence?

Green, LW, 2006. *Am J Public Health*

Public health asks of systems science, as it did of sociology 40 years ago, that it help us unravel the complexity of causal forces in our varied populations and the ecologically layered community and societal circumstances of public health practice.

We seek a more evidence-based public health practice, but too much of our evidence comes from artificially controlled research that does not fit the realities of practice.

What can we learn from our experience with sociology in the past that might guide us in drawing effectively on systems science? (*Am J Public Health.* 2006;96: 406–409. doi:10.2105/AJPH.2005.066035)

Toolkit approach to health promotion and prevention

Livingood et al. 2011. *Am J Prev Med*

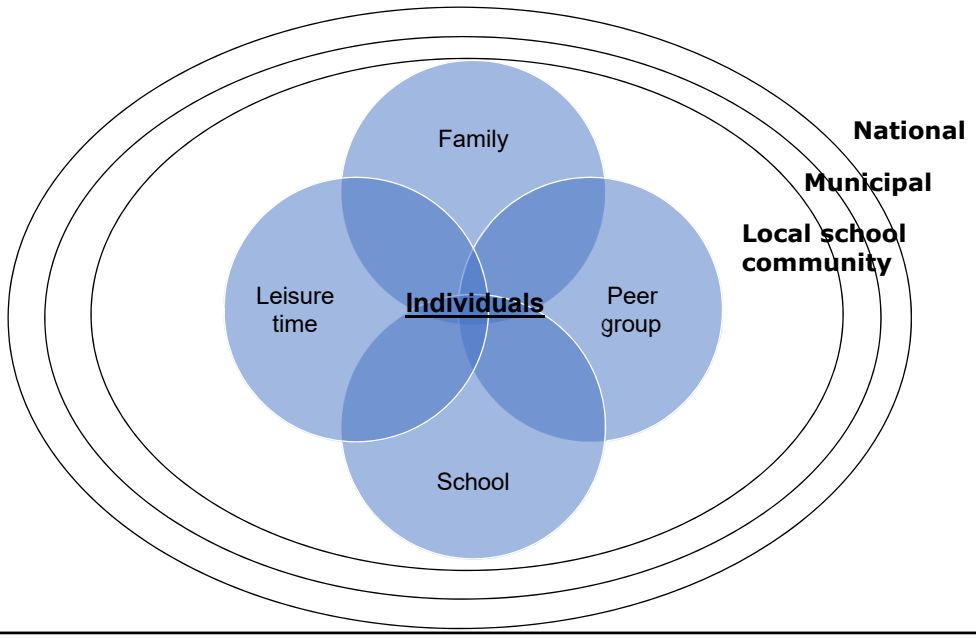
Applied Social and Behavioral Science to Address Complex Health Problems

William C. Livingood, PhD, John P. Allegrante, PhD, Collins O. Airhihenbuwa, PhD, MPH, Noreen M. Clark, PhD, Richard C. Windsor, PhD, MPH, Marc A. Zimmerman, PhD, Lawrence W. Green, DrPH

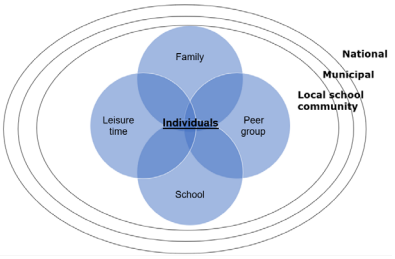
Abstract: Complex and dynamic societal factors continue to challenge the capacity of the social and behavioral sciences in preventive medicine and public health to overcome the most seemingly intractable health problems. This paper proposes a fundamental shift from a research approach that presumes to identify (from highly controlled trials) universally applicable interventions expected to be implemented "with fidelity" by practitioners, to an applied social and behavioral science approach similar to that of engineering. Such a shift would build on and complement the recent recommendations of the NIH Office of Behavioral and Social Science Research and require reformulation of the research–practice dichotomy. It would also require disciplines now engaged in preventive medicine and public health practice to develop a better understanding of systems thinking and the *science of application* that is sensitive to the complexity, interactivity, and unique elements of community and practice settings. Also needed is a modification of health-related education to ensure that those entering the disciplines develop instincts and capacities as applied scientists.

(Am J Prev Med 2011;41(5):525–531) © 2011 American Journal of Preventive Medicine

Icelandic Model: Major domains of intervention focus



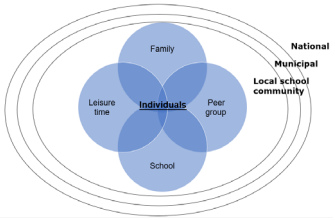
Objective



- Long-term cultural change
- Paradigm shift

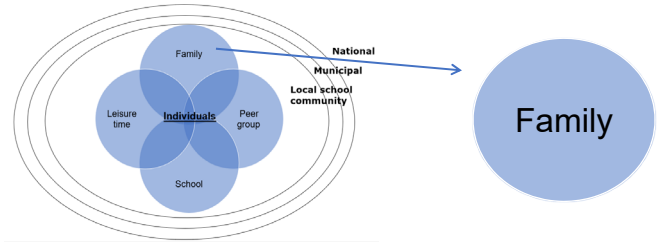
- Takes time
- Relationship building, and maintenance
- Continuation
- COLLABORATION

Focus and aims



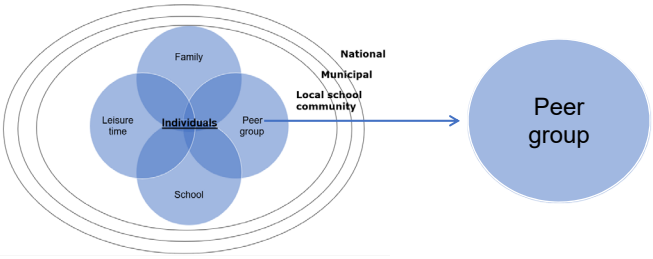
- Primary substance use prevention
- Main focus on the adolescent social environment - substance use is perceived to be socially produced
- Focus on environmental change over time in relevant age-groups (for example, 8th-10th graders), not behavior changes within cohorts
- Work with well-established risk and protective factors within the four domains
- Not time-limited, but an ongoing effort to alter society on behalf of young people
- Quick and consistent dissemination and translation of annually updated results as a diagnostic and monitoring tool for policy makers, administrative leaders and practitioners (incl. parents)
- Aims to create a collaborative dialogue between researchers, policy makers and practitioners, > to empower communities and practitioners to take ownership of the issue at the local level
- Consistent, annual, repetitive cycle

Risk and protective factors: Parents and family examples



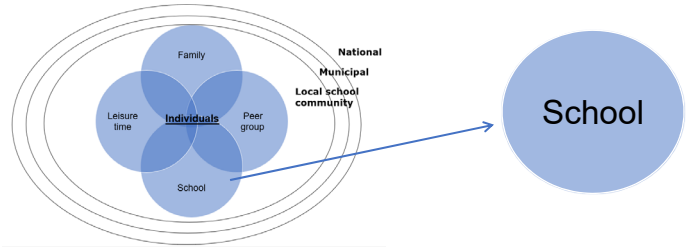
1. Time spent with parents
2. Parental support
3. Parental monitoring (know where are and with whom)
4. Parental co-communication and collaboration

Risk and protective factors: Peer group examples



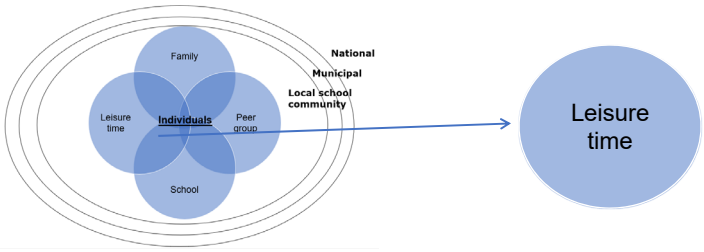
1. Decrease engagement with substance using friends
2. Parents knowing friends and parents of friends (social capital)

Risk and protective factors: School environment



1. School engagement and commitment to studies
2. School well-being (positive school climate)
3. School safety (e.g., bullying and other violence)

Risk and protective factors: Leisure time



1. Late outside hours
2. Participation in organized recreational and extracurricular activities (e.g., sports, youth clubs, scouts, drama club, etc)
3. Prevent unsupervised gatherings such as parties

Underscoring collaboration

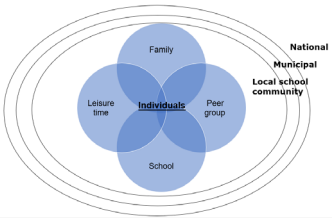
At the municipal level…

1. Researchers do research
2. Policy makers set and enact policy
3. Administrative leaders and practitioners apply policy based on research-to-practice
4. All communicate and collaborate

Research to Practice:
Dissemination of results that are in local ownership

- To maximize influence, annual data reports should have direct relevance to those they serve - people working on different levels

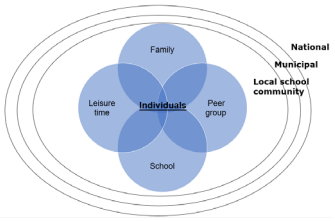
- City level
- District level
- Neighborhood level
- School community level



- Encourage the distribution of findings to all relevant agents and open discussions and dialogue

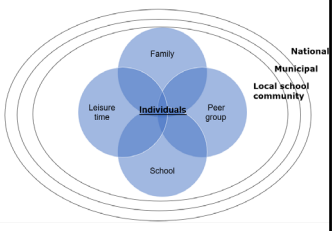
Iceland: Key intervention activities, PROCESS

- Long-term cooperative agreements with municipalities
  - Facilitates continuation, long-term collaboration, and long-term funding (typically 5-year cycles)
  - Ensures access to schools
- Long-term school community commitment
  - Supervising contact agent in schools
  - Efficient and active parental groups in schools
- Lobby and strengthen political relations, both local and National
- Consistent annual research report dissemination and translation of results to all involved – Public Health Education

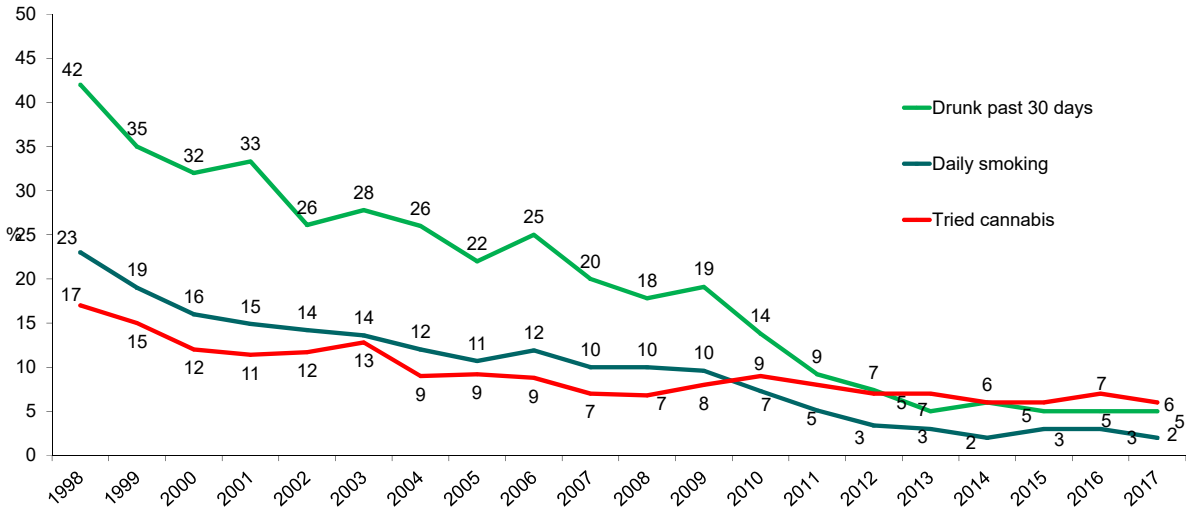


Iceland: Key intervention activities, OUTCOMES (no drugs!)

- Increased parental monitoring and co-communication at the school-community level (e.g., parental groups, parental walks, parental contracts)
- Decrease un-supervised gatherings where drug/alchol use is likely to occur
- No smoking and alcohol use policy before, during, and after school-related events, strictly enforced (e.g., 10th grade "post-exam celebrations")
- Increased funding and participation in organized extracurricular- and recreational activities (sports, music, drama, art, etc) and facilitate availability to all (f.ex. leisure card)
- Decrease late outside hours (specific time standards)
- Improve school climate



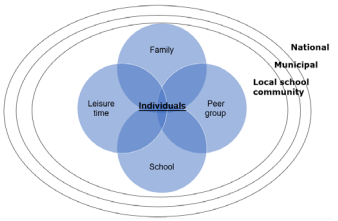
Iceland: Positive development over 20 years (10th grade students)



ICELANDIC CENTRE FOR SOCIAL RESEARCH AND ANALYSIS

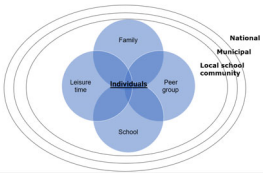
ICSRA

How it works: The role and responsibilities of researchers



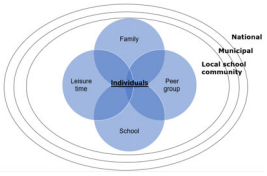
- Define risk and protective factors
- Collect, process and analyze data
- Create national, municipal, and school-community level reports – disseminate quickly and effectively to all
- Present and translate findings to policy-makers (incl. elected officials), administrative leaders at national, municipal and school-community levels, school faculty, prevention professionals, other relevant professionals, and parents. Recommend and discuss intervention activities at all levels
  - Lots of meetings!

How it works: The role and responsibilities of policy makers and administrative leaders



- Procure funding at national (i.e., Ministry-) and local (i.e. municipal) levels for:
  - Research (ICSRA contracts)
  - Local prevention personnel
  - Organized extracurricular and recreational activities for children and youth
  - Other interventions (that may be locally tailored and specific)
  - NGOs with specific focus (Home & School, Together group)
- Facilitate population-wide participation in research, through schools
- Pass laws and set directions for prevention and health promotion work

How it works: The role and responsibilities practitioners



- Prevention specialists at municipal, district and school-community levels, youth workers, faculty and other school personnel, other professionals, …and leading parents:
  - Organize and support parental organizations and establish their involvement at the municipal, and school-community levels
  - Organize municipal level and/or school-community meetings with professionals and parents for the discussion of research findings
  - Assist in setting strategies and goals for the year ahead
  - Enforce/support locally-tailored interventions
  - Facilitate a dialogue with the parent-community
  - Promote participation in organized recreational- and extracurricular activities

The difference between the Icelandi Model approach and many other intervention programs*

Traditional Approach	Icelandic Approach
Short-term	Long-term
Prescriptive, top-down	Collaborative
Focus on isolated, single outcomes (e.g., Smoking)	Focused on holistic change and many outcomes
Career driven, research intense	Community driven, service intense
Limited benefits to community partners	Fosters sustained and long-term benefits to community partners

*Mann, MJ

WV USA Example - positives

- High level of interests at the County and school community levels
- Working relationships created with County Superintendents offices, Principals, and schools
- Data collection successful with high response rates
- Quick and efficient report dissemination
- Variable relationships similar to elsewhere (Youth in Europe, Planet Youth, etc)

WV USA Example - challenges

- Limited primary prevention infrastructure at the County/area level
- Inactive/weak parent organizations at the middle and high school levels
- Rural – problems of outreach, communication, and transportation
- Resistance/confusion concerning the ownership of research findings and distribution of reports to relevant agencies and organizations
- Limited openness to higher level authority or interference regarding family matters – Appalachian culture

Most relevant publications

MODEL DESCRIPTION, PHILOSOPHY AND THEORY

- Sigfusdottir, ID., Thorlindsson, Th., Kristjansson, AL., Roe, KM., Allegrante, JP. (2009). Substance use prevention for adolescents: The Icelandic Model. *Health Promotion International*, 24(1), 16-25.
- Sigfusdottir, ID., Kristjansson, AL., Gudmundsdottir, ML., Allegrante, JP. (2010). A collaborative community approach to adolescent substance misuse in Iceland. *International Psychiatry*, 7(4), 86-88.
- Sigfusdottir, ID., Kristjansson, AL., Gudmundsdottir, ML., Allegrante, JP. (2011). Substance use prevention through school and community-based health promotion: A transdisciplinary approach from Iceland. *Global Health Promotion*, 18(3), 23-26.

DATA COLLECTION PROCEDURES

- Kristjansson AL, Sigfusson J, Sigfusdottir ID, Allegrante, JP (2013). Data collection procedures for school-based surveys among adolescents: The Youth in Europe Study. *Journal of School Health*, 83, 662-667.

STEPS TO IMPLEMENTATION (unpublished, in review)

- Kristjansson, AL., Mann, MJ., Sigfusson, J., Thorisdottir, IE., Allegrante, JP., Sigfusdottir, ID. (in preparation). Theory and Practice-Based Processes in Adolescent Substance Use Prevention: The Icelandic Model for Primary Prevention of Substance Use. Part I—Theory, Guiding Principles, and Effectiveness.
- Kristjansson, AL., Mann, MJ., Sigfusson, J., Thorisdottir, IE., Allegrante, JP., Sigfusdottir, ID. (in preparation). Theory and Practice-Based Processes in Adolescent Substance Use Prevention: The Icelandic Model for Primary Prevention of Substance Use. Part II—Practice-Based Steps in Implementation.

TRENDS AND EVALUATION

- Kristjansson, AL., James, JE., Allegrante ,JP., Sigfusdottir, ID., Helgason, AR. (2010). Adolescent substance use, parental monitoring, and leisure time activities: 12-year outcomes of primary prevention in Iceland. *Preventive Medicine*, 51, 168-171.
- Sigfusdottir, ID, Kristjansson, AL, Thorlindsson, Th, Allegrante, JP. (2008). Trends in prevalence of substance use among Icelandic adolescents, 1995-2006. *Substance Abuse Treatment, Prevention, and Policy*, **3**:12.
- Kristjansson, AL., Sigfusdottir, ID., Thorlindsson, T., Mann, MJ., Sigfusson, J., Allegrante, JP. (2016). Population trends in smoking, alcohol use, and primary prevention variables among adolescents in Iceland, 1997-2014. *Addiction*, 111, 645-652.

RISK AND PROTECTIVE FACTORS

- Kristjansson, AL., Sigfusdottir, ID., James, J., Allegrante, JP., Helgason, AR. (2010). Perceived Parental Reactions and Peer Respect as Predictors of Adolescent Cigarette Smoking and Alcohol Use. *Addictive Behaviors*, 35, 256-259.
- Kristjansson, A.L., Sigfusdottir, I.D., Allegrante, J.P. (2013). Adolescent substance use and peer use: A multilevel analysis of cross-sectional population data. *Substance Abuse Treatment, Prevention, and Policy*, **8**:27.
- Kristjansson, AL., Allegrante, JP., Sigfusdottir, ID. (2018). Perceived parental reactions to substance use among adolescent vapers compared with tobacco smokers and non-users in Iceland. Public Health, 164, 115 – 117.
- Kristjansson AL., Mann, MJ., Smith, ML., Sigfusdottir (2018). Social Profile of Middle School Students Who Use Electronic Cigarettes: Implications for Primary Prevention. *Prevention Science, 19*, 805 – 812.

Thank you

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October 18, 2018

Questions and concerns:

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