

IPREV: A National Interactive Platform for Promoting Mental Health and Preventing Risk Behaviour – A Case Study of a Comprehensive School- and Community-Based Prevention System

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BACKGROUND: Infrastructural support has become a critical factor in the implementation of prevention at the regional and national level. The complexity of risk behaviour prevention requires a diverse and systematic approach. **AIM:** This case study aims to describe an example of a structured national digital infrastructural support system for school- and community-based prevention. **METHODS:** The case study is based on a qualitative analysis of published documents, studies, and grey literature, together with a descriptive analysis of the iPREV Alpha version, tested and operated in 2021–2025. Qualitative grounded theory methods were used and combined with descriptive statistics. **FINDINGS:** The structure of the system has been developed over the past 25 years, and iPREV consolidates this process by transforming a one-way delivery model into an interactive and collaborative framework. It digitises

three core components: a catalogue of prevention programmes, education and training support, and quality assurance in prevention. Subsequent development is focused on networking and linking stakeholders in prevention and users of iPREV, as well as on promotional activities. The final phase of the implementation addressed system interaction, the strengthening of cooperative principles, and the enhancement of sustainability. **CONCLUSION:** The implementation of iPREV illustrates the fragility of the existing prevention system and the weaknesses associated with plurality, the absence of a shared theoretical framework, and widespread misunderstandings of what evidence-based prevention entails and how to support it. The case study highlights the need for continuous dialogue, harmonisation of approaches, and coordinated promotion at the local, regional, and national levels.

Keywords | School prevention – Community-based prevention – Prevention infrastructure – Capacity building – Quality assurance – Risky behaviour – Mental health – Evidence-based prevention

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1 INTRODUCTION: PREVENTION INFRASTRUCTURE AND SUPPORT

Risk behaviours, including substance use and other mental and behavioural health problems, represent a major public health challenge with long-term consequences for individuals, families, communities, and society. Prevention strategies should be tailored to the developmental needs and competencies of the target population (Newton and Lee, 2019). Although evidence-based prevention has advanced considerably over recent decades, the development of sustainable prevention infrastructure has received far less attention. The successful implementation of preventive interventions depends not only on the availability of effective programmes but also on the existence of systems that support training, quality assurance, dissemination, monitoring, and cross-sector collaboration. Building and sustaining such infrastructure remains a major challenge in many countries.

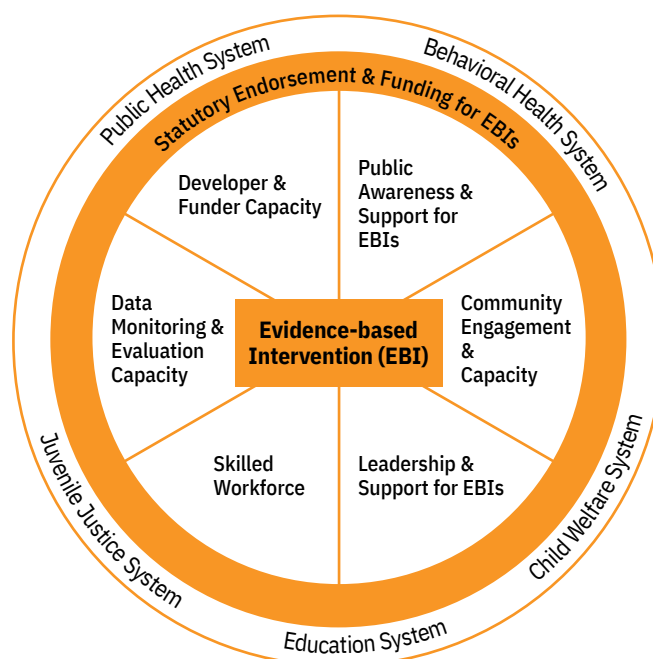
Evidence-based prevention has developed into a multi-level process operating within an institutional environment that is complex, difficult to predict, and often fragmented and unstable. Over the past two decades, there has been increasing recognition of the need to understand the barriers and facilitators affecting the implementation, adoption, and sustainability of evidence-based strategies and interventions (Chambers et al., 2020). Therefore, the implementation of prevention interventions and the establishment of comprehensive school- and community-based prevention systems represent long-term endeavours with often uncertain sustainability. Prevention is an integral part of the addiction field with one logical frame in the historical continuity. The exponential growth of treatment, harm reduction, and prevention programmes in the second half of the twentieth century contributed to the emergence of a distinctive institutional infrastructure in the field of addictions, which Thomas Babor (2017) described as *addiction studies*. In the area of prevention, however, the developmental trajectory was different. Rather than being accompanied by systematic institutional capacity building, investment was directed primarily towards individual interventions and workforce training, with comparatively little attention being paid to the development of dedicated institutional infrastructure. A parallel can be observed in higher education, where degree programmes designed to train addiction professionals have often contained little or no prevention-specific content. This gap was first documented through detailed analyses of curricula in Europe (Pavlovska et al., 2017) and later in North America (Pavlovska et al., 2019).

The *Blueprint for a National Prevention Infrastructure* (National Academies of Sciences, Engineering, and Medicine, 2025) places its primary emphasis on an evidence- and research-based strategy and proposes a four-step procedural model, ranging from the identification of best practices, through the assessment of funding needs and research gaps, to the articulation of actionable recommendations. While this framework is valuable for describing and mapping key processes and requirements, other approaches focus more explicitly on the structural dimensions of prevention infrastructure. For example, the National Research Council and Institute of Medicine (2009) defines three

interrelated pillars: (1) education and training for the prevention workforce, (2) access to prevention delivery systems, and (3) funding for research and service provision, including promotion and local efforts. The authors emphasise the importance of consistent, rigorous quality standards and prevention-specific training across a wide range of disciplines.

Similarly, the effectiveness of initiatives designed to improve mental, emotional, and behavioural outcomes among young individuals relies heavily on the presence of supportive systems across three core domains: research and innovation, training and career development, and the implementation of evidence-based interventions (Chambers et al., 2020, National Research Council and Institute of Medicine, 2009). Key challenges therefore concern not only the development of such comprehensive systems, but also their sustainability and the conditions required to support the process. Building upon extensive US experience and expertise, Fagan et al. (2019) identified a set of such general enabling conditions, including public policy and funding, research and evaluation, and community support and partnerships (Figure 1).

Figure 1 | Fagan's model (Fagan et al., 2019)



Over time, the fundamental principles of evidence-based prevention have undergone a gradual process of normalisation (Sloboda et al., 2023), increasingly shaping practice despite ongoing challenges and local implementation failures. Over the past decade, recent regional and national experiences, together with an expanding evidence base, have led to the first comprehensive strategies for building, supporting, and sustaining prevention infrastructure. A prominent example is the Strategic Prevention Framework promoted by SAMHSA (2022), which is based on a five-step data-driven process supported by detailed methodologies and guidance documents. This model is intended to prevent and reduce substance misuse and related problems by building capacity, planning and implementing

effective programmes, and evaluating outcomes. Early externalizing behaviors and mental health symptoms can be precursors for serious mental and behavioral disorders later in life, making it essential to review preventive interventions and implement those with evidence (Rojas et al., 2019).

In the Czech Republic, prevention is one of the four pillars of national drug policy and is closely linked to the broader framework of school- and community-based prevention of risk behaviour. The current system has evolved over more than 25 years through a series of policy initiatives, quality assurance reforms, workforce development projects, and implementation support mechanisms. A major milestone was the development of national quality standards and related monitoring, training, and certification systems, which gradually formed the basis of a national prevention infrastructure (Miovský et al., 2022; Miovský et al., 2015).

Striving for quality enhancement further expanded the system by developing a nation-wide System of Evidence of School-based Prevention Activities (SEPA), strengthening workforce training, and piloting quality assurance mechanisms in practice, thereby creating the foundations of the current prevention infrastructure. (Gabrhelík, 2015).

The Czech Republic formulated quality standards for school- and community-based prevention between 2000 and 2003 (Pavlas Martanová, 2012). Since 2005, the certification process has been ongoing and partially linked to financial support. Certification reflects compliance with quality standards and serves multiple objectives, including enhancing the quality of programmes and services, supporting the development of provider networks, integrating school-based drug prevention into broader prevention systems, and ensuring effective and sustainable public funding. In 2008, the concept of social pathology prevention was revised and reframed as the prevention of risk behaviour, drawing on Jessor's conceptual framework (Jessor et al., 1991; Jessor & Jessor, 1977). Risk behaviour encompasses types of conduct that may lead to health, social, educational, or other harms for an individual and/or community, including substance use, bullying, eating disorders, and risky sexual behaviour (Miovský, 2015; Miovský et al., 2022). Risk factors involve specific characteristics, variables, or hazards that increase the likelihood of an individual developing a disorder relative to the general population (Mrazek & Haggerty, 1994).

Despite these developments, the system has faced persistent challenges, including fragmentation, limited coordination, inconsistent implementation support, and the absence of sustainable infrastructure linking prevention providers, schools, training systems, and quality assurance mechanisms. These challenges ultimately stimulated the development of iPREV, a national digital platform designed to integrate key components of prevention infrastructure within a single interactive environment.

The aim of this case study is to describe a practical example of a national digital infrastructure supporting school- and community-based prevention of risk behaviour.

2 METHODS

This study uses a historical and descriptive case study design to examine the evolution of the Czech prevention infrastructure through the development and implementation of the iPREV platform. The case study design was selected to capture the historical development of the system and the interactions among policy, practice, quality assurance, workforce development, and digital innovation.

The analysis drew upon multiple sources of information, including peer-reviewed publications, policy and project documentation, internal development materials, and descriptive operational data generated during pilot implementation between 2021 and 2025. The authors were directly involved in the development of the platform. To reduce potential bias, the study relied on multiple documentary sources and focused on a transparent descriptive account of system development. Data were reviewed and thematically synthesised to reconstruct the historical development of the system, identify its key components, and describe their interrelationships. Descriptive statistics were used where available to illustrate the scope and utilisation of selected platform functions.

Data covered materials published between 1999 and 2025, obtained from multiple sources (53 documents together): (1) peer-reviewed publications describing earlier stages of the prevention system's development, evidence-based approaches to prevention, competencies, and competency models; (2) policy documents, project reports, and methodological materials (grey literature); (3) internal development documentation related to the iPREV Alpha version, and (4) descriptive operational data generated during pilot testing (2021–2025). The analytical process focused on organising and synthesising historical and documentary evidence in order to describe the evolution of the national prevention infrastructure and the development of its key components. References to the second stage of platform development are included only to illustrate the immediate continuation of the implementation process and are not part of the primary analytical case.

The study was based primarily on publicly available materials, institutional documentation, and aggregated operational data describing the development and implementation of the system. No personal data at the individual level were analysed, and the study did not involve human participants. Several authors were directly involved in the development of the platform; to reduce potential bias, the study drew on multiple documentary sources and focused on a transparent description of system development.

3 RESULTS

The core concept of the iPREV platform, developed between 1999 and 2015, was published in a consolidated form as a four-volume collective monograph in Czech (Miovský et al., 2015). It synthesised and described all the partial components of the system and their theoretical foundations. All the key components were also published in a series of monothematic issues

of *Addictology*,¹ a peer-reviewed journal dedicated to addiction science, including English-language versions.

Two social media channels (Facebook and Instagram) were created to support the iPREV platform. Analysis of social media data shows that the audiences of these networks differ substantially. On Facebook, the followers are predominantly in the 25–34 age cohort, with women accounting for almost 81%. On Instagram, the 18–24 and 25–34 age groups are represented almost equally, with men accounting for almost 30%. The published content features posts on trends in prevention, techniques for mental health support, and substances currently used by adolescents (e.g. kratom, synthetic cannabinoids, and nicotine pouches), with some being primarily informative, while others are educational. The channels also disseminate news about iPREV, educational activities, and events. Direct interaction with the iPREV target groups is essential: following each such engagement, both platform visits and social media followership increase. According to Google Analytics, since 2023 the number of active users has reached 33,000 (January 2026). The most frequently visited component of the platform is the catalogue of prevention programmes, followed by the educational webinars. Usage statistics were derived from Google Analytics, where active users were defined as users with at least one recorded interaction during the reporting period.

The individual components of the national prevention infrastructure were developed incrementally across four successive phases within EU-supported projects, which provided both legitimacy and the necessary space for piloting, testing, and implementation:

Phase I (1999–2005): the initial phase was funded and managed through the Phare Twinning 2000 project between the Czech Republic and Austria.

In addition to a national needs assessment (Miovský & Van der Kreeft, 2002), the project produced a set of core priorities and a procedural blueprint for the development of a national prevention system. All key components were piloted and formally endorsed at government level through Resolution No. 1045 in 2003, which approved the full set of results and recommendations. Although in the two years following the completion of the project virtually none of the key stakeholders (including the relevant ministries) implemented the recommendations, the phase was nevertheless brought to a successful close in 2005 with the formal adoption of the first version of the national prevention quality standards.

Phase II (2006–2015): this phase, focused on the formulation and development of the national prevention system, was funded and managed through the VYNSPI I and VYNSPI II projects.

Growing criticism from the professional community, pointing to the inactivity of key stakeholders, led to an agreement to

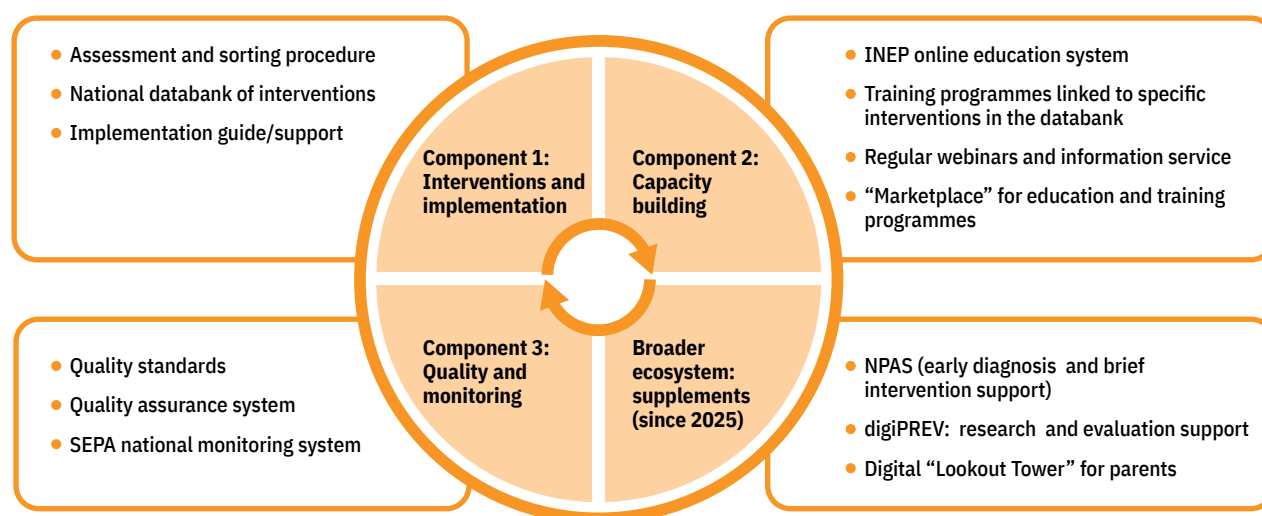
prepare and implement a national project capable of building on the outcomes of Phase I. The results of Phase I represented only a basic conceptual framework, including a limited number of practical examples, and had not been developed in a form that would allow for large-scale dissemination and nationwide implementation. The VYNSPI I project (2009–2011) therefore made it possible to elaborate all the partial components of the system into a more generalised form. VYNSPI II (2014–2015), a project directly following up on the previous efforts, piloted these newly-developed components in several regions of the Czech Republic. The overall process of developing and institutionalising the prevention support system was described by Miovský (2015), drawing on the main outputs published in the form of the aforementioned four-volume Czech-language monograph. The monograph provides the core theoretical framework, conceptual background, and descriptions of the individual system components, including experience gained from the pilot testing conducted in 2014 and 2015 (Miovský et al., 2015).

Phase III (2016–2020): a period focused on identifying an implementation strategy and technical solutions for establishing sustainable support for the national prevention infrastructure.

The rapid obsolescence of the outputs of Phase II, together with the persisting lack of engagement on the part of key stakeholders, revealed the vulnerability of the emerging system. High costs and the low efficiency of conventional implementation mechanisms led to the near-failure of the ambitious implementation plan developed at the end of Phase II (Miovský & Gabrhelík, 2015). It proved impossible to establish a systemic implementation framework or a stable funding mechanism to promote and develop the national prevention support system within either the Ministry of Education or the Ministry of Health. While the outcomes of Phase II remained available to practitioners, schools, and communities, genuine system-level support remained insufficient and poorly integrated. Two critical problems became apparent: the inadequate legislative grounding of prevention and the absence of reliable and stable resources to fund and support the infrastructure. The process culminated in a crisis situation in 2019, when even the developing and already partially implemented quality assurance system was called into question (Miovský et al., 2022). This situation became a key impetus for seeking solutions that would make both the process and the system less dependent on government support and central institutions. The COVID-19 pandemic added further urgency, leading to the development of the iPREV web platform as an independent, bottom-up initiative. The project brought together key stakeholders involved in the previous initiatives who joined forces in a single consortium acting as the umbrella organisation for iPREV.

1 Addictology Journal webpages with the special issue No.3/2012: <https://www.addictology.cz/journal-archive/2012-2/3-2012/> and No. 1/2015: <https://www.addictology.cz/journal-archive/2015-2/1-2015/>

Figure 2 | Schematic representation of the core structure of the IPREV “ecosystem”, including all its components



Phase IV (2021–2025): formulation of the strategy for, and conceptualisation of, digital infrastructural support for prevention and mental health – iPREV (Testing version)

In late 2020 and during the first half of 2021, a consortium of institutions² under iPREV articulated the core strategy for supporting and developing prevention infrastructure, as well as formulating the fundamental concept of a digital interactive platform. In practice, this meant that the outputs from the previous three development phases were gradually digitised during this period, with a dedicated team of staff from the participating institutions being put in charge of the process. Funded solely by the consortium, the digitisation and the development of the platform combined elements of development, research, and educational projects, alongside the “third mission” of the university (supporting projects and activities in the public interest). This approach gave rise to a collaborative environment and a committed team that brought the initiative to fruition, culminating in the launch of the Testing version of the digital system in the second half of 2021. This also marked the start of a testing phase and efforts to create conditions for increasing the sustainability of the emerging iPREV ecosystem (information online HUB).

The iPREV platform was officially launched at the National Conference on Primary Prevention of Risk Behaviour in autumn 2022. Subsequently, the Testing version of the platform was presented at regional conferences on the prevention of

risk behaviour and the promotion of mental health, addiction science conferences, parliamentary seminars, and meetings of regional and national coordinators for prevention and drug policy. Its visibility and dissemination were further enhanced through collaboration with the Ministry of Education, the Office of the Government of the Czech Republic, and the wider network of school and local prevention coordinators. These activities, together with webinars, has the potential to strengthen the community dimension of the project and facilitated direct engagement with practitioners, who provided valuable feedback on current issues in the field and on areas requiring further attention.

The core structure (Testing version) comprises three main components (see Figure 2), described in detail in Sections 3.1–3.3. This core structure was digitised in the years 2020 to 2022 as part of Phase IV, outlined above. Since 2024, the core structure has been progressively expanded with supplementary modules functioning as independent thematic and functional units (see Figure 2), including a dedicated portal for early diagnosis and brief interventions (NPAS). This contributes to the development of a broader “ecosystem” of closely interconnected platforms (see Section 3.4 for further details), which the iPREV core structure links together to provide a user-friendly framework. The uniqueness of the system lies in its homogeneous architecture and the tight user integration of its various components and functionalities.

² The iPREV consortium is a non-commercial project led by Charles University bringing together institutions involved in the creation, development, and testing of the IPREV digital platform. This platform serves as the foundation for the gradual construction of a broader, emerging “ecosystem” of interconnected tools and applications, all operated within a unified framework under the IPREV name. The institutional core of the consortium currently comprises three faculties of Charles University, the Czech National Institute of Public Health, Diagnostický ústav a středisko výchovné péče, an assessment and educational institution for children and adolescents with behavioural disorders, based in Krč, in the Prague 4 District, the Pedagogical Psychological Counselling Centre of the City of Brno, and the Professional Association for the Prevention of Risk Behaviour (OSPRCH).

Core component 1: national databank of programmes and implementation support

The availability of preventive interventions and programmes and support for their implementation are critical aspects of a functional infrastructure. The National Databank of Preventive Programmes and Interventions constitutes one of the three core components of iPREV and was identified from the outset as a key element of the overall project. Its primary aim is to provide an accessible tool that supports the development, evaluation, and dissemination of evidence-based preventive interventions

in the fields of mental health promotion and risk behaviour prevention. In line with current directions in prevention science, the tool facilitates meaningful linkages across individuals, communities, schools, and organisations.

The National Databank classifies preventive programmes and interventions according to four fundamental criteria:

- (1) the level of prevention (universal, selective, and indicated);
- (2) the thematic domain of the intervention: the structure of thematic domains is designed to evolve in line with advances in prevention science and currently includes: health promotion, safety, and healthy lifestyles; specific domains such as addictology, bullying, and sexual health; crime prevention, and prevention programmes for adults;
- (3) the target age group for which the intervention is intended;
- (4) programme duration and regional availability.

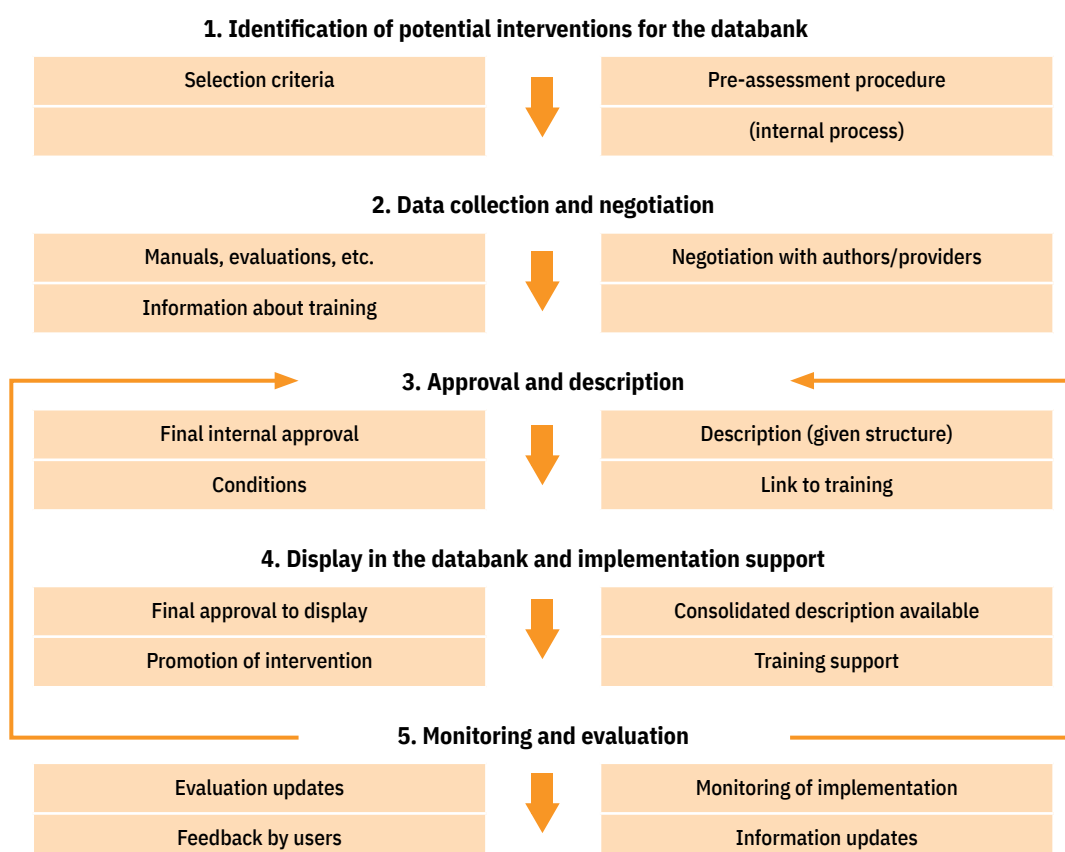
Technically, the system is organised around a five-step process (see Figure 3).

The process of selection, assessment, description, and inclusion in the databank is carried out by the platform's internal team. It is therefore an independent process, over which the authors or providers of an intervention have only indirect influence. The five steps illustrated in Figure 3 outline a managed procedure

that begins with the identification of a suitable preventive intervention (on the basis of predefined criteria) and culminates in final approval, agreement on terms with the licence holder, and the publication of information about the intervention. The fourth step also involves the promotion of the intervention, access to training, and the clear specification of the conditions under which the intervention can be obtained by a given school or community. The fifth step comprises ongoing monitoring of the implementation process and the collection of feedback from schools and communities. This is essential for continuous evaluation and for decisions on whether an intervention should remain in the databank or be removed. For example, if licence holders or trainers fail to comply with agreed rules, or if the information about the intervention and training does not correspond to users' experiences, the intervention may be removed from the databank, including the withdrawal of relevant education and training (see also Component 2 in Section 3.2).

The National Databank is linked to implementation support, which consists of two main strands. The intervention itself and its manual typically include guidance and recommendations for implementation (recommended practice); this part is usually prepared by the licence holder and/or the provider. In parallel, however, the iPREV platform offers its own manuals, guidance, and information services for schools and communities. These services include general recommendations and guidelines on how to work with individual interventions, how to combine them, and how to carry out the overall implementation process in practice. In Component 2 (Section 3.2), this support is

Figure 3 | Schematic representation of the five-step procedure for developing the content of the National Databank of Preventive Interventions



further reinforced through dedicated education and training programmes.

To facilitate rapid orientation for users searching for preventive interventions, each entry in the National Databank of Preventive Interventions is accompanied by a graphical label. This label provides a concise visual summary of the level of prevention, thematic domain, and age category, together with information on technical, organisational, and staffing requirements. It also includes details about the level of evaluation, safety considerations, intervention costs, and availability. Before an intervention can be included in the databank, each provider of a prevention intervention is required to complete a structured form that serves as a standardised programme description (part of Step 1 in Figure 3). The form comprises key descriptors (single-word summaries of the categories listed above), a programme abstract, theoretical background, objectives, target group, timeline and structure, content, staffing requirements, contraindications (limitations), evaluation procedures, material and spatial requirements, supervision needs, evidence of effectiveness, possible linkages and recommended combinations, available support formats, and information about the implementing organisation. In addition, users can download the *Methodology for Quality Support in Prevention*, building on the publication by Mioviský et al. (2015), which addresses current topics and provides practical guidance on ensuring quality and effectiveness in school-based prevention. The methodology was developed in cooperation with a professional society and a pedagogical-psychological counselling centre (Nováková et al., 2024).

In 2025, at the time of the transition of the iPREV platform from the Testing to the Full version (see Discussion), the databank comprised a total of 35 individual interventions and programmes. The iPREV internal team plans to expand the databank by adding five or six new interventions and programmes each year. From the perspective of long-term development and sustainability, a key selection criterion is coverage of the main target age groups and the principal thematic areas of risk behaviour. The team seeks to maintain a balanced thematic portfolio, ranging from addictions, risky sexual behaviour, and sexual health to aggression and bullying. Selection also takes into account the complexity of implementation, the overall availability of implementation support, the conditions under which the intervention can be delivered, and the costs of the intervention and of staff training. A non-commercial principle is preferred. The iPREV platform therefore gives priority to interventions and training programmes that are based on a non-commercial model.

Core component 2: capacity building and support for training and education

Ensuring the availability of high-quality evidence-based preventive interventions and providing support for their implementation is the primary objective of **Component 1** (described in Section 3.1). A set of activities associated with capacity building is closely linked to this component. Education and the professional competence of prevention specialists constitute an essential prerequisite and a key objective of Component 2. Overall, Component 2 can be divided into several interrelated areas of

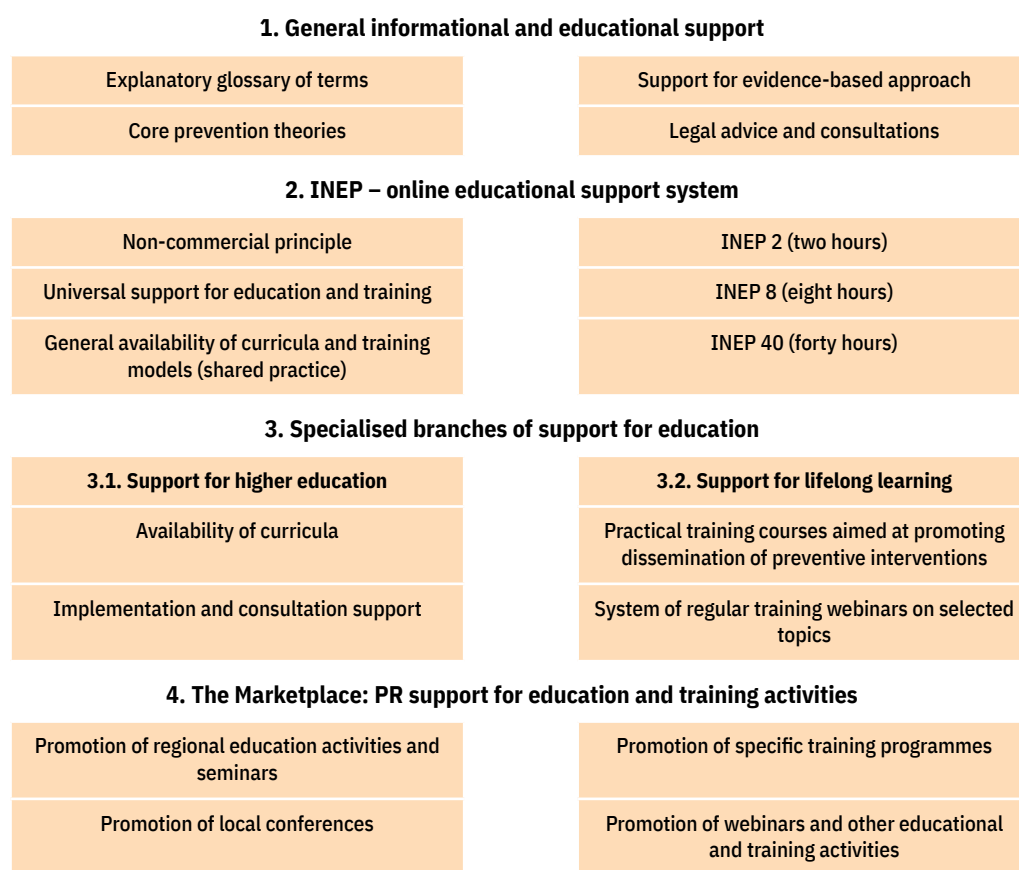
activities and services. As emphasised by the National Research Council, “a well-trained workforce, an educated public, and an informed complement of policy makers and funders who will support prevention are all important components of success” (NRC, 2009).

Component 2 consists of four core areas. Their interconnections and interdependencies are illustrated in Figure 4, which also indicates the functionalities associated with each area. Within the iPREV digital platform, it was necessary to provide support for education, training, and general informational guidance across a broad scope and from multiple perspectives. General informational and educational support (Area 1 in Figure 4) includes, for example, a terminological glossary of core prevention concepts, as well as general educational resources for both the theory and practice of prevention. It also encompasses services pertaining to legal advisory support related to the application of preventive methods and interventions in schools and communities. This has historically been – and continues to be – one of the most sought-for forms of educational support among prevention practitioners.

The second area of educational support within Component 2 is highly specific and is represented by a comprehensive system of online education, INEP (Introduction to Evidence-Based Prevention). The development of the national system and standards for prevention education has led to the creation of three versions of online courses (two, eight, and 40 hours), all of which are based on the European Universal Prevention Curriculum (EUPC) (EUDA, 2019). The courses are fully operational, subject to continuous evaluation, and regularly updated. They are accessible online 24/7 and are open to anyone interested in acquiring initial (basic) education in prevention. INEP courses are provided free of charge and can be used freely for non-commercial educational purposes. INEP also draws on additional outcomes of the UPC-Adapt project and on the collective work of all the members of the UPC-Adapt project consortium, while being specifically adapted to the Czech prevention context.³ The courses include online presentations, recorded live lectures, short quizzes, required readings, and supplementary study materials. Upon completion of all requirements, participants are issued with a printable certificate. The decision to develop three different versions of the INEP courses was deliberate, as it became evident that some target groups were unwilling or unable to complete the standard 40-hour course (the full version). Consequently, shorter eight-hour and two-hour adaptations were introduced. The entire system is modular in design. It can therefore be used either as a standalone course (accredited and certified, including the option of micro-credentials awarded by Charles University) or integrated into broader educational programmes for prevention professionals.

The second component of the IPREV platform, which is closely linked to INEP, provides a specialised form of educational support for education and training providers. It is divided into

3 The Czech adaptation of the EUPC was formally published and made available in PDF format by the National Focal Point (Reitox): https://www.drogy-info.cz/data/obj_files/33620/1125/Evropské_kurikulum%20prevence_fin.pdf

Figure 4 | Schematic representation of the four key areas for capacity building, including core functions and principles

two branches (see Area 3 in Figure 4). The first branch comprises services and support aimed at universities and colleges. It consists of a set of support materials and activities designed to facilitate the introduction of prevention education, for example as stand-alone courses within higher education curricula. This support includes, inter alia, model syllabi and examples of how the EUPC can be implemented within university settings (see, for example, Miovský et al., 2019). This university-focused support area serves as a practical tool for students in fields such as addiction studies, pedagogy, special education, social work, healthcare, and related disciplines. Support is delivered through a wide range of study materials, references to relevant resources, and dedicated online courses and webinars. Across all these functionalities, the IPREV platform primarily draws on the Universal Prevention Curriculum (UPC). The UPC⁴ was developed by a team of highly qualified scientists and prevention professionals, led by Professor Zili Sloboda, and has been repeatedly evaluated and tested. It provides comprehensive coverage of prevention-related topics, including: prevention theory and background; an introduction to prevention science and evidence-based approaches; evidence-based preventive interventions and policies; basic principles of the physiology and pharmacology of addictions, and methods for prevention research, monitoring, and evaluation.

The second branch involves targeted support for continuing professional development and lifelong learning and takes two principal forms (see Area 3 in Figure 4): practical training courses for specific preventive interventions and a series of regular webinars. The training courses are closely linked to **Component 1** (the National Databank of Preventive Programmes and Interventions) so that each intervention listed in the databank has an associated training programme and implementation support package. By contrast, the webinars are thematically diverse and constitute the backbone of the systematic educational support, building on Area 1 in Figure 4. The IPREV team organises online webinars every month. These are led by experts and address issues that are highly relevant to children and adolescents both in the Czech Republic and internationally and that are commonly encountered by school staff, parents and caregivers, and prevention practitioners. Examples of such topical issues include kratom, nicotine pouches, vaping, self-harm, energy drinks, and relevant legislation. Regional coordinators for risk behaviour prevention play a key role in promoting these webinars and in establishing an effective dissemination network; owing to their timely and engaging topics, the webinars have rapidly gained popularity, with attendance typically ranging from 200 to 700 participants, many of whom register repeatedly, thereby forming an additional important professional network. All webinars are recorded and subsequently made available on demand (24/7).

4 See also: <https://www.issup.net/training/universal-prevention-curriculum>

The fourth and final area of educational support (see Figure 4) is referred to as the “marketplace”. This area is not thematically

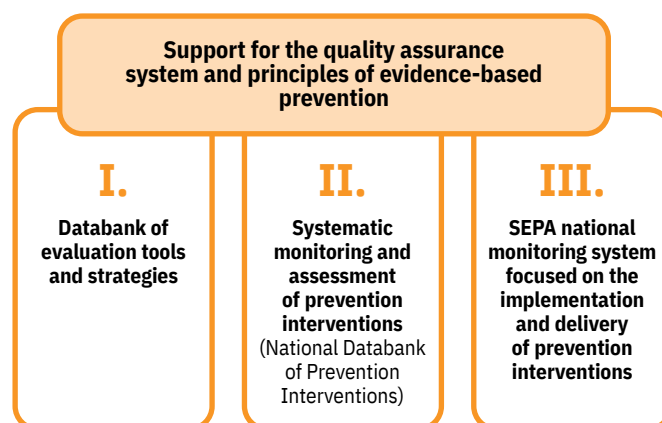
delineated in a strict sense. Its primary function is to promote and facilitate information exchange among prevention professionals about local and regional conferences, workshops, and various types of webinars. In practice, it operates as a digital “noticeboard” where providers of prevention-related education and training can post information about events and activities they organise.

Core component 3: Quality, evaluation, monitoring, and research support

The key focus of iPREV team activities within Component 3 is on supporting quality and effectiveness and on the broader promotion of evidence-based approaches in prevention. These activities include cooperation with governmental and non-governmental organisations, particularly in the development, testing, and implementation of quality standards, as well as systems for the certification of service providers and preventive interventions. The Czech Republic has developed a national quality assurance system in prevention (Miovský et al., 2022; Miovský et al., 2023). Prevention standards have been under development since 2002, with the first generation implemented in 2005. Since then, the standards have undergone substantial revisions (Pavlas Martanová et al., 2012; Government Council, 2021). Compliance with these standards has been ensured through a certification process. Certification based on the fulfilment of the standards represents a formal guarantee by the state and professional societies that services are accessible to their target populations and meet recognised professional criteria. Certified services are provided by qualified staff, comply with applicable legal requirements, respect the rights and safety of clients and staff, and adhere to established ethical principles. In 2019, the certification process for prevention was suspended (Miovský et al., 2023). However, in 2023 a decision was taken to resume certification and undertake a comprehensive revision and update of the standards. The iPREV team is actively involved in this revision process (2024–2026). As part of the revision, a comparative analysis of the national standards and relevant European and international frameworks in the field of prevention was conducted (EDPQS, WHO/UNODC, MQS/EQUS, Council of the European Union). The analysis identified areas insufficiently covered in the national standards, such as community-based prevention. In response, the revised standards will incorporate requirements derived from these documents.

To provide schools with an additional tool for selecting high-quality prevention providers, a new national register of providers of preventive activities is currently being established. Its aim is to enable the registration of entities operating in the field of prevention services following an assessment of their compliance with basic organisational quality management standards. The iPREV team is a member of the working group responsible for the development of this national register. However, support for the national quality assurance and certification system and cooperation within it represent only the most general level of activities within Component 3 (see also Figure 5). This component encompasses three additional and more specific areas of activity and functionality.

Figure 5 | Schematic representation of the key areas and functions of Component 3 of iPREV: quality assurance and monitoring



The first specific area of activity within Component 3 is the operation of a databank of evaluation tools and strategies. The iPREV team continuously monitors the availability of evaluation instruments and the implementation of evaluation studies. It selects appropriate evaluation tools and, where necessary, participates in their adaptation to the Czech language and cultural context. These tools are subsequently included in the databank, where they are made available free of charge, together with their manuals. The databank also provides examples of good practice drawn from completed and published evaluation studies. In this way, the databank contributes to the development and promotion of a policy of disseminating validated evaluation tools and strategies intended for the academic community, prevention providers, and policy makers.

The second area of specific activities within Component 3 (see Figure 5) is closely linked to Component 1, specifically to the National Databank of Preventive Programmes and Interventions. The process of selecting, assessing, and preparing descriptions of interventions for inclusion in the databank also functions as a quality assessment process, conducted according to predefined criteria. The outcome of this assessment (see also the procedure described in Figure 3) forms part of the description of each intervention in the databank and is made available to users. It can thus be seen as a secondary, independent evaluation system, which is intended, among other objectives, to facilitate users’ orientation when selecting and combining individual interventions for schools and communities. In the future, a closer integration of this process with the registration and certification of prevention service providers and preventive interventions is envisaged. At present, however, such a step is constrained by the absence of a clear legislative framework and limited engagement on the part of key stakeholders in the Czech Republic.

The third specific area within Component 3 was initiated in 2015 with the establishment of SEPA, a national monitoring system, described in detail by Gabrhelík (2015). The system has undergone continuous development, testing, and refinement. By 2025, SEPA had been adopted by nearly 3,000 schools in the Czech Republic, representing more than 50% of all registered schools nationwide. It thus constitutes a comprehensive evaluation and monitoring system that has been implemented

and operated across all regions of the Czech Republic for more than a decade. The distinctiveness of the SEPA system lies in its two core functions. First, SEPA is primarily designed to monitor school-based prevention, specifically the types of preventive interventions delivered to target groups and the intensity with which they are implemented. Data is entered directly by schools that voluntarily enrol in the system. This data includes descriptions of the interventions delivered, their frequency and intensity, and other implementation details. As a result, individual schools and administrators, as well as, at a general level, local authorities and the Ministry of Education have an accurate overview of which types of interventions are actually delivered to specific target groups and in which settings. The second key function of SEPA is support for implementation. The system provides schools with structured guidance throughout the entire implementation process, including recommendations on the combination of interventions and the coverage of relevant target groups. SEPA therefore represents a critical linkage to Component 1 and to the entire implementation support framework as a whole, with a particularly close connection to the National Databank of Preventive Interventions (see also Figure 3). This linkage is reflected, for example, in the monitoring of interventions that are implemented as part of the operation of the databank (specifically Figure 3, Step 5).

iPREV serves as a bridge between research and practice (see also Section 3.4, which introduces the new digiPREV functionality). The team maintains close and ongoing contact with practitioners and systematically responds to emerging issues in the field, such as synthetic cannabinoids, suicide prevention, and nicotine pouches. Although the underlying information is derived from systematic searches of expert scientific databases and other relevant sources, it is presented in a clear, readable, and practice-oriented format. In addition to analytical articles, the platform produces practical guidance materials, including those intended for the implementation of prevention plans and the selection of high-quality prevention programmes for schools (Nováková et al., 2024). Users can find information in the Quality section about evaluation, quality standards (both international and national), quality standards in education, ethics, and the theoretical background related to the overall topic of quality assurance.

The iPREV team members are regularly invited to conferences, professional meetings, and community events, and they actively participate in a range of national initiatives, including the resumption of certification in prevention, the revision of quality standards, and the development of the national concept of child and adolescent addiction care (Society for Addictive Diseases, 2020). The team members are frequently approached for expert consultations, lectures, and webinars, and have been invited as co-authors to contribute to a number of key publications in the field of prevention, including compilations of examples of good practice (Professional Society for the Prevention of Risk Behaviour, 2023) and evidence-based programmes (Ministry of Health, 2024).

New components introduced in 2025: the transition from the interactive iPREV platform to a comprehensive “iPREV ecosystem”

The development, testing, and pilot implementation of the Testing version of the iPREV platform were primarily focused on the digitisation of the existing content and on the creation of a user-friendly environment integrating the functionalities of the three core components described in Sections 3.1–3.3. The gradual consolidation of the system and the achievement of operational stability were prerequisites for the successful implementation of the Alpha version. The actual engagement of schools and communities subsequently generated further demand for improvement and expansion. This was made possible by targeted project support from the Ministry of Education and the Office of the Government of the Czech Republic in 2025, when iPREV was awarded four⁵ major projects (see also the *Broader ecosystem supplements* segment in Figure 2). Together, these projects facilitated the transition of the iPREV system from the Testing to the Full version by the end of 2025, with the Full version being officially launched in December 2025. The Full version is characterised by two steps. The first involved a complete technical revision of the entire iPREV online platform, including improved navigation and an enhanced user experience across all the components. The second step represents a shift from the basic iPREV platform (defined by the core components) to a more comprehensive “iPREV ecosystem”. In addition to the main components described in Sections 3.1–3.3, a set of complementary platforms was developed, each focusing on specific thematic extensions. The Beta version gave rise to a body of closely interconnected platforms which substantially expand the functionality of the core system. The general architecture of the system is illustrated in Figure 2, with three new platforms (“broader ecosystem supplements”) added in 2025 to enhance the three core components: (a) NPAS – early diagnosis and brief intervention support, (b) digiPREV – research and evaluation support, and (c) a digital “Lookout Tower” offering parental guidance and support regarding behavioural addictions.

NPAS – screening and brief interventions for substance use and addictive behaviours: linking the National Addiction Screening Portal with iPREV (www.npas.cz)

Substance use screening and brief interventions constitute a fundamental systemic measure within modern addiction policy, contributing to the broader prevention framework across healthcare, education, social services, and the justice system. Grounded in scientific and clinical evidence, they provide an effective, validated, and safe method for the early identification of, and response to, emerging issues related to substance use and addictive behaviours. In this context, the National Addiction Screening Portal (NPAS) was developed for professional use. In 2025, it was integrated into the iPREV system and is now managed by the iPREV team. NPAS forms a key component

5 The National Portal of Addictology Screening was established with financial support from the Office of the Government of the Czech Republic as part of the project AA-34-25.

of indicated prevention, expanding its scope and approach by incorporating the element of screening and brief interventions.

digiPREV – a digital academic “marketplace” (www.digiprev.cz): higher-quality and more effective prevention and support for young academics

The general lack of interest in prevention science has resulted in a long-term shortage of capacity for research and evaluation in the field, a problem further exacerbated by the existing gap between academia and preventive practice. The digiPREV platform has therefore set two primary objectives: (1) to support the development of qualification and research projects that respond to the needs of preventive practice with direct societal impact and (2) to devise strategies for addressing the lack of funding for prevention research and for enhancing the quality of preventive practice. DigiPREV thus represents an structural solution with the potential to strengthen both the quality of Czech preventive practice and the professional development of students and researchers. The platform will also utilise modern technologies and elements of artificial intelligence, which can make research and evaluation processes more efficient and rigorous. One of the main benefits of digiPREV is the opportunity to engage students in addressing issues that are genuinely relevant to preventive practice. Many organisations, schools, and counselling centres have long lacked the capacity for systematic evaluation, data collection, or analysis of their own processes. Students conducting research projects as part of their qualification work can fill this gap effectively by contributing independent perspectives, methodological support, and professionally guided investigations that organisations can put to practical use. Their work often enriches practice not only on a one-off basis, but also by providing organisations with materials for further development or planning of prevention-specific activities. The integration of academia and prevention practitioners also aims to foster greater interest in prevention science among postgraduate students, postdoctoral researchers, and early-career scientists. Similarly, this was the purpose of the akaPREV⁶ network for practitioners established in 2025, an infrastructure open to both academic staff and organisation-based professionals. In practical terms, the system primarily facilitates direct connections between prevention providers (interested in the evaluation of, and research into, their interventions and programmes) and researchers and students who have the interest and capacity to respond to such demand.

Digital “Lookout Tower” – guidance and support for parents regarding behavioural addictions (www.digirozhledna.cz)

DigiRozhledna (a digital “Lookout Tower”) is a platform designed to support “digital parenting”, providing direct assistance and guidance to parents on how to raise children in a digitalised world. The aim of the platform is to help parents and caregivers

assume an optimal, evidence-based parenting approach to children’s use of digital media. In addition to international scientific evidence and expert recommendations, the platform draws on findings from two Czech research projects⁷ concerned with digital media and parenting. Last but not least, the platform builds on demand from practice, incorporating questions, comments, and suggestions raised directly by parents themselves.

4 DISCUSSION

iPREV aggregates long-term activities in the field of prevention capacity building and the development of quality assurance systems within prevention. The original (Testing) version, built around three components (a databank of preventive programmes, support for the education of professionals, and quality and safety in prevention), has expanded significantly since 2022 through the establishment of collaborations with academics, frontline practitioners, schools, students, and other stakeholders. The platform responds to developments in the field and to its emerging needs. It is therefore able to provide support to target groups in situations where complications arise, such as the suspension of certification processes or the accreditation of educational courses. These processes were important for distinguishing high-quality programmes and interventions. iPREV partially replaces them through its own components and thus seeks to provide target groups with the highest possible level of support in the design and implementation of preventive activities. For a prevention system to function effectively, it requires not only professionals, but also the involvement of schools and stakeholders. It is necessary to take current research into account and to support evidence-based prevention. Monitoring and evaluation need to be carried out, and planning should be based on the results. Long-term funding, support for human resources, and support for the implementation of effective strategies are key.

Over the years, iPREV has shifted its role from an information platform to a collaborative hub that enables connections among academics, practitioners, school staff, and parents and caregivers, as well as entities responsible for coordinating and funding prevention. Its original components are being further expanded to include relevant areas such as brief interventions, support for digital parenting, and support for research and evaluation in prevention. In particular, the engagement of local stakeholders, such as authorities, the local public, and NGOs, in the planning, development, and execution of projects and project-related decision-making has been brought up as a relevant factor in promoting sustainability (Aarseth et al., 2017).

Prevention, involving the systematic use of screening and early intervention before negative health outcomes become evident, is a cost-effective strategy. Given the substantial financial burden placed on healthcare systems by avoidable high-risk behaviours, the continued neglect of timely implementation and adequate reimbursement for screening and referral to treat-

6 “aka” as “akademie”, Czech word for academia.

7 Prevention and Education in the Field of Technological Addictions. Supported by: Department of Drug Policy, Office of the Government of the Czech Republic, project no.: AA-35-25.

ment by health insurers, together with insufficient provision of accessible interventions for parents and their children, constitutes an immense waste of resources. This is a common theme in the research on the benefits and costs of prevention. Some programmes designed to prevent teen substance use and other behavioural problems have been found or estimated to be stunningly good investments (NIDA, 2022). The effective functioning of the system requires capacity building and the integration of primary care, educational settings, and specialised services. For prevention to be effective, it should be tailored to the developmental needs and competencies of the target population (Newton and Lee, 2019).

There is a growing demand for evidence-based programmes aimed at supporting healthy youth development. However, this expansion has also generated a degree of confusion, stemming from divergent interpretations of what constitutes “evidence-based” practice and from inconsistent information regarding which programmes legitimately meet this criterion. Although registries designed to identify evidence-based programmes are intended to simplify the evaluation of programme effectiveness, their differing standards and rating systems often contribute to further confusion. The benefits of using evidence-based programmes, and the critical importance of adhering to rigorous standards of evidence, particularly when programmes are scaled up, have been repeatedly highlighted. One prominent example of an evidence-based programme registry is *Blueprints for Healthy Youth Development*, hosted by the University of Colorado Boulder. *Blueprints* features unparalleled criteria for identifying evidence-based programmes and operates in a manner comparable to the U.S. Food and Drug Administration, systematically evaluating evidence, data, and research to determine which programmes meet its rigorous standards of proven efficacy (Mihalic & Elliott, 2015).

Beyond programme registries, international literature increasingly emphasises that evidence-based prevention requires supportive implementation systems, not only isolated evidence-based interventions. Frameworks such as Communities That Care (Hawkins et al., 2008), the Icelandic Prevention Model (Kristjansson et al., 2020), and the International Standards on Drug Use Prevention (2018) all point out the importance of coordinated governance, workforce development, quality assurance, stakeholder collaboration, and continuous monitoring. Although these initiatives differ in their organisational models and national contexts, they share the premise that sustainable prevention depends on the functioning of the prevention infrastructure. From this perspective, the iPREV platform can be understood as a digital implementation infrastructure that integrates existing system components. Considering the significant burden of mental and behavioral disorders, the high costs of treatment, and the underutilization of mental health services, preventive interventions should be accessible and effective throughout all developmental stages, from infancy to adolescence (Rojas et al., 2019). The interventions should be developed in accordance with quality standards and include interactive teaching methods, training of facilitators and peers, normative education, development of personal and social skills, and delivery through structured lessons over multiple years (Newton and Lee, 2019). International and European quality standards, together with the

above-mentioned principles of effective and safe prevention, are integral components of the IPREV platform.

Recent years have also revealed weaknesses in the national prevention system. One of them is the lack of long-term funding. One-year grants are administratively demanding and time-consuming and do not allow for smooth planning of activities or the contracting of experts. Without university support, it would currently not be possible to operate the IPREV platform. Securing long-term stable funding is therefore one of the key challenges for the upcoming period. In 2023 and 2024, funding for the platform was secured from two main sources: the Ministry of Education, Youth, and Sports and the Prague City Council. In 2025, additional funding was provided by the Office of the Government of the Czech Republic. The integration of the national databank with efforts such as evidence-based prevention projects supported by the EMCDDA, NHS, SAHMSA, NIDA, etc., elaborates on parallels, linkages, and inspirations – including the limitations they face. At present, there are only a small number of projects in the Czech Republic with rigorously documented, evidence-based effectiveness. In the Czech Republic, the range of prevention programmes and interventions is highly variable, and not all of them are aligned with effective and safe prevention practices. The educational courses in preventive topics were accredited as a sign of quality; however, the accreditation system was cancelled in recent years. The legislation in the prevention field is insufficient, as is funding for rigorous research. Furthermore, schools do not have sufficient support when selecting programmes. The iPREV platform responds to this across all its core components. The databank includes verified programmes, educational courses and webinars are offered to professionals, and the quality section provides information and materials on effective and ineffective prevention.

Despite the existence of a quality assurance system in the Czech Republic, compliance with the standards was not mandatory before 2008, and beyond the NGO sector that had voluntarily adopted them, providers delivering ineffective prevention activities continued to gain access to schools. Legislative complications led to the suspension of certification based on compliance with standards in 2019. This situation seriously undermined the safety and effectiveness of school-based prevention and was further exacerbated by the COVID-19 pandemic. The resulting dysfunction of the quality assurance system, together with the growing need for digital solutions, created the impetus for the development of a platform designed to support schools and providers of prevention activities. iPREV is targeted at schools, communities, parents and carers, prevention professionals, students in relevant fields, and researchers and academics, as well as professional societies and policymakers. It promotes informed decision making and evidence-based approaches, facilitates professional networking and the development of community-based prevention systems, and contributes to cultivating the field so that prevention in schools and communities is safe and effective.

At the end of 2023, a decision was taken to resume certification and to revise the quality standards according to the current situation and aligned to European and international quality standards. The iPREV team is actively involved in both pro-

cesses. Between 2019 and 2023, the Department of Addictology participated in the FENIQS-EU project, which focused on quality standards and their implementation in practice across European countries. The outputs of this project are planned to be reflected in the current revision of the standards (Jeziorska et al., 2023; Jerkovic et al., 2023). Although the Czech standards define requirements for education and, in part, for staff competences, the profession still lacks solid legislative grounding. Members of the Department were also involved in the WAVE project (Reg. No. GA-101045870), where they worked on review studies addressing competences, competence models, and standards in the education and training of addiction care professionals (Nováková et al., 2023; Zborník et al., 2023). These outputs will likewise be taken into account in future revisions of staff-specific standards. The success of prevention activities depends on several critical components: a proficient workforce, a knowledgeable public, and well-informed policymakers and funders committed to supporting prevention efforts (National Research Council and Institute of Medicine, 2009).

Strengths and limitations

This study has several strengths. It documents more than two decades of development of a national prevention infrastructure and draws on multiple sources of evidence, including scientific publications, policy documents, project outputs, institutional materials, and operational data. The long observation period made it possible to reconstruct the evolution of the system and to describe the integration of key prevention-support functions within a single digital framework.

The findings should also be interpreted in light of several limitations. First, this study was designed as a descriptive case study and does not evaluate the effectiveness of the iPREV platform or its impact on prevention outcomes. Second, several authors were directly involved in the development and implementation of the platform. Although this provided access to historical documentation and detailed knowledge of system development, it may also have influenced interpretation. To reduce this risk, the analysis relied on multiple documentary sources and focused on a transparent description of the development process. Third, the findings are derived from a single national setting and may not be directly transferable to countries with different policy, institutional, or funding environments. Future research should examine implementation processes, user engagement, and the long-term effects of similar digital prevention infrastructures. The study documents the development and utilisation of the platform rather than its effectiveness. No data were available to assess whether the platform improved prevention quality, workforce competencies, implementation fidelity, or outcomes among target populations.

5 CONCLUSION

The development of iPREV illustrates one possible pathway towards strengthening national prevention infrastructure through digital integration of existing system components. Although the platform itself does not guarantee implementation quality, it creates conditions that may facilitate coordination, dissemi-

nation of evidence-based practice, and communication among stakeholders. Future research should focus on evaluating user engagement, implementation processes, and the long-term contribution of the platform to prevention practice and mental health promotion.

Ethics approval and consent to participate

Not applicable. No human subjects (institutional case study).

Informed consent

Not applicable. No human subjects (institutional case study).

The entire core team participated in the case study. All sources are publicly accessible.

Consent for publication

Not applicable.

The entire core team participated in the case study. All sources are publicly accessible.

Data availability

The data supporting the findings of this study are available from the corresponding author upon reasonable request, subject to applicable ethical and confidentiality restrictions.

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Competing interests

The authors declare that they have no competing interests.

Authors' contributions

Michal Miovský: Conceptualization; Methodology; Investigation; Formal Analysis; Data Curation; Writing – Original Draft; Writing – Review & Editing; Visualization; Supervision; Project Administration; Funding Acquisition.

Other co-authors: Methodology; Investigation; Formal Analysis; Data Curation; Writing – Original Draft; Writing – Review & Editing; Visualization;

All authors reviewed and approved the final version of the manuscript.

Declaration of generative AI and AI-assisted technologies

The authors declare that no generative AI or AI-assisted technologies were used in the preparation of this manuscript.

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