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Healthy lifestyle of children and youth

Project report

Verdal kommune

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NORD universitet

Healthy lifestyle in children and youth – Module 3: Mental health among children and youth (6-20 years old). Preventive and promoting measures

A collaboration between
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The Healthy Life Central in Verdal, Norway
&
Nord University, Norway

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Preamble

In 2019, Norway signed a new cooperation agreement with Poland on a new Programme under the Norwegian Financial Mechanism 2014-2021. The Polish Health Programme called "Improved prevention and reduced inequalities in health" has a total budget of 23,529,412 euros. The Programme consists of one open call and two pre-defined projects on e-health and telemedicine and on healthy lifestyle of children and youth. The Polish Ministry of Health is the Programme Operator, responsible for developing and implementing the Programme. The Norwegian Directorate of Health is the Donor Programme Partner, responsible for advising the Programme Operator and the donor through the development and implementation of the Programme.

The project "Healthy lifestyle of children and youth" has three separate parts with a total budget of 5 million euros. The Polish Ministry of Health is the Project Promoter, whilst Verdal Healthy Life Centre and the Norwegian Cancer Society are the Donor Project Partners. This report is one of the deliverables of this project, under module 3 in the field of mental health.

The Polish health care sector faces several challenges at different levels. Public health awareness is limited, so efforts are needed to inform the Poles, especially children and youth, their parents, teachers and caregivers, about the importance of positive health choices to prevent diseases and promote well-being.

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Glossary

Mental health and mental health care

The term *mental health* is defined by the World Health Organization (WHO) as «a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community» (1). Having good mental health is not just about an absence of suffering and illness, but also about feeling motivation, coping and experiencing pleasure in everyday life (2).

Mental health care can be understood as work to promote and improve the mental health of individuals. Its purpose is to assist in processes that develop experiences of coherence and opportunities to master everyday challenges. It includes efforts to point out, and seek to change, conditions in society that create mental ill health and contribute to stigmatization and social exclusion (3).

Mental health problems and mental disorders

In this report, a distinction will be made between the concepts of *mental health problems* and *mental disorders*. The concept of *mental health problems* is about psychological symptoms at such a level that there is strain in the everyday life of children and adolescents, but not necessarily to the level and extent that it can be characterized as a diagnosis or disorder (4). The term *mental health problems* will also cover terms as psychological problems/distress and mental issues/difficulties. *Mental disorder* is used when the mental symptom load is so great and of such a nature that it meets the requirements of a diagnosis (4).

Public health (work)

Public health is defined as the health status of a limited population, such as a country or region. The term includes economic, physical, mental and environmental conditions which affect health status (5). *Public health work* is defined as use of science or experience to prevent illness, extend life and promote health through organised effort in society, public or private organisations, groups or individuals (5).

Preventive and health promotion work

It is normal to differentiate between preventive health and health promotion work. *Preventive health* consists of reducing the factors which threaten people’s health, such as measures which aim to reduce illness, harm, social problems, mortality or risk factors. *Health promotion work* aims to ensure the existence of factors that bring excess and pleasure in people's everyday

lives. In health promotion work, the focus is on factors that can give the population increased control over and opportunities to improve their own health. Health promotion measures therefore focus on the individual's resources, social functioning and the ability to make choices that are positive for health.

«Best practice»

The EU has developed a comprehensive framework which defines «best practice», and presents a selection of criteria to decide on «best practice» measures within preventive health work (6). In this report, it is considered inappropriate to use this framework, because many potentially good measures that can have good effect may nevertheless be excluded because they do not meet *all* the criteria.

We have therefore chosen to use the term "best practice" for measures selected on the basis of predetermined inclusion and exclusion criteria (cf. Appendix 1), and we define it as follows:

"Best practice comprises all measures that: meet the requirements of the target audience; look at preventive and/or health promotion measures aimed at mental health or suffering; which is or has been implemented in a Norwegian setting; has been evaluated or followed up, or has shown itself to have promising potential in work with mental health or suffering; and which does not specifically look at mental disorders or diagnoses.

Introduction

The aim of this report

This report is part of the "Health lifestyle of children and youth" project. The report forms Module 3 of the project, and will be used as a knowledge base in the subsequent parts of the project.

The theme of the report is mental health among children and youth, aged 6-20 years. More specifically mental health promotion and preventive work in the field of mental health. The report has been commissioned by the Polish Ministry of Health and will form a knowledge base for measures and screening tools to be implemented in Poland to improve mental health and reduce social inequality in mental health problems among Polish children and youth.

The report describes "best practice" measures that either promote good mental health or reduce mental health problems, or screening tools for mapping mental health or symptoms of mental health problems. The setting for the measures or screening tools can be at school, at home, in their everyday life and online. It must be highlighted that the report addresses general mental health and mental health problems and does not focus on mental disorders or illnesses (requires a diagnostic interview).

The target group is children and youth (aged 6-20 years), their parents or family, school staff, or other caregivers for children and youth. The measures and screening tools should have been tried out on the equivalent target groups, in Norway. They should occur on either national, regional or local level. The measures should further promote better mental health or work preventive towards symptoms of mental health problems.

In the report there are presented some key characteristics about mental health in Norway, the Norwegian health services and school system in order to put the measures into a context and provide background information, before the measures are presented.

Mental health among children and youth in Norway

Trends in mental health

Worldwide, there has been an increase in mental health problems among children and youth over the last 10-15 years (7-11), including in Norway (12-14). This topic was a central theme when the Directorate of Children, Youth and Family Affairs presented the "Adolescence Report" in 2017 (15). According to the report, the majority of Norwegian children and youth are satisfied with their lives: they are active, have good relationships with parents and friends and have a positive view of the future. Despite this, there has been a worrying increase in mental health problems. The most common mental health problems are stress-related – worrying a lot about things and feeling like everything is a struggle. One in three Norwegian youth is "quite or very" bothered by such thoughts over the course of a week (15). Both boys and girls have stress-related problems, but the proportion is clearly greatest among girls, especially when it comes to feeling unhappy, sad and depressed, and worrying a lot about things. The proportion who are "quite or very bothered" by such feelings is more than twice as large among girls as boys (15).

Below are some central, selected figures from the Adolescence Report:

- From 1998 to 2015 the proportion of girls aged 16 to 24 years who have consulted a psychologist (in the last 12 months) has increased from 4 to 14%.
- Over twice as many boys compared to girls, in the age group 6-15 years, are in contact with the educational psychology service (PPT= children and youth's psychiatric clinic (BUP)) or psychology as a result of behaviour or well-being problems. Between 2005 and 2012 the proportion of boys went up and of girls went down.
- The proportion of young people who have been «quite or very bothered» by various mental health difficulties increases from 5% to 10% between lower and upper secondary education.

Help-seeking and mental health problems

In the course of childhood, a large number of children and youth experience mental health difficulties or problems. For some, these will remain over time and continue into adult life. In order to promote good mental health and prevent mental health problems, there needs to be a safe and trust-based system where children and youth are not afraid to seek help. In Norway, the system works "reactively" with help-seeking models where those seeking help must first acknowledge that they have a problem, which can be both challenging and demanding, and

then they have to look for help. In the event of uncertainty or lack of recognition, far fewer people with early stage mental health problems may seek and get help they may benefit from. (16). A Norwegian study showed that 34% of adolescents with the highest level of symptoms reported seeking help, while among adolescents with the second highest level of symptoms, only 24% had sought help (17). This is supported by the report from the Norwegian Institute of Public Health (FHI), which highlights low levels of help-seeking among those with mental health problems (18). According to the report only half of children and youth with the highest symptom scores have sought help.

There may be several reasons why children and adolescents fail to seek help: social labelling or stigma associated with mental illness, a feeling of concern about having to seek help, lack of knowledge about where to seek help or lack of trust in health care (especially in the event of previous poor experience).

Social inequalities in health

Social inequalities have been observed in health between different socio-economic groups in Norway (19). The longer education and the higher income a group has, the higher the proportion of the group's "members" will have good health. There is a linear relationship between socioeconomic status and health, statistically speaking, so a slightly higher socioeconomic status will correspond to slightly better health, and this applies across the income scale.

Status in Norway

In the last few years, three major reports have been presented with focus on social inequality, distribution of health and the state of health in Norway: *Social Inequality in Health: a Norwegian Overview (20), Public Health Policy Report (21)* and *The Public Health Report 2018 – the State of Health in Norway (summary version) (19).*

In *the Public Health Policy Report* characteristics and development trends in the state of health in Norway are presented.

- An increase in economic differences in Norway, across the entire income scale.
- In part, considerable and long-term social differences in use of tobacco, diet and physical activity. It is very important that healthy choices are made easier for everyone – this is about price and availability, information and labelling and cooperation with the business community.

- Children who have been in contact with child welfare services are less likely to complete higher education, and a higher proportion of them become recipients of health-related benefits later in life. Having good services that follow up vulnerable children is therefore an investment both for the individual and for society.

From the Public Health Report 2018, the message is clear: those with longer education and a good economic situation live longer and have fewer health problems than groups with lower levels of education and poorer finances. Some main findings:

- Social differences in longevity have increased: women and men with the highest levels of education live 5-6 years longer and have better health than those with the lowest levels of education.
- Man-made environment (e.g. workplaces, schools, healthcare, sports facilities, noise and pollution") can directly affect people's health through access/lack of access.
- The social differences apply to nearly all illnesses and conditions.
- There are major social health differences in living habits and other influential factors, and several chronic diseases are largely the result of the population's lifestyle choices over time.

Socio-economic differences in mental health

One of several major challenges, where there is an increase in mental health problems among children and adolescents, is that a general increasing symptom burden in the young population will probably affect those with the worst starting points the most. Research suggests that there is a social gradient in mental health problems among adolescents (15). Some main findings from the Adolescence Report mentioned in the previous chapter (15):

- The proportion of young people with numerous mental health issues decreases somewhat with increasing social status.
- The extent of mental health problems is significantly higher among young people from families with poor finances, measured both subjectively and objectively (national registers)
- Young people in families where both parents have low levels of education (equivalent to no education beyond secondary school) report the most mental health problems, especially compared to adolescents where both parents have a high level of education.
- The proportion of young people who are bullied most is highest among young people with the lowest socio-economic status.

- The same young people more frequently report mental health issues such as worrying, sleep problems, feeling low or sad, or feeling hopeless about the future.

Work to level out social differences in health

On the basis of the report *Social Inequality in Health: a Norwegian Overview*, an action report was prepared, and an article with recommendations in different areas to level out social health inequalities. «29 recommendations to combat social inequalities in health" (22) is divided into the following 7 topics: growing up, income inequality, education, working life, health behaviour, healthcare and structural measures and implementation. In the article there is a focus on the entire causal chain of social health inequalities, and the point is made that social inequality in health is caused by an entrenched structural bias of economic and social resources in the population.

In Norway, work to level out social inequalities in health are grounded in the Public Health Act (23). The Public Health Act requires both state authorities and municipalities to assess the health and distributional consequences of different measures. The law stipulates that municipalities should work systematically in public health, have an overview of the health of the population, and ensure there are suitable measures and evaluation of the municipality's public health work in the long and short term. In the design of measures to reduce social inequalities in health, emphasis is placed on two principles (20):

1) Broad, population-oriented strategies or measures that reach everyone, in addition to measures specifically aimed at high-risk groups. High-risk strategies alone will not be sufficient.
2) Measures must be directed towards all links in the causal chain that lead to social inequality in health. Not least, it is important that efforts are made to counteract the fundamental social causes of health inequalities.

Societal factors have a major impact on children and youth's mental health, and political frameworks and policies affect the conditions children and youth experience in all arenas (24). Societal factors affect individual children and youth through complex and mutually influencing processes over time. This makes it challenging to show how political decisions, reforms and societal changes affect the mental health of individuals and groups. A system that builds on equal opportunities and fair access to resources for everyone is a good start in preventive and health promotion work for children and youth's mental health.

The Norwegian health care system

Organisation and structure

Norway has a universal public health system which is one of the pillars of the Norwegian welfare society. The organisation is based on the principle of equal access to services for all, regardless of socioeconomic status and geographical location. (25). The Norwegian health service is semi-decentralized. This means that the Ministry of Health and Social Care is responsible for specialist health services, while the municipalities are responsible for primary health care.

Public health and mental health work

Work in public health and mental health care can be said to take place at three different levels – nationally, regionally and locally.

National level

At national level, the Ministry of Health and Social Care has the overall responsibility for public health work in the country and shall ensure that the population receives good and equal health and care services. Through national authorities and legislation, guidance is laid down for how work on public health and mental health care should be carried out, at all levels, nationally, regionally and locally.

Health-related laws

In order to ensure good health services for the entire population, health has been enshrined in several parts of Norwegian legislation. Some of the most important for public health and mental health work are: the Public Health Act, the Health and Care Services Act, the Patient and User Rights Act and the Specialist Health Services Act. The Child Welfare Act and the Social Services Act will also be mentioned.

- *The Law on Public Health (Public Health Act)* (23) shall contribute to a social development that promotes public health, including levelling out social health differences.
- *The Law on Municipal Health and Care Services (Health and Care Services Act) (26)* applies to all health and care services provided by municipalities, and shall ensure that all persons residing in the municipality are offered necessary health services and ensured equitable services.

- *The Law on the Specialist Health Services (Specialist Health Services Act)* (27) aims to promote public health and counteract disease, injury, suffering and disability. The act shall contribute to an equitable service provision, ensure the provision is adapted to the needs of patients and ensure that the service provision remains available.
- *The Law on Patient and User Rights (Patient and User Rights Law)* will ensure the population equal access to services by giving patients and users specific rights to the health and care services, including the GP scheme that applies to any resident of a Norwegian municipality.
- In addition, both the *Law on Social Services in Labour and Administration (Social Services Act)* (28) and the *Law on Child Welfare Services (Child Welfare Act)* (29) are both important in ensuring children and youth and their families a safe upbringing with good health and development, and holistic and coordinated services.

Political policies

In addition to national health authorities and legislation, public health is also dealt with at a political level. The focus and emphasis on general mental health is relatively new in Norway.

- In 1998, the Government presented the "Mental Health Escalation Plan" (1998-2008), which was intended to strengthen the provision of people with mental health disorders (30).
- After 2008, Norway no longer had any such coherent plan or strategy, until 2017 when the current government presented "Master your whole life – the Government's Strategy for Good Mental Health (2017-2022)" - a comprehensive and cross-sectoral strategy for children and youth's mental health, at individual and societal levels, for both health promotion, disease prevention and curative measures (31).
- The same government also presented the *Public Health Report – A Good Life in a Safe Society* in 2019 (32), which aims to promote quality of life and mental health throughout the population. It is stated in the report that mental health should be an equal part of national and local public health work.

Regional level

In 2002, the specialist health service in Norway was reorganised, and five regional health enterprises were established in Norway. A regional health enterprise (RHF) is a state-owned health enterprise that covers all public enterprises within the specialist health service within a limited geographical area (a region). The specialist health service includes hospitals, district

psychiatric centres, institutions for multi-disciplinary, specialised substance abuse treatment and private practitioner specialists.

Regional knowledge centres

Regional knowledge centres for children and youth / Mental health and child welfare (RKBU/RBUP) are regional centres for children and youth's mental health (RKBU North, Mid-Norway, West and East-South). The centres focus on prevention, competence building, research and dissemination to strengthen children and youth's mental health and to develop municipal provision in this area. The target group for *RKBU/RBUP* is the public service system, i.e. decision-makers in the health and care services, child welfare services, kindergartens and schools.

The Knowledge Centre for Addiction (KoRus) is a regional centre of expertise in the addiction field. There are seven regional KoRus centres in Norway. The social task of the centres is to strengthen competence and quality in relevant services. The centres are aimed at municipal and state services and have particular responsibility towards the municipalities. The centres should implement targeted measures to strengthen competence in public health work and early intervention, as well as work aimed at people with addiction problems.

The regional resource centres on violence, traumatic stress and suicide prevention (RVTS) are resource centres for those working with people who are affected by violence and sexual assault, traumatic stress, migration or suicide issues. There are five *RVTS* that contribute to competence building in the field. The centres work in a multi-disciplinary way with, for example, health and social care services in the municipalities, specialist health services, public, private and voluntary organisations offering assistance to people affected by violence and crisis.

Local level

Public health and mental health work at the local level is largely done in the municipalities. This is based on the Municipal Health and Care Services Act, which was implemented in 2011 and made the municipalities responsible for primary health and care services.

Programme for public health work in municipalities

Much of the work done nationally and regionally also aims to be offered at the local level. In 2017, a ten-year initiative (2017-2027) started on municipal/local public health work: "Programme for public health work in municipalities 2017-2027" (33) – a long-term

strengthening of municipalities' efforts to promote health and quality of life in the population. Key topics include children and youth, mental health and prevention of substance abuse.

The programme is currently developing initiatives in all counties and municipalities in Norway. An overview of descriptions of measures and evaluation schemes in the programme can be found at: Forebygging - Handling. Existing measures can be divided into the following categories: levelling out of social health inequalities; kindergarten and school; coping skills in children and youth; participation and activity; leisure and social meeting places and prevention of addiction.

Municipal health and social care services

The right to a general practitioner (GP) (regulations on GP scheme in the municipalities), health visitor centres and school health services (regulations on health visitor centres and school health services) are also pivotal for public health and mental health work in the municipality.

- *The purpose of the regulations in the GP scheme* is to ensure that all inhabitants of a municipality receive the necessary general practitioner services, and that all individuals resident in Norway have access to a GP.
- Regulations on health visitor centres and school health services shall ensure that all municipalities have a health centre for children and youth (0-20 years) and pregnant women, and school health services at all primary, secondary and upper secondary schools.

Health visitor centres for young people (HFU) are a free, multi-disciplinary service for all children and youth (up to 20 years) in the municipality. The service provides advice in connection with mental health and social problems, eating disorders, addiction and violence. HFU must be accessible and attractive to children and youth and should have "drop-in offers", ensure the need for anonymity, have employees with knowledge of youth's health and able to communicate with children and youth, and should have an overview of current provision and services for children and youth - HFU can function as "door opener" for other services and provision.

The school health service is covered in the chapter "Norwegian school system ".

Public versus private health care services

In Norway, public health care is very strong. In 2017, health spending accounted for 10.4% of GDP, and public sources (funding from central and local authorities and national insurance) account for 85.5% of health spending, which is the highest proportion in Europe (25). The private healthcare sector is relatively small and well regulated. In the municipalities, the majority of general practitioners are self-employed, but embedded in the public system through contracts with the municipalities (25) and legislation.
Commercial health providers have a smaller role in specialist care and account for approximately 10% of the total operating costs of somatic services, approximately 13% of mental health care, approximately 37% of substance abuse services and approximately 11% of nursing beds.

The largest share of private funding is spent on pharmaceuticals, dental care and long-term treatment, and annual ceilings have been set for cost distribution to protect the population from excessive health spending. The proportion of Norwegian households with private health insurance has increased over the past decade, but the role of such insurance in health funding remains negligible.

Non-governmental organisations and interest organisations

There are also several not-for-profit private actors and interest organisations working with public health and mental health care in Norway.

- *The Norwegian Association of Youth Mental Health (MHU)* is an independent, nationwide, non-profit interest organization. *MHU* is open to youth who have or have had mental health problems or others who need care, regardless of religion, beliefs, ethnicity, level of function, sexual orientation or gender identity. MHU is mainly financed through membership fees and government grants.
  Link to web page in Norwegian: Mental Helse Ungdom
- *The National Development Centre for Children and youth (NUBU)* is a centre of knowledge and competence that develops, implements and evaluates evidence-based measures (for behavioural problems) aimed at children and youth, parents, families, kindergartens and schools. *NUBU* is partly financed by the Directorate of Children, Youth and Family Affairs, and receives grants for specific projects from several public actors.
  Link to web page in English: The National Development Centre for Children and Youth (NUBU)

- *The Mental Health Council* is a non-profit umbrella organisation consisting of 31 member organisations. Each year, the organization awards the "taboo prize", an honourable and honorary award given to individuals/businesses who through words and action have an positive impact on mental health; breaking down prejudice, breaking taboos, and promoting transparency about mental health. The organization is largely financed by the Dam Foundation.
  Link to the web page in English: The Mental Health Council
- *Voksne for barn ("Adults for children", VFB)* is a non-profit member organisation that works to promote good mental health and safe conditions for all children to grow up. The organisation is divided into local teams across the country, which work for children and youth in their community. VFB addresses key mental health issues and offers various initiatives and tools for children and youth, parents and in schools.
  Link to the web page in Norwegian: Voknse for Barn

Grant Schemes

In order to work with, and to ensure the stimulation and involvement of private actors and organisations in the work on mental health, there are several grant schemes.

- *The Directorate of Health* has its own grant scheme for GPs, municipalities/counties and organisations (private/non-profit).
  Link to web page in Norwegian: Tilskudd - Helsedirektoratet

Specific grant schemes under the Directorate of Health:

- «Strengthening and development of health visitor centres and the school health service» (Norwegian link: Styrking og utvikling av helsestasjons- og skolehelsetjenesten - Helsedirektoratet)
- «Mental health in school» (Norwegian link: Psykisk helse i skolen - Helsedirektoratet)

- *The DAM Foundation* is one of Norway's biggest foundations and gives funding to health and research projects aimed at improving health through participation, activity and coping for people in Norway.
  Link to web page in Norwegian: Stiftelsen Dam

Norwegian school system

Almost every Norwegian children and youth participate in compulsory and secondary education from the age of 6 to 19. Mental health promotion and preventive work should take place where children and youth are. The school arena is therefore central to mental health work, and mental health has also been shown to be linked to school-related factors such as stress and pressure (20, 34-36).

In Norway, the school structure is divided into primary and secondary education. Compulsory schooling covers all primary and lower secondary schools in Norway and there is free mandatory schooling for children aged 6-16 years (37). Compulsory school is divided into two levels: primary (children aged 6-12 years) and lower secondary (young people aged 13-16 years). The right to primary and lower secondary school is enshrined in the Education Act, which ensures the right and duty of children and youth to attend public primary and lower secondary education (38). On completion of compulsory lower secondary school, everyone is entitled to apply for 3-5 years of full-time upper secondary education. Public upper secondary education is free, and the right to undertake upper secondary education applies until the year youth turns 24.

Participation in compulsory and upper secondary education

In Norway, 9 out of 10 compulsory-level schools are public, a proportion which has fallen every year since 2006 (39). A rough estimate of figures from the Education Department and Statistics Norway suggests that:

- Around 94% of all children and youth (6-16 years) in Norway are in public compulsory school (40).
- Around 60% of children (age 6-9 years) participate in after school care within schools (SFO) or activity school (AKS)
    - These are offers that facilitate play, cultural and leisure activities based on age, level of function and interests of the children (39).

For upper secondary education, the figures for participation are lower, which is linked to the fact that upper secondary education is voluntary. Some key figures from the OECD's 2017 indicator report on the education sector (41, 42), show that:

- Around 89% of Norwegian 18-year-olds are in upper secondary education.
- Around 87% of youth in the age group 15-19 years in Norway are in education.

- Around 90% of the population is expected to complete upper secondary education during their lifetime.
- Of all pupils/trainees participating in upper secondary education or training, around 78% complete their studies/training within 5-6 years.

The duty and the right to participate in school are two central reasons why Norway has remained at the top of world lists in terms of education for all (41).

"Public health and coping with life" on the schedule

In the autumn of 2020, the curriculum in compulsory and upper secondary education was updated. In the overall section, under "principles of learning, development and formation", public health and coping with life were presented as a new interdisciplinary topic. The aim is to increase pupils' competence in good mental and physical health and lifestyle habits, as well as information on sexuality and gender, drugs, media use, and consumption and personal finances (43). Coping with life is about students' being able to understand factors that influence their own lives, and the topic should also teach students how to deal with progress and adversity, and personal and practical challenges in the best possible way.

School health service

All Norwegian schools have to provide school health services (26) – a free service for all pupils (between 5 and 20 years) who are in compulsory education. In the school health service, pupils can contact a school nurse – and in some cases a school doctor, physiotherapist or psychologist. Youth don't have to book or have an appointment with the school health service, they can just turn up. The nurse should be a safe professional, where as a child or youth you can get advice and guidance on, among other things, body and health, puberty, sexual orientation, difficult thoughts, feelings and concerns. In addition to the nurse, the school health service offers a school start health check (in 1st grade in primary school), teaching in groups and classes on physical, mental and sexual health, a health talk in 8th grade and vaccination. All employees in the school health service have strict confidentiality, with some few exceptions.

Method

To find initiatives that have been implemented in Norway and have been evaluated, a specialist librarian carried out the search for this report, Module 3. In mid-January 2021, systematic literature searches were carried out in the databases MEDLINE, EMBASE, PsycINFO and Web of Science. The search was limited to articles published after the year 2000. The search yielded a total of 1,091 hits (after duplicate check). Search strategy details can be found in Appendix 1.

The location of the initiative could be in school and everyday life, as long as the measure was either aimed at children and youth themselves, parents/family, teachers in schools or other caregivers – and where the purpose of the measure was to improve mental health or reduce mental health problems for children and youth. Both face-to-face and digital measures were included in the search and in the review of articles. The measures included in the report had to have been implemented in Norway, at the national, regional or local level.

The inclusion and exclusion criteria used for selecting "best practice" measures in the field of mental health and health problems in children and youth (6-20 years) are shown in Appendix 2.

To get an overview of screening tools used in Norway, aimed at mental health and mental health problems, a literature search was carried out in the database PsyktestBarn, on 23 February. Search strategy details can be found in Appendix 3.

Supplementary searches and grey literature

A supplementary search by a specialist librarian was carried out on 22 February 2021, based on feedback from the client on the module's mid-term report. The search was specifically aimed at picking up relevant measures that had not been identified in the first search, and it was performed by manual searches in Google Scholar and Google.

During the project period, specific, manual searches for "grey literature" and other supplementary information regarding mental health promotion and prevention work were also carried out. This involved several non-systematic searches for individual articles and other information to substantiate and put the findings of the main search into context.

Results

The results chapter is divided into three parts, each of which addresses publishing and communication channels, screening tools and practical measures for mental health and mental health problems.

Part 1) *Digital infrastructure* presents publishing, information and communication channels on mental health and other similar fields, intended for children and youth, parents, health professionals and schools. Digital tools and other online resources are also presented here.

Part 2) *Screening tools for mental health and well-being* presents a selection of Norwegian screening tools (either developed in Norway or translated into Norwegian) used to map mental health, symptoms of mental health problems or other related factors in Norwegian children and adolescents.

Part 3) *Practical measures* presents a selection of practical measures aimed at mental health and mental health problems in different arenas which form part of children and youth's everyday lives.

Part 1) Digital infrastructure for better mental health

As part of the supplementary searches several informative websites, knowledge databases, publishing channels and digital tools were found. These may be controlled by either national authorities or private organisations.

Publication, information and communication channels from national authorities

- *Helsebiblioteket ("Electronic health library")* is a website that provides free access to professional procedures, reference works, databases, journals and other knowledge resources for healthcare professionals.
  Link to web page in English: The Norwegian Electronic Health Library
- *Ung ("Young")* is the public information channel for youth and offers information and guidance for youth aged 13-20 years. *Ung* is a reliable, clear and confident player that youth can take seriously and trust. The website has topics such as body, sexuality, mental health, leisure, work and education.
  Link to web page in English: "Young"
- *DIGI-UNG ("DIGI-Youth")* is relatively new and will become a programme that delivers readily accessible and quality assured information, guidance and services to youth – through a comprehensive digital offering across sectors that contribute to coping and self-help in mental health.
  Link to information in English: "DIGI-Youth"

Knowledge databases and electronical journals

Til beste is a website containing knowledge and news about mental health and child protection. The website is a collaboration between the four regional knowledge and competence centres RKBU and RBUP. The website refers to four different reference sites listed below.

Link to web page in Norwegian: Tilbeste

- *IN SUM* is a database for systematic reviews on the effects of measures for children and youth's mental health and welfare. IN SUM's primary target group is researchers, leaders and decision-makers, as well as universities/colleges and other centres of expertise. IN SUM provides relevant knowledge of specific measures for those working with children and youth, as well as youth themselves and their parents.
  Link to web page in English: INSUM

- *Ungsinn* is an electronic scientific journal on measures for children and youth's mental health and contains systematic knowledge summaries about individual measures. The summaries of the measures are prepared according to a specific method. The conclusion of the measures is summarised in an evaluation and classification, where each measure is classified at one of six evidence levels:
    - *Level 5:* Measures with strong evidence of effect. *Level 4*: Measures with satisfactory evidence of effect. *Level 3:* Measures with some documentation of effect. *Level 2:* Theoretically justified measure. *Level 1:* Well-described measure. *Level 0:* Ineffective measure.

  Link to web page in English: Ungsinn
- *Tiltakshåndboka (English: "The Initiatives Handbook")* is a tool for professionals at all service levels and acts as an electronic journal. The handbook consists of easy access to summarized and quality-assessed research on follow-up of children and youth's mental health. The handbook is openly available to the public and is therefore a useful resource for users, parents, teachers and other people who want greater insight into the knowledge base.

  Link to web page in Norwegian: Tiltakshåndboka
- *PsykTestBarn* is an electronic journal that publishes articles on evaluated measurement characteristics of Norwegian versions of tests and screening tools for mental health. The journal contributes to informed choices and responsible use of tests and screening tools in practice.

  Link to web page in Norwegian: Psyktestbarn. *English summaries are available on each test and screening tool.*

Digital tools and self-help resources

The Psychology Association for Digital Health (DigPsyk) is a professional interest organisation under the auspices of the Norwegian Psychology Association. In connection with the ongoing pandemic, DigPsyk has created an overview of various health technology tools and online self-help resources. Below is a selection:

Link to information in English (not official web site): Digital solutions for mental health care

- *Assistert selvhjelp ("Assisted self-help")* develops online coping tools for people with mental health problems. On the website, 8 different tools based on the guided self-help method are presented: coping with anxiety, depression, sleep difficulties, stresses and strains, worries, self-esteem, perfectionism and exposure. For private individuals, there are

costs associated with the tools, but it is possible to get free access by contacting low threshold services such as Fast Mental Health Services, municipal health services or GPs
Link to the web page in Norwegian: Assistert Selvhjelp

- *Psykologisk veiledning* ("*Psychological guidance*") is a website with various self-help programmes for many of the most common mental health problems. All materials for the programmes are free and there is no need to register to access these.
  Link to the web page in English: Psychological guidance
- *Braive* is an online mental health service that offers e-learning programmes where users can begin mental training on their own initiative. The site offers programmes including for depression and anxiety, sadness, sleep problems, and a separate programme associated with COVID-19: "mentally strong in a time of Covid19." There are costs associated with using the tools, but according to the website, people with a reduced financial situation can get in contact and access the programme for free.
  Link to the web page in English: Braive

Part 2) Screening tools for mental health and well-being

Below is a selection of the search results from PsykTestBarn, with the exception of one screening tool – Symptom Checklist (SCL), which is a result of supplementary search.

Strength and difficulties questionnaire (SDQ)

SDQ was developed by Robert Goodman and published in 1997. It was translated into Norwegian in 1999. *SDQ* is a set of questionnaires with three informant versions: parents, teachers and children aged 11 years or older. The questionnaire maps mental health, friend relationships and prosocial behaviour in children aged 4-17 years and is divided into five different subscales: emotional symptoms, behavioural problems, hyperactivity/attention problems, relationships with peers and prosocial behaviour. The three different versions are *SDQ-P* (parent version), *SDQ-T* (teacher version), and *SDQ-S* (self-report), which have 25 questions across the five subscales. Robert Goodman owns the rights to the questionnaires.

Norwegian link with English summary available: Psyktestbarn - SDQ

Resilience Scale for Adolescents (READ)

READ was developed in Norway in 2006 (44), and is a self-report questionnaire for children and youth (no specified age group) that measures resilience: the ability to manage stress and negative life events. READ consists of 28 statements that are positively formulated and form a total of 5 subscales: personal competence, social competence, social support, family cohesion and personal structure. READ is a questionnaire that is well suited for research. It is copyrighted and the licensees can be contacted to access the test.

Norwegian link with English summary available: Psyktestbarn - READ

The Inventory of Life Quality in children and adolescents (ILC)

ILC was developed in Germany in 2006 and translated into a Norwegian version in 2012. The questionnaire measures health-related quality of life in children and youth aged 6-18 years with mental and somatic disorders– but can also be used in healthy children and adolescents. The questionnaire consists of seven test items with a five-part scale, and there is both a parent version and a self-report version. Self-reporting takes place in interview form and is for children between 6-11 years. The Norwegian edition of ILC is available from Hogrefe Psykologiförlaget AB.

Norwegian link with English summary available: Psyktestbarn - ILC

Eyberg Child Behavior Inventory (ECBI)

ECBI was developed in the United States in the 1970s and translated into a Norwegian version in 1999. The screening tool is intended to detect behavioural problems in children and youth aged 2-16 years, and can be used for screening, clinical activity and research purposes. ECBI contains 36 items that are scored on an intensity scale and a problem scale. Scores on the intensity scale help assess the child's behaviour, while scores on the problem scale help assess the challenges the child's behaviour represents to parents or other caregivers. Psychological Assessment Resources (PAR) in the United States manage licenses for the use of ECBI.

Norwegian link with English summary available: Psyktestbarn - ECBI

KIDSCREEN

KIDSCREEN was developed through an international collaboration led by Germany and was translated into a Norwegian version in 2006. KIDSCREEN is a questionnaire that measures health-related quality of life in children and youth aged 8 to 18 years. The questionnaire is available in three different versions for children and three versions for parents, with 52, 27 and 10 questions respectively. There are no norms, but the psychometric characteristics of KIDSCREEN indicate that the questionnaire can be recommended to measure quality of life in children and youth in the normal population, but also in clinical samples. KIDSCREEN can be used free of charge, but the KIDSCREEN group must be contacted first, (http://www.KIDSCREEN.org/english/project/project-coordination/)

Norwegian link with English summary available: Psyktestbarn - KIDSCREEN

Hopkins Symptom Checklist (HSCL-5 and 10)

SCL-90 SCL was developed in the United States in the 1970s. There is a lack of information about when the questionnaire was translated into Norwegian, but has been used in Norwegian health and living conditions surveys since the 1980s. SCL-5 and SCL-10 are two short variants derived from the self-report questionnaire SCL-90 (45), and have shown themselves to be strongly correlated versions of the original (46). SCL-5 and 10 measure symptoms of anxiety and depression. Based on average scores, symptom loads are calculated, and one usually operates with a cut-off score that estimates whether or not you have symptoms of anxiety and depression (46).

English article with information: The Hopkins Symptom Checklist (HSCL): a self-report symptom inventory

Part 3) Practical measures of preventive and promoting mental health work

From the systematic literature search, there were about 30 articles evaluating various measures of mental health promotion and preventive work. These articles described a total of 11 practical measures that have been or are implemented in Norway, and which comprise the results in Part 3.

The results did not contain any measures implemented or used regionally. The measures are therefore defined as being at national or local level of action. Measures described as national level are initiated, developed or owned from a national point of view, either by the Norwegian authorities or by regional knowledge centres. These measures will either be facilitated as optional, as recommended measures or as statutory provisions. Measures described as at the local level are initiated and developed at the local level, in a particular municipality or by private organisations or individuals.

Some measures are designed to be offered in several different contexts, but most of the measures are mainly offered in specific arenas (for example, in school).

- 7 of the measures are mainly school-based and are offered as school programmes.
- 3 of the measures are mainly aimed at municipalities and various health services.
- 1 of the measures is a self-help programme aimed at children, youth and parents/family.

The measures are presented in order according to the targes group's age.

PMTO – Parent Management Training

Owner/provider:

Parent Management Training – the Oregon model (PMTO) is one of several interventions in the programme Early Intervention for Children at Risk (TIBIR) which is owned and run by the Norwegian Center for Child Behaviour and Development (NUBU).

Reach:

PMTO is a national-level measure. The programme was developed to be implemented in municipalities, but can be offered at health centres or individual clinic level. The programme currently exists in all counties in Norway and in over 100 municipalities/districts.

Purpose/aim:

The aim of PMTO is to train parents in core «parenting skills» which can prevent, reduce or stop problem behaviour in children and youth. PMTO has two goals, one linked to children's behaviour and the other to the development of skills in parents.

Target groups:

PMTO is aimed at parents with children aged 3-12 years who have or are at risk of developing serious behaviour problems, where the patterns of interaction between the parents and the children are characterised by a persistent negativity.

Time period:

PMTO was developed by Oregon Social Learning Center (OSCL) in the USA in the 1960s and was introduced to Norway in 1998. The initiative is currently in use in Norway.

Implementation/components:

The initiative consists of guidance for parents and can take place either individually or in groups. It starts with an initial conversation with the parents, where the child's and the parent's resources and difficulties are mapped out. The process starts with an pre-survey, where parents fill out a standardised questionnaire, the «Eyberg Child Behavior Inventory» (ECBI) (66) – to ascertain the extent of the child's behaviour difficulties and the parent's challenges linked to these. The actual guidance consists of consultations between the therapist and the parents, and the work format is usually weekly meetings, lasting anything from 10 to 40 weeks. The treatment meetings are usually an hour long and the themes discussed are tackled in a planned order. The normal duration of treatment is six to eight months. Children can participate in these meetings, and the aim, in such instances, is to give the parent an opportunity to practise the skills they learn along the way. It is normal that the parents are

given material to work with at home between the meetings. In addition, there is a follow-up telephone conversation between the parent and the therapist once a week.
Over the course of the programme, various themes and skills will be worked on in a planned order. Relevant themes are positive involvement, negative consequences of undesired behaviour, problem solving, and involving the school or nursery. These themes, and the order they follow, are flexible.

The educational material for parents is a handbook, which describes important themes, has concrete suggestions for what the sessions with therapists should cover and how to work with specific themes. It also emphasises the importance of the flexible sessions and therapists, and that there is space for themes that families specifically want to work with.

Costs:
No costs for the guidance/course are mentioned on the programme's home page, but according to the homepages of several municipalities, the programme is free. For municipalities, training and follow-up from the Center for Child Behaviour and Development, and the regional implementation teams, is also free.

Effects:
The programme has been shown to reduce parent-reported externalising problems in children, increased teacher-reported social competence and strengthening parents' discipline (67). The programme has also been shown to have good effect on both genders, with a slightly stronger effect on girls (68). Another study concluded that the programme has long-term effects, and that both parental discipline and cohesion in the family is stronger a year after treatment (69)

Evaluation:
The initiative was last evaluated by the journal Ungsinn in 2018 and achieved an evidence level of 5.

Limitations linked to Covid19:
According to a status report dated 6 July 2020, from BUFDIR (the Norwegian Directorate for Children, Youth and Family Affairs), PMTO has been available throughout the crisis and is operating normally in all regions. No delays have been notified (Status report 6 (bufdir.no).

References:
English web page for information: PMTO (Parent Management Training, Oregon)

AART – Adapted Aggression Replacement Training

Owner/provider:

AART (formerly ART) was developed in 1987 in the USA. The initiative started in Norway in 2002, and Norway was later gained permission to develop an adapted Scandinavian version of the programme, called «Adapted ART» (AART). The initiative is owned and run by PREPSEC Norway and VID Specialized University, which is also responsible for implementation of the initiative. PREPSEC Norway is a national community organisation.

Reach:

AART is a national-level programme. It has been developed to be implemented in nurseries, schools, child welfare and other support centres.

Purpose/aim:

The main aim of AART is to improve children and youth's social competence and replace aggression with more purposeful reactions and behaviour patterns. Another aim is to teach children and youth to connect thoughts and feelings to concrete skills and actions, and reflect on this.

Target groups:

AART has traditionally been aimed at children and youth with behaviour difficulties, but it has developed into a more general initiative for children and youth aged 4-20, who have, or are developing, behaviour difficulties. In Norway, AART is primarily described as a health-promoting and preventative initiative for any children and youth.

Time period:

ART was first used in Norway in 2002 and was adapted for the Scandinavian context in 2015 when it gained the name AART. The initiative is still in use.

Implementation/components:

There are three component parts in the AART programme: 1) social skills training, 2) controlling anger and 3) moral reasoning. Each of the three components is covered once per week. The programme is primarily carried out over 30 hours across 10 weeks, with three sessions per week from 45 to 90 minutes long. The sessions are generally group-based with 4-8 children (recommended 6-8) in each group, with two certified trainers. The individual sessions are built up according to a fixed structure of three parts: an introduction where the theme of the day is presented; covering the relevant component where participants practise the topic through role play; and the ending, where the participants evaluate the session and are

given homework tasks to put the day's theme into practice – the content will vary according to the theme. It is also possible to adapt and carry out the sessions according to the specific needs of the participants.

«AART – A method for training in social competence" is a subject book that describes the initiative and is used in training. The book contains an in-depth description of, and the rationale behind, the main components. In addition, examples related to the general structure and the structure of sessions, content and implementation are presented.

Costs:

Running AART requires certified trainers. The certificate can be gained by following an eight-day course with practice and a practical test at the end. The course fee is around 14000 NOK (around 1350€). This includes course materials and certification. The costs of implementing the AART programme are covered by the institutions themselves. The target groups for the certification are teachers, child welfare workers/professionals, and others who work with children and youth. There is no formal pre-requisite in terms of qualifications.

Effects:

A study from 2006 showed an increase in social skills and reduced problem behaviour reported by parents of children who had been through the ART programme (58). This is supported by a new study from 2010 by the same authors (59).

Evaluation:

The initiative was last evaluated by the journal Ungsinn in 2017 and achieved a level of evidence of 3. There has been no evaluation of the further developed version AART which is currently used in Norway.

Limitations linked to Covid19:

No information can be found about delayed courses or how the programme is carried out within national guidelines or other coronavirus restrictions.

References:

English web page for information: ART (Aggression Replacement Training)

PALS – Positive Behaviour, Supportive Learning Environments

Owner/provider:

PALS is the Norwegian version of the school-wide, multi-level model, «School-Wide Positive Behavioral Intervention and Support (SW-PBIS)» developed in the USA. The model has been further developed and adapted for the Norwegian context by the Norwegian Center for Child Behaviour and Development (NUBU), which owns the programme and is responsible for training and implementation in Norway.

Reach:

PALS is a national-level programme. It was developed to be implemented in all municipalities and schools. The programme is currently existing in every county in Norway.

Purpose/aim:

The main aim of PALS is to: develop a positive learning environment and a school culture which strengthens pupils' educational and social skills, and prevent and reduce problem behaviour in the learning environment by proactive, rather than reactive, measures. Another aim is increasing employees' competence by developing the school as a learning organisation.

Target Group:

PALS is aimed at pupils (aged 6-16 years) and employees in compulsory education.

Time period:

The national implementation of PALS started in Norway in 2006. In the school year 2013-14 PALS was implemented in 209 schools in several of the counties of Norway. The initiative is currently in use.

Implementation/components:

When implemented PALS, a PALS team is established. The team consists of 5-7 individuals who are representative of the school's management, employees, parents, educational mental health teams and pupils. The PALS work on training is organised at three levels in an intervention and measures pyramid. This division differentiates between the seriousness of the problem and its prevalence and is adapted to the pupils' varying levels of function and need for help and support. The different interventions in PALS are organised in the same pyramid: *level 1) universal (primary preventative) measures* are for all pupils, and the aim is to limit development of risk at the lowest possible level of intervention. Pupils who don't reach satisfactory results in the first universal measures are followed up through the two further levels. *Level 2) selected (secondary preventative) measures* are for those pupils who show

moderate risk behaviour, and *level 3) indicated (tertiary preventative) measures* are for those pupils who show high risk behaviour. This level includes both targeted and customised measures, and pupils in this group can also receive offers of working with other agencies. For pupils in years 1-6, (age 6-13), the screening tool, «Elementary Social Behavior Assessment: ESBA» is used to evaluate ther social skills. This is a 3-point teacher observation scale where the pupils in each class can be evaluated as a group or individually three times a year.

The initiative is based on a set of evidence-based core components for the model's three levels. In module 1, the focus is on approaches like: good relations promote a good learning environment; whole school expectations of prosocial behaviour and encouragement; recognition and positive involvement are central for teaching the pupils new social and educational skills, as well as preventing and reducing problem behaviour. In modules 2 and 3 more differentiated approaches are offered. *The FAST method (find, analyse, select, test)* contains concrete methods for evaluating and reducing problem behaviour in teaching situations. *SISU (Check in check out)* is a short-term intervention offered on a daily basis to pupils. SISU is adapted to the individual pupil, and the aim is to promote the pupil's mastery of and motivation for learning by increasing positive interaction with adults and fellow pupils. *SNAP (Stop now and plan)* is another social skills training programme where pupils can learn cognitive problem-solving skills and anger management. SNAP can be taught in groups or individually and is aimed at children under 12 years, who show aggressive and anti-social behaviour.

Costs:

For municipalities who want to implement the PALS model, there are costs linked to training PALS supervisors, 12.000NOK (around 1150€). After this, there are costs of 2500NOK per year for supervisors to keep training up-to-date. According to the owner of the initiative, there are no direct costs for those receiving the PALS model, and participation in PALS is free for schools. There is an option to buy physical handbooks but these can be downloaded for free from NUBU's home pages.

Effects:

In a study of PALS, changes were studied 20 months after implementation, where a medium effect was found on problem behaviour in the school environment and the classroom, and a large effect was seen in the number of pupils who had behaviour problems reported by teachers (70). In a later evaluation by the same authors, no effect on problem behaviour was found a year after implementation, but small changes were found after 3 years for general

problem behaviour, moderate problem behaviour and serious problem behaviour in the school environment, as reported by teachers (71). Effects have also been found in teachers' individual and collective mastering strategies and a large effect for teachers' use of positive, supportive strategies (72).

Evaluation:

The initiative was last evaluated by the journal Ungsinn in 2018 and achieved an evidence level of 5.

Limitations linked to Covid19:

We found no information about how PALS is carried out in relation to national guidelines or other coronavirus restrictions.

References:

English web page for information: PALS in Norway

Olweus programme (OPBB) – a school-wide programme to prevent bullying and antisocial behaviour

Owner/provider:

The Olweus programme was developed and implemented in Norway, at the University of Bergen in 1999. In 2001, the Norwegian parliament granted funds for introducing the Olweus programme on a large scale into Norwegian schools. RKBU Vest / NORCE is the owner of the programme and runs the programme.

Reach:

Olweus is a national-level programme. The programme was developed to be implemented in all schools, and is in use in almost every county in Norway.

Purpose/aim:

The aim of Olweus is to reduce existing bullying problems and to prevent bullying and create safe and positive learning environments for all.

Target groups:

Olweus is aimed at pupils in compulsory school, aged 6-16 years. To a certain extent the programme is also aimed at adults (staff at school and parents at home), by increasing consciousness of and knowledge about bullying, and by engaging adults.

Time period:

The national implementation of Olweus started in Norway in 2001, and the programme was introduced into ca. 600 Norwegian schools. The programme is currently in use.

Implementation/components:

Great emphasis is placed on work with Olweus being well-anchored in the individual school, and the decision to implement the programme is taken by the school owner (municipality) and the school management. On implementation, a group is set up (the coordination group) with the task of monitoring and introducing the programme according to the planned progression. In addition, one member of the school staff is designated as the programme coordinator, and has practical tasks linked to the organisation of ongoing work.

In the programme, measures are developed at school, class and individual levels based on the four principles listed under Main Aim above. *School-level measures* include having school rules about bullying, an inspection system, pedagogic discussion groups (for staff), establishing a coordination committee for bullying prevention work, annual pupil survey

using questionnaires, celebrating anti-bullying work, improving inspection and anchoring in the coordination committee. *Initiatives at class level* include introducing and maintaining school rules on bullying, role play, regular class meetings to discuss bullying, classroom and learning environments and parent meetings. *Initiatives at individual level* focus on guiding pupils on how to react if they see bullying, individual structured conversations with bullies and victims, conversations with parents and creating individual measures. The measures at school, class and pupil levels are essential components of the programme and cannot be left out.

Comprehensive material on the programme has been produced and is used for the implementation of Olweus. Part of the material is the Olweus pupil questionnaire about bullying, which is completed before and after the introduction of the programme to evaluate the effect. The results are presented to the school and contain important and easily understood information about issues such as the prevalence of bullying. This screening provides a better basis for systematic work on prevention and reduction of bullying. Web-based lectures have also been developed with reflective tasks as an introductory course for the programme. These are freely available on the webpages of the initiative owner.

After the programme has been implemented, the school can be certified as an «Olweus school». The aim is to support the school's work by maintaining the use of the programme after implementation, and a minimum standard has been developed for carrying out the measures and quality control work in the schools.

Costs:

For schools who want to implement Olweus, the costs are mainly linked to training instructors or buying in instructors who are already qualified. This is also linked to costs of purchasing materials. Introducing the programme to a school is estimated to cost around 10-15000NOK (around 1300€).

Effects:

Results from a Norwegian studies suggest that there has been a reduction in levels of bullying (being bullied or bullying) in schools who have adopted the programme (73, 74). In the results of a report commissioned by the Norwegian Directorate for Education and Training, in 2014, it was concluded that Olweus had contributed to a reduction in bullying during the 1990s and 2000-2010 (75).

Evaluation:

The initiative was last evaluated by the journal Ungsinn in 2020 and achieved an evidence level of 5.

Limitations linked to Covid19:

On the webpages of the initiative owner, it states that all planned courses, guidance and teaching activities are cancelled or delayed, and that work is being done on finding alternative teaching methods for some training and courses to ensure they can be carried out.

References:

English web page for information: Olweus Bullying Prevention Program

FRIENDS for life

Ownder/provider:

FRIENDS for life was developed in Australia by Paula Barrett in 2004, which is also the owner of the programme. The first Norwegian edition came out in 2005. RKBU Vest were responsible for distribution and implementation, as well as training, accreditation and certification of the initiative in Norway up to 2018, when the contract with the owner ran out.

Reach:

FRIENDS is a national-level programme. It was developed to be implemented in schools, community health services and specialist health services.

Purpose/aim:

The main aim of the programme is to develop skills so children and youth can better cope with anxiety, and reduce anxiety symptoms. Another aim is to normalise difficulties, and strengthen communication within the family, as well as promoting the parents' role as models.

Target groups:

FRIENDS is aimed at children and youth aged 8-15 years, who have anxiety or symptoms of anxiety. The initiative can be used as treatment where there is already a diagnosis of anxiety, or as a preventative measure for children and youth who either have symptoms of anxiety or are at risk of developing symptoms of anxiety.

Time period:

The first Norwegian edition of the initiative came out in 2005. It has been used for 13 years. There is some uncertainty as to whether the measure has been used since the contract with the owner ran out in 2018.

Implementation/components:

FRIENDS exists in two versions adapted to the developmental level of the child: a child version (8-12 years) and a version for youth (12-15 years). The measure can be adapted to be carried out individually or in groups. The word FRIENDS is an acronym and serves as a reminder of the skills the child or youth learns: *Feelings*: be aware of your own and other feelings, *Relax*: use relaxation exercises, *I can try*: positive self-talk, *Encourage*: stepwise problem solving. *Nurture*: rewarding yourself for both effort and achieving goals. *Don't Forget*: the need to practise skills and be brave. *Stay Happy*: using support structures and people. The letters in the acronym form the 7 steps that are followed in order through the

lessons. For groups, the lessons normally last 90 minutes with 6-8 participants. Individual sessions normally last 60 minutes.

Both the child and youth versions have a therapy manual with a detailed description of how the programme should be carried out, as well as a workbook for participants. The manuals include an introduction and explain the goals, target groups and theoretical principles behind the programme. At the end are the instructions and guidelines for each lesson, including preparation and activities to do in the lesson and at home. Typically, the exercise is planned with a therapist, but is actually carried out as homework. FRIENDS is mainly built on skills training where the goal is coping with anxiety. Participants therefore learn skills which are considered to be important for controlling the development, maintenance and experience of anxiety. The emphasis is not on academic learning, and the therapist should explain the programme in terms of skills training rather than describing a situation where the child has a problem which needs to be fixed.

Costs:

The manuals cost 250NOK (25€) and the workbooks for children and youth cost 150NOK (15€). The training itself is free but costs for 30 hours guidance have to be covered. Typical guidance costs are 1100NOK (110€) per hour. This can be divided between the participants in a group-based delivery.

Effects:

The initiative has shown itself to have promising potential both through schools and in clinics. In both arenas, a significant reduction was seen in anxiety symptoms from baseline to post-intervention (76). Both group and individual treatment has found to have good effect (reduced symptoms of anxiety) compared with the control group at 10 weeks (77).

Evaluation:

The initiative was last evaluated by the journal Ungsinn in 2018 and achieved an evidence level of 4.

Limitations linked to Covid19:

There is some uncertainty around the use of the initiative after 2018, before COVID19.

References:

English web page for information: and English: FRIENDS for Life

Mental Health First Aid

Ownder/provider:

The owner of the initiative Mental Health First Aid (PF) is psychology specialist Solfrid Raknes, who developed the initiative in conjunction with professional reference groups from various environments within cognitive behaviour therapy and mental health services in Norway.

Reach:

PF is a local-level tool. It was developed to be used in different situations and arenas where there is a perceived need for help to deal with difficult feelings. The initiative can be used by parents at home, teachers in school or other caregivers who work with children or youth.

Purpose/aim:

The main aim is to be a health prevention measure for mental health difficulties. Another aim is that PF should help children and youth developing their knowledge, skills, and coping strategies linked to feelings to make them better equipped to master their own feelings.

Target groups:

The target group is children and youth aged 8-18 years. The initiative was developed to be adaptable for two different groups, with a version for children up to 12 years and one for youth 13-18 years. There is also a course on Mental Health First Aid, which is aimed at employees in health and support services for children and youth, in schools and in after-school care who work with children who have difficulties or are at risk.

Time period:

The concept started in 2007, and the self-help tool had its beginnings in 2008 before being launched in 2010. The launch included the two programmes aimed at children and youth, and the initiative is still in use today.

Implementation/components:

Mental Health First Aid as an initiative is a «first aid box» which works as self-help material and conversational tools. The «box» consists of two booklets, two figures, a block of «helping hands» and a guide. The booklets form a user handbook for parents and other helpers/caregivers, and contain information about the initiative, the contents in the «first aid box», and how to use the box. This involves a short introduction to mental health education around feelings and thoughts, and how this is linked to and can affect what we do and how it feels in the body. In the booklets, two central concepts are presented, green thoughts and red

thoughts. Red thoughts are negative thoughts, while green thoughts are realistic and more appropriate thoughts. In connection with this, children and youth are encouraged to think about what they can do if they become afraid, sad or angry, and who they have around them who can help.

With the use of figures, children and youth can express feelings which they associate with the movements of the figures. The use of the figures is an attempt to get children and youth to relate actively, in a playful and externalising way to the red and green thoughts. «The helping hand» is used to show how to deal with difficult situations: thumb (what is happening), index finger (feeling), middle finger (red thought), ring finger (green thought), little finger (what can I do?) and palm (who can help me?). «The helping hand» becomes a resource for clearing space when thoughts and feelings become overwhelming or difficult.

Costs:

Adults for Children (former owner of the initiative) offer training in Mental Health First Aid for parents and caregivers in the larger cities in Norway, and if there is demand. A course lasts 3 hours and costs around 650NOK (around 60€) per participant. The boxes are not included in the course fees and a box costs 499NOK (50€). The book about the initiative or the guide costs 189NOK (20€). On request, Adults for Children can also arrange shorter or longer training for groups or organisations.

Effects:

There have been no analyses of the effect of the initiative, but a case study concluded that the methodology in Mental Health First Aid may help make understanding of emotions simpler by dichotomising them (61).

Evaluation:

The initiative was last evaluated by the journal Ungsinn in 2020 and achieved and evidence level of 2.

Limitations linked to Covid19:

According to webpage of the owners of the initiative, support packs are offered to nurses who need them in relation to COVID-19. The owner of the initiative offers digital seminars and guidance on promoting mental health.

Bibliography/references:

English web page for information: Mental health first aid

«Everyone has mental health»

Ownder/provider:

The initiative is owned by the Norwegian Council for Mental Health and is run by "Stiftelsen psykiatrisk opplysning". The programme is funded by the Directorate of Health.

Reach:

«Everyone has mental health» is a national-level programme. It was developed as a learning programme for secondary schools.

Purpose/aim:

The main aim of the programme is to put mental health on the agenda in secondary schools by providing ready-to-use teaching schemes. It is a health-promotion initiative which has the aim of preventing youth people from developing mental difficulties. Other aims are to challenge youth's attitudes and prejudices about mental health and mental health problems, create openness and safety so the youth dare to talk about mental health and feelings, and give increased knowledge about the different parts of the support services and where individuals can go or look for help.

Target groups:

The target group is pupils in lower secondary school age 13-16 years.

Time period:

«Everyone has mental health» has been used in Norwegian schools since 2002 and has been in existence ever since. The initiative has courses annually, and the last course should have been held on 20 November 2020 but is marked as cancelled for reasons that are not mentioned.

Implementation/components:

The initiative takes the form of a teaching programme divided into three project modules, one module for each year group in school; 8th, 9th and 10th grade (age 13-16). For 8th grade, the theme is «experience of self and identity», for 9th grade the theme is «otherness», and for 10th grade, the theme is «fear of the unknown». Altogether, the three modules offer a thorough introduction into the concept of mental health, as well as giving space for developing sub-themes such as mental distress and coping. The teaching scheme is carried out by the teachers, and there are up to three project days scheduled for each year group. The teacher is free to adapt the scheme to their own class. For each project module, there are sub-themes with ready-made tasks and suggestions, and for each theme the material describes the purpose of

the work, followed by three different ready-made tasks the teacher can choose between or adapt to their class. The structure and implementation are adapted to the pupils' age, class level and ability to work independently. The ready-made tasks and suggestions are set up so that the pupils can work actively with the theme through their own reflection and knowledge-seeking.

The initiative is described in separate teaching material aimed at teachers and other who will administer the teaching. The teaching material consists of a folder with descriptions of the theoretical underpinning, guidance for the teacher and suggestions of ready-made activities for pupils. In the first part of the folder, the theoretical pathway options behind the initiative are presented, with background. The main part of the folder consists of detailed suggestions for project work for the different year groups.

Costs:

Course days for «Everyone has mental health» are arranged by the programme owner (Stiftelsen psykiatrisk opplysning), and each school represented on the course receives free teaching schemes for all year groups. The initiative is supported and funded by the Directorate of Health.

Effects:

There are few studies which have evaluated the effects of «Everyone has mental health». A study from 2012 concluded that a low-cost measure such as «Everyone has mental health» can play a part in increasing the mental health competence in children and youth, and that both gender and age should be taken into account when working with measures aimed at mental health (60).

Evaluation:

The initiative was last evaluated by the journal Ungsinn in 2012 and achieved evidence level 2.

Limitations linked to Covid19:

No information found about delayed courses or how they are carried out with reference to the national guidelines or other coronavirus restrictions (such as closed schools).

References:

Norwegian web page for information: Alle har en psykisk helse

Urgent Mental Health care (UMH)

Owner/provider:

The Directorate of Health started Urgent Mental Health care (UMH) as a pilot project in 2012, at the request of the Health and Social Affairs Department. UMH is based on the programme, «Improving Access to Psychological Therapy» (IAPT). The measure is owned by the Directorate of Health, and training is offered in conjunction with the National Competence Centre for Mental Health (NAPHA).

Reach:

UMH is a national-level measure. It was developed to be implemented in municipalities. As of December 2020, UMH is represented in all the counties of Norway and in around 55 municipalities.

Purpose/aim:

The main aim of UMH is to give more people access to direct help without long waiting times so that mental health problems don't develop. The initiative is designed to be easily accessible and free. Another aim is to increase the ability to work and prevent long-term sick leave for those in employment.

Target groups:

The target group is anyone over 16 with mild to moderate symptoms or suffering from anxiety, symptoms or suffering from depression, incipient addiction problems or sleep problems, in the municipalities where UMH has been implemented.

Time period:

UMH was started as a pilot project in 2012 and was set up initially in ten municipalities in 2013. The initiative is still in use.

Implementation/components:

UMH is a low threshold offer which individuals can seek directly. The GP, in agreement with the user, will often be an important partner. UMH is based on guided self-help and cognitive therapy. Treatment and follow-up are undertaken by a multi-disciplinary team with at least one psychologist linked to each team. UMH is organised according to the «mixed care» model, and the entry level of care is agreed in discussion with the person seeking help.

The actual treatment offer can be divided into three levels. *Level 1) Guided self-help*. At this level self-help materials are offered (brochures, books, internet-based treatment), and follow-

up conversations are held to share experiences of materials and to give encouragement. *Level 2) Group course*. At this level, individuals are presented with a model for cognitive understanding and techniques to change thought and behaviour patterns which maintain or increase depression or anxiety. *Level 3) Individual treatment.* This is a time-limited, structured, psychological treatment approach based on cognitive therapy (2-15 hours of treatment). The treatment is intended to be job focussed and is about how work generally promotes mental health and how long-term sick leave can worsen both the situation and the pressure of symptoms.

Costs:

UMH is a free, low-threshold offer. Municipalities have, until 2021, been able to apply for establishing grants and salary support for setting up UMH. The arrangement has been reorganised and all municipalities can, among other things, apply for free continuing education on the UMH model.

Effects:

A study has shown considerable reduction in symptoms 12 months after treatment with UMH, where both low and high-intensity treatments were associated with significant, long-term symptom reduction in anxiety and depression (64). Another study has shown greater effect than «treatment as usual» (65). The Norwegian Institute of Public Health evaluated the project in 2012, where the results showed a reduction in symptoms of anxiety and depression.

Evaluation:

The initiative has not been evaluated by the journal Ungsinn, but the evaluation by the Norwegian Institute of Public Health was very positive.

Limitations linked to Covid19:

Several municipalities report that there will be changes in the UMH offer, which are mainly related to not being able to meet physically as a result of COVID19. Some UMH centres have been taking enquiries as usual and give guidance for self-help as usual. According to the home pages of NAPHA individual conversations are mainly being carried out by telephone and several group offers and courses have been delayed.

References:

English web page for information: Urgent Mental healthcare (UMH)

VIP and VIP Partners (guidance and information about mental health in youth)

Owner/provider:

The VIP programme is operated in cooperation between the Directorate of Health and the Learning and Coping Centre at Vestre Viken Health Trust. The initiative is owned by Vestre Viken Health Trust and is financed by the Directorate of Health.

Reach:

VIP is a national-level programme. It was developed to be offered to and implemented in schools. As of 4 February 2021, VIP is represented in every county and around 120 secondary schools over the country.

Purpose/aim:

The overarching aim of VIP is to make pupils better equipped to take care of their mental health and to become aware of the help they can reach for mental health problems or disorders.

Target groups:

The target group for the initiative are pupils in upper secondary school, aged 16-18 years, teachers and local health professionals. All school staff are offered the chance to improve their competence in the field of youth's mental health. The target group for the VIP programme are pupils in the 1st year of upper secondary school, while VIP Partners is aimed at all students in upper secondary school.

Time period:

The VIP programme started as a project in Norwegian schools in 2000-01 and became part of the Norwegian Directorate of Health's initiative «Mental health in schools» in 2005.

Implementation/components:

VIP is carried out in five phases. The initiative is based on a teaching scheme for pupils of three hours, plus two hours. The first three hours are with their own class teacher, where mental health is a theme, the last two hours are a meeting with health personnel (of whom at least one must be based in the school). Phase 1 is a training conference for all the employees in the school and health personnel from the mental health services. Phase 2 consists of a collaborative meeting for the teachers and health professionals who will work together in a class. In phase 3, the work begins with the pupils, where, among other things, the topic of mental health is taught. In phase 4 there are class visits from specialist professionals, and phase 5 involves an annual evaluation of the initiative in the classes – which is then discussed

by the form teachers, the school administration and healthcare professionals in a summary meeting.

VIP Partners is the VIP programme's practical initiative, starting with 2-4 hours training of teachers by the programme provider. Before the first day of school, the individual class teacher prepares the partner pairings and groups, and the programme advises that the first day of school is used for introducing the programme to the class. Then time is set aside for partner exchanges every 3 weeks. It is more common for participating schools to continue the measures throughout the school year and with all age groups.

The programme has been fully described in separate material. This includes: a VIP implementation folder that all schools receive at the training conference; VIP booklet for pupils; guidance booklet for teachers and a guidance booklet for healthcare professionals.

Costs:

The VIP programme is financed and run in cooperation with the Directorate of Health, and schools, therefore, get all materials for free.

Effects:

Studies have shown small to moderate effects after implementation of the initiative, in particular, better knowledge of and familiarity with mental health and seeking help (56, 57). According to VIP's own webpages, VIP makes youth better at seeking help at an early stage, and the programme has an effect on levels of anxiety in pupils.

Evaluation:

The initiative was last evaluated by the journal Ungsinn in 2012 and achieved an evidence level of 3. Several articles have been presented since then.

Limitations linked to Covid19:

According to VIP's own Facebook page, the programme has been carried out digitally, using Microsoft Teams, for the first time because of closed schools and national guidelines as a consequence of COVID19.

References:

English web page for information: VIP and VIP Partnership

COMPLETE – Dream School and Attendance Team

Owner/provider:

The COMPLETE project was part of the Ministry for Education and Research's «Increasing completion rates for upper secondary schools» and functioned as a cooperation between nine different organisations. The project was led and owned by the University of Bergen (UiB) and consisted of two interventions - Dream School and Attendance Team. Dream School was developed by the membership organisation Adults for Children, which also delivers the programme. Attendance Team was developed by the Pupil Service and Follow-up Service at Bodin Upper Secondary School in Bodø.

Reach:

COMPLETE is both a national- and local-level programme. It has been tested in several upper secondary schools in Norway. Dream School is an ongoing offer, where the programme provider contacts lower and upper secondary schools. Attendance Team does not currently appear to be on offer.

Purpose/aim:

The main aim of COMPLETE was to improve the psycho-social learning environment in upper secondary provision, and by that contribute to increased completion and attendance in upper secondary schools.

Target groups:

The initiatives Dream School and Attendance Team cover the whole school, and both staff and pupils covers the target group. Dream School is mainly aimed at pupils in lower and upper secondary school, where the focus is on pupils in transition between lower and upper school. For Attendance Team, the main target group was pupils at risk of dropping out of upper secondary education and not gaining qualifications for working life.

Time period:

COMPLETE started as a randomised school study in 2016 with initiatives from Dream School and Attendance Team. The project ended in 2019. Dream School has become a model for working systematically with pupils' psycho-social environments at schools across the country and is currently in use.

Implementation/components:

Dream School works, largely, as a process, which starts at the beginning of the school year and continues throughout the year. The initiative is a systematic way of working, promoting a

positive learning environment in classrooms, and has two main «components». *1) Pupil mentors*, a central part of Dream School. They function as role models and examples for the pupils in the school. They also take part in mapping the need that pupils have for experiencing security, involvement, belonging and motivation. *2) Resource group*. The school creates a group of 5-7 people including management, teachers, advisors, support staff and the pupil council. The resource group gets training through a 2-day workshop run by the programme deliverer, and then the resource group has responsibility for implementation, execution and training in Dream School. The programme deliverer holds an introductory meeting with the school leadership and resource people where criteria, frameworks, implementation plan and practical questions are clarified. In addition to these two components, laying the foundation for and training the rest of the staff are central.

The Attendance Team is a multi-disciplinary but co-located team. The Attendance Team works to create good transitions between compulsory school and upper secondary education by ensuring better information for pupils and parents, and better cooperation with compulsory level schools. At the beginning of upper secondary education, a questionnaire should be used to collect information on health and well-being, followed by conversations with those pupils whose score suggest that they may have difficulties. The scoring is based on a European form about health-related quality of life within the school health services – Kids Screen. In situations where the class teacher feels that pupils have invalid reasons for absences, they are called in for a meeting. If the absence continues the Attendance Team are called in, and the focus is on setting rules, supporting and guiding. Incipient absence is tackled straight away, and attempts are made through dialogue to uncover the reason for the absence. The aim is to get the pupil back to school and have a sense of being seen, valued and not given up on.

Costs:

COMPLETE ran during the period 2016-2019 and the running costs of the project (100.000 NOK, around 10.000€) were financed by the organisation Adults for Children in cooperation with the Directorate for Health. No information is available for the cost of training from Adults for Children to individual schools.

Effects:

Results from a study using data from COMPLETE indicated that a support teacher can be a significant factor both for a sense of belonging in class and for good mental health (62), and that the school programme should include initiatives which focus on the teachers' behaviour and pupil support. The project's own final report states that no effects were found for Dream

School or Attendance Team in terms of psycho-social environment, mental health, school performance or absence over the three years.

Evaluation:

Neither the project nor the individual initiatives have been evaluated by the journal Ungsinn.

Limitations linked to Covid19:

The project ended before the COVID19 pandemic arrived in Norway.

Bibliography/references:

There is an English protocol of the project (63).

DU programme – Young People Coping with Depression

Owner/provider:

The DU programme – Young People Coping with Depression - is owned by the Norwegian Council for Mental Health (NCMH), an independent humanitarian umbrella organisation. The Council has responsibility for implementing the programme. Implementation is through Fagakademiet, a non-profit making organisation owned by the Norwegian Medical Association and the Norwegian Union of Municipal and General Employees (Fagforbundet).

Reach:

The DU programme is a national-level programme. It was developed to be offered through municipal support services, but also through specialist health services. As of 17 February 2021, according to the NCMH home page, there are course leaders in every county and in 95 municipalities in Norway.

Purpose/aim:

The overall intention of the DU programme is to reduce symptoms of depression, as well as preventing the development of depression and relapse. The aim is that participants will: understand the relationship between ways of thinking and depression; gain knowledge about risk factors; and learn appropriate coping strategies to prevent the recurrence of depression.

Target groups:

The target group for the programme is youth aged 14-20 years of age with light to moderate depression or symptoms of depression. Participation in the course is based on an assessment conversation, which maps the youth's needs, and evaluates whether the DU programme is the right measure as well as considering other initiatives which might be relevant.

Time period:

The programme has been in existence for nine years. In 2012 a revised youth version of the Coping with Depression course (KiD) was set up and was given the name DU – Young People Coping with Depression.

Implementation/components:

DU is offered as a group initiative for 8-12 children and youth, with both girls and boys in the groups. The initiative consists of 10 sessions with a clearly defined structure and content for each session. The first eight sessions are conducted weekly and last approximately 2.5 hours. The last two sessions are held three and six weeks after the eighth session and cover daily use of the methods and end the course. These final sessions are somewhat shorter, lasting around

1.5 hours. Throughout the course, emphasis is on the youth's own reflections and active participation in the group. The group process is central. The sessions, methodology and theory are described in a course book, which also forms the youth's workbook through the course.

The course is led by a course leader and an assistant course leader. The role of course leader changes through the course, from being a teacher and motivator, to someone who facilitates and promotes discussion and reflection. To be a course leader, a minimum of 3 years relevant tertiary education and training is required, as well as extra training through courses.

Costs:

The price of the course for children and youth varies between municipalities, but between 400-700NOK (ca. 50€) including the course book and any refreshments. To become a course leader, individuals undertake training which in 2016 cost around 7500 NOK (ca. 730€). The Norwegian Directorate for Health and Social Affairs has given economic support to the course for some years, which has led to reduced course costs.

Effects:

Several studies have looked at the before and after effects in youth who have participated in the course, and have found moderate to strong reductions in symptoms of depression (52-55), and small to medium effect on self-experienced social relationships in school (53).

Evaluation:

The initiative was last evaluated by the journal Ungsinn in 2016, and, at that point, achieved evidence level 3.

Limitations linked to Covid19:

Because of restrictions in relation to Covid19, several municipalities have chosen to delay planned courses of the DU programme.

References:

English web page for information: Adolescent Coping With Depression Course

Summary and conclusions

The aim of this report is to contribute a knowledge summary of what is being done in mental health promotion and preventive work for children and youth in Norway. Through a systematic and a supplementary literature search, this work presents useful initiatives, screening tools, information and communication channels and digital tools aimed at children and youth.

Initiatives at all levels of society

Successful work with mental health requires initiatives at all levels of society: national, local, in organisations and schools, groups/families and individuals. At national level in Norway there are guidelines for how work in mental health should happen in the rest of society. There are laws to ensure that work in public health includes mental health and levelling out of social inequalities. In addition, legislation aims to ensure Norwegian citizens fair and equal health services regardless of their socio-economic background, religion, beliefs or sexual orientation. General practice services, school health services and health centres for youth are good examples of this. Through measures at society level, social conditions can be affected throughout the population: the right to education, the right to health care and a fair distribution of resources. These can, in turn, affect individual circumstances, such as the opportunity to make positive choices and to make changes in lifestyle.

Availability and good digital infrastructure

For measures to be put into practice successfully in society, it is important that they are available for everyone, at all levels. Access to information about services, tools or initiatives has to be easily accessible, and it is vital to increase the level of knowledge in the population. In the report, significant information and knowledge channels for children/youth, parents/families, teachers or other caregivers are presented, which are a central part of the digital infrastructure in Norway. These are characterised by ease of access, lack of costs and with the aim of making sure that users get necessary information and increase their knowledge about: existing measures, information channels, educational services and digital tools which can be used to learn more about mental health and reduce mental health suffering. It can be very challenging to make sure everyone can reach easily available and reliable information, particularly those who need it most. Therefore, there needs to be support for a digital infrastructure which is easy to find and use, free and reliable.

Social inequalities in health

Health problems are divided by social strata, including in Norway. This is, partly, because of major differences in living habits and influential factors such as use of tobacco, diet and physical activity. To reduce social inequalities in health it is therefore vital that information and initiatives are accessible and set up so they reach those who need them most. If this is not done, it can lead – in a worst case – to developing and implementing serial measures for those who need them «least». This is highly inappropriate and ineffective in efforts to reduce mental health problems and reduce social inequalities in health.

Through legislation, there has been a decentralisation of the health service in Norway, and responsibility for primary health services has moved to municipal level. This is about facilitating access to provision, services and activities, and strengthening professional competence locally. For children and youth to be offered good health and welfare services, regardless of their socio-economic background, there is a prerequisite that the services are offered where the children and youth are. Decentralisation of the health services, and systematic spreading of competence between services, can be effective factors in work to reduce health problems and reduce social inequalities in health.

For implementation to be successful, there is a need to:

- Spread information and knowledge about tools and measures for children and youth, parents/families, schools and other caregivers – this must be done at national and local level. Good initiatives are no use if no-one knows about them.
- Make initiatives and tools accessible so that users or caregivers know where to find them and can access them. Municipal health centres and internet resources are important in this aspect of the work. It is also about making sure everyone has access, regardless of their socio-economic background and where they live.
- Make mental health problems a safe topic and make secure frameworks so that children and youth dare, want and are motivated to talk about such problems, and seek help if they need it.
- Identify health issues and map the situation in society and the locality. Match the need and the measures to the situation.

Summary of the knowledge base

The presentation of digital infrastructure, tools and self-help resources shows that there is reason to be optimistic about work with mental health problems. In Norway, there is a lot of useful information and there are a number of free resources, available to all. The work for the future is about increasing accessibility and evaluating the extent to which the people who need help most are being reached.

The presentation of practical initiatives shows that much of the work with mental health is channelled through schools. The advantage of school-based programmes is that children and youth have, through education laws, both a right and a duty to access free education in Norwegian schools. This means that everyone in school has access to, and is exposed to, some kind of initiative through compulsory school attendance.

The work done in Norway is characterised, according to this report, by the existence of many initiatives and tools with good aims. There are no major costs attached to access or implementation of practical initiatives, and several of those outside the school system are also free. In addition, there is a lot of information and good internet resources which are publicly and relatively easily available.

References

1. Organization WH. World Health Organization 2021 [Available from: https://www.who.int/.
2. World Health Organization. Mental health: strengthening our response: WHO; 2018 [Available from: https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response.
3. Andersen AJ. Psykisk helsearbeid. Store medisinske leksikon 2019.
4. Norsk Helseinformatikk. Psykisk helseproblemer: Norsk Helseinformatikk (NHI); 2018 [Available from: https://nhi.no/symptomer/psyke-og-sinn/psykiske-helseproblemer/.
5. Nylenna M, Braut GS, Thelle DS. Folkehelse. Store medisinske leksikon2021.
6. European Commision. CRITERIA TO SELECT BEST PRACTICES IN HEALTH PROMOTION AND DISEASE PREVENTION AND MANAGEMENT IN EUROPE - Updated version -2018. Available from: https://ec.europa.eu/health/sites/health/files/major_chronic_diseases/docs/sgpp_bestpracticescriteria_en.pdf.
7. Potrebny T, Wiium N, Lundegård MM-I. Temporal trends in adolescents' self-reported psychosomatic health complaints from 1980-2016: A systematic review and meta-analysis. PLOS ONE. 2017;12(11):e0188374.
8. Ottová-Jordan V, Smith ORF, Gobina I, Mazur J, Augustine L, Cavallo F, et al. Trends in multiple recurrent health complaints in 15-year-olds in 35 countries in Europe, North America and Israel from 1994 to 2010. European Journal of Public Health. 2015;25(suppl_2):24-7.
9. Twenge JM, Cooper AB, Joiner TE, Duffy ME, Binau SG. Age, period, and cohort trends in mood disorder indicators and suicide-related outcomes in a nationally representative dataset, 2005-2017. J Abnorm Psychol. 2019;128(3):185-99.
10. Blomqvist I, Henje Blom E, Hägglöf B, Hammarström A. Increase of internalized mental health symptoms among adolescents during the last three decades. European journal of public health. 2019;29(5):925-31.
11. Bor W, Dean AJ, Najman J, Hayatbakhsh R. Are child and adolescent mental health problems increasing in the 21st century? A systematic review. Australian & New Zealand Journal of Psychiatry. 2014;48(7):606-16.
12. Potrebny T, Wiium N, Haugstvedt A, Sollesnes R, Torsheim T, Wold B, et al. Health complaints among adolescents in Norway: A twenty-year perspective on trends. PLOS ONE. 2019;14(1):e0210509.
13. Myhr A, Anthun KS, Lillefjell M, Sund ER. Trends in Socioeconomic Inequalities in Norwegian Adolescents' Mental Health From 2014 to 2018: A Repeated Cross-Sectional Study. Frontiers in Psychology. 2020;11(1472).
14. Kvaløy VRK. Selvopplevd helse, kroppsmasse og risikoatferd blant ungdommer i. Nord-Trøndelag 2017-19. Helsestatistikk-rapport nummer 1 fra Ung-HUNT4

Levanger HUNT research center; 2019.
15. Sletten MA. Oppvekstrapporten 2017. Barne-, ungdoms- og familiedirektoratet; 2017.
16. Idsoe T, Keles S, Bringedal G, Børve T, Ogden T. Utenfor rekkevidde. Tidsskrift for Norsk psykologiforening. 2018;55/12, 2018:1122-8.
17. Zachrisson HD, Rödje K, Mykletun A. Utilization of health services in relation to mental health problems in adolescents: A population based survey. BMC Public Health. 2006;6(1):34.
18. Reneflot A, Aarø LE, Aase H, Reichborn-Kjennerud T, Tambs K, Øverland S. Psykisk helse i Norge. Folkehelseinstituttet; 2018.
19. Bruun T, Denison E, Gjersing L, Husøy T, Knudsen AK, Strand BH. Folkehelserapporten - kortversjon. Helsetilstanden i Norge 2018. Folkehelseinstituttet 2018.
20. Dahl E, Bergsli H, van der Wel KA. Sosial ulikhet i helse: en norsk kunnskapsoversikt. Høgskolen i Oslo og Akershus; 2014.
21. Helsedirektoratet. Folkehelsepolitisk rapport 2017. Helsedirektoratet; 2018.

22. Arntzen A, Bøe T, Dahl E, Drange N, Eikemo TA, Elstad JI, et al. 29 recommendations to combat social inequalities in health. The Norwegian Council on Social Inequalities in Health. Scand J Public Health. 2019;47(6):598-605.
23. Lov om folkehelsearbeid, LOV-2011-06-24-29 (2011).
24. Skogen JC, Smith ORF, Aarø LE, Siqveland J, Øverland S. Barn og unges psykiske helse: Forebyggende og helsefremmende folkehelsetiltak. En kunnskapsoversikt." [Mental health among children and adolescents. Health-promoting and preventive public health interventions. A summary of evidence about effects.]. Oslo: Folkehelseinstituttet 2018.
25. Saunes IS, Karanikolos M, Sagan A. Norway: Health system review. Health systems in Transition, 2020.; 2020.
26. Lov om kommunale helse- og omsorgstjenester m.m., LOV-2011-06-24-30 (2011).
27. Lov om spesialisthelsetjenesten m.m., LOV-1999-07-02-61 (1999).
28. Lo om sosiale tjenester i arbeids- og velferdsforvaltningen, LOV-2009-12-18-131 (2009).
29. Lov om barneverntjenester, LOV-1992-07-17-100 (1992).
30. St.prp. nr. 63 (1997-98). Om opptrappingsplan for psykisk helse 1999 - 2006 Endringer i statsbudsjettet for 1998: Helse- og omsorgsdepartementet; 1998.
31. Helse og omsorgsdepartementet. Mestre hele livet - Regjeringens strategi for god psykisk helse (2017-2022). 2017.
32. Helse og Omsorgsdepartementet. Folkehelsemeldinga - Gode liv i eit trygt samfunn. 2019.
33. Helsedirektoratet. Program for folkehelsearbeid i kommunene: Helsedirektoratet; 2019 [Available from: https://www.helsedirektoratet.no/tema/folkehelsearbeid-i-kommunen/program-for-folkehelsearbeid-i-kommunene#bakgrunnforprogrammet.
34. Myklestad I, Røysamb E, Tambs K. Risk and protective factors for psychological distress among adolescents: a family study in the Nord-Trøndelag Health Study. Soc Psychiatry Psychiatr Epidemiol. 2012;47(5):771-82.
35. Eriksen I, Bakken A. Stress, press og psykiske plager blant unge - hva sier NOVA-forskningen? ; 2018.
36. Klungsøyr S. Oh, I get by with a little help from my friends. Sammenhengen mellom skolestress, sosial støtte og psykiske plager ved oppstart av videregående skole. Bergen Open Research Archive2019.
37. Utdanningsdirektoratet. Grunnskolen - fakta og læringsresultater Utdanningsdirektoratet2019 [Available from: https://www.udir.no/tall-og-forskning/finn-forskning/tema/utdanningsspeilet-2019/fakta-om-grunnskolen/#.
38. Lov om grunnskolen og den videregående opplæringa, § 3-1 (1998).
39. Statistisk sentralbyrå. Befolknings utdanningsnivå. 2019: Statistisk sentralbyrå; 2019 [Available from: https://www.ssb.no/utdanning/faktaside/utdanning.
40. Utdanningsdirektoratet. Tall om elever, skoler, spesialundervisning og særskilt norsk: Utdanningsdirektoratet; 2020 [Available from: https://www.udir.no/tall-og-forskning/statistikk/statistikk-grunnskole/tall-om-elever-og-skoler/.
41. Organisation for Economic Co-operation and Development. Education at a Glance 2017: OECD Indicators. OECD Publishing, Paris; 2017.
42. sentralbyrå S. Gjennomføring i videregående opplæring: Statistisk sentralbyrå; 2020 [Available from: https://www.ssb.no/vgogjen.
43. Utdanningsdirektoratet. Folkehelse og livsmestring: Utdanningsdirektoratet; 2020 [Available from: https://www.udir.no/lk20/overordnet-del/prinsipper-for-laring-utvikling-og-danning/tverrfaglige-temaer/folkehelse-og-livsmestring/.
44. Hjemdal O, Friborg O, Stiles TC, Martinussen M, Rosenvinge JH. A New Scale for Adolescent Resilience: Grasping the Central Protective Resources Behind Healthy Development. Measurement and Evaluation in Counseling and Development. 2006;39(2):84-96.
45. Derogatis LR, Lipman RS, Rickels K, Uhlenhuth EH, Covi L. The Hopkins Symptom Checklist (HSCL): a self-report symptom inventory. Behav Sci. 1974;19(1):1-15.

46. Strand BH, Dalgard OS, Tambs K, Rognerud M. Measuring the mental health status of the Norwegian population: A comparison of the instruments SCL-25, SCL-10, SCL-5 and MHI-5 (SF-36). Nordic Journal of Psychiatry. 2003;57(2):113-8.
47. Garvik M, Idsoe T, Bru E. Motivation and Social Relations in School Following a CBT Course for Adolescents With Depressive Symptoms: An Effectiveness Study. Scandinavian Journal of Educational Research. 2016;60(2):219-39.
48. Idsoe T, Keles S, Olseth AR, Ogden T. Cognitive behavioral treatment for depressed adolescents: results from a cluster randomized controlled trial of a group course. BMC Psychiatry. 2019;19(1):155.
49. Keles S, Idsoe T. Six- and Twelve-Month Follow-up Results of a Cluster Randomized Controlled Trial of a CBT-Based Group Course. Prevention Science. 2020.
50. Garvik M, Idsoe T, Bru E. Effectiveness study of a CBT-based adolescent coping with depression course. Emotional and Behavioural Difficulties. 2014;19(2):195-209.
51. Andersen B, Nord E. Effects of programs in school for preventing mental problems. Norsk Epidemiologi. 2010;20:15-22.
52. Morin AH. The VIP Partnership Programme in Norwegian Schools: An Assessment of Intervention Effects. Scandinavian Journal of Educational Research. 2020:1-14.
53. Gundersen K, Svartdal F. Aggression Replacement Training in Norway: Outcome evaluation of 11 Norwegian student projects. Scandinavian Journal of Educational Research. 2006;50(1):63-81.
54. Gundersen K, Svartdal F. Diffusion of treatment interventions: exploration of 'secondary' treatment diffusion. Psychology, Crime & Law. 2010;16(3):233-49.
55. Skre I, Friborg O, Breivik C, Johnsen LI, Arnesen Y, Wang CEA. A school intervention for mental health literacy in adolescents: effects of a non-randomized cluster controlled trial. BMC Public Health. 2013;13(1):873.
56. Holth I, Madsen OJ. Behandling på boks - En kasusstudie av selvhjelpsverktøyet 'Psykologisk førstehjelp' som normativ diskurs. Matrix - Nordisk tidsskrift for psykoterapi. 2013;30:285-303.
57. Brandseth OL, Håvarstein MT, Urke HB, Haug E, Larsen T. Mental well-being among students in Norwegian upper secondary schools: the role of teacher support and class belonging. Norsk Epidemiologi. 2019;28(1-2).
58. Larsen T, Urke HB, Holsen I, Anvik CH, Olsen T, Waldahl RH, et al. COMPLETE – a school-based intervention project to increase completion of upper secondary school in Norway: study protocol for a cluster randomized controlled trial. BMC Public Health. 2018;18(1):340.
59. Sæther SMM, Knapstad M, Grey N, Smith ORF. Twelve Months Post-treatment Results From the Norwegian Version of Improving Access to Psychological Therapies. Frontiers in Psychology. 2019;10(2303).
60. Knapstad M, Lervik LV, Sæther SMM, Aarø LE, Smith ORF. Effectiveness of Prompt Mental Health Care, the Norwegian Version of Improving Access to Psychological Therapies: A Randomized Controlled Trial. Psychotherapy and Psychosomatics. 2020;89(2):90-105.
61. Abrahamse ME, Junger M, Leijten PHO, Lindeboom R, Boer F, Lindauer RJL. Psychometric Properties of the Dutch Eyberg Child Behavior Inventory (ECBI) in a Community Sample and a Multi-Ethnic Clinical Sample. Journal of psychopathology and behavioral assessment. 2015;37(4):679-91.
62. Ogden T, Hagen K. Treatment Effectiveness of Parent Management Training in Norway: A Randomized Controlled Trial of Children With Conduct Problems. Journal of consulting and clinical psychology. 2008;76:607-21.
63. Kjøbli J, Ogden T. Gender differences in intake characteristics and behavior change among children in families receiving parent management training. Children and Youth Services Review. 2009;31:823-30.
64. Hagen K, Ogden T, Bjørnebekk G. Treatment Outcomes and Mediators of Parent Management Training: A One-Year Follow-Up of Children with Conduct Problems. Journal of clinical child and adolescent psychology : the official journal for the Society of Clinical Child and Adolescent Psychology, American Psychological Association, Division 53. 2011;40:165-78.

65. Sørlie MA, Ogden T. Immediate Impacts of PALS: A school-wide multi-level programme targeting behaviour problems in elementary school. Scandinavian Journal of Educational Research. 2007;51(5):471-92.
66. Sørlie M-A, Ogden T. School-Wide Positive Behavior Support–Norway: Impacts on Problem Behavior and Classroom Climate. International Journal of School & Educational Psychology. 2015;3(3):202-17.
67. Ogden T, Sørlie MA, Hagen KA. Building strength through enhancing social competence in immigrant students in primary school. A pilot study. Emotional and Behavioural Difficulties. 2007;12(2):105-17.
68. Olweus D, Limber SP. Bullying in school: evaluation and dissemination of the Olweus Bullying Prevention Program. Am J Orthopsychiatry. 2010;80(1):124-34.
69. Olweus D, Solberg ME, Breivik K. Long-term school-level effects of the Olweus Bullying Prevention Program (OBPP). Scandinavian Journal of Psychology. 2020;61(1):108-16.
70. Eriksen I, Hegna K, Bakken A, Lyng S. Felles fokus: En studie av skolemiljøprogrammer i norsk skole2014.
71. Fjermestad K, Wergeland GJ, Rogde A, Bjaastad J, Heiervang E, Haugland B. School-based targeted prevention compared to specialist mental health treatment for youth anxiety. Child and Adolescent Mental Health. 2020;25.
72. Wergeland GJ, Fjermestad KW, Marin CE, Haugland BS, Bjaastad JF, Oeding K, et al. An effectiveness study of individual vs. group cognitive behavioral therapy for anxiety disorders in youth. Behav Res Ther. 2014;57:1-12.

Attachments

Attachment 1: Search strategy details

Database: MEDLINE **Date:** 17.01.2021 **Results:** 502

1	Adolescent/ or Minors/ or Young Adult/ 2471698
2	Mental Health/ 41112
3	school health services/ or school mental health services/ or school nursing/ or Community Mental Health Services/ or primary health care/ or Adolescent Health Services/ 123691
4	exp health planning/ or health promotion/ or Health Literacy/ or Health Education/ 474944
5	Program Development/ or Program Evaluation/ 84664
6	preventive health services/ or primary prevention/ or secondary prevention/ or tertiary prevention/ 51840
7	Nursing Assessment/ or Outcome Assessment, Health Care/ or Process Assessment, Health Care/ or "Outcome and Process Assessment, Health Care"/ or Patient Outcome Assessment/ or Treatment Outcome/ 1132002
8	pc.fs. 1314673
9	or/3-8 2849662
10	1 and 2 and 9 2546
11	(adolescen* or boys? or girls? or juvenile* or kids? or pubescen* or pupil? or teens or teenage* or teen-age* or underage* or under-age* or youngster* or youth* or (young adj (adult* or people* or person? or men? or women?)) or early adulthood or secondary school* or high school* or student?).ti,ab,kf. or minors.ti. 955868
12	(((mental or psychological or emotional or psychosocial or psycho-social or socioemotional) adj1 (health or hygiene or distress or complaint* or symptom* or problem? or difficulties)) or wellbeing or well being or wellness or anxious or anxiet* or depression* or depressed or ((depressive or internalizing or externalizing) adj (symptom* or tendenc*)) or self-harm or self-mutilat* or stress or suicide or suicidal or sleep or attention deficit or hyperactivit* or ((conduct or behavio*) adj problem*)).ti,ab,kf. 1725766
13	(campaign* or program* or intervention* or best practice* or evaluat* or prevent* or promot* or school health or school nurs* or ((communit* or primary) adj2 (health* or care))).ti,ab,kf. 7025748
14	11 and 12 and 13 67957
15	10 or 14 69652
16	(norway* or norwegian* or scandinavia* or nordic countr* or svalbard*).ti,ab,kf. or Norway/ 71781

17 15 and 16 537

18 limit 17 to yr="2000-Current" 502

Database: APA PsycInfo **Date:** 17.01.2021 **Results:** 589

1 ("200" or "320").ag. 849995

2 mental health/ 68583

3 1 and 218080

4 school based intervention/ 19200

5 prevention/ or preventive mental health services/ or suicide prevention/ or intervention/ or mental health services/ or suicide prevention centers/ 135875

6 school nurses/ 881

7 mental health services/ or community mental health services/ or community mental health centers/ or mental health literacy/ or mental health programs/ or outreach programs/ 49921

8 primary health care/ 18748

9 program development/ or educational programs/ or program evaluation/ 45699

10 program evaluation/ or educational program evaluation/ or mental health program evaluation/ 20696

11 "treatment process and outcome measures"/ or treatment effectiveness evaluation/ or treatment outcomes/ 58021

12 health promotion/ 25341

13 or/4-12293918

14 3 and 13 3260

15 (adolescen* or boys? or girls? or juvenile* or kids? or pubescen* or pupil? or teens or teenage* or teen-age* or underage* or under-age* or youngster* or youth* or (young adj (adult* or people* or person? or men? or women?)) or early adulthood or secondary school* or high school* or student?).ti,ab,id. or minors.ti. 1015747

16 (((mental or psychological or emotional or psychosocial or psycho-social or socioemotional) adj1 (health or hygiene or distress or complaint* or symptom* or problem? or difficulties)) or wellbeing or well being or wellness or anxious or anxiet* or depression* or depressed or ((depressive or internalizing or externalizing) adj (symptom* or tendenc*)) or self-harm or self-mutilat* or stress or suicide or suicidal or sleep or attention deficit or hyperactivit* or ((conduct or behavio*) adj problem*)).ti,ab,id. 961451

17 (campaign* or program* or intervention* or best practice* or evaluat* or prevent* or promot* or school health or school nurs* or ((communit* or primary) adj2 (health* or care))).ti,ab,id. 1400718

18	15 and 16 and 17	84549
19	14 or 18	86375
20	(norway* or norwegian* or scandinavia* or nordic countr* or svalbard*).ti,ab,id.	15436
21	norway.lo.	18473
22	20 or 21	24670
23	19 and 22	624
24	limit 23 to yr="2000-current"	589

Database: Embase **Date:** 17.01.2021 **Results:** 263

1	*adolescent/ or *"minor (person)"/ or *young adult/	29277
2	*mental health/ or *mental disease/	136697
3	1 and 2	624
4	(adolescen* or boys? or girls? or juvenile* or kids? or pubescen* or pupil? or teens or teenage* or teen-age* or underage* or under-age* or youngster* or youth* or (young adj (adult* or people* or person? or men? or women?)) or early adulthood or secondary school* or high school* or student?).ti,ab,kw. or minors.ti.	1220476
5	(((mental or psychological or emotional or psychosocial or psycho-social or socioemotional) adj1 (health or hygiene or distress or complaint* or symptom* or problem? or difficulties)) or wellbeing or well being or wellness or anxious or anxiet* or depression* or depressed or ((depressive or internalizing or externalizing) adj (symptom* or tendenc*)) or self-harm or self-mutilat* or stress or suicide or suicidal or sleep or attention deficit or hyperactivit* or ((conduct or behavio*) adj problem*)).ti,ab,kw.	2253154
6	(campaign* or program* or intervention* or best practice* or evaluat* or prevent* or promot* or school health or school nurs* or ((communit* or primary) adj2 (health* or care))).ti,ab,kw.	9362474
7	4 and 5 and 6	97373
8	3 or 7	97714
9	(norway* or norwegian* or scandinavia* or nordic countr* or svalbard*).ti,ab,kw.	70381
10	*Norway/	1574
11	9 or 10	70406
12	8 and 11	580
13	limit 12 to embase	279

14 limit 13 to yr="2000-current" 268

15 remove duplicates from 14 263

Database: Web of Science **Date:** 18.01.2021 **Results:** 650

1 1,433,464 TOPIC: ((adolescen* or boys$ or girls$ or juvenile* or kids$ or pubescen* or pupil$ or "teens" or teenage* or teen-age* or underage* or under-age* or youngster* or youth* or (young Near/0 (adult* or people* or person$ or men$ or women$)) or "early adulthood" or ("secondary" Near/0 school*) or ("high" Near/0 school*) or student$))

2 2,679,616 TOPIC: ((((("mental" or "psychological" or "emotional" or "psychosocial" or "psycho-social" or "socioemotional") Near/0 ("health" or "hygiene" or "distress" or complaint* or symptom* or problem$ or "difficulties")) or "wellbeing" or "well being" or "wellness" or "anxious" or anxiet* or depression* or "depressed" or (("depressive" or "internalizing" or "externalizing") Near/0 (symptom* or tendenc*)) or "self-harm" or self-mutilat* or "stress" or "suicide" or "suicidal" or "sleep" or "attention deficit" or hyperactivit* or (("conduct" or behavio*) Near/0 problem*)))

3 8,843,889 TOPIC: ((campaign* or program* or intervention* or best-practice* or evaluat* or prevent* or promot* or school-health or school-nurs* or ((communit* or "primary") NEAR/1 (health* or "care"))))

4 103,567 TOPIC: (norway or norwegian* or "scandinavian" or nordic-countr* or "svalbard")

5 650 #4 AND #3 AND #2 AND #1 [Indexes=SCI-EXPANDED, SSCI Timespan=2000-2021]

Attachment 2: Inclusion and exclusion criteria for selecting measures

Selection of best practice measures for mental health or mental problems among children and youth aged 6-20 years

Selection of papers – first reading

- Does the abstract describe some sort of measure, course or tool (hereafter coined "measure") to promote better mental health or ways of preventing mental problems OR describe a screening tool to map mental health, mental problems or associating factors for children and youth (6-20 years old)

    - If yes → include
    - If no → exclude

- If the abstract describes a measure aiming to promote better mental health or ways of preventing mental problems/issues OR screening tool where the abstract unequivocally shows that the target group does not consist of Norwegian children or a Norwegian setting, where the age group is way off, or other, decisive demands / criteria:

    - Exclude

Important note: Arena for the measures can be both in school and outside as long as the measure focuses on one of the following pre-defined target groups: children and youth; parents or family, staff in school or other caregivers for children and youth (aged 6-20 years).

Selection of papers – second reading

- Measures should aim at promoting mental health or ways of preventing mental problems.

    - As stated earlier this report will focus on general mental health and mental problems (i.e. symptoms of anxiety and depression), and not mental disorder or diagnoses.
    - If measures or screening tools exclusively focuses on mental disorders or diagnoses it will be excluded.

- Measures should be directed towards children and youth in the age group 6-20 years, parents or family, teachers or other caregivers relevant for or working with children and youth.

- The measure or screening tool should be in current use, or should have been applied previously in a Norwegian setting (nation-wide, regional or local setting)

    - Preferably: Measure or screening tool should be in current use as per 2021.
    - Measures that have been completed or terminated should also be included, if monitoring or evaluation shows that the measure has been effective, or if experience, practice-based knowledge or professional judgment indicate that this is a measure with a promising potential.

- The measure ought to have been evaluated or monitored.

    - This criterion was used in the first round of the second reading. Measures that were not monitored or evaluated were not excluded, but stored separately, to be considered as measures with promising potential in the next round.

Exclusion criteria for measures or screening tools

- Measures or screening tool focusing on children *younger than 6 or older than 20 years old.*

- Measures or screening tool that do not look at mental health or mental problems.

    - Can be included if measure or screening tools looks at well-known determinant for mental health or mental problems.

- Measures exclusive*ly* directed at specific sub-groups of children and youth (i.e. children diagnosed with a mental disorder or mental illnesses).

Attachment 3: Filters and criteria for search in PsykTestBarn

Norwegian link to database: Psyktestbarn - Finne psyktestbarn artikler (r-bup.no)

Filter:

- Search in: Tests
- Article status: Published
- Subjects: Anxiety, behavioral problems, depression, general mental health, life quality and psychosocial functioning.

Selection criteria:

- Does the abstract describe a screening tool for mapping mental health or symptoms of mental health problems among children and youth (aged 6-20 years), or related factors or determinants?
    - If yes → include
    - If no → exclude
- If the abstract describes a screening tools which is exclusively targeted to map mental diagnoses or disorders or is targeted towards children and youth which have a mental diagnosis or disorder:
    - Exclude
    - Include if the abstract describe that the screening tool can also be used on healthy children or young people, or can be used to also map general mental health or symptoms.

Important note: The screening tools can be conducted in both school and outside, and be based on self-reporting or reporting from parents or family, teachers, caregivers or other professionals.