

MENTAL HEALTH AMONG YOUTH IN NORWAY

WHO IS RESPONSIBLE? WHAT IS BEING DONE?



norden

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Welfare and Social Issues



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FOREWORD

Youth in the Nordic Region - Mental Health, Work and Education

All children and young people are a huge resource. We have never had such well-educated and competent youngsters in the Nordic countries as we do today. At the same time there are all the more young persons who claim to be suffering from mental illness, and young persons who, for various reasons, risk ending up in vulnerable situations. Growing mental illness amongst young people is one of the most serious public health challenges facing our Nordic society.

The project Youth in the Nordic Region focuses on young persons who suffer from or are at risk of suffering from mental illness, as well as their situation at school and their later transition to work and providing for themselves. A further important topic of the project is early retirement and retirement on mental health grounds amongst young adults.

As part of the project we have produced reports which shed light on various aspects of these areas. The report you are holding in front of you aims to give a quick, clear overview of who does what in Norway in matters concerning young persons who suffer from or risk suffering from mental illness, and end up in long-term unemployment and with no meaningful purpose in life.

We have produced summaries of all the Nordic countries plus Greenland, the Faroe Islands and Åland. All summaries can be ordered or downloaded from www.nordicwelfare.org. We would like to point out to our readers that the summaries do not include everything that is done and that important and useful contributions may be lacking.

The Nordic countries have a lot of challenges in common; one of these is to ensure that all children and young persons enjoy good living conditions. We also know that particular efforts and investments are required for a heterogenous group of young people who are at risk of exclusion owing to mental illness, dropping out of their studies, long-term unemployment and other factors.

We can learn a lot from each other's different solutions and contributions. So let yourself be inspired!



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MENTAL HEALTH PROBLEMS OF YOUNG PEOPLE IN NORWAY

In Norway, mental ill-health is often referred to as mental health problems or mental health disorders. About half of the Norwegian population will have experience of mental health problems during the course of their lives, and about one-third during the course of one year.

The incidence of mental health problems is at about the same as that found in other Western countries and, according to some reports, has remained relatively stable. Some data has been gathered specifically on the incidence of mental health problems among young people but much of what is known refers to the adult population in general.

The Norwegian Institute of Public Health published national figures on the incidence of mental health disorders in 1990 and 2003, without finding any evidence of an increase over time. In addition, four surveys entitled Health and Living Conditions, commissioned by Statistics Norway Health and administered between 1998 and 2008, do not indicate any particular changes in mental health problems. Nor is there anything that indicates that young people are considerably more vulnerable than older people, or that the general state of health in the younger part of the population has become significantly worse in the past ten years (Mykletun et al., 2009).

However, several factors suggest that the incidence of mental health problems is growing within the population. Notably, there has been a sharp increase in the number of mental health disorders being treated. There has also been an increase in the number of recipients of health-related benefits caused by mental disorders. Most young people receiving health-related benefits do so on the basis of a mental health diagnoses (Grødem, Nielsen & Strand, 2014). The number of young people receiving health-related benefits is relatively high, and has been consistently high since the 1990s (Brage & Bragstad, 2011).

The latest findings in the NOVA (Norsk institutt for forskning om oppvekst, velferd og aldring) youth research surveys also indicate that there has been an increase in the number of young people with symptoms of mental health problems. These surveys, based on large, selected groups of young people, have been administered on several occasions between 1992 and 2012 (Hegna, Ødegård & Strandbu 2013; NOVA 2013). The proportion of young people with symptoms of mild mental health problems increased during this period. The proportion who reported sleeping problems increased from 22% to 35%, the proportion who reported feeling increasingly hopeless about the future increased from 16% to 27%, and the proportion who reported worrying about many things increased from 36% to 43% (ibid).

Anxiety disorders, depressive disorders, and drug-related disorders are the three most common groups of mental disorders among the Norwegian population. More young people than older have mental health problems. In the years 2002 to 2008, we can see an increase of 2 percent in the 16-30 age group who report mental health problems. In 2002, 14 percent of 16-22-year-olds and 8 percent of 23-30-year-olds reported mental health problems, but in 2008, these figures had increased to 16 and 10 percent (Jensen, 2009). The proportion of young people who report mental health problems increases with the number of negative life events. Examples of such events include sickness or death in the close family, the breakdown of a long-term relationship, and financial problems. Surveys consistently show that young people with mental health problems have experienced some dramatic events in the past year more than in the general population of young people (Mykletun et al., 2009).

In Norway in 2012, there were 515 cases of suicide recorded (10.4 suicides per 100,000 inhabitants), 369 of which were men and 146 women. After a doubling of the suicide rate for both men and women from the end of the 1960s until the end of the 1980s, with a peak in 1988, the suicide rate for both genders fell by approximately 25 percent over the following seven years. Since 1994, we have seen relative stability in the suicide rate, for both men and women. There can be major fluctuations in the suicide rate from year to year, but we see no statistical trend in the past ten years (Norwegian Directorate of Health, 2014). There are big differences in the suicide risk between

age groups and genders. From 15 to 64, the risk of suicide is consistently 2-3 times greater for men than for women. After the age of 65, the risk falls for women, but rises for men. For 15-year-olds, there is virtually no suicide in the population (ibid).

The extent of deliberate self-harm, where the intention is not to commit suicide, is uncertain. Self-harm is more common among young people than adults, and more widespread among girls than boys. In a Norwegian study of more than 4000 Norwegian young people, 10.7 percent reported that they had deliberately harmed themselves (Tørmoe et al, 2013). There is limited knowledge about self-harm and its causes. However, the study does indicate a significant overlap with the risk of suicidal behaviour (Bridge et al, 2009). People who have been exposed to stressful life events are more likely to develop a feeling of hopelessness and mental pain, or a lack of ability to regulate feelings, which again increase the risk of suicidal behaviour.

While the incidence of mental health problems and behaviours appears to have increased over time, if more stringent measures of mental health problems are applied, a more moderate increase is found. If we look at all available documentation on trends in mental health problems, there is no strong evidence that there has been a considerable increase in the incidence of mental disorders in the population (Soest and Hyggen, 2013).

These are of course indirect indicators of the incidence of mental disorders, which also reflect how society manages such disorders. There is no definite knowledge about the cause of this, but it is one of the most current discussions in the field. Does working life make high demands that are no longer manageable and that are now the cause of exclusion? Are doctors and the health system now better at detecting and diagnosing mental health problems, or has the proportion of young people with mental health problems actually risen? (Grødem, Nielsen & Strand, 2014).

Consequences of mental health problems in young people

In Norway, as in many other OECD countries, the proportion of people receiving disability benefit for mental health problems has increased steadily in the past 20 years (OECD, 2012). Mental health problems are one of the biggest health challenges in Norway, as measured by a number of factors such as impact on children, sick leave costs, various social security costs, burden of disease and mortality (Holen & Waagene, 2014). The biggest burdens on society are the most common mental health disorders such as depression, anxiety and alcohol abuse (Holte 2012). Increased mortality, sick leave and early retirement are some of the most important consequences of mental health problems (Skogen et al., 2013).



Another challenge is that these disorders present a barrier to education and participation in the labour market. Young adults with mental health problems are less likely to complete education, and have major problems in getting a foothold on the labour market. About half of those who do not complete upper secondary education report mental health problems as one of the main reasons (Markussen & Seland, 2012). This knowledge is of particular concern when we also know that incomplete secondary education is one of the biggest risk factors for becoming permanently outside the labour market (Olsen and Tägtström, 2013).

Overall, there has been a steady increase in the number of young people and young adults who are permanently outside the labour market because of mental health problems. Data from the Norwegian Labour and Welfare Administration (NAV) shows that there is a mental health disorder behind every third disability benefit claim in Norway, and behind approximately half of young people with disabilities (Brage and Thune, 2008). One of the reasons for the increase in the number of young people on disability benefit can be various changes in working life that make it more difficult than before for young people with mental health problems to find a job and hold on to it. In particular, the greater focus on communication, customer contact and social skills can be problematical for people with mental health problems (Berg and Thorbjørnsrud, 2009). A parallel explanation is that increasing demands from working life can increase the mental burden. The increasing exclusion of young people shown in the statistics may be a sign that many young people are not able to cope with these demands, and so end up claiming disability benefits (Brage and Thune, 2008).

A review of the research literature, carried out by the Nordic School of Public Health (NHHV) in 2011, on the relationship between unemployment and mental health among young people in the Nordic region found that exclusion from the labour market is linked with an increased risk of impaired mental health among young adults (Reneflot and Evensen, 2011). It also indicates that young women who are unemployed are more vulnerable than young adult men, and that unemployment is more harmful for young adults than other adults. Having a job is important for the financial independence of young women and men, their social status, self-esteem, use of their own skills, and

their physical and mental activity. Losing a job, or not entering the labour market, can therefore have a negative effect on mental health. Poor mental health can also affect motivation and the ability to find a new job, increasing the risk of long-term or permanent exclusion from working life. Mental health problems can therefore be both a consequence of lack of connection to working life and a cause of it (Reneflot and Evensen, 2011).

NEET

In recent years, there have been extensive discussions in Norway and other countries concerning the excessive number of people, particularly young people, living on benefits instead of paid work. In international research literature, young people (18-29 years) who are not in work, education or training programmes are called NEET (Not in Employment, Education or Training). NEET is a concept or designation without a standardised definition, and there can be different ways of defining the group (Grødem, Nielsen & Strand, 2014); some definitions can be very broad.

One way of tightening the definition is to look at the proportion of people who are NEET over several years. By looking at how many young people are defined as NEET in three consecutive years, it was found that the proportion of NEET young people in Norway was about 12%. In the period 2000 to 2010, an increase was found in the proportion of NEET young people receiving health-related benefits. This increase is related to reduced work-related health (ibid). When we also know that most young people who receive health-related benefits do so on the grounds of mental health problems, there are reasons to assume that the NEET group also contains a significant proportion of young people with mental health problems.

Being outside education and working life for several years greatly increases the risk of permanent exclusion, and the prognosis is very poor in terms of becoming established in working life. In a Fafo report (2014), Grødem, Nielsen and Strand argue that it might be appropriate to ask whether the increase of health-related benefits can really be attributed to declining health among young people, or whether health-related benefits ‘offered’ by the state are a solution to a problem that has its roots in young adults fall-

ing outside the labour market. The authors ask: Are we on the way to changing labour market policy directed towards young people into health policy? We leave the question open here, and support the report's statement that this is one of several questions linked to health-related benefits among young people that deserve more research.

Gender differences

If the extent of mental health problems are compared by gender, it is the youngest women (16-22 years) who are suffering the most. Here, the proportion has risen from 12 to 25 percent over a ten-year period. In comparison, 5 percent of men in this age group report mental health problems. In the general population, 7 percent of men and 12 percent of women report mental health problems. A number of studies on mental health confirm that far more women than men suffer from slight mental health disorders like anxiety and depression. Wichstrøm (1999) found that two of every three young people with depression symptoms are girls. Only drug-related disorders are far more common among men than women (Norwegian Institute of Public Health, 2011). These studies suggest that young men and women express and manage difficult emotions in different ways.

It is also interesting to note that gender differences in the prevalence of mental health disorders change during puberty (Mykletun et al. 2009). Before puberty there are more boys than girls who have mental health disorders, often behavioural problems, and who are treated for these. However, after puberty, the girls dominate with increasing emotional problems. Furthermore, before puberty, behavioural and developmental disorders occur about as frequently as emotional problems. After puberty, the incidence of emotional problems doubles, while behavioural disorders are actually reduced (ibid).

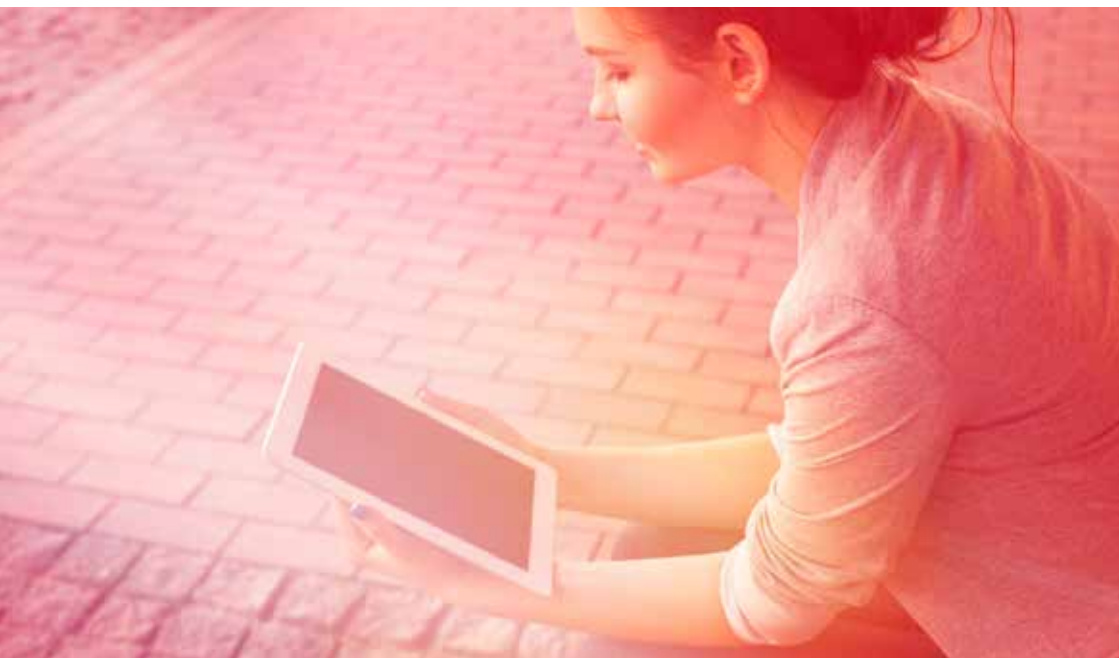
The major national survey of over 60,000 young people aged 13-16 in 150 Norwegian municipalities showed that far more girls than boys struggle with mental health problems (NOVA, 2014). This applies first and foremost to typical symptoms of stress, such as "thinking that everything is a burden" or "worrying too much about things". The proportion of girls with various mental health problems also increased from 2010 to 2013. For boys, the proportion has remained quite stable. However, the extent of

mental health problems flattens out in the transition to upper secondary school, after rising fairly steadily during the course of compulsory school (ibid).

Clear gender differences can also be seen in terms of self-harm and eating disorders, where the incidence is far higher among young women than young men (Sommerfeldt & Skårderud, 2009). A possible interpretation is that women are socialised to manage emotional challenges by acting on themselves, while men are more socialised to act on others, for example, using violence (ibid).

Young people's living conditions and relationship with mental health

Individual studies show that young people in low-income families experience that their health is worse than children and young people in the rest of the population (Sandbæk and Pedersen, 2010). The 'Youth Data Report' confirms this (NOVA, 2014). The study shows that a high proportion of young people struggle with symptoms of mental health problems, and it is those in families with low incomes who most frequently report these symptoms. No less than 34% of young people in families with poor advice report depressive symptoms. Annual surveys of living conditions also confirm that people with low incomes more often struggle with mental health problems than others.



OVERALL RESPONSIBILITY AND NATIONAL GUIDELINES

Major changes have occurred in the past 25 years in the range of services for people with mental health problems in Norway. In line with the World Health Organization (WHO) and The declaration of Helsinki (2004) institutional psychiatry in Norway has been reduced considerably, while locally-based services and district psychiatric centres (DPS) have been built up.

The responsibility for the range of services for young people with mental health problems, as for all inhabitants with mental health problems, is divided between administrative levels. Municipalities are responsible for operation and planning of general health and social services, the county councils have a similar responsibility for specialist health services, while the state has the ultimate responsibility for legal and financial framework conditions relating to the services. The state also has responsibility for training personnel at higher education level, for social benefits and labour market measures.

The Ministry of Health and Care Services has the overall responsibility for ensuring that the population has access to good and equal health and care services. National focus areas in mental ill-health regarding young people are described in the Development Plan for Mental Health 1999-2008 (Government Bill No. 63 (1997-1998)) and in the Government's Strategy Plan for Child and Adolescents' Mental Health – 'Together on Mental Health' (2003). The background to the Development Plan can be found in Report to the Storting No. 25 (1996-97) 'Openness and Wholeness', which describes the challenges in the services for people with mental disorders. The Development Plan strengthens and restructures the services to create a more decentralised support service.

Children and young people are a prioritised group in the Development Plan. An overall objective in the plan is that the municipalities will give children, young people

and adults an equal range of services, regardless of social background and where in the country they live. The Strategy Plan for Child and Adolescents' Mental Health is based on the Development Plan, and is a description of how the Government wants to support and develop the mental health of children and young people. It contains strategies and measures that will be implemented by various ministries, indicating a holistic approach to supporting the mental health of children and young people.

Through the *Development Plan for Mental Health 1999-2006*, significant funds were allocated to strengthening the range of services for children and young people, both in the municipal health services and in the specialist health service. The plan was originally an eight-year development plan with tangible measures and a financially obligatory action plan to strengthen the range of services for people with mental health problems. However, the plan was extended by two years, and continued until 2008.

Evaluation of the Development Plan for Mental Health (2001-2009), carried out by the Research Council of Norway, shows that many more people are receiving help for their mental health problems, including children and young people. Before the Development Plan, about 2 percent of children and young people received help from the specialist health service. In line with the target of the Development Plan, the proportion has increased to 5 percent. In addition to greater capacity, the evaluation also showed a need for better coordination in services and strengthened coordination between the different organisations and services that patients and users come into contact with. Good interaction and cohesive services are an important focus in the *Coordination Reform* (2008-2012). The Coordination Reform advocated continued strengthening of municipal services for children and young people with mental health problems.

The National Strategy for Work and Mental Health (2007-2012) is a national five-year broad initiative targeting young people under 35 with mental health disorders, possibly with simultaneous drug abuse habits. The strategy is a supplement to Report to the Storting No. 9 (2006-2007) Work, Welfare and Inclusion. An important aim is to coordinate the respective initiatives from the new Labour and Welfare Administration (NAV), the health and social services and schools, and collaboration for a more inclusive working life (the IA collaboration). The strategy plan has helped people with

mental health disorders to access a more coordinated range of services from the work and welfare administrations and the health and care sector. Nevertheless, the challenges are still great, and many of the young people encounter prejudices on account of their mental health disorders.

Experience from the National Strategy Plan for Work and Mental Health shows that a long-term and systematic initiative is needed in order to attain a change for the individual, for working life and for society. Consequently, the Government is continuing and developing the initiative in the Follow-up Plan for Work and Mental Health (2013-2016). The follow-up plan concerns everyone with mental health problems, including those who also have drug-related problems. The measures in the follow-up plan are in addition to other services for the target group. Services and measures will be arranged so that people with mental health problems and drug-related problems can maintain and strengthen their connection to work. The follow-up plan is based on experiences from the strategy plan and continues the methods and measures that give best results. We describe some of these measures in the section ‘What is being done? Central measures’.

Inclusive Working Life (the IA agreements) are agreements between the authorities and parties in working life that started in 2001. The IA agreements are based on collaboration and trust between authorities, employers and employees. The overall objective of the IA collaboration is to improve the work environment, improve job attendance, prevent and reduce absence through sickness, and prevent exclusion and dropout from working life (Norwegian Government, 2014). The Government’s vision is an inclusive working life with equal rights, obligations and possibilities for participation for everyone. Everyone is to have the chance to use their competencies in working life for the benefit of themselves and society. Based on the vision, the Government put forward the **Job Strategy for People with Disabilities** in 2012 (Ministry of Labour and Social Affairs, 2013). The strategy supplements the ongoing initiative for work and mental health, through a series of measures to ease entry to ordinary working life, including an adaptation guarantee, a new adaptation supplement for job-seekers and more follow-up measures. The strategy is cross-sectoral and is mainly concerned with reducing or removing barriers in relation to working life.

WHO IS RESPONSIBLE FOR FOLLOWING UP YOUNG PEOPLE WITH MENTAL HEALTH PROBLEMS?

Municipalities have a legal obligation and responsibility for work regarding mental health and their inhabitants. The specialist health service steps in when more specialised investigation and treatment are needed. A key challenge for the municipal health service is to evaluate when the young person's mental health problem is of such a level that the condition requires referral to the specialist health service.

The municipality's responsibility for following up young people with mental health problems involves all municipal services that have contact with young people. Young people between 16 and 29 receive health services for children and young people, and services for adults where child and youth services do not extend to young people over the age of 18. The next section includes a brief description of the most central services for young people with mental health problems. Some of these services are intended for all age groups, some from 0-20, and some from 18 years and over.

Primary health service

The primary health service, comprising the regular general practitioner (GP) service, health centres, the school health service and other mental health services are important players, both in preventive work and in the follow-up and treatment of young people with mental health problems. Many people with mental health problems first contact their GP. Only a small number of these patients have such serious disorders that they are referred to the specialist health service. Most patients with slight to moderate mental health disorders are treated and followed up by their GP. The GP has a key role as 'door-opener' to other services and benefits. This applies both to referral to the specialist health service, in relation to access to financial benefits such as sickness benefit, temporary disability benefit and early retirement, and in relation to NAV in terms of rehabilitation, employment testing and medical certificates.

The health centres and the school health service are central in capturing the early stages of mental health problems in young people, advising parents, and if necessary referring the young person to more specialised follow-up. The service also includes health centres for young people, which are low-threshold services to young people in secondary and upper secondary education.

Specialist health service

Because of the need for specialised investigation and treatment, it is the specialist health service that is responsible for child and adolescent psychiatry (BUPA) until the age of 18, and then the mental health service for adults from the age of 18. BUPA comprises both decentralised and centralised departments. Health services are mainly provided by decentralised polyclinics. Specialised psychiatric investigation and treatment for people over 18 are mainly provided by district psychiatric centres (DPS). DPS is a decentralised specialised service and involves *community mental health* centres adapted to Norwegian conditions. When more specialised treatment is needed, for example institutionalised treatment, this is given at centralised hospital departments.

There is a ‘waiting time guarantee’ for children and young people under 23, with the right to prioritised health care, i.e. health care in the specialised health service. Under the terms of the guarantee, nobody should wait for health care for more than 65 working days after referral.

Other psychological and advisory services

The educational-psychological counselling service (PPT) gives both psychological and special educational help to children and young people. The child welfare service offers a number of services, such as setting up support contacts, financial assistance, and environmental therapy measures. The social services help to find accommodation for people who cannot safeguard their interests on the housing market, for example because of various disabilities.

Follow-up service

The follow-up service (OT), is a county council service, and is responsible for following

up all young people between 16 and 21 who are not in education or work. The service was set up in connection with a new reform for upper secondary education in Norway, 'Reform 94'. The reform ensured that all young people aged 16-19 would be entitled to three years of education that could lead to higher education admission qualification, vocational skills or partial skills. The county councils were given responsibility for ensuring sufficient places to everyone who wanted to go through upper secondary education. Every year, the follow-up service contacts young people who are not in education, employment or training (NEETs), as long as they are covered by the legal right to upper secondary education. The service gives advice and guidance about education and career choices, and will ensure that the target group is offered education, work, or other activities. The service is voluntary, and not something forced upon young people.

NAV

The Labour and Welfare Administration (NAV) is both a state and municipal administration, and is a very important player for young people with mental health problems who are outside formal education and work. NAV administers benefits such as unemployment benefits, rehabilitation benefits, sickness benefits and early retirement pensions.

The labour market policy in Norway is based on universal application, with equal terms and rights for everyone. Tailored measures targeting young people with mental health problems are rare, but these people form one of the priority groups in general health care. Individually adapted measures and services must be normative for all, but a distinction has been made between job-seekers who do not need assistance ('ordinary job-seekers') and 'people with impaired work capabilities' who need more extensive assistance and follow-up (Report to the Storting, No. 9 (2006-2007) Work, Welfare and Inclusion). In the section on measures, we describe in more detail the central reforms and measures that are important for people with mental health problems and those who have problems with completing upper secondary education and getting a foothold in working life.



WHAT IS BEING DONE? IMPORTANT MEASURES

Some of the measures we describe here are specifically directed towards young people with mental health problems. Some measures are not directly aimed at young people with mental health problems, but are nevertheless measures that are very significant for this group of young people. Some measures are aimed at adults over 18 but are relevant to young people with mental health problems.

Mental health in school

‘Mental health in school’ is a subsidy scheme originating from the Development Plan for Mental Health. The subsidy scheme is aimed at contributing to health-promoting and preventive measures that strengthen the schools’ own structures and skills in the field. The scheme was a national school initiative (2004-2008) with educational programmes for compulsory and upper secondary schools¹. The programmes give children and young people knowledge about mental health, how to befriend someone who has mental health problems, and knowledge about the local support system. Pupils, teachers and school management in compulsory and upper secondary schools are the primary target group. Secondary target groups are local health services and parents and guardians.

A report based on a questionnaire given to teachers, school managers and school owners, on the theme of mental health in schools, shows that teachers have good knowledge about what is important for the mental health of pupils and what can indicate that a pupil has a mental health disorder (Holen & Wagene, 2014). A large number of teachers in school are supposed to work systematically, both to prevent mental health issues and to promote good mental health in the pupils. However, it is only a small number of teachers who report that schools actually do this. The survey also shows that teachers are active in adaptation for pupils with mental health issues, both in and outside actual teaching. At the same time, teachers say they need and want more skills, resources and better facilitation from school managers and school owners.

¹ www.regjeringen.no

The VIP programme (**Guidelines and Information about the Mental Health of Young People**), is one of the educational programmes in Mental Health in Schools, and is a service for people in upper secondary education. The aim is to increase knowledge about and the ability to recognise signs of mental health problems and disorders, and to lower the threshold for seeking help. The pupils are taught about mental health, both by their own teachers and by health staff. The school and services like nurses, the PP service², and specialist health service collaborate to support the pupils. Teachers, counsellors and health staff attend courses to improve their ability to be able to detect problems in pupils at an early stage and to be able to initiate appropriate measures. The intention is that both pupils and schools will feel comfortable about seeking advice or help from the other services if they need it. The initiative will also help schools create a health-promoting environment around the pupils.

An evaluation study found that the VIP programme appeared to be effective (Andersen & Nord, 2010). The study was based on 880 pupils in a county where the VIP intervention was implemented, who were compared with 811 pupils in a county that had not implemented VIP. The areas measured were ‘general knowledge about mental health’, ‘ability to link symptoms to diagnoses’, ‘knowledge about support services in mental health generally’, and ‘knowledge about the immediate support services in mental health’. When compared with the effectiveness of other studies, both in Norway and internationally, the effectiveness of VIP was shown to be good. It remains to be seen whether the VIP programme has long-term effects of a satisfactory level.

‘New GIV’

In 2011 the Norwegian Government initiated ‘New GIV’, a three-year project to increase completion of upper secondary education. The initiative mainly comprises three different projects: 1) A statistics project that will evaluate goal attainment in New GIV, 2) A transition project focusing on the collaboration between municipalities and county councils as they follow up pupils with poor school performance, and 3) A follow-up project that will strengthen the follow-up service and collaboration between

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county councils and NAV as they engage with young people who are outside upper secondary education and working life. The collaboration through New GIV is key to preventing young people with mental health problems dropping out of education and working life. Good interaction between the health sector, the knowledge sector and the work and welfare administration is necessary in order to offer a good range of services to young people with mental health problems.

The Follow-up Project is one of the focus areas in New GIV, where the aim is to strengthen the efforts for young people who are on the way to ending, or have ended, upper secondary education. This will be done by testing new educational models that combine work experience with curriculum objectives in upper secondary education and by strengthening the collaboration between the different players that are responsible for the target group. Another objective is to develop the skills of the staff.

An evaluation report of the Follow-up Project has been published based on a survey of measures initiated for the target group (Sletten, Bakken & Sandlie, 2013). The survey also assesses how school managers and personnel in the Follow-up Service and NAV experience the collaboration relationships and the initiatives directed towards the target group. In addition, the report gives a picture of how young people experience the measures in which they participate, and how the upper secondary measures that have been initiated within the framework of New GIV work. The main conclusions of the report are:

- There are effective measures for young people who are outside education and work. Many of the initiated measures are aimed at increasing the formal competencies of the young people. Around 30 percent of all measures in the counties have a combination of curriculum objectives and work practice as goals.
- Most of the measures involve collaboration between several players. The collaboration is mostly between the Follow-up Service (OT) and NAV, and employees of the two agencies are largely satisfied with how the collaboration works - both in terms of planning measures, guidance and the follow-up of young people.

- The survey indicates that, so far, the Follow-up Project has had greatest impact on the collaboration between the players concerned. This point corresponds to the evaluations from employees both in OT and NAV, and is also shown by the evaluation of skills enhancement.

The report shows that young people receiving the measures are consistently satisfied with the support sessions they have attended, and experience that they have had a positive outcome from participation. The proportion of satisfied people is greatest among young people who participate in measures that involve school-based education and in measures where the goal is completion of upper secondary education.

The questionnaire surveys aimed at practitioners and staff working with young people every day have consistently found, so far, that that project has mostly been effective at



strengthening collaboration relationships. Although many of the measures for young people in the OT target group are aimed at giving young people documented skills in combination with work experience, relatively few of those working with young people on a daily basis feel that the Follow-up Project has helped to increase the use of educational programmes that combine work experience with curriculum objectives.

Guarantee schemes for young people

Guarantee schemes for young people are aimed at preventing long-term unemployment and passivity for young people aged 20-24, who may already have experienced uninterrupted periods of unemployment or who have not had a place in school in the past six months (Report to the Storting, No. 46 (2012-2013), More in Work). The guarantee schemes contain three main types of measures:

- *Youth guarantee.* Young people under 20 who have no school place and no job. This group will be offered labour market measures.
- *Measures guarantee* Young people between 20 and 24 who have been unemployed for six months or more: This group will be guaranteed an offer of labour market measures.
- *Follow-up guarantee.* Young people between 20 and 24 who have been unemployed for three months or more: This group is guaranteed follow-up from the NAV office, with a focus on job-seeking, own activity and motivation.

In 2013, the guarantee scheme for young people aged 20-24 was changed (Report to the Storting, No. 46, 2012-2013). The target group for the guarantee schemes was broadened to also include young people with reduced working capability and young people with disabilities. The aim was to direct the guarantees to the group of young people that most needs help to enter the labour market and to direct more attention to the individual needs of the young person. The changed guarantees mean that young people who need help to get into work, but do not have impaired work capabilities, will be given an activity plan within a month of receiving a follow-up measure from the NAV office. For young people with a need for help to get into work who also have impaired work capability, a target has been set whereby 90 percent of all participants

will have an approved activity plan at all times. This is a group that often requires a more cohesive approach, which can take longer to establish. The guarantee related to the rapid preparation of an activity plan helps the individual to be given the necessary follow-up at an early stage, and quickly get started with activities aimed at participation in work or education.

Qualification programme

The Qualification Programme (KVP) was initiated in 2007, and became a nationwide programme from 2010. It is the government's most important instrument in fighting poverty. The aim of the programme is to help more people get into work and activity through more frequent, obligatory assistance and follow-up, especially in cases where the route can be relatively long and uncertain. The target group is people with considerably reduced work capability and no or very limited work experience or earned rights in the social security system. The usual alternative is receiving financial social benefits. KVP is a legal responsibility for the municipalities, and is administered by the local NAV offices. KVP is a full-time programme for up to two years, which is individually adapted and aimed at work participation. The programme can also be combined with health services, such as treatment for mental health problems and drug dependence.

Of those who completed KVP according to plan in the period 2008-2010, around two-thirds have not come into ordinary work or education (Schaft & Spjelkavik, 2014). Of those who completed the programme in 2010 and 2011, 26 percent were in work six months after completing the programme. Among those who had found jobs, there were still many who continued to receive social benefits or other benefits from the NAV office. Those who completed the programme in 2010 were also monitored two years after the end of the programme. After two years, the proportion in work had fallen from 26 to 20 percent. Ten percent had a stable link to work throughout the period (ibid).

Follow-up Plan for Work and Mental Health

We mentioned earlier that, with the implementation of the Follow-Up Plan for Work and Mental Health, various measures have been initiated to strengthen the link to

education and working life for people with mental health problems. The measures are mainly aimed at adults over 18. Here, we briefly describe the key measures for our target group. There are also a number of measures that are particularly directed towards people with serious mental health disorders (such as ‘Work Proficiency Follow-up’), but because these are not directly aimed at young people, the target group for this report, these will not be considered here.

*Rapid mental health help*³ is based on the British model ‘Improved Access to Psychological Therapies’ (IAPT). The service is directed towards people over 18 who have had slight to moderate levels of depression and/or anxiety. The aim is treatment within a short time, so that problems do not become exacerbated. The offer is to be free, with no referral requirement. However, cooperation with the family doctor is encouraged, if the GP has not been involved from the start.

The treatment is based on guided self-help and cognitive therapy, which is a well-documented treatment method for mental health disorders. This type of service is a good tool for giving people real treatment, while helping to develop the skills of health personnel in municipalities. Twelve municipalities received funding for the project in 2013, and another five in 2014. Remaining in, or returning to, work is a key objective. The service will be evaluated by the Norwegian Institute of Public Health.

Guidance and follow-up pilots at NAV offices will meet the users’ need for coordinated follow-up assistance. The service is aimed at users needing methodical and targeted follow-up over time in order to get into work. Guidance and follow-up pilots help ensure close and coordinated follow-up in phases in which the person, for example, is sick, under treatment, waiting for action or school, looking for a job or needing support to stay in work. The pilots also collaborate closely with the health services so that the service to the individual is individually adapted and comprehensive.

Study with support (SMS) is a follow-up programme for people with mental health problems who wish to enter higher education. People with varying or reduced work capability during education will be given a better service regarding follow-up on restart,

3 www.psykiskhelsearbeid.no

implementation and transition to work. The idea is taken from the USA programme, 'Supported Education'.

Employer pilots are employed at the NAV Working Life Centres, and help workplaces with support and guidance as to how to retain existing and including new employees with mental health problems. The background to setting up this measure is that employers need more knowledge, advice and guidance about mental health problems and drug-related problems. Employer pilots work both at system and individual level, and have specific competency in mental health.

Employees with user experience (MB) is a model taken from Århus, where the aim is to ensure genuine user involvement and influence, and to help build bridges between the 'healthy and sick' and 'specialist and user'. The model involves education that will qualify earlier users of mental health services / municipal services for work in companies or organisations that offer service to people with mental health problems. The education will put employees in a position to use their user experience in the best possible way. The employees will, for example, help to increase understanding of mental health disorders among staff and develop a more user-adapted range of services.

Follow-up and LOS function

Municipalities in Norway can receive state funding to appoint people (pilots) who will be responsible for providing follow-up support to young people, helping the young people with contacts to necessary support services, and contributing to the adaption of help given in schools or by other services. The work will take place in collaboration with parents and relevant services. The subsidy scheme is a tool to assist completion of upper secondary education. The scheme is aimed at young people aged 14-23 who are at risk of ending up outside school and work⁴. The initiative is particularly aimed at young people for whom high levels of absence from school or lack of connection to a school are linked with challenges such as lack of care, support and follow-up from parents, lack of a social network, experience of bullying and social isolation, health problems in the form of drug misuse, mental health disorders, and reduced functional ability.

4 www.bufdir.no

How can the help be made more effective?

There are many measures aimed at vulnerable young people in general. In an evaluation of the development work, *'Vulnerable young people, 17-23 years, in transition phases'*, it is emphasised that trusting and flexible follow-up is crucial in successfully strengthening the young person's link to school and work, and in improving their everyday lives and ability to lead an independent life (Kristiansen & Skårberg, 2010). Good contact with a stable adult and own involvement are other factors that are emphasised by the young people themselves as being particularly important.

This development work is mainly aimed at vulnerable young people who have had contact with the child health services, and not specifically at young people with mental health problems. However, we want to draw attention to those recommendations relevant for the target group in this report, since several studies involving vulnerable young people highlight this as being particularly significant in the work and follow-up (Follesø, 2011, Anvik & Gustavsen, 2012). There are strong indications that frequent, individual and flexible contact, and follow-up are important in measures and support that are directed towards young people with mental health problems.

Withdrawal, passivity and isolation are likely outcomes for people with mental health problems, if nobody intervenes. Withdrawal, which is usually initially in the form of long sickness absences, worsens the state of health. In its report, *'Mental Health and Work'*, the OECD (2013) points out that Norway would benefit greatly from measures that counteract withdrawal, because the proportion of sickness absence due to mental health disorders is particularly high in Norway. The OECD's analyses show that the challenges relating to work and mental health require a coordinated range of services from several bodies and sectors. In practical terms, they recommend better collaboration between the work and welfare administration, GPs and district psychiatry centres (DPS). They also recommend using staff from the NAV offices in the DPS, and using GPs in the work and welfare administration. There is a need for more refinement of the work in the DPS, and greater emphasis on work and mental health in training of GPs.

The school health service and the educational-psychological service are key in detecting and following up young people with mental health problems. It would therefore be beneficial to increase the resources available to the school health service, and to strengthen cooperation with the Educational Psychology Services. Mental and/or social problems are among the most common reasons why pupils drop out of school. These are more significant problems than pupils being tired of school, suffering from low motivation, making the wrong choices or experiencing difficult home conditions (Ministry of Labour and Social Affairs & Ministry of Health and Care Services, 2013). It is necessary to look more closely at what types of skills schools need, and the degree to which only teaching skills are sufficient to meet the diversity of pupil's abilities and needs (ibid). Closer contact between upper secondary schools, the work and welfare administration, and the municipal health services is another measure that would improve follow-up of young people with mental health problems. OECD recommends expanding the qualification programme for young people with mental health problems, thereby ensuring that such problems are detected and treated.

Research shows that several factors can promote mental health, such as security, a sense of belonging, skills and meaning (Holte 2012). We find this in other arenas than health care – the workplace, family, nurseries, school, and various leisure time activities can all help to promote mental health. Mental health problems can be prevented to varying degrees, but in addition to the health-promoting factors, early intervention has been shown to be important (Major et al. 2011). Children and young people spend a lot of time at school, so school is one of the important arenas for this work.

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AUTHORITIES**

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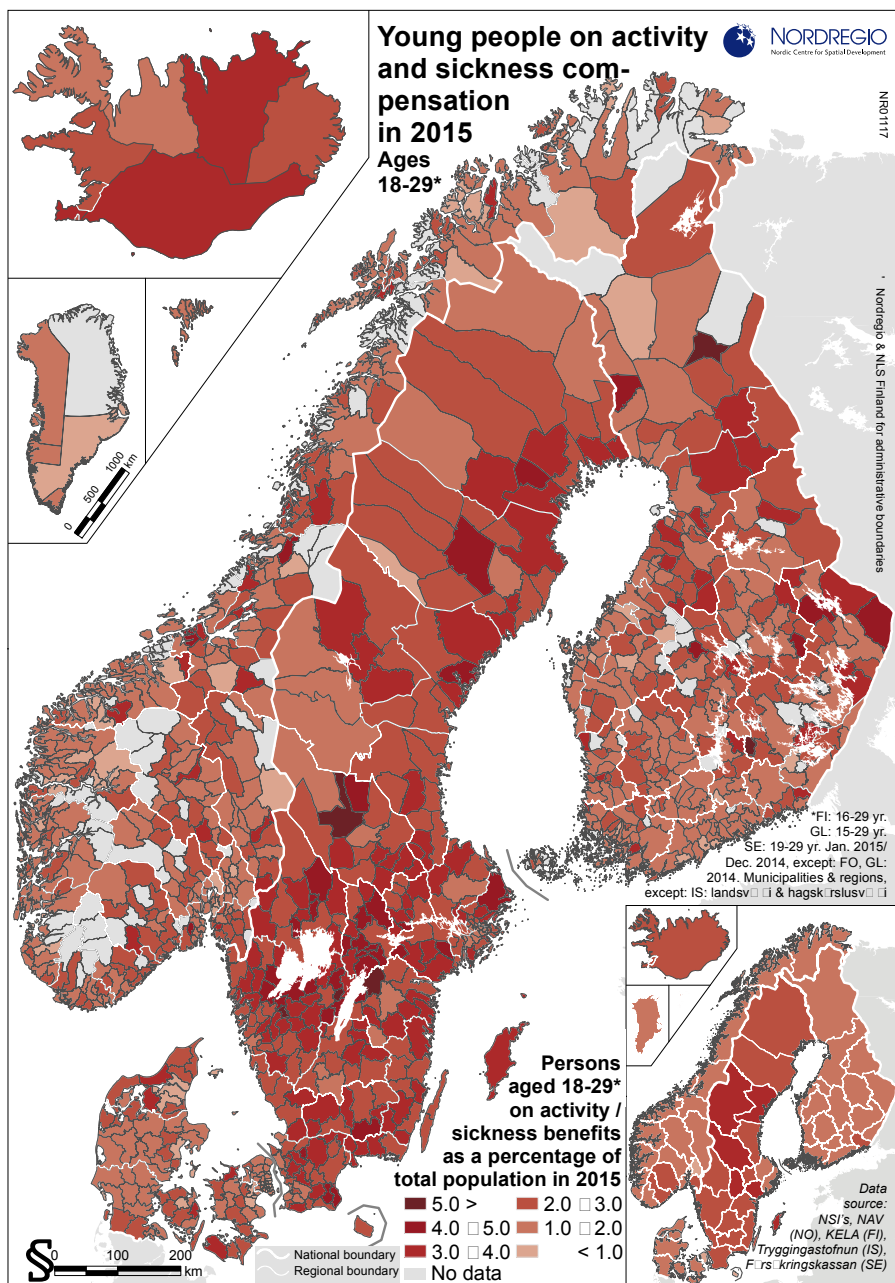
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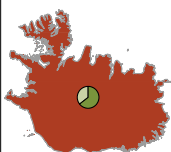
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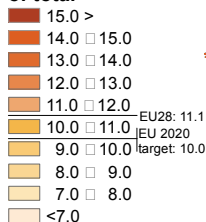
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- Kirkens Bymisjon/The Church City Mission in Norway: www.bymisjon.no
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- Mental helse ungdom/Organization promoting mental health: www.mentalhelse.no
- Natteravnene/Parents organization: www.natteravnene.no
- Norske Kvinners Sanitetsforening/The Norwegian Women's Public Health Association: www.sanitetskvinnene.no
- Norges barne- og ungdomsorganisasjoner/The Norwegian Children and Youth Council: www.lnu.no
- Redd Barna/Save the Children: www.reddbarna.no
- Rådet for psykisk helse/Norwegian Council for Mental Health: www.psykiskhelse.no
- Røde Kors Ungdom/Red Cross Youth: www.rodekors.no/ungdom
- Samarbeidsforumet av funksjonshemmede organisasjoner/Norwegian Disability Federation: www.safo.no
- Voksne for Barn/Organization promoting mental health for children: www.vfb.no



Early school leavers in 2014 by NUTS 2 regions Persons with at most lower secondary education, aged 18 to 24*



Early school leavers: percentage share of total

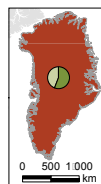


EU28: 11.1
EU 2020
target: 10.0

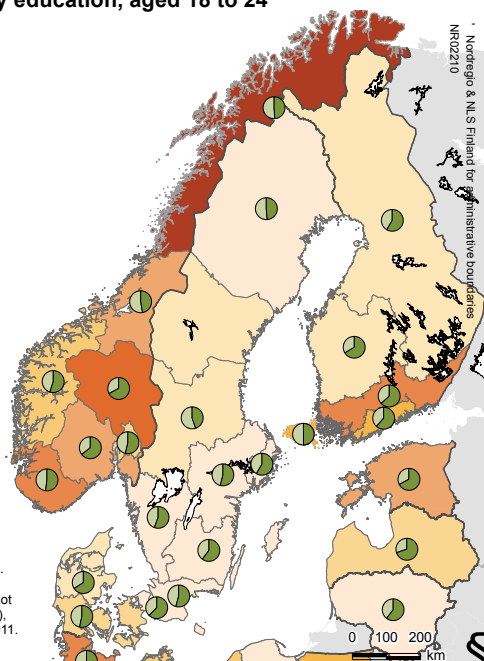
Early school leavers: gender shares

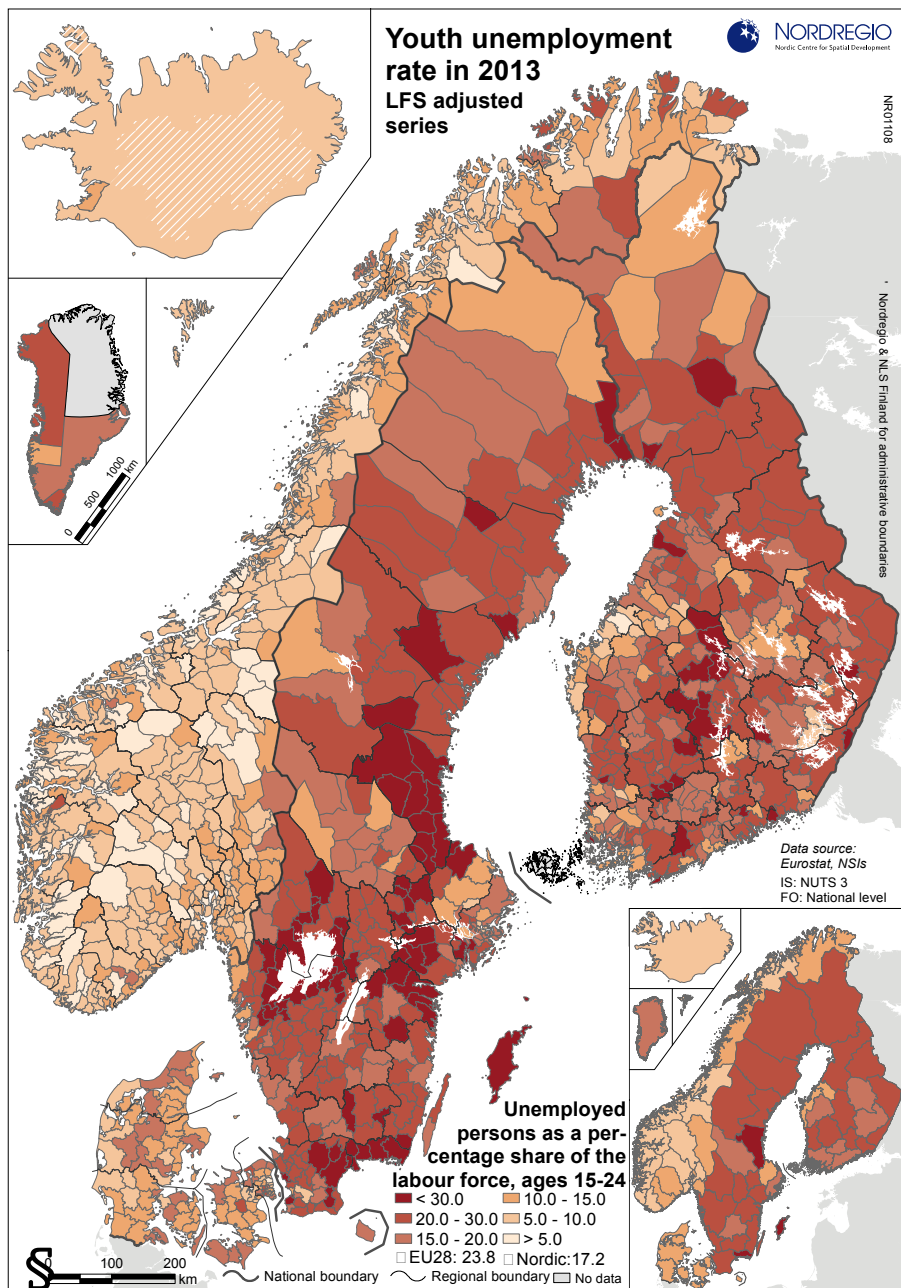
Females Males

EU28:



* Percentage of the population aged 18 to 24 having attained at most lower secondary education and not being involved in further education or training. Regional level: NUTS 2. In EE, IS, LT & LV, NUTS 2 equals national level. AX, GL: estimates. AX: Share of early school leavers probably over estimated, as students studying in Sweden are not included in estimates. SJ: Jylland, Nordjylland (DK), Mellersta Norrland (SE): No gender data. FO: 2011. Source: Eurostat & (for AX, FO, GL) NSI's.

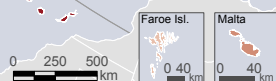
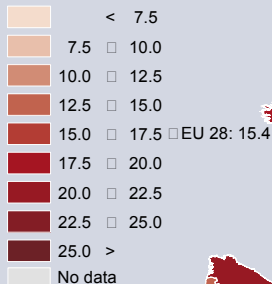




NEET rates in European countries in 2014

Young people neither in employment nor in education and training (NEET)

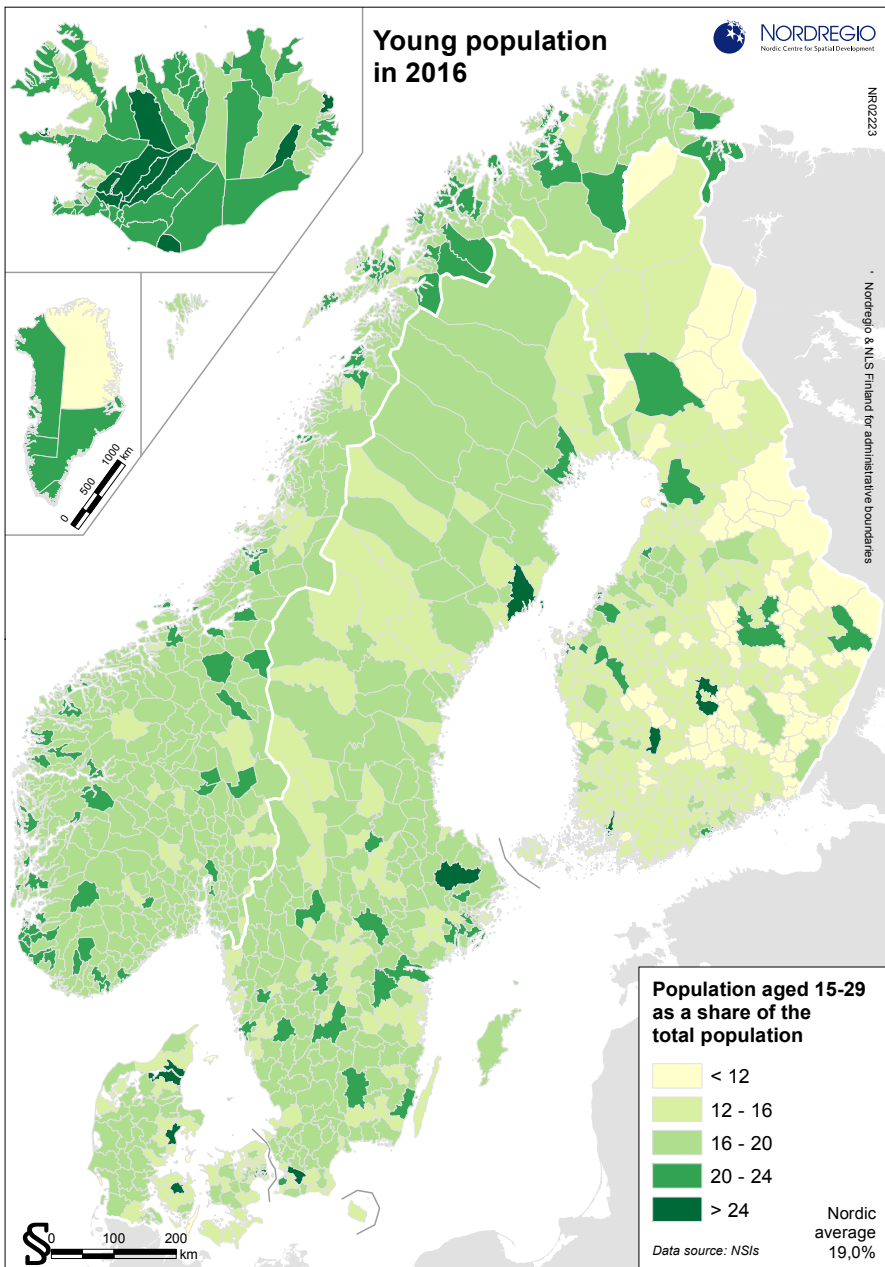
NEET percentage of total population, ages 15-29




FO: 2011
Source: Eurostat, NSIs

NR01116

Nordregio, NLS Finland & ESRI for administrative boundaries



A stylized map of the Nordic region, including Denmark, Finland, Iceland, Norway, Sweden, the Faroe Islands, Greenland, and Åland, set against a blue background. The map is white and shows the outlines of the countries and islands.

The Nordic co-operation involves Denmark, Finland, Iceland, Norway and Sweden, as well as the Faroe Islands, Greenland and Åland.

NORDIC CENTRE FOR WELFARE AND SOCIAL ISSUES – AN INSTITUTION UNDER THE NORDIC COUNCIL OF MINISTERS

Although there are some national differences in the Nordic welfare systems, there are also great similarities between the countries. National differences provide opportunities for comparison and learning from each other's experiences. The Nordic Centre for Welfare and Social Issues is a key-actor in explaining, supporting and developing the Nordic welfare model.

Our work aims at developing strategic input to politicians, compiling research findings and arranging Nordic and international conferences on current welfare issues.

Our focus areas are:

- Welfare policy
- Disability issues
- Labour market inclusion
- Alcohol and drug issues
- Welfare technology

Nordic Council of Ministers

The Nordic Council of Ministers is the official inter-governmental body for co-operation in the Nordic region. The ministers within each specific policy area meet a few times a year to collaborate on matters such as working life issues, social and health policy, and education and research.

Within each policy area, there is also a committee of senior officials, comprising civil servants whose task is to prepare and follow up issues.

Nordic Council

The Nordic Council is the official parliamentary body of the Nordic co-operation. Members of the Nordic Council are members of parliament in the individual countries.

The Nordic Council meets twice a year. The decisions taken at the meetings are implemented by the Nordic Council of Ministers and the Nordic governments. The day-to-day political work is carried out in committees and political party groups.



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