UNODC
United Nations Office on Drugs and Crime

# Review of National Prevention Systems based on the UNODC/WHO International Standards on Drug Use Prevention

Final report of the pilot in Norway

United Nations Office on Drugs and Crime, Vienna

in collaboration with KORUS Oslo

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28 September 2023

*Pre-publication version*

*This document has not been formally edited*

## Acknowledgements

UNODC would like to acknowledge and thank the following for their contribution in making the realization and publication of this report possible:

- The Government of Norway, particularly the Ministry of Health and Care Services, for its financial contribution, as well as its willingness to use the national drug prevention system of the country as the focus of the first pilot;
- The colleagues at the Ministry of Health and Care Services, particularly Mr. Torbjørn K. Brekke, as well as Ms. Hege Christina Bredesen and Ms. Herdis Dugstad, for their vision, patience and unfailing support;
- The experts that provided input in the development of the tool: Mr. Gregor Burkhart, EMCDDA, Ms. Amy Goldstein, National Institute on Drug Abuse, United States of America, Mr. Fernando Salazar Silva, Cayetano Heredia University, Peru, Mr. Goodman Sibeko, University of Cape Town, South Africa, Mr. Harry Sumnall, Liverpool John Moore University, United Kingdom, Ms. Dijana Jerkovic, FENIQS project, Ms. Kimberly Johnson, ICUDDR, Mr. Roman Koposov, The Arctic University of Norway;
- All the stakeholders involved in drug prevention in Norway, who contributed their time and knowledge to provide information about the interventions implemented in the country, as well as its system. It is hoped that they will find the results of this process of interest and use in improving their work for the health and wellbeing of children, youth, families and communities in the country.
- All the KORUSes, in particular Katrin Øien, Kristian Hartveit, Sven Gustafsson and Pål Domben, for supporting the preliminary piloting of the tools, for motivating prevention practitioners to provide information through the questionnaire and providing additional information;
- Ms. Yvonne Larsen, Mr. Skule Wigenstad and Mr. Alexander Sollie Hvaring of KORUS Oslo, for leading the process of data collection and serving in the Review Committee to support the analysis of the information, complementing, translating and contextualizing and without which this process would not have been possible,
- Mr. José Antunez, Ms. Asli Ertem, Mr. Wadih Maalouf, Mr. William Wagner of the UNODC Prevention, Treatment and Rehabilitation Section for supporting the process, particularly the management of the data for the production of the report;
- Ms. Giovanna Campello for conceptualizing and leading the process, analyzing the data and writing this report.

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# Introduction

Evidence-based prevention of drug use promotes the wellbeing and health of children, youth, adults, families and communities, as described in the *International Standards on Drug Use Prevention*, *Second Updated Edition*, published by the United Nations Office on Drugs and Crime (UNODC) and the World Health Organization (WHO)[1].

The *Review of Prevention System* (RePS)[2] is a tool that has been created by UNODC to allow the assessment of the extent to which the drug prevention system of a country or a sub-national entity (e.g. a municipality) is in line with the *Standards* with a view to identifying areas of strength and weakness to allow improvement.

This report presents the results of the assessment of the national prevention system of Norway, undertaken on the basis of the *RePS* and serving as first pilot of this tool. Following this pilot assessment, a process of adaptation at global level will be led by UNODC, in order to avail the tool to all Member States.

Following this Introduction, the report presents the process of data collection, as well as a summary of the methodology of analysis (Chapter I.). Chapter II. provides a summary of the overall information collected about the interventions implemented in the country, while Chapter III. describes the results of the analysis of the first component of the Review, namely the quality of implemented interventions by age, by level of risk, by setting of implementation and by Region. Finally, Chapter IV. describes the results of the second component of the Review, the quality of the systems as a whole, leading to the Conclusions, summarizing key points of strengths as well as opportunities for improvement, indicating some possible action points.

[1] UNODC/WHO (2018), *International Standards on Drug Use Prevention*, United Nations Office on Drugs and Crime, Vienna, Austria.
[2] UNODC (2023, available on request), *Review of Prevention Systems (RePS), Ttool utilized during the pilot in Norway*, United Nations Office on Drugs and Crime, Vienna, Austria.

# I. Process and methodology

The *RePS* tool was developed by UNODC in 2022 on the basis of the *Standards* and with the informal input of a global group of experts, as acknowledged above. The undertaking of the pilot assessment followed the process and methodology described in the tool and will be shortly summarized here as it pertains to the pilot in Norway.

## A. Launch and data collection

The pilot was officially launched in September 2022 through a presentation by UNODC during a conference on "Alcohol and drug prevention in the Nordic countries" organized by the Norwegian Ministry of Health and Care Services and funded by the Nordic Council of Ministers. On the margin of the conference, UNODC presented the methodology to national stakeholders and specifically representatives of KORUSes from various regions of Norway that would support the data collection.

*RePS* includes two substantive components, following the structure of the Standards. The first component assesses the extent to which existing interventions[3] are evidence-based and is based on Chapters 1. and 2. of the *Standards*, while the second assesses the quality, including the coherence, of the system as a whole and is based on Chapter 3.

### *1. Data collection for the first component (interventions)*

The data collection under the first component is undertaken through a questionnaire (Annex 2 of the *RePS*) that needs to be filled in by as many practitioners as possible to provide basic information about the prevention interventions they implement (including: the age of the target group, the setting of implementation, the level of risk targeted, a brief description of interventions, whether the interventions had been evaluated and how, as well as supportive documentation).

In the Norwegian pilot, the data collection under the first component relied heavily on the support of KORUS Oslo, as well as of all the other KORUSes in the country. In particular, following the launch and the presentation, KORUS Oslo briefed and mobilized all the other KORUSes, clarifying the process and raising further awareness and interest in the pilot. In addition, KORUS Oslo translated the questionnaire in Norwegian, created an online version and piloted it among some colleagues. Once the online questionnaire was finalized, all the KORUSes

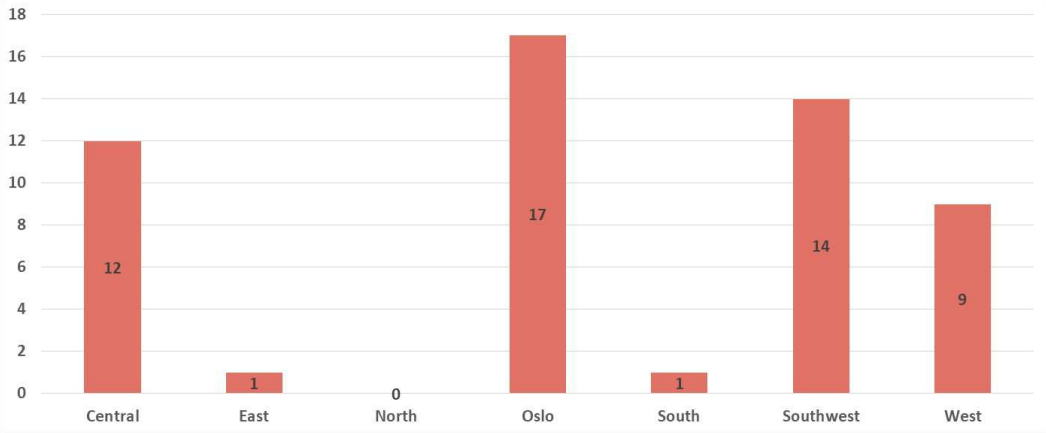
[3] Although in the Standards the term 'strategy' is utilized to refer to one self-contained programme or policy, in the case of the pilot in Norway, it was decided to utilize the term 'intervention' as more comfortable to the national stakeholders.

were requested to reach out to as many practitioners implementing prevention interventions of different kinds.

Each practitioner was provided with a 'key', identifying a single respondent and allowing the input of the details of up to 3 interventions. Respondent could and some did request more than one key. In total, 99 keys were distributed and 87 (81%) were utilized, providing details about 187 interventions.

Figure 1. presents the geographical region of the respondents, applying the regional definitions utilized by the KORUSes. As it can be gauged, the majority of respondents were from Oslo (17), followed by the Southwest (14), the Central (12) and the West (9) region. Only one respondent was from the East and the South region and none from the North region. This discrepancy could be taken to reflect the level of support that the different KORUSes were able to provide to the process. In addition, a specific follow-up was undertaken with regard to the implementation of prevention interventions in the Region North, particularly among the Sami people, which confirmed the implementation of policies and interventions available nationally.

*Figure 1.*
*Geographical region of respondents*




## 2. Data collection for the second component (system)

The data collection under the second component is based on a second questionnaire (Annex 4 of the *RePS*) to be filled in by entities with the mandate to coordinate and manage prevention at the national level. The questionnaire request information about the following six elements of a prevention system, largely based on the characteristics of an effective prevention system described in chapter 3. of the Standards:

1. A range of interventions and policies based on evidence;
2. Supportive policy and regulatory frameworks;
3. Evidence-based planning and use of research;
4. Coordination amongst different sectors and levels;
5. Strong delivery system; and,

6. Sustainability.

This questionnaire was in English and was not translated. It was distributed as electronic file by the Ministry of Health to the following Ministries: Ministry of Health, Ministry of Education, Ministry of Culture and Equality, Ministry of Justice and Public Security, Ministry of Labour and Social Inclusion, Ministry of Local Government and Regional Development, Ministry of Children and Families. Ministries filled in the questionnaire providing information: the Ministry of Health and the Ministry of Children and Families. In addition, the Directorate of Health and the Public Health Institute also provided input.

## B. Screening

The information provided by practitioners on the prevention interventions implemented in the country (first component) were screened by a Reviewing Committee comprised of two staff of KORUS Oslo and one of UNODC. Although the screening was undertaken organically during the review of each intervention, for the sake of clarity, it is herewith described as comprising different phases.

In a first phase, the Reviewing Committee screened each of the entries to assess whether it was possible to assess them as unique prevention interventions. This led to the discarding of a number of entries, as follows:

- Five entries, providing the description of an intervention that was part of treatment and care (including harm reduction), and not prevention of drug use as defined in the *Standards* (i.e. aiming at avoiding or delaying initiation of substance use and/or progression to substance use disorders);
- Six entries including information that was too scant to assess (e.g. only a title); and,
- Three entries that were describing planned, as opposed to ongoing interventions.

It should be noted that, although the Reviewing Committee included people with a deep knowledge of prevention in Norway, as well as extensive contacts, it was not always possible to request further information and/or further information was not forthcoming. Some interventions, therefore, were penalized by the scant description and/or lack of supporting documentation.

In addition, a number of entries were merged, as they described different lines of actions of a single intervention (two entries were merged into one, three times and three entries were merged into one, once). Conversely, a number of entries were split, as they described recognizable different interventions under a single entry (seven entries was split into two, each, and one entry was split into five entries).

In a second phase, it became apparent that some of the entries described the local implementation in a specific municipality/ region of a policy/ service/ intervention that it is implemented nationally. These 21 interventions were not assessed separately. Rather, they were superseded by one single intervention, the quality of which was assessed as implemented in all regions.

The choice between which interventions were really implemented nationally, often with a legal mandate, and which interventions were only 'offered' nationally and truly implemented only in specific locations was based on knowledge of KORUS, triangulated with information available online where possible and relevant.

Some examples of interventions that were superseded in this way include the entries regarding the local implementation of: the Akan model in the workplace, the National Alcohol Act in entertainment venues, the national guidelines for schools and for provision of mental health services in children.

As a third phase of screening, it became apparent that many of the interventions described were not interventions per se, but rather part of all the efforts that are needed to maintain an implementation structure that actually delivers interventions (for example: training of counsellors).

These 14 interventions were not assessed, but the information was fed in the assessment of the implementation structure of the national prevention system, which is undertaken under the RePS second substantive component. Example of this kind include: the training and local coordination of Akan stakeholders; mentoring, networking, training on HAP; coordination meetings of the SLT or other interagency cooperation models; training on leading sisterhood/ brotherhood youth groups; HKH model.

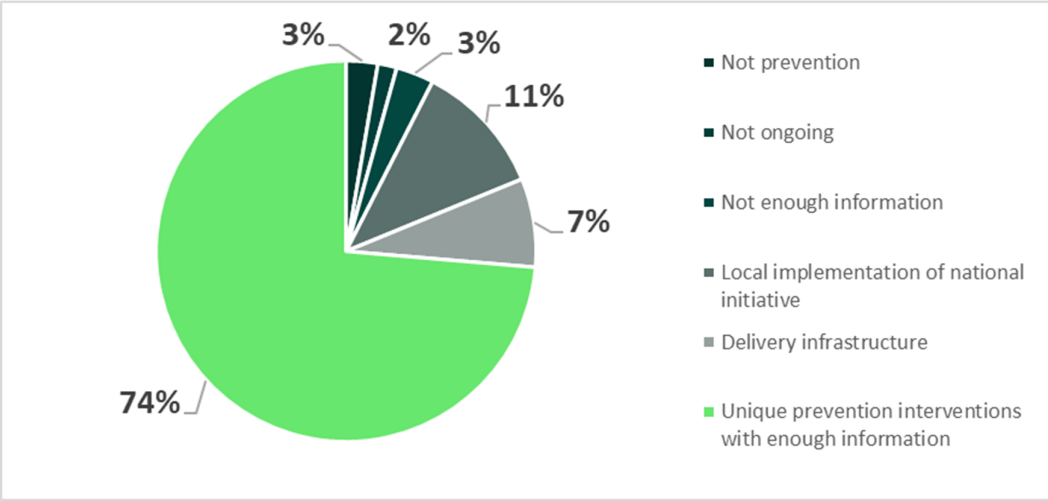
Finally, information about 17 additional interventions was provided by the Reviewing Committee, covering:

- Models/ guidelines implemented at the national level;
- Policies or interventions that had been identified as effective in the Standards, but for which no information had been reported by the respondents to the questionnaire (e.g. ante-natal services for pregnant women); and,
- Other interventions connected to, but not described by, the respondents to the questionnaire.

Out of a total of 187 entries (including those merged and split), this resulted in 130 entries (74%) describing interventions focused specifically on prevention and with enough information to allow an assessment of the extent to which they are evidence-based. Figure 2. provides an overview of the proportion of the entries discarded in the different phases of screening.

*Figure 2.*

*Proportion of entries discarded during the different phases of screening*




## C. Categorization

During the screening, the Reviewing Committee also categorized each intervention according to age, level of risk, setting of implementation.

### *1. Age*

Each intervention was categorized according to the age of the group targeted, which in line with the *UNODC/WHO International Standards on Drug Use Prevention*, and for the purposes of this study and document, were defined as follows: pregnancy, infancy (zero to two/ three years of age), early childhood (two/ three to five/ six years of age), middle childhood (six to nine/ ten years of age), early adolescence (10/11 to 13/14 years of age), older adolescence (14/15 to 18/19 years of age), youth adulthood (19/20 to 25 years of age), adulthood (25 to 65 years of age), senior citizens (more than 65 years of age).

If an intervention targeted more than one age group, it was accounted for in each of the age groups targeted. As a consequence, in all the graphs by age, there appear to be more interventions than the total. Although the interventions targeting adults could be mostly taken to implicitly target senior citizens, only policies (such as alcohol policies) and interventions explicitly mentioning people above 65 years of age as target group were categorized as such.

### *2. Level of risk*

Each intervention was categorized according to the level of risk of the target group, which in line with the *Standards*, and for the purposes of this study and document, were defined as follows: universal: interventions targeting a population at large (e.g. all students); selective: interventions targeting a group whose risk is significantly above the average (e.g. students in socially marginalized communities); and, indicated: interventions targeting individuals

particularly at risk, including individuals that might have started experimenting and are therefore at particular risk of progressing to disorders. Multi-component interventions targeting groups at different level of risk were categorized as 'multi-level'.

### 3. Settings

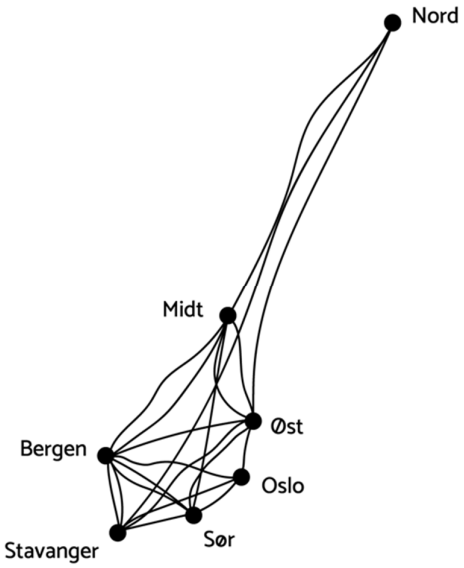
Each intervention was categorized according to the setting in which it was reported to be implemented: family, school, workplace, health setting, community.

In line with the *UNODC/WHO International Standards on Drug Use Prevention*, and for the purposes of this study and document, the setting 'community' was utilized to comprise venues such as youth centres, street, entertainment venues, media, etc. It should be noted that parents/ caregivers/ families can be reached in different settings. However, if an intervention was implemented with parents in a health setting, or in schools, it was still categorized as having been implemented in the setting 'family'. Finally, multi-component interventions implemented in different settings were categorized as 'multi-setting'.

### 4. Geographical region of implementation

Each intervention was categorized according to its geographical region of implementation, applying the definition utilized by the KORUSes as described in Figure 3. and comprising the Central, East, North, Oslo, South, Southwest and West regions. Interventions that were reported to be implemented in all regions or nationally were categorized as 'national' and accounted for in each of the regions.

*Figure 3.*
*KORUS Regions*



## D. Analysis

### *1. Analysis for the first component (interventions)*

In this part of the analysis, each intervention that had been screened to be a unique ongoing prevention intervention with sufficient information, was assessed with regard to the extent to which it was evidence-based on the basis of the *Standards* and according to the methodology described in Annex 3 of the *RePS* and illustrated in Figure 4.

The methodology assessed as 'evidence-based' interventions that have been evaluated to be effective, possibly in the local/ national context, on the basis of documented strong scientific methodology (case control or stronger) reporting positive outcomes in terms of decrease of initiation, use or progression. Interventions targeting children under 10 could report positive outcomes in terms of intermediate variables, as per Annex 6 of the *RePS.* Interventions providing documentation of a planned or ongoing evaluation with a strong methodology studying relevant outcomes as described above were assessed to be 'innovative'.

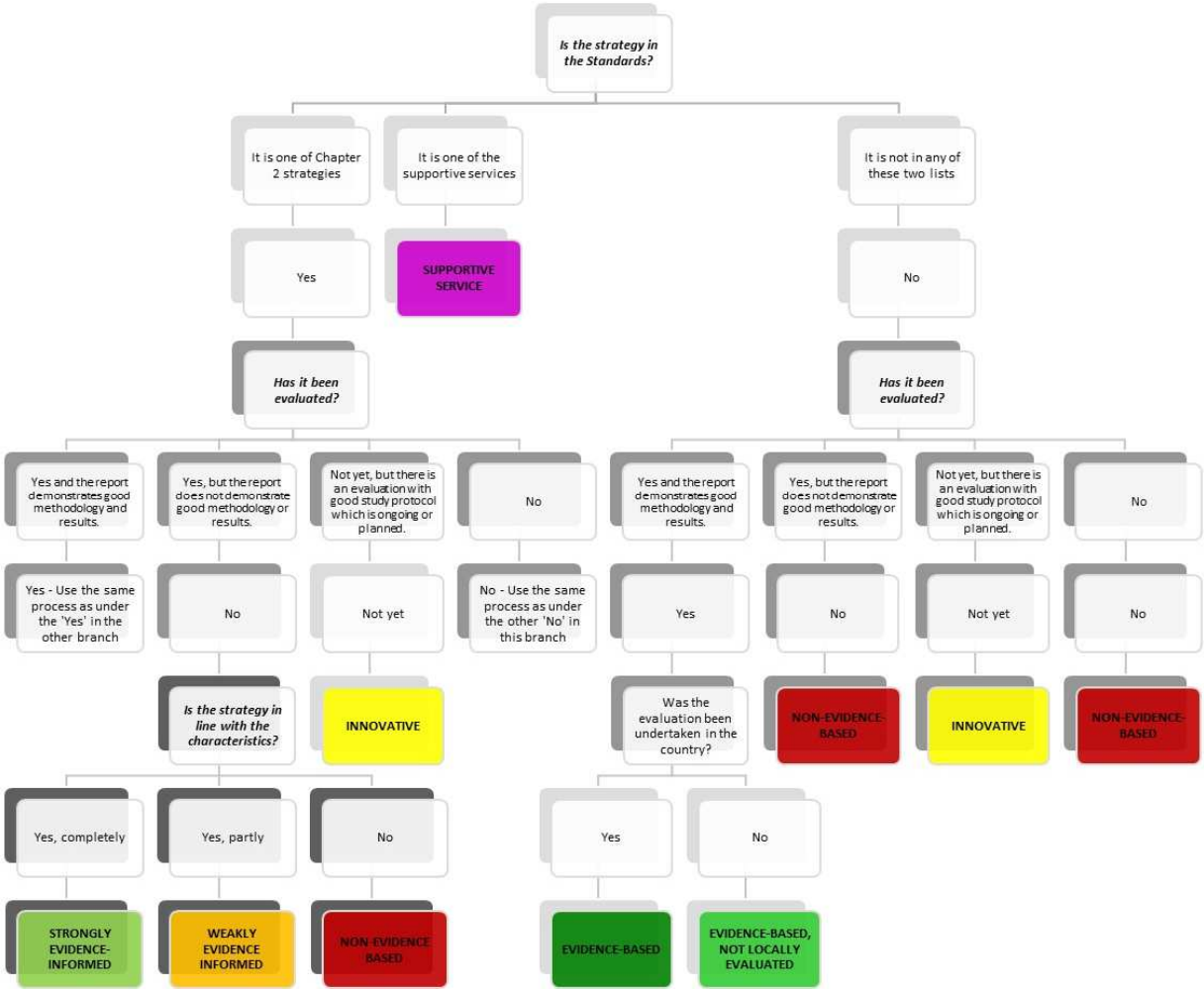
Interventions that were assessed to be 'supporting services', as per Annex 1 of the *RePS*, were coded as such and not further analysed.

An intervention without an evaluation was further assessed depending on whether it was an intervention included in Chapter 2. of *Standards* as one of those that had been found to be effective. If this was not the case, the intervention was coded as 'non-evidence-based'. If this was the case, the intervention was compared to the list of characteristics included in the *Standards* as being associated to positive, no or negative outcomes. Depending on which characteristics were apparent from the documentation, the intervention was assessed as being 'strongly evidence-informed', 'weakly evidence-informed', or 'non-evidence-based'.

Interventions were then analyzed by age, level of risk and setting of implementation, both nationally and by region. The results of such analysis are presented in Chapter III. below and fed into the analysis of the second component of the assessment.

A key limitation in the methodology needs to be acknowledged in the fact that the assessment of some interventions might have been penalized by the unit of analysis being one single 'intervention'. For example, a preventive education intervention providing 'information only' would not be considered evidence-based per the *Standards*. However, if another intervention were to be providing a component of 'interactive personal and social skills practicing' to the same target group, the two could be part of an evidence-informed package. Wherever there was evidence of the reach of the same target group, this has been taken into account (e.g. training of staff in entertainment venues), including through merging. However, as mentioned above, this was not always possible on the basis of the information provided and follow-up was not always successful.

*Figure 4. Overview of the assessment process*



## 2. *Analysis of the second component (the system)*

This part of the analysis utilized the methodology described in Annex 5 of the *RePS*, which describes a set of six elements and corresponding 17 criteria, largely based on Chapter 3. of the *Standards*, which need to be met in order for a national prevention system to be considered to be supportive of evidence-based prevention practice and thus in line with the *Standards*.

Accordingly, the results of the analysis of the first component of the Review, as described in Chapter III. Below constituted the basis for the analysis of the first element and corresponding set of criteria, as described below.

The analysis of the other five elements and corresponding sets of criteria was undertaken on the basis of the information provided in the questionnaires on the system (Annex 4 of the *RePS*) and integrated with information arising from the respondents to the questionnaires on the interventions (Annex 2 of the *RePS*).

A positive lesson learned of this process is that the extent to which the information contained in the so-called "Annex 2 questionnaires" contributed to the analysis of this second component much more than foreseen in the original methodology.

A first draft of the analysis was discussed by the Reviewing Committee to ensure the lack of misinterpretation and misrepresentation of information.

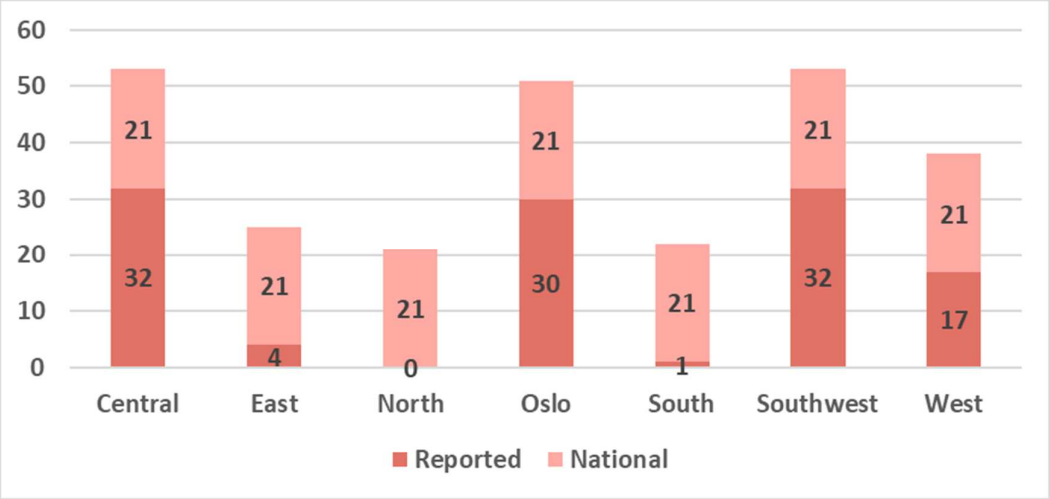
# II. Overall information

Together with the region of the respondents, the screening and categorization process provided an overview of the coverage of different kinds of activities in the country.

## A. Regions

The regions with the largest number of interventions reported were: the Central and Southwest regions (32 interventions each), the Oslo region (30), followed by the West region (17). The East, South and North regions report 4, 1 and 0 interventions respectively. Twenty-one (21) interventions were reported to be implemented nationally in all regions. Figure 4. summarizes the data.

*Figure 5.*
*Interventions by region of implementation*




The lower number of interventions reported in certain regions cannot be taken to indicate a lower volume of implementation of prevention, as it is clearly linked to the number of respondents as reported above. In addition, all regions were covered by the national policies and interventions.

As mentioned above, a specific follow-up was undertaken with regard to the implementation of prevention interventions among the Sami people in the Region North. While no reports of specific interventions were received, the follow-up confirmed the implementation of policies and interventions available nationally.

Respondents reported specific interventions implemented in the following 30 municipalities (in alphabetical order): Årdal; Askøy; Bjerkreim; Bjørnafjorden; Frøya & Hitra; Giske; Gjesdal; Hå; Hareid; Hjelmeland ; Kvam; Lierne; Melhus; Midtre Gauldal; Oppdal; Ørland; Oslo; Øygarden; Rindal; Sandnes; Several; Sokndal; Sola; Stavanger; Stjørdal; Stord; Suldal; Ullensvang; Verdal; Voss.

A limitation of the study that should be noted is the fact that it was not possible to analyze the coverage of the interventions in terms of population. Respondents were requested to provide information about the number of people reached by each intervention in the past year. However, due to the heterogeneity of the age and of the characteristics of the target groups, as well as the fact that more than a third of interventions (47 or 34%) did not report any estimate, this analysis was not possible. Similarly, although Annex 2 requested information about two basic dimensions of quality of interventions (the requirement of training and the existence to ensure fidelity of implementation), it was not possible to include the analysis of these two dimensions at this stage.

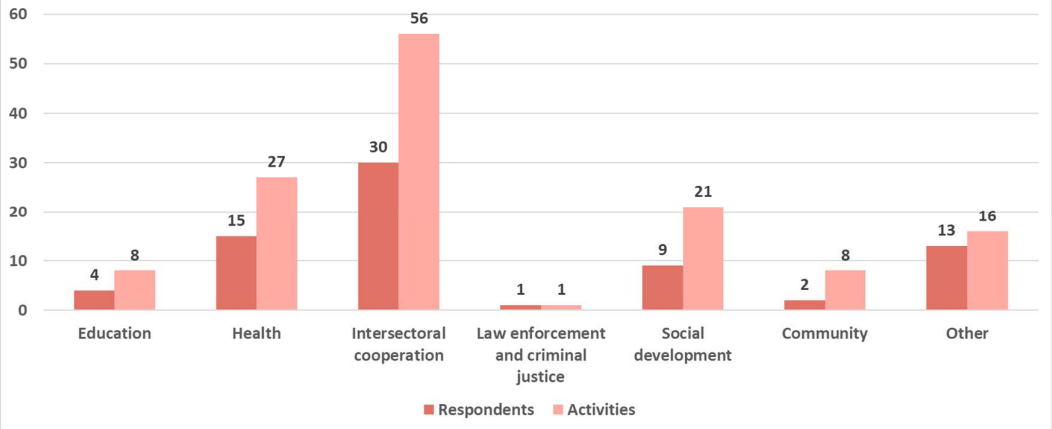
## B. Sector of respondents

In the questionnaire, respondents were requested to self-identify as belonging to a sector, choosing among: education, health, law enforcement and criminal justice, social development, community and other. As per Figure 5., most respondents belonged to the health sector (15 respondents reporting on the implementation of 17 interventions), social development (9 respondents reporting on the implementation of 21 interventions), and education (4 respondents reporting on the implementation of 8 interventions). In addition, 1 law enforcement respondent, 2 community respondents, and 13 other respondents reported on a total of 25 additional interventions.

The majority of interventions (56) were reported by the 30 respondents belonging to the SLT - Samordning av Lokale kriminalitetsforebyggende Tiltak ("Coordination of local crime prevention measures"), a model of intersectoral collaboration connecting all the agencies from all sectors involved in drug prevention at the local level. Therefore, a new 'intersectoral collaboration' category was created to acknowledge this specific delivery modality in Norway, which was also utilized by other intersectoral collaborations.

*Figure 6.*

*Respondents and number of interventions implemented by sector*



## C. Age

Figures 7. to 15. summarize the age targeted by the interventions nationally and in each region. Most interventions are implemented targeting early adolescents (86), older adolescents (113) and young adults (60). This is followed by a significant number of interventions targeting prenatal (19), infancy (23), early childhood (24), middle childhood (25) and adulthood (25). Finally, ten interventions were reported targeting senior citizens. This general proportion was maintained in all regions, even in the North region for which the interventions included were only those implemented nationally. However, there is also implementation of interventions targeting the different ages of childhood, as well as adulthood and even senior citizen.

*Figure 7.*

*Number of implemented interventions by age – All Norway*

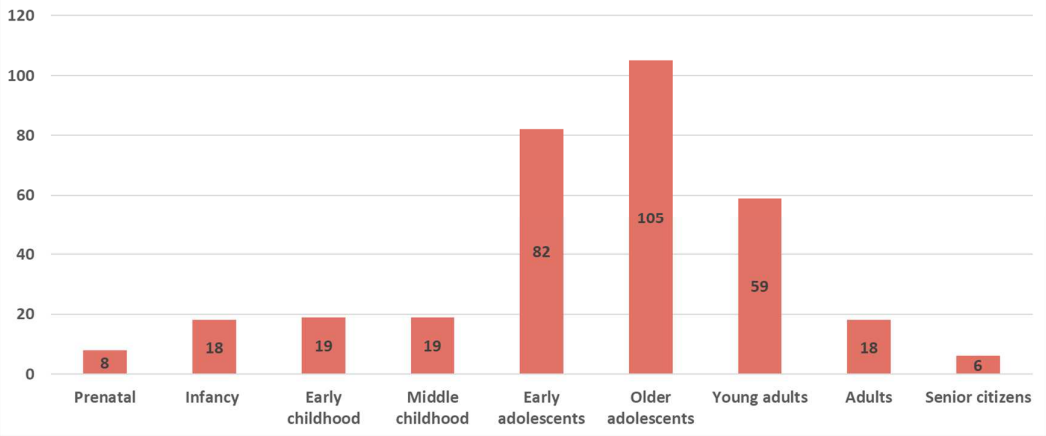



*Figure 8.*

*Number and percentage of implemented interventions by age – All Norway*

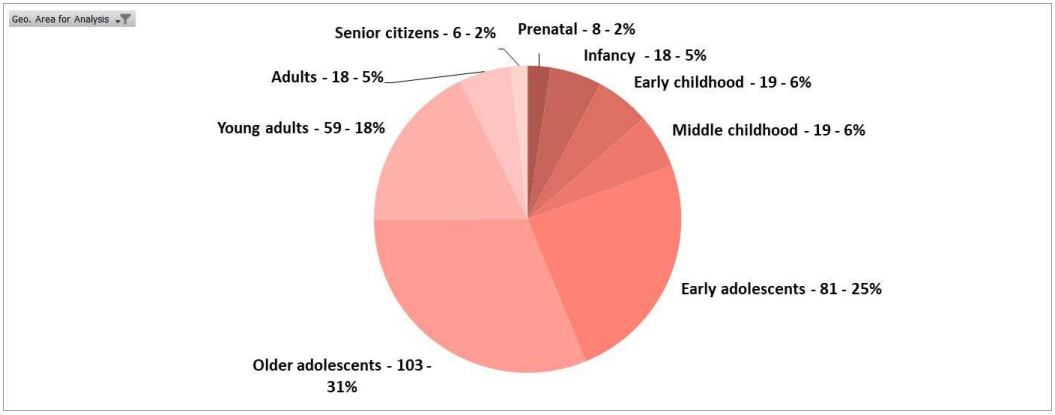


*Figure 9.*

*Number of implemented interventions by age – Region Central*

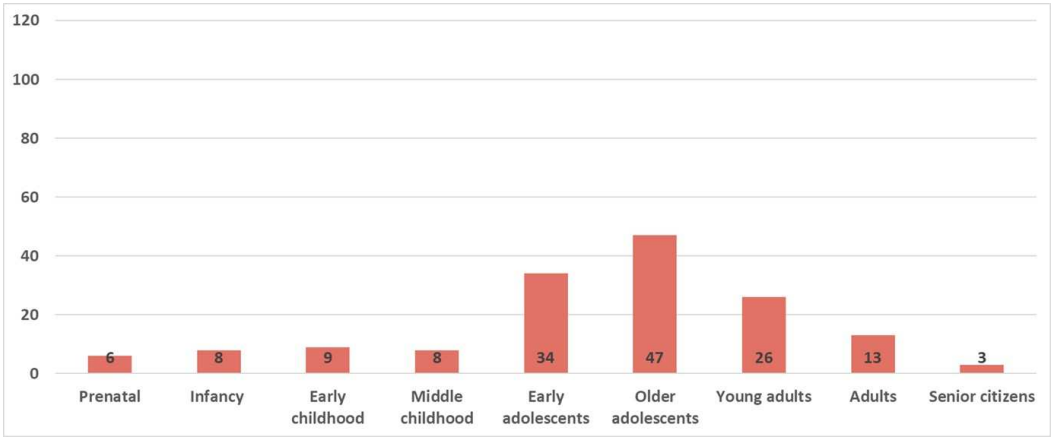



*Figure 10.*

*Number of implemented interventions by age – Region East*

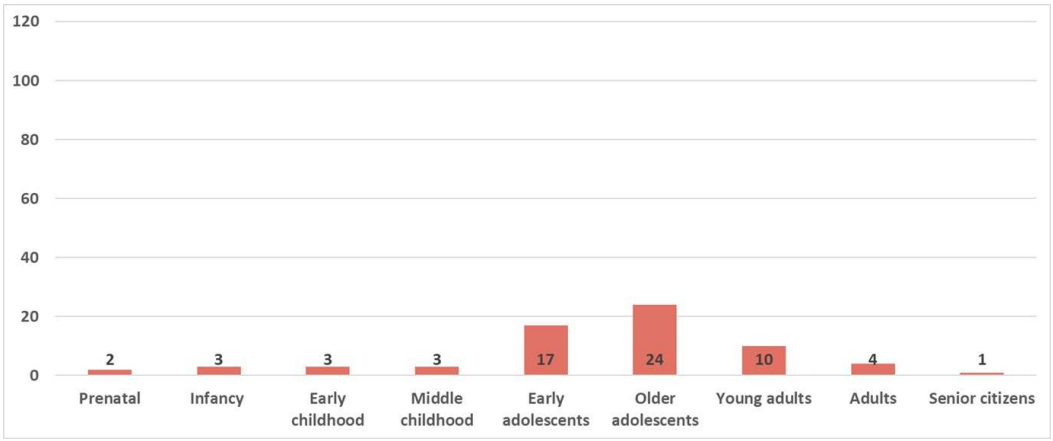



*Figure 11.*

*Number of implemented interventions by age – Region Oslo*

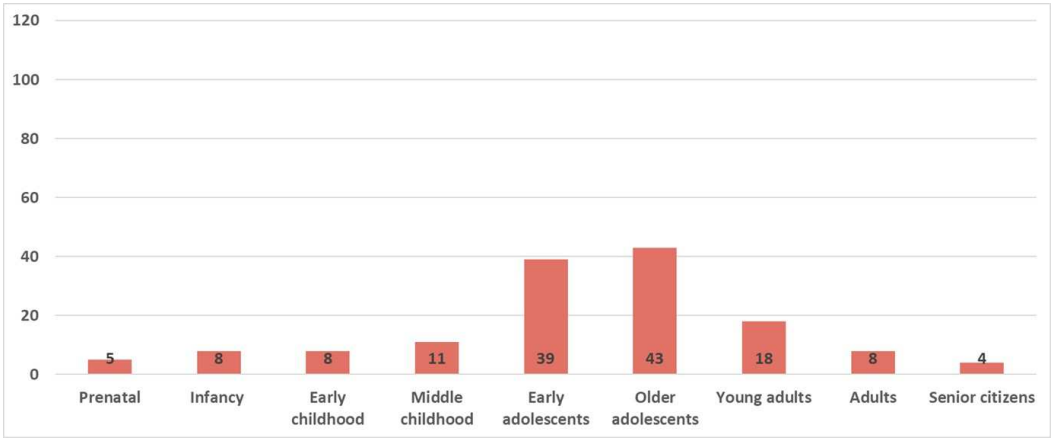


*Figure 12.*

*Number of implemented interventions by age – Region North*

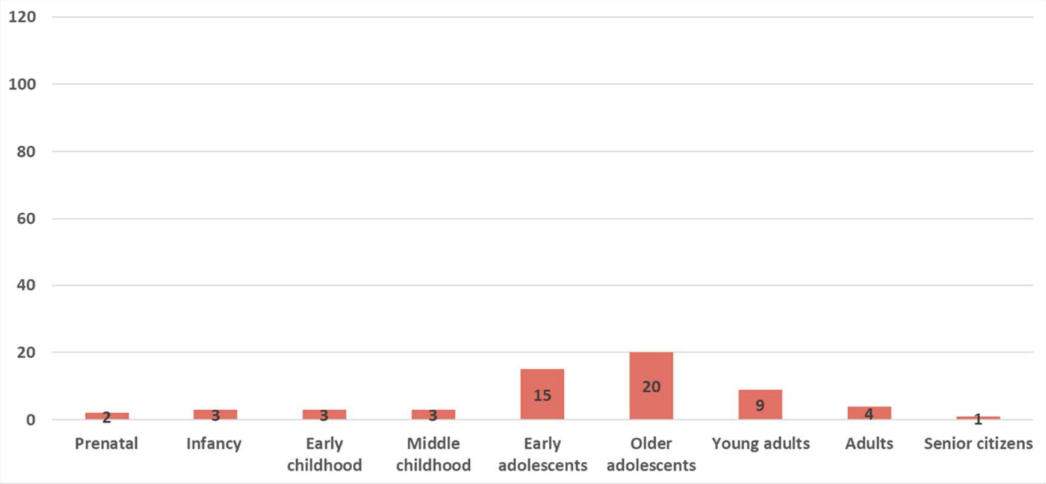



*Figure 13.*

*Number of implemented interventions by age – Region South*

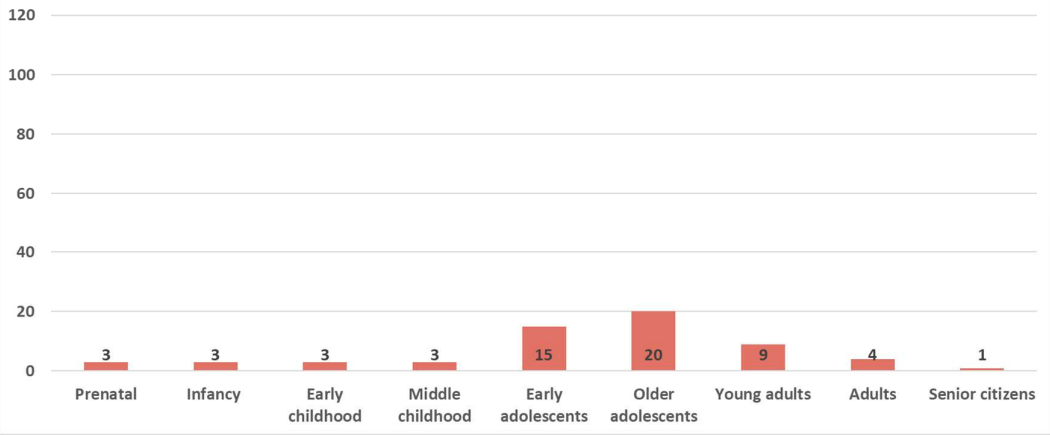


*Figure 14.*
*Number of implemented interventions by age – Region Southwest*

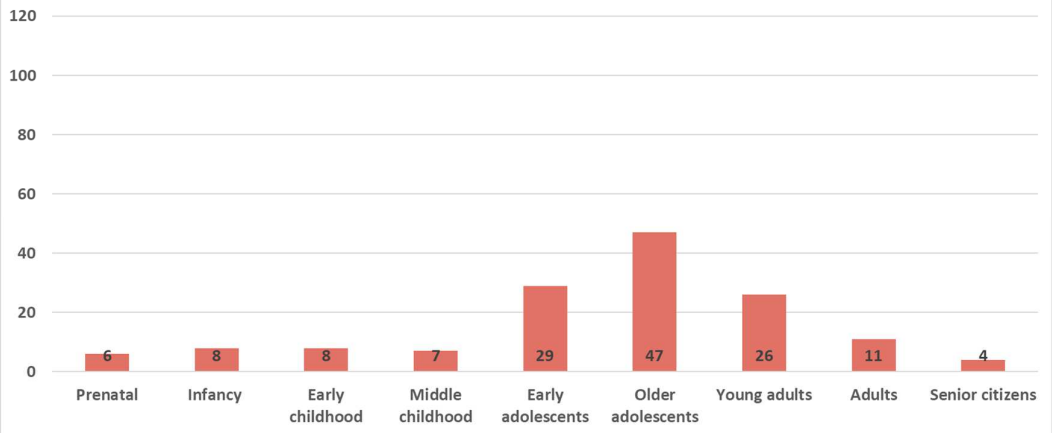
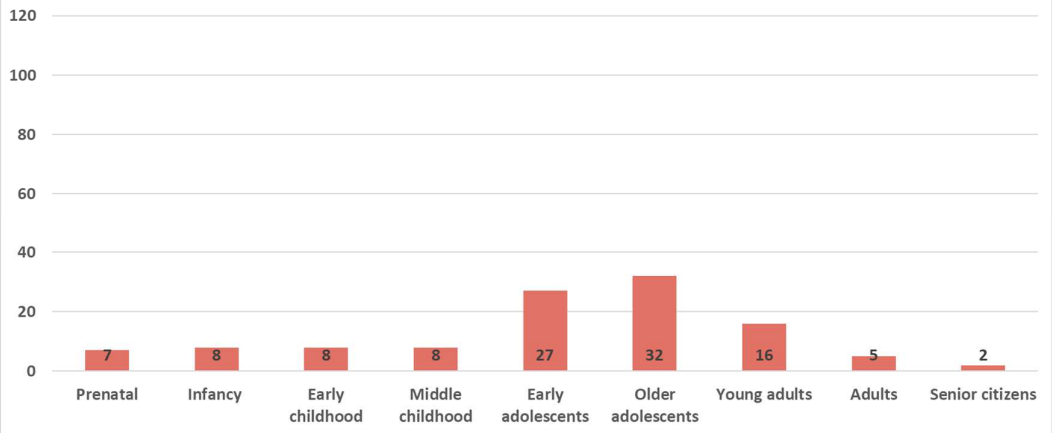



*Figure 15.*
*Number of implemented interventions by age – Region West*




## D. Levels of risk

Figures 16. to 24. summarize the distribution of implemented interventions by levels of risk, both nationally and by region. Overall, most interventions (56 or 45%) were implemented at universal level, followed by selected (39 or 31%), indicated (28 or 22%) and multi-level (3 or 2%) interventions.

An overview of the entries indicated that universal interventions were mostly working with children in school and with parents, while selected interventions were working in the community with youth at risk and some with parents. Indicated interventions mostly comprised different ways of offering screening, brief intervention and referral to treatment in various settings (community, school, health services). Finally, only few interventions comprised activities at different level integrated in a way that could not be disaggregated. These included the AKAN

model of providing services in the workplace. This is in line with the description of workplace programmes that are linked to positive outcomes. In addition, two other interventions were categorized as "multi-level": an outreach services in one specific municipality and a programme to provide services to senior citizens.

Interestingly, the distribution in the single regions is different, with a preponderance of universal and indicated interventions, and less selected. This is due to the distribution of national interventions that are accounted for in each region, in addition to those specifically reported to have been implemented in the region. The distribution of interventions implemented at national level is clearly visible in Figure 20., which refers to Region North. As mentioned above, due to the fact that no respondent from Region North provided information about interventions implemented in the Region, the Region is only represented by interventions that are implemented at national level. Interestingly, such interventions reported no intervention at the selected level.

*Figure 16.*
*Number of implemented interventions by level of risk – All Norway*

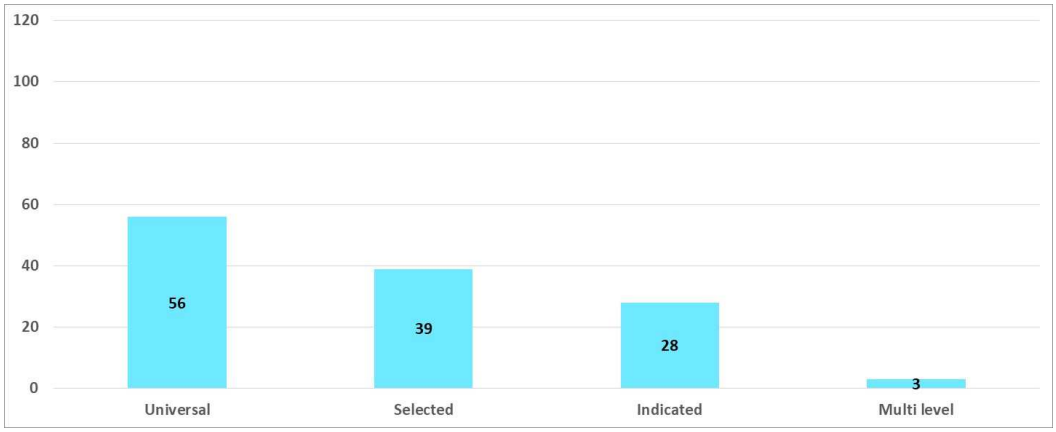



*Figure 17.*
*Number and percentage of implemented interventions by level of risk – All Norway*

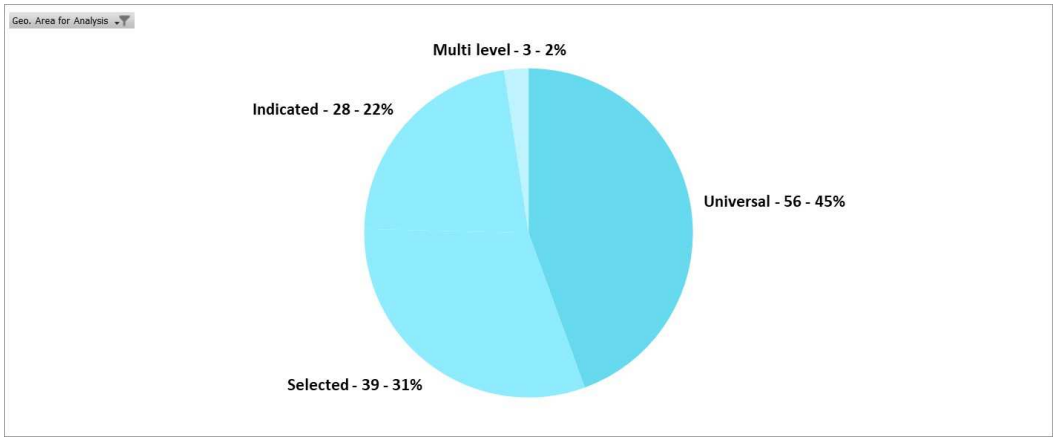


*Figure 18.*

*Number of implemented interventions by level of risk – Region Central*


*Figure 19.*

*Number of implemented interventions by level of risk – Region East*

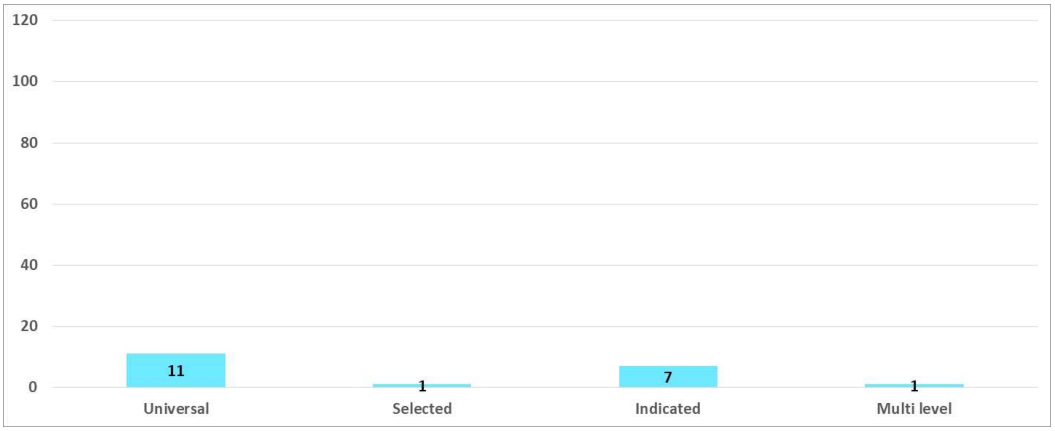



*Figure 20.*

*Number of implemented interventions by level of risk – Region Oslo*

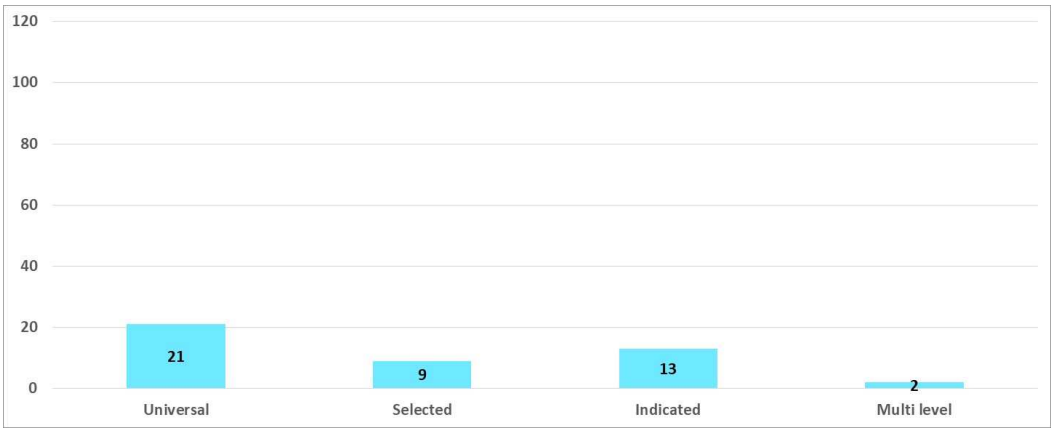


*Figure 21.*

*Number of implemented interventions by level of risk – Region North (National)*

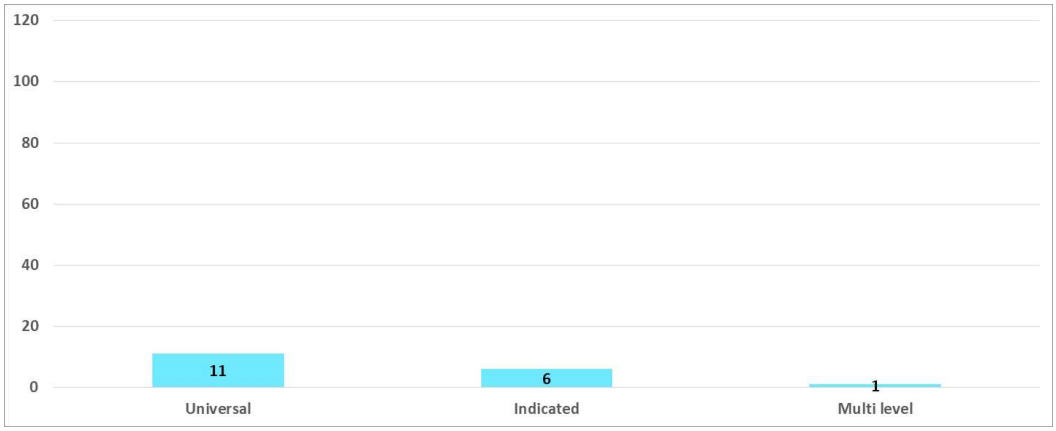



*Figure 22.*

*Number of implemented interventions by level of risk – Region South*

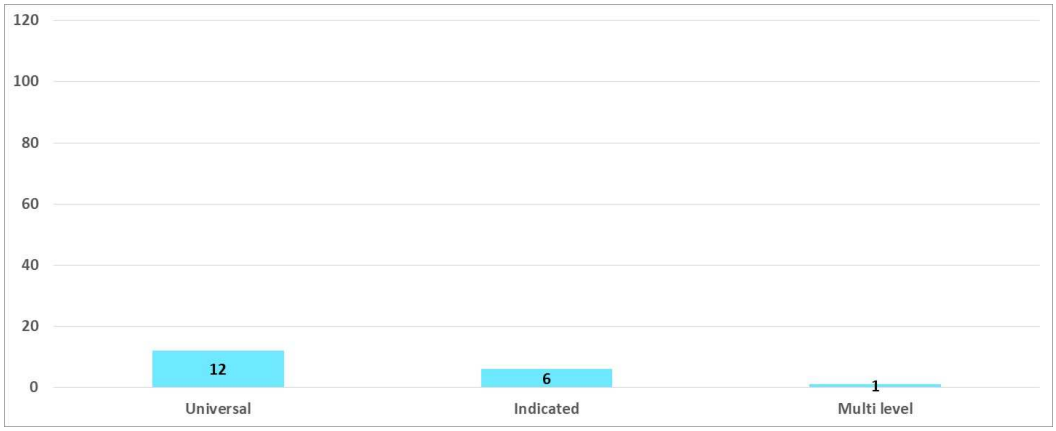



*Figure 23.*

*Number of implemented interventions by level of risk – Region Southwest*

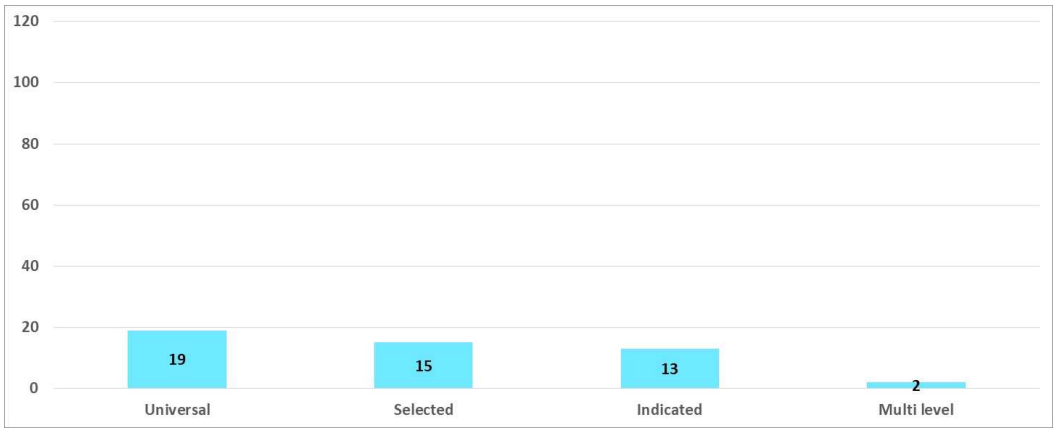
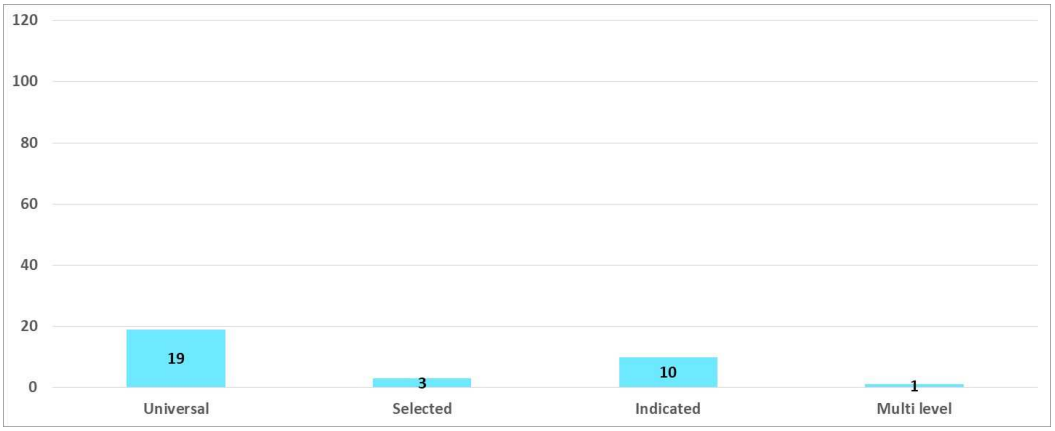


*Figure 24.*
*Number of implemented interventions by level of risk – Region West*




## E. Setting of implementation

Figures 25. to 33. summarize the distribution of implemented interventions by setting of implementation, both nationally and by region.

Nationally, most interventions were reported to be implemented in the community (42 interventions, 33%) and in schools (32 interventions, 25%). This was followed by a substantial number of interventions implemented in families (21 interventions, 16%) and in health settings (17 interventions, 13%). Only a minority were multi-settings (14 interventions, 11%) or was implemented in the workplace (3 interventions, 2%).

This national pattern was repeated in the regions reporting more interventions (Oslo, Southwest), while regions reporting fewer interventions, such as Central, East, North (national) and South reported a more even spread, reflecting the spread of interventions implemented nationally.

Both nationally and in all regions interventions were reported to be implemented in all settings. It should also be noted that a small number of interventions should not necessarily be taken to signify lower coverage: for example, the AKAN model mentioned above of intervention in the workplace is implemented nationally in countless locations, even if it counted as one single intervention.

*Figure 25.*
*Number of implemented interventions by setting of implementation – All Norway*

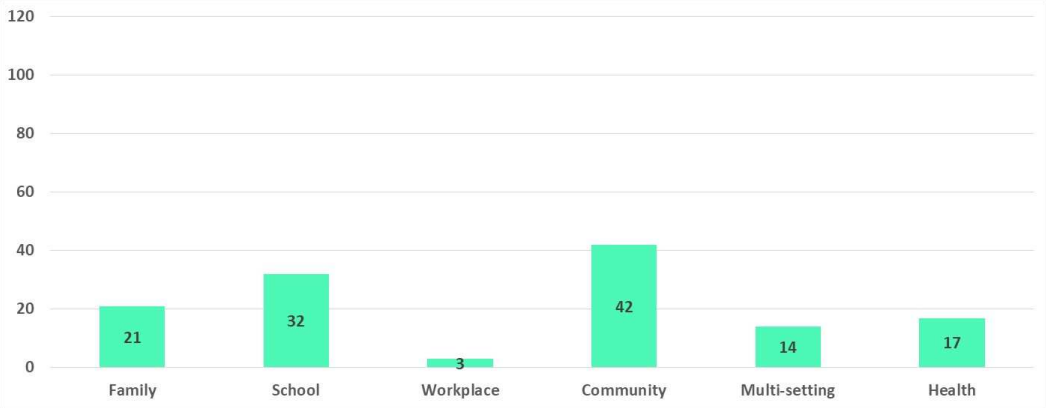



*Figure 26.*
*Number and percentage of implemented interventions by setting of implementation – All Norway*

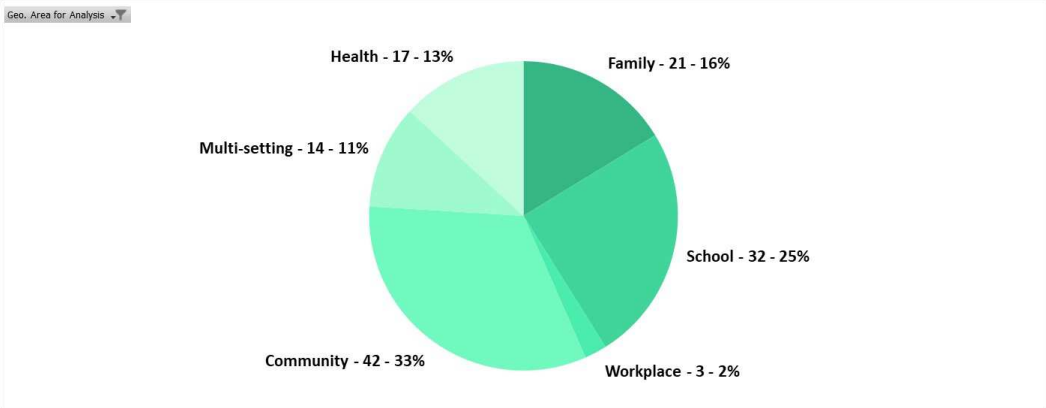



*Figure 27.*
*Number of implemented interventions by setting of implementation – Region Central*

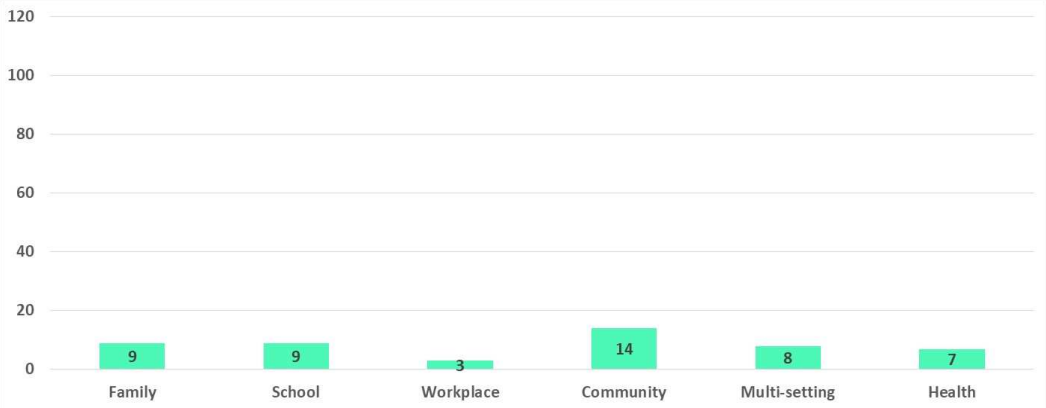


*Figure 28.*
*Number of implemented interventions by setting of implementation – Region East*

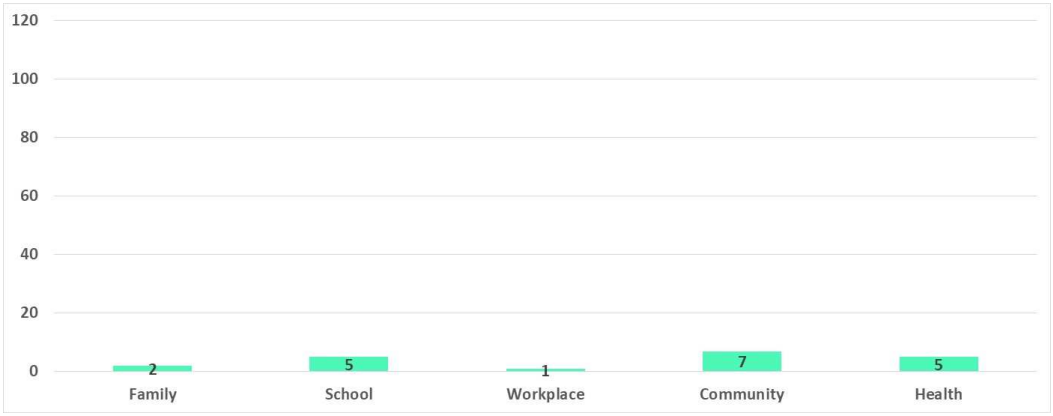



*Figure 29.*
*Number of implemented interventions by setting of implementation – Region Oslo*

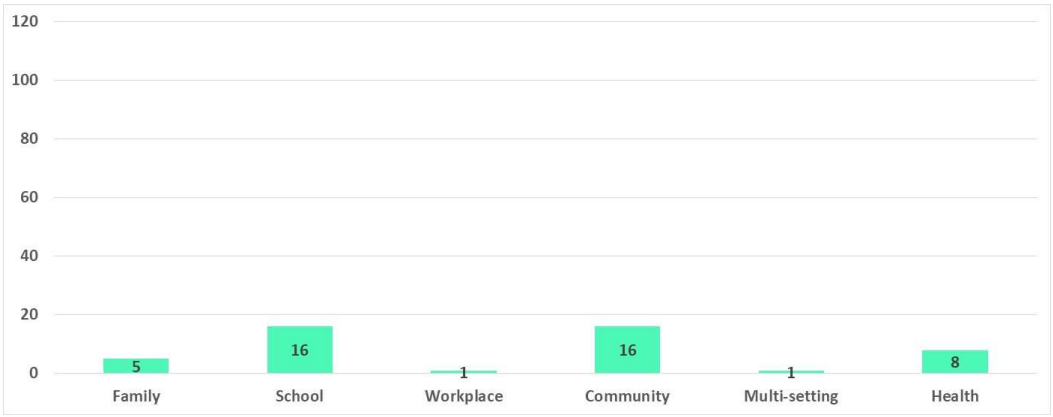



*Figure 30.*
*Number of implemented interventions by setting of implementation – Region North (National)*

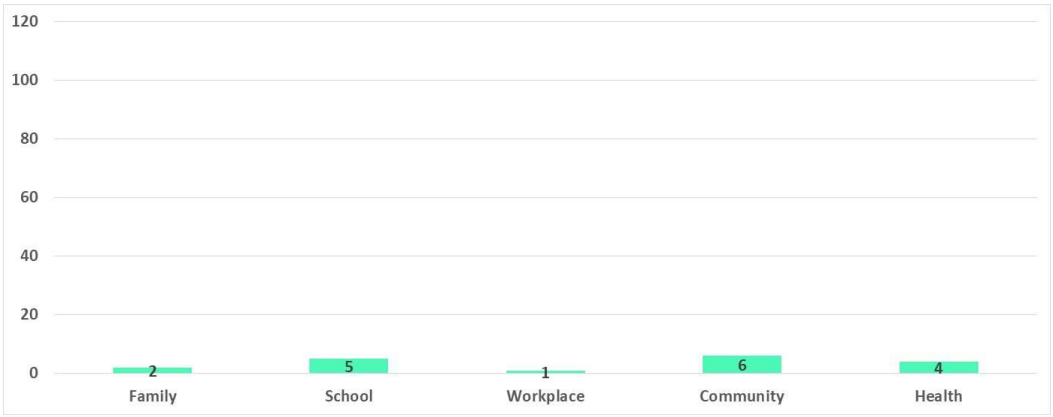


*Figure 31.*

*Number of implemented interventions by setting of implementation – Region South*

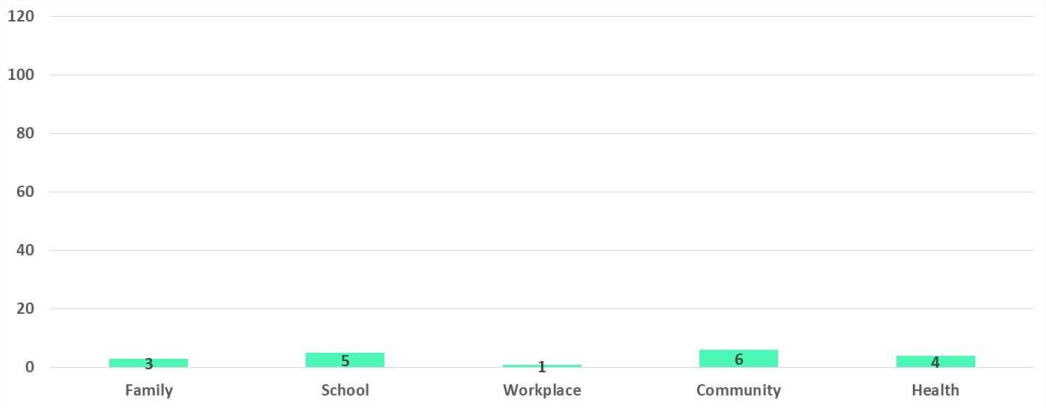



*Figure 32.*

*Number of implemented interventions by setting of implementation – Region Southwest*

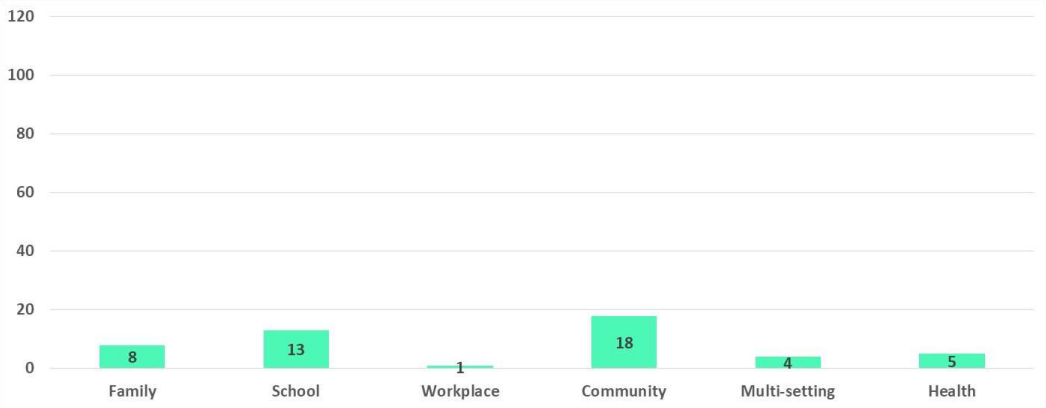
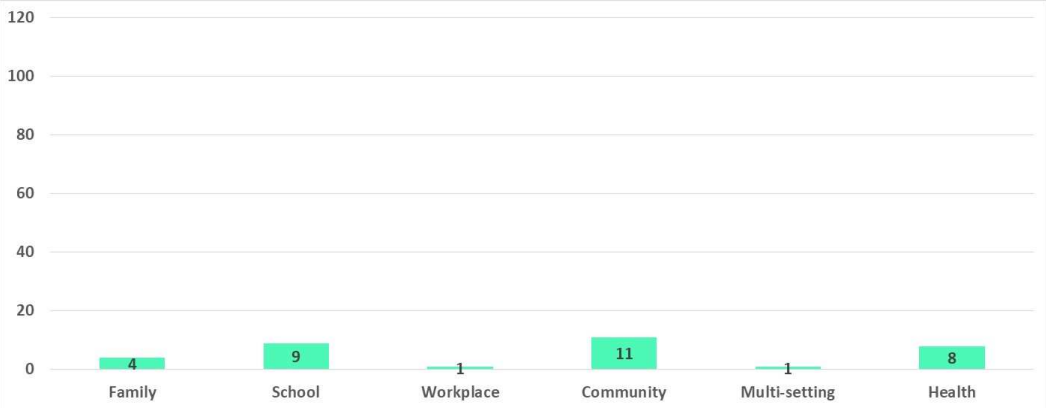



*Figure 33.*

*Number of implemented interventions by setting of implementation – Region West*



# III. Quality of interventions

This section describes the results of the assessment process of the first component of the Review undertaken with the methodology described in Chapter I. above. The number and percentages of interventions are presented by quality, first overall, then disaggregated by the age of the group targeted, then by the level of risk of the target group, the setting of implementation and the Region of implementation.

## A. Overall assessment of quality

Figures 34. and 35. describe the overall quality of interventions nationally, in terms of both absolute numbers and percentages. Approximately one fourth of interventions were assessed to be evidence-based, including: 1 intervention (1%) that was evidence-based, but had not been locally evaluated, 1 (1%) innovative intervention (including a planned/ ongoing evaluation with strong methodology) and 30 interventions (23%) that were strongly-evidence informed, having included all characteristics associated with effective programmes. Twenty-two interventions (17%) were assessed to be weakly evidence-informed, having included only some of the characteristics associated with effective programmes and 33 interventions (25%) were assessed to be non-evidence based, being new and non-evaluated or having included characteristics associated with non-effective programmes. Finally, 43 interventions (33%) were assessed to be supporting services, i.e. services that, while not having been included in the Standards as effective interventions, had been identified in Annex 2 of the *RePS* as contributing to the overall health and resilience of children, youth and adults. The following sections in this chapter will further analyse the quality of interventions by age, level of risk of the target group and setting of implementation, including a descriptive summary of the interventions, as well as short descriptions of specific interventions describing the rationale behind the assessment are included under Section 2. Assessment of quality by age earlier in this Chapter. In view of the large amount of items to describe, specific interventions are named only if they were reported to be implemented by more than one respondent or they were of national significance.

*Figure 34.*

*Number of implemented interventions by quality – All Norway*

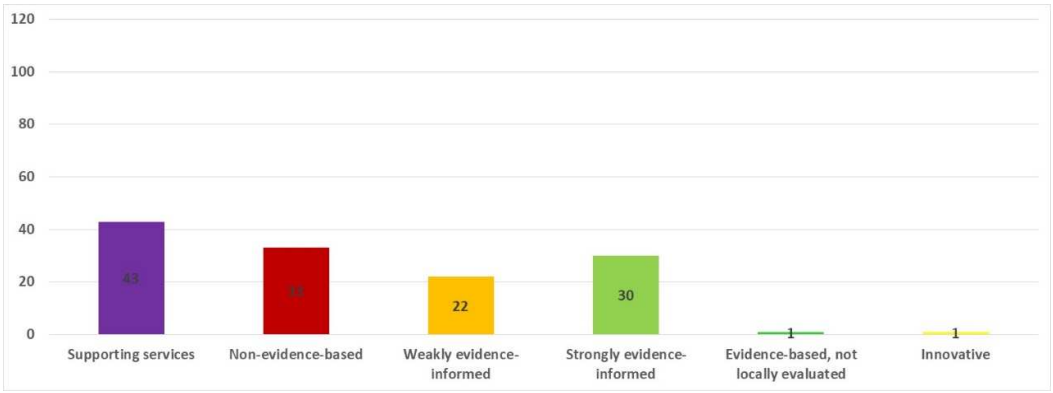
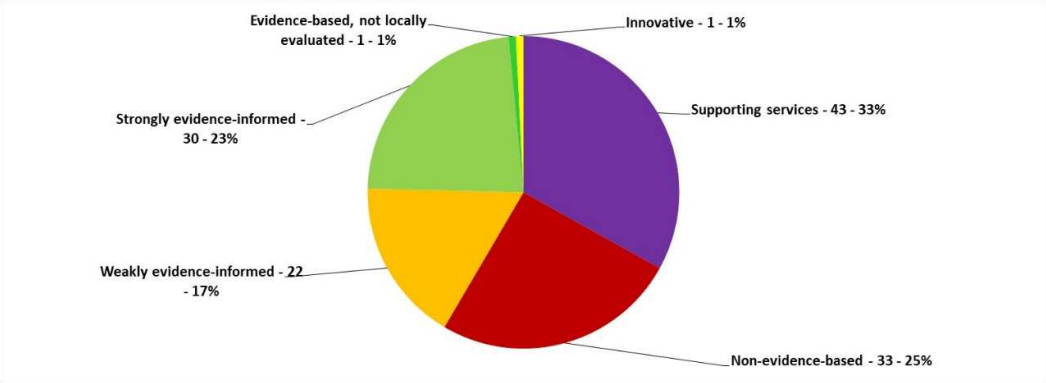


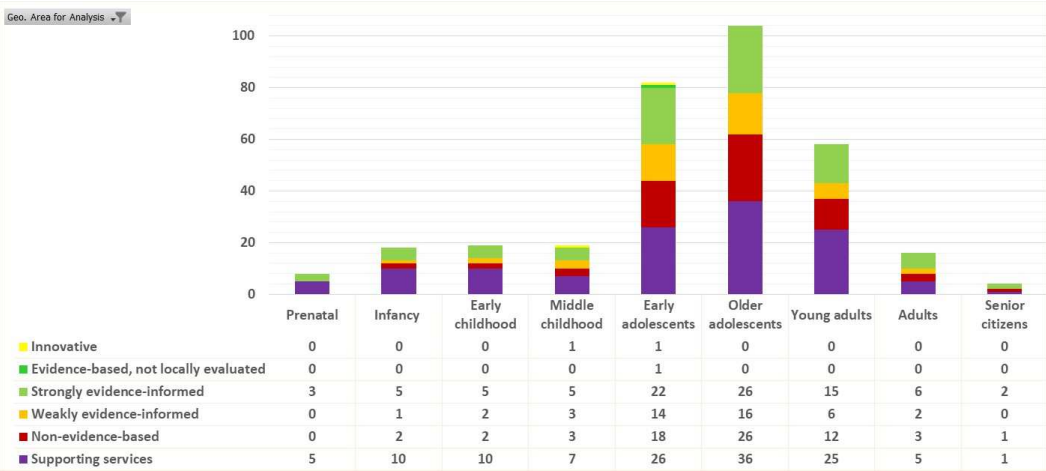
*Figure 35.*
*Number and percentage of implemented interventions by quality – All Norway*




## B. Assessment of quality by age

Figure 36. illustrates and presents the data of implemented interventions by quality and age group targeted, all ages reporting relatively similar proportion of supporting services, interventions that would warrant improvement and/or evaluation (weakly evidence-informed and non-evidence-based interventions) and stronger interventions (assessed to be strongly-evidence informed, evidence-based, not locally evaluated and innovative interventions).

*Figure 36. Number of implemented interventions by age and quality*




| | Prenatal | Infancy | Early childhood | Middle childhood | Early adolescents | Older adolescents | Young adults | Adults | Senior citizens |
|---|---|---|---|---|---|---|---|---|---|
| Innovative | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 |
| Evidence-based, not locally evaluated | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 |
| Strongly evidence-informed | 3 | 5 | 5 | 5 | 22 | 26 | 15 | 6 | 2 |
| Weakly evidence-informed | 0 | 1 | 2 | 3 | 14 | 16 | 6 | 2 | 0 |
| Non-evidence-based | 0 | 2 | 2 | 3 | 18 | 26 | 12 | 3 | 1 |
| Supporting services | 5 | 10 | 10 | 7 | 26 | 36 | 25 | 5 | 1 |

The following sub-sections provide a descriptive summary of the interventions in each of the ages, grouped by quality.

### *1. Prenatal*

This group includes interventions working with pregnant women with a preventive effect on the life of their child-to-be, e.g. 5 interventions categorized as **supporting services**, mostly BTI (Bedre Tverrfaglig Innsats or "Better Interdisciplinary Action"), a structure and a model for

early identification and interdisciplinary cooperation between actors involved with a pregnant woman, child or youth at risk and reported by numerous respondents. The three (3) interventions categorized as **strongly-evidence-informed**, in line with the characteristics associated with positive outcomes, included national tobacco policies and national alcohol policies, categorized as active at all ages, as well as the national guidelines to provide screening, brief intervention and referral to treatment for pregnant women.

## 2. *Infancy*

In addition to the interventions found to be **supporting services** during the 'pre-natal' age, and which continued in infancy, the 10 interventions assessed as 'supporting services' in this age include the provision of day care for children aged 1-5 nationally, which covers 93.4% of children. They also include the screening and referral of mental health issues of new parents foreseen as part of the child health services offered under the "National guidelines for health promotion and preventive work in the child", as well as a subsidy card for leisure interventions in one location and free, low-threshold service parent-initiated counselling for families with issues that need to be addressed.

Among the interventions that would warrant improvement and/or evaluation, the two **non-evidence based** interventions comprised sessions for parents that are too focused on information and too little on skills to be in line with the characteristics associated with effective programmes in the Standards and a programme that is the training of all municipal staff using the a modified version of the ICDP programme. Although ICDP, a parenting programme, was assessed to be strongly-evidence-informed (see below), its implementation targeting municipal staff working with children on the rationale that they are all caregivers is completely novel and would warrant an evaluation to document its effectiveness. The one **weakly evidence-informed** programme works with children 1 to 16 on conversational groups that meet throughout the school year focusing on self-discovery, managing one's own thoughts and feelings and including information on various issues including substances. These components are only partly in line with those associated with effective programmes in the Standards.

Stronger interventions include the 5 **strongly evidence-informed** interventions that comprise tobacco and alcohol policies described under the 'pre-natal' age, as well as the services provided to children under the "Guidelines for health promotion and preventive work in the child" that include screening and of early onset of mental health disorders in children and referral to services, as well as the actual provision of services. In addition, through the ICDP (International Child Development Programme), groups of parents led by 2 certified instructors meet for 8 interactive evening seminars on: parental role, challenges for today's children/youth, better understanding their children and more sensitive child rearing, self-reflection, including "homework" tasks to work on with their children at home. These are characteristics in line with those identified as associated with effective programmes in the Standards and this programme would warrant an evaluation.

### 3. Early childhood

The interventions targeting this age are the same as those targeting infancy (see above), with one exception, the UNODC "Listen First" campaign (translated into Norwegian) on the Science of Care and the Science of Skills targeting parents and caregivers was deemed to include only some of the characteristics associated with effective programmes in the Standards and thus **weakly evidence-informed**.

### 4. Middle childhood

In terms of **supporting services**, this age was targeted by the same interventions as in 'early childhood'. The same was true with regard to **non-evidence-based** and **weakly evidence-informed** interventions, with the addition of one non-evidence-based intervention providing education in school and not including characteristics associated with effective programmes in the Standards. In addition, the "Core curriculum – values and principles for primary and secondary education" (Overordna del – verdiar og prinsipp for grunnopplæringa) of the Directorate of Education (Utdanningsdirektoratet) was assessed to be weakly evidence-informed as it included some, but not all of the characteristics associated with effective programmes (i.e. interactivity, addressing of normative beliefs, emphasis on personal and social skills and clear indications of the age at which it is useful to start discussing the substances per se).

In addition to the interventions that were found to be **strongly evidence-informed** in 'early childhood', one respondent reported the provision of mental health services in schools. Moreover, another reported one intervention (iLAG) creating attractive meeting places with interventions for 5th-7th graders to foster togetherness and prevent loneliness and depressive symptoms. The intervention has a clear theoretical basis and study including a control is planned/ongoing assessing intermediate variables and was thus assessed as **innovative**.

### 5. Early adolescence

In addition to the 7 interventions assessed to be **supporting services** in middle childhood, 17 respondents reported providing different kinds of outreach work to vulnerable children and/or services to provide healthy opportunities for leisure interventions and/or vocational skills and job opportunities. One intervention provided information about services to parents. A model reported was the implementation of BAPP - Barn av foreldre med rus- og psykiske problemer, a model that targets children of parents with addiction and/or mental health issues with motivational conversations with children/families, group programmes for children/youth/families and preventative family intervention. Based on a Dutch programme called KOPP, reporting positive effects on intermediate variables, and targeting an at-risk group for which no evidence-based model is available, it would warrant an evaluation of its own.

With regard to **non-evidence-based interventions**, in addition to two interventions assessed to be non-evidence-based in middle childhood, this includes a significant number of education programmes (12) for students and/or parents that have been assessed to be non-evidence-based due to various combinations of characteristics associated with non-effective programmes in the Standards, including: preponderance of information and non-interactive techniques, rather than

interactive practicing of skills, limited structure such as 'dialogues' or 'conversations' and/or single sessions.

Two respondents reported utilizing the 'Sisterhoodhood' and/or 'Brotherhood' model of group work. This kind of intervention is not included in the *Standards* per se and, in the absence of an evaluation of its effect in preventing drug use, it was assessed as 'non-evidence-based'. However, the model appears to have been based on a careful process of development and would warrant an evaluation.

The HAP app, reported to be used by one respondent, was also assessed as non-evidence based, due to its lack of evaluation. The *Standards* identify some interventions that were found to be efficacious also delivered through computers. However, they do not include the provision of motivational interviewing/ brief intervention with a view to cessation of use and preventing the transition to disorders through an app. As such, this intervention is breaking new ground and, in the absence of an evaluation, its effectiveness is not known. However, as a digital solution, the app has been carefully developed and, if evaluated to be effective, would potentially fill an important gap with regard to evidence-based use of digital solution to prevent drug use and transition to drug use disorders.

Finally, this group includes one respondent utilizing the so-called 'follow-up on drug contracts'. This is the practice where youth enter in a contract with an official authority, pledging not to use. This practice has been discontinued in many parts of Norway, due to the fact that it is deemed not to have a legal basis and it raises ethical questions as to how 'voluntary' these contracts are. Moreover, the practice has no basis in scientific evidence, not having been included in the Standards, either as a stand-alone intervention or as part of a multi-component programme. In the absence of an evaluation assessing its effectiveness in preventing drug use, this was assessed 'non-evidence-based'.

**Weakly evidence-based interventions** report some, but not all the characteristics that have been found to be associated with effective programmes in the Standards. In addition to 3 interventions also targeting middle childhood (the conversational groups, Listen First and the core curriculum), many interventions (6) in this group supported parents with their parenting skills, often including a component of information (Tuning into Teens and others). Areas of weaknesses were typically in relation to the content (e.g. only one area of parenting) or limitations with regard to the number and/or the interactivity of sessions.

Two programmes worked to address individual psychological vulnerabilities (rePULSE and FLYT), one respondent described their drug preventive education in secondary schools that included a limited component of personal and social skills, another reported on a safe mentor programme with a limited focus on the training of the mentoring and one on drug free events, that were categorized as weakly evidence-informed due to their inclusion of a few positive characteristics of programmes in entertainment venues.

In addition to the national polices and services and the mental health counselling in schools assessed to be **strongly evidence-informed** in middle childhood, there are a significant number of interventions (8) focusing on SBIRT (screening, brief intervention based on motivational interviewing and referral to treatment services), delivered in a number of settings (school, community, health services, workplace, law enforcement). These include the use of the HAP (CCP – Cannabis Cessation Programme) model (6 respondents), as well as the National guidelines for health promotion and preventive work in the child.

Three interventions delivered in schools and including characteristics found to be associated with effective programmes in the Standards were a prevention programme offered in secondary and upper secondary schools on decision making, alcohol, drugs, etc. with interactive techniques and appropriate information and structure and two interventions on the delivery of constructive policies on the use of drugs in schools. 'Kjentmann' (Celebrity) is a model implemented in all regions to ensure the early identification of drug use among students in the context of a caring climate based on dialogue and support, as per the Standards, while 'Rusforebyggende' (Drug Prevention) are guidelines and practical tools for drug prevention for the schools of the Oslo region, including reference not only to the development of policies in schools and the use of the Kjentmann model, but also to drug education, work with parents (recommending the use of the strongly evidence-informed programme "Utsett! – Delay!" (see below), connection to health and social services.

Similarly, two additional models including characteristics found to be associated with effective programmes in the Standards, but targeting parents were: the ICDP model for early adolescents and Utsett! ("Delay"), including discussions both of different dimensions of parenting and of information about drugs.

Always in this group, FACT Ung is a model of integrated services to young people aged 12-18 with serious mental disorders, aiming at providing the opportunity to live and participate in the local community; an evaluation with strong methodology reported only on intermediate variables.

Finally, interventions targeting this age include the local adaptation (with no local evaluation) of an evidence-based programme for parents "Strengthening Families Programme", which was thus assessed to be **evidence-based, not locally evaluated**, as well as the **innovative** intervention also targeting middle childhood and described under that age group.

### *6. Older adolescence*

A significant number of **supporting services** already discussed under early adolescence (26) also target older adolescents and many additional respondents (11) reported providing different kinds of outreach work to vulnerable adolescents, youth centres, healthy opportunities for leisure interventions, including Glidelås, a model of intersectoral cooperation to prevent drop-out among identified at-risk youth moving from lower secondary to upper secondary school. In addition, one model created parental networks for parents of at-risk youth, while another

provided therapy and counselling for young people who have grown up in families with substance issues.

In addition to 13 **non-evidence-based** interventions already discussed under early adolescence and that also target older adolescents, including the HAP app, Sisterhood and Brotherhood, and educational interventions for adolescents and/or their parents, this group includes a number of additional interventions providing education to students and/or parents (9), which that have been assessed to be non-evidence-based due to various combinations of characteristics associated with non-effective programmes in the *Standards*, including: preponderance of information and non-interactive techniques, rather than interactive practicing of skills, limited structure such as 'dialogues' or 'conversations' and/or single sessions, use of people in recovery talking about their experiences.

Three respondents reported on work to follow-up children who use, including through drug testing. As discussed above, drug testing is not identified in the Standards as an effective component of working with youth either to prevent initiation or transition to drug dependence. Finally, a respondent reported freely available information films about substances, with factual information about short term and long-term effects, prevalence and harm prevention, with no report of formative research in terms of effectiveness in preventing drug initiation or transition.

In addition to 10 **weakly evidence-informed** interventions already discussed under early adolescence and that also target older adolescents through preventive education for adolescents and/or parents, addressing individual psychological vulnerabilities or providing drug free events, 5 more respondents reported similar interventions. In addition, one programme on school attachment reported implementing a concerted effort (limited to the first weeks of school) to create a safe and welcoming environment and build student relations as well as student-staff relations.

Many **strongly evidence-informed** interventions (17) targeting older adolescents had already been discussed under early adolescents

In addition to the 17 **strongly evidence-informed** interventions already discussed under early adolescence and that also target older adolescents, including national policies on tobacco, alcohol, health services, policies in schools and outreach interventions offering SBIRT and other support in a number of settings, including through the HAP model, this group included 5 additional interventions implementing similar activities. In addition, as older adolescence is the first age in which people can legally work, this is the first age where the AKAN model of workplace prevention appears and is assessed; the model is strongly evidence-informed, with all the component that have been found to be associated with effective programmes in the Standards. In addition, it is supported by a strong delivery structure, as it is evident from the many respondents that reported on offering of regular training, mentoring, communications, information on the website, etc.

### 7. Young adulthood

Most **supporting services** targeting young adults (27) had already discussed under older adolescence, providing various kind of support to youth at risk. In addition, one respondent reported on a network of human resources leaders in the municipality to ensure that young adult newcomers are quickly employed and included in the local community.

All **non-evidence-based** interventions already discussed under older adolescence (including various initiatives based only on information, drug testing and the HAP app), while with regard to **weakly evidence-informed** interventions, four had already been discussed above (regarding school start, addressing individual psychological vulnerabilities, and entertainment events). In addition, two respondents reported on two information campaigns that included some elements that have been found to be associated with effective programmes in the Standards.

Also with regard to **strongly evidence-informed** interventions, most (14) interventions have already been analysed under older adolescence (tobacco and alcohol policies, SBIRT in a number of settings including the HAP model, AKAN in the workplace), in addition, one respondent reported on the training for nightlife employees, which is compulsory for all establishments that serve alcohol after 0100 in the municipality. In the context of the strong national alcohol policies, this completes the components that have been found to be associated with effective programmes in entertainment venues in the Standards.

### 8. Adults

All interventions reported to target adults also targeted young adults and were therefore already assessed in the previous slides. These included: 5 **supporting services**, such as outreach and/or support services, particularly mental health services, for people at risk, including pregnant women; 3 **non-evidence-based** interventions (the HAP app and the films about substances); 2 **weakly evidence-informed** interventions (information campaigns and drug free events); and, 6 **strongly evidence-informed** interventions (tobacco and alcohol policies, SBIRT in a number of settings including the HAP model, AKAN in the workplace, and training of staff in entertainment venues).

### 9. Senior citizens

Among the interventions targeting adults and younger ages, a **supporting service** for mental health explicitly serving also older persons and the **strongly evidence-informed** tobacco and alcohol policies were considered to target also senior citizens. In addition, only one respondent reported on a programme specifically targeting senior citizens. A multi-component programme targeting different levels of risk was carefully developed on the basis of formative research with the target group and has developed a clear operational manual covering screening, counselling and treatment. While there is no clear equivalent in the Standards and the lack of evaluation means that its effectiveness is not known, it is clear that it is a very promising programme that would deserve an evaluation, filling a gap for this underserved population.

## C. Assessment of quality by level of risk

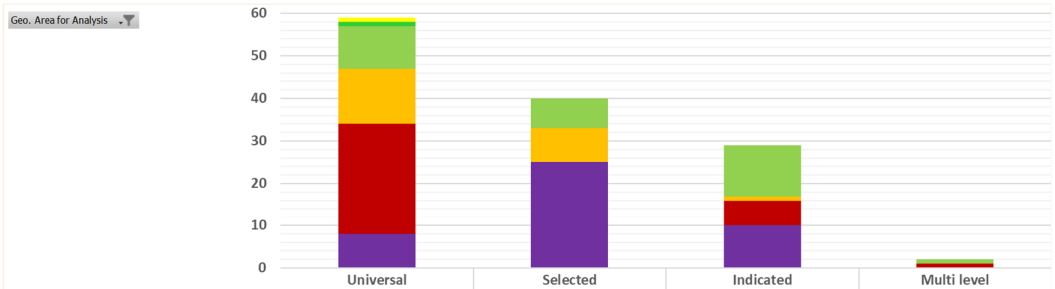
Figure 37. reports the number of interventions implemented in all regions by level of risk of the target group. Interventions were reported to be implemented at all levels of risk and all levels of risk included supporting services, interventions that would warrant improvement (non-evidence-based and weakly evidence informed), as well as stronger interventions (strongly evidence-informed and evidence-based, not locally evaluated) with one innovative intervention implemented at universal level.

However, there is a clear imbalance in the way interventions of different quality are distributed among levels of risk. Supporting services constitute the majority (24 out of 40 or 60%) of selected interventions and a significant part of indicated interventions (10 out 28 or 36%), but much less so among universal interventions (8 out of 59 or 13%).

Conversely, non-evidence-based interventions appeared to be over-represented among universal interventions (26 out of 59 or 44%), compared to indicated interventions (5 out of 28 or 18%) and selected interventions among which no intervention was non-evidence-based. Weakly evidence-informed interventions were more equally distributed between universal interventions (13 out of 29 or 22%) and selected interventions (8 out of 40 or 20%), while only one intervention out of 28 or 3% was weakly evidence-informed at indicated level.

Finally, strongly evidence-informed interventions were reported to be implemented significantly more at indicated level (12 out of 28 or 43%), than at selected (7 out of 40 or 18%) or at universal (10 out of 59 or 17%) levels. Finally, the only two evidence-based and innovative interventions were delivered at universal level.

*Figure 37.*
*Number of implemented interventions by level of risk (All Norway)*




| | Universal | Selected | Indicated | Multi level |
|---|---|---|---|---|
| Innovative | 1 | 0 | 0 | 0 |
| Evidence-based, not locally evaluated | 1 | 0 | 0 | 0 |
| Strongly evidence-informed | 10 | 7 | 12 | 1 |
| Weakly evidence-informed | 13 | 8 | 1 | 0 |
| Non-evidence-based | 26 | 0 | 6 | 1 |
| Supporting services | 8 | 25 | 10 | 0 |

The following sub-sections provide a descriptive summary of the interventions in each of the levels of risks, grouped by quality; the reader is reminded that short descriptions of specific interventions describing the rationale behind the assessment are included under Section 2. Assessment of quality by age earlier in this Chapter.

### 1. Universal level

The 8 interventions assessed to be **supporting services** at the universal level include the provision of day care for children aged 1-5 nationally, which covers 93.4% of children, as well the provision youth centres and leisure time opportunities that did not specify the targeting of group particularly at risk (6) and one respondent providing basic support and information to parents.

The vast majority of universal level interventions that were assessed to be **non-evidence-based** (17 out of 26) were preventive education or approaches for children and youth, mostly in schools, but one also through media, including various combinations of characteristics associated with non-effective programmes in the Standards, such as: preponderance of information and non-interactive techniques, rather than interactive practicing of skills; information too based on scare tactics, rather than a realistic discussion on risks, especially short-term, and the normative nature of use; limited structure such as 'dialogues' or 'conversations' and/or single sessions; and, use of people in recovery talking about their experiences. Similarly, 3 interventions targeted parents with content based only or almost exclusively on information about drugs, not a characteristic that has been found to be linked to effectiveness in the Standards. Finally, two interventions (the delivery of ICDP to all municipal personnel working with children, Sisterhood and Brotherhood) were assessed to be non-evidence-based due to their lack of evaluation of a kind of intervention that is not already listed in the Standards as having a preventive effect.

With regard to **weakly evidence-informed** interventions, most provided prevention education to either children in school (5) or to parents (4) with at least some (but not all) of the characteristics indicated in the Standards as being linked to effectiveness, particularly a number of structured (not free-flowing) sessions and a strong focus on skills (personal and social skills and parenting skills), including the core curriculum for primary and secondary education. In addition, weakly evidence-informed interventions at the universal level included: two respondents providing drug free events (assessed as weakly evidence-informed due to their inclusion of a few positive characteristics of programmes in entertainment venues), one programme on school attachment implementing a concerted effort (limited to the first weeks of school) to create a safe and welcoming environment and build student relations as well as student-staff relations; and, the UNODC "Listen First" campaign (translated into Norwegian) on the Science of Care and the Science of Skills targeting parents and caregivers was deemed to include only some of the characteristics associated with effective programmes in the Standards.

The **strongly evidence informed** interventions comprised a series of policies delivered at the national level: tobacco policies, alcohol policies, the national guidelines for pre-natal care (including the provision of screening, brief intervention and referral to treatment for pregnant women), the national guidelines for health promotion and preventive work in the child (including the screening and referral of early onset of mental health disorders in children), school policies, including the Kjentmann model, and the Oslo guidance for drug prevention in schools ("Rusforebyggende"), all described above. In addition, this included a programme of preventive

education among children and one for parents strongly rooted in the provision of skills ("Utsett!" – Delay).

Finally, interventions at universal level include the local adaptation (with no local evaluation) of an evidence-based programme for parents "Strengthening Families Programme", which was thus assessed to be **evidence-based, not locally evaluated**, as well as the **innovative** intervention (iLAG), aiming at attractive meeting places with interventions for 5th-7th graders to foster togetherness and including a planned/ongoing evaluation as described above.

### 2. Selected level

The majority (15) of **supporting services** implemented at selected levels provided a range of support and opportunities for youth at risk, from safe spaces to spend time, leisure time or employment opportunities, and counselling and other health services. Some interventions targeted specifically ethnic minorities or children at particular risk of abuse. One particular intervention (BTI – "Better Interdisciplinary Action") focused on the early identification and interdisciplinary cooperation between actors supporting pregnant women, children or youth at risk). Two additional intervention offered counselling to parents and one created a network of human resources leaders in the municipality to ensure that young adult newcomers are quickly employed and included in the local community.

Among the **weakly evidence-informed** interventions, three addressed individual psychological vulnerabilities, two provided parenting skills parents of youth at risk, two provided providing education connected to the end of schooling celebrations ("Russ"), one provided mentoring to youth at risk.

The **strongly evidence-informed** interventions included 5 interventions providing SBIRT in various settings (outreach or schools), plus a prevention programme, conducting sessions in secondary and upper secondary schools on decision making, alcohol, drugs, etc. with interactive techniques and appropriate information and structure, and an intervention providing training for nightlife employees, which, in the context of the strong national alcohol policies, completes the components that have been found to be associated with effective programmes in entertainment venues in the Standards.

### 3. Indicated level

**Supporting services** for individuals at risk (indicated level) included support to children identified as at risk, including of school drop out and including children of parents with substance use disorders (6), various forms of mental health services for older adolescents and adults (4), including the identification and referral of mental health issues among new parents and including for parents of children at risk.

Among **non-evidence-based** intervention at indicated level, four involved the use of drug contracts and/or drug testing, two interventions without evidence of effectiveness in the Standards. In addition, the HAP app is also in this category in spite of its systematic development, due to the lack of evaluation.

One **weakly evidence-informed** intervention aiming at addressing individual psychological vulnerabilities (repulse) was complemented by 12 **strongly evidence-informed** interventions, mostly (9) providing SBIRT and other support in a number of settings (school and outreach), including through the HAP model, as well as 3 providing mental health services for children up to early adolescence, as per the Standards.

### *4. Multi-level*

The two multi-level interventions include: the programme targeting senior citizen that, due to its lack of evaluation, had been assessed to be **non-evidence-based;** and, the AKAN model delivered in the workplace, which as per the Standards, includes a package of activities targeting employees at different level of risks. As described above, this intervention has been assessed to be **strongly evidence-informed.**

## D. Assessment of quality by setting of implementation

Figure 38. reports the number of interventions implemented in all regions by setting of implementation. Interventions were reported to be implemented in all setting of implementation and all settings included supporting services, interventions that would warrant improvement (non-evidence-based and weakly evidence informed), as well as stronger interventions (strongly evidence-informed and evidence-based, not locally evaluated) with one innovative intervention implemented in the community.

Some preponderances can be observed in the distribution as follows. **Supporting services** are disproportionately delivered in health settings (8 out of 17 or 47%) and in the community (19 out of 42 or 45%), followed by multi-setting (5 out of 14 or 36%), workplace (1 out of 3 or 33%) and family (6 out of 21 or 29%), with a minority in schools (4 out of 33 or 12%).

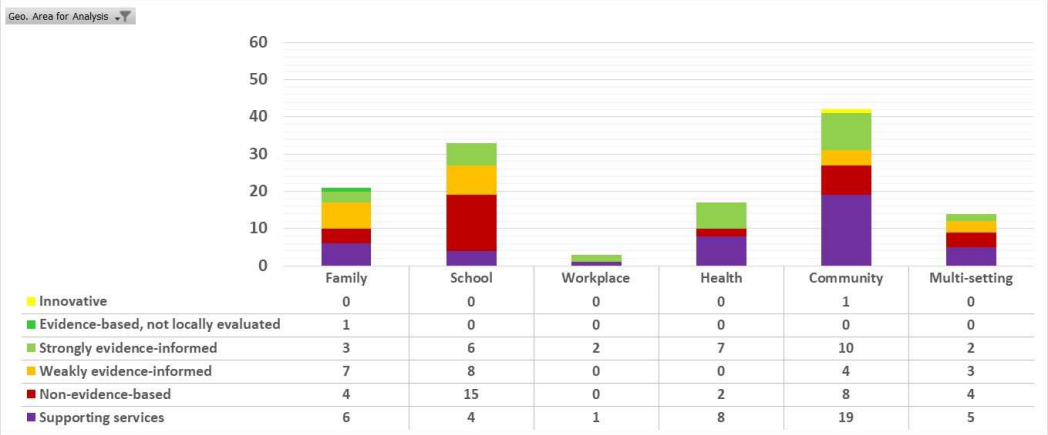
**Non-evidence-based** intervention were reported to be implemented more in schools (15 out of 33 or 36%), followed by multi-setting (4 out of 14 or 29%), less so in families (4 out of 21 or 19%) and in the community (8 out of 42 or 19%) and none in the workplace.

With regard to **weakly evidence-informed** interventions the distribution was more homogenous among those implemented in families (7 out of 21 or 33%), in schools (8 out of 33 or 24%), in many settings (3 out of 14 or 21%), and in the community (4 out of 42 or 10%), while none were reported to be implemented in the workplace and in health settings.

**Strongly evidence-informed interventions** enjoyed strong implementation in the workplace (2 out of 3 or 66%) and in health settings (7 out of 17 or 41%), followed by intervention implemented in the community (10 out of 42 or 24%), multi setting, in schools (6 out of 33 or 18%), as well as in families (3 out of 21 or 14%) and in many settings (2 out of 14 or 14%).

Finally, one **evidence-based intervention, non-locally-evaluated** was reported to be implemented in families and one **innovative** intervention was reported to be implemented in the community.

*Figure 38.*
*Number of implemented interventions by setting of implementation and quality*




| | Family | School | Workplace | Health | Community | Multi-setting |
|---|---|---|---|---|---|---|
| Innovative | 0 | 0 | 0 | 0 | 1 | 0 |
| Evidence-based, not locally evaluated | 1 | 0 | 0 | 0 | 0 | 0 |
| Strongly evidence-informed | 3 | 6 | 2 | 7 | 10 | 2 |
| Weakly evidence-informed | 7 | 8 | 0 | 0 | 4 | 3 |
| Non-evidence-based | 4 | 15 | 0 | 2 | 8 | 4 |
| Supporting services | 6 | 4 | 1 | 8 | 19 | 5 |

The following sub-sections provide a descriptive summary of the interventions in each of settings, grouped by quality; the reader is reminded that short descriptions of specific interventions describing the rationale behind the assessment are included under Section 2. Assessment of quality by age earlier in this Chapter.

## 1. Family

The 6 **supporting services** targeting families include 2 entries providing counselling services for parents (including specifically parent-initiated), the delivery of BTI (Bedre Tverrfaglig Innsats or "Better Interdisciplinary Action", a structure and a model for early identification and interdisciplinary cooperation between actors involved with pregnant women at risk (3 entries) and the screening and referral of mental health issues of new parents in the context of the National guidelines for health promotion and preventive work in the child. Two **non-evidence-based** interventions focused only on providing information on drugs to parents, while the 7 **weakly evidence-informed** interventions included at least one of the dimensions of parenting skills identified in the Standards as being linked to effective practice, but might have benefited by a more exhaustive content or a stronger delivery method (more or more interactive sessions). The three **strongly evidence-informed** interventions implemented two models (Uttsett! – Delay! and ICDP) that included all the characteristics linked in the Standards to effectiveness, including a series of structured and interactive sessions focusing on building attachment, as well as skills in monitoring and being involved in the life of children and effectively setting healthy boundaries. Finally, the local adaptation (with no local evaluation) of an evidence-based programme for parents "Strengthening Families Programme" was assessed to be **evidence-based, not locally evaluated.**

## 2. School

Four **supporting services** were reported to be implemented in schools, including the provision of day-care to 0 to 5 years of age, as well as an intervention specifically aimed at preventing drop-out (2 entries) and conversation groups. All the 15 **non-evidence-based** interventions in

schools were preventive education interventions that reported various combinations of characteristics associated with non-effective programmes in the Standards, including: preponderance of information and non-interactive techniques, rather than interactive practicing of skills, limited structure such as 'dialogues' or 'conversations' and/or single sessions, use of people in recovery talking about their experiences. Conversely, 5 **weakly-evidence informed** interventions, including the core curriculum for primary and secondary education, comprised at least some (but not all) of the characteristics indicated in the Standards as being linked to effectiveness, particularly a number of structured (not free-flowing) sessions, a strong focus on skills (personal and social skills) and, if appropriate to the age, realistic discussion of the risks and normative nature of use. In addition, one intervention focused on building school attachment through activities limited to the beginning of the school, another on providing education connected to the end of schooling celebrations ("Russ"), and one on addressing individual psychological vulnerabilities. **Strongly evidence-informed** interventions were six, four of which focusing on providing SBIRT and counselling in this setting and two related to the delivery of constructive policies on the use of drugs in schools ('Kjentmann' (Celebrity) and 'Rusforebyggende' (Drug Prevention)) as described above.

### *3. Workplace*

The three interventions implemented in workplaces included a **supporting service** ensuring that young adult newcomers are quickly employed and included in a local community and two **strongly evidence-informed interventions**, one providing SBIRT in schools and workplaces in a specific region and the AKAN model described above and implemented nationally.

### *4. Health settings*

Of the five **supporting services** implemented in health settings, four were related to the provision of mental health services to children and youth and one was specific to children and youth of parents with substance use and mental health disorders (BAPP, as described above). The two **non-evidence-based** interventions referred to the use of drug contracts, not a interventions found to be effective in preventing transition to drug use, and the programme for senior citizens, due to its lack of evaluation in spite of careful development, as described above. Of the seven **strongly evidence informed** interventions, four provided SBIRT especially focusing on the transition of disorders, two were with regard to the provision of mental health services for children, a specific intervention in one location and National guidelines for health promotion and preventive work in the child, including screening and referral of early onset of mental health disorders in children. Finally, this group included the guidelines for pre-natal care mandating SBIRT for pregnant women.

### *5. Community*

Interventions implemented in the community comprise interventions implemented in youth centres, street, entertainment venues, media, etc. and included 19 **supporting services**, most (18) providing different kinds of outreach work to vulnerable children, counselling, healthy opportunities for leisure, vocational skills/ job opportunities, including for children and youth

particularly at-risk of harmful sexual abuse or ethnic minorities, with one intervention providing support to parents of at-risk youth. Eight **non-evidence based** interventions included the utilization of the HAP app, the use of the Sisterhood/ Brotherhood, as well as the provision of prevention information through various media, including films (see above for a description of all of these). The four **weakly evidence-informed** interventions included one intervention addressing individual psychological vulnerabilities, two organizing drug free entertainment events and the local implementation of a national information campaign. Finally, the 10 **strongly evidence-informed** interventions included the national tobacco and alcohol policies, including complemented by training of staff in entertainment venues, SBIRT offered in community settings, including through the HAP model, and a preventive education model for adolescents strongly based on personal and social skills. The **innovative** (due to its planned/ ongoing evaluation) intervention iLAG (creating attractive meeting places with interventions for 5th-7th graders to foster togetherness and prevent loneliness and depressive symptoms) is also implemented in community settings.

### *6. Multi-setting*

Five **supporting services** included the utilization of the BTI (Better Interdisciplinary Action) model for support of pregnant women, children and youth at risk, as well as other interventions to support youth at risk in different settings. The four **non-evidence-based** interventions included three following up youth with drug contracts and/or drug testing and the utilization of a modified version of the ICDP parenting programme for all municipal staff, all described above. The two **weakly evidence-informed** interventions included FLYT, a programme addressing individual psychological vulnerabilities and providing education connected to the end of schooling celebrations ("Russ"), while the two **strongly evidence-informed** intervention provided SBIRT, including through the HAP model.

## E. Assessment of quality by region

Figures 39. to 56. illustrate the number and percentages of implemented interventions in each of the regions. The overall pattern of quality is largely the same in all regions with minimal variations: this is important because it means that evidence-based and non-evidence-based interventions are not concentrated in one or few regions. The following sub-sections provide a short summary of the interventions by quality in each region; the reader is reminded that short descriptions of specific interventions describing the rationale behind the assessment are included under Section 2. Assessment of quality by age earlier in this Chapter.

### *1. Region Central*

Twelve interventions (24%, less than the national average of 33%) were assessed to be **supporting services**, including the provision of day care for children aged 1-5 nationally; different kinds of outreach work counselling, healthy opportunities for leisure, vocational skills/ job opportunities for vulnerable children, including a network of human resources leaders in the municipality to ensure that young adult newcomers are quickly employed and included in the

local community; the provision of mental health services for children, including through the BAPP - Barn av foreldre med rus- og psykiske problemer, model for children of parents with substance use or mental health issues; and, mental health services and other support for parents, including as part of the child health services offered under the "National guidelines for health promotion and preventive work in the child".

Twelve interventions (24%, only slightly less than the national average of 25%) were assessed to be **non-evidence based**, comprising a number (7) of education/ information programmes for students and/or parents; that have been assessed to be non-evidence-based due to various combinations of characteristics associated with non-effective programmes in the Standards, including: preponderance of information and non-interactive techniques, rather than interactive practicing of skills, limited structure such as 'dialogues' or 'conversations' and/or single sessions. In addition, two respondents reported utilizing so-called follow-up on 'drug contracts', an intervention without evidence of effectiveness in the Standards, as described above. Finally, the 'non-evidence-based' group comprises two interventions that were assessed as such due to their lack of evaluation, in spite of their careful development, as also described above: the HAP app and the training of all municipal staff using the ICDP parenting programme.

The 9 (18%, only slightly less than the national average of 17%) **weakly-evidence-informed interventions** include interventions that comprise only some of the characteristic associated with positive outcomes, as discussed above: educational interventions for children and youth based at least partly on personal and social skills, including the core curriculum for primary and secondary education; educational activities targeting parents with some focus on parenting skills, including the UNODC Listen First campaign; educational activities to the end of schooling celebrations ("Russ"); the provision of drug free events; and, the FLYT programme addressing individual psychological vulnerabilities.

In terms of **strongly-evidence informed** interventions (16 or 32%, less than the national average of 23%), some where the implementation of national policies and initiatives, including the following: tobacco and alcohol policies; SBIRT for pregnant women as mandated in the guidelines for pre-natal care, screening and referral of early onset of mental health disorders in children (as mandated in the National guidelines for health promotion and preventive work in the child) and related services; SBIRT for adolescents in school and through youth centres as provided for in the National guidelines for health promotion and preventive work in the child; the Kjentmann model of supporting school policies on drugs; the AKAN model. In addition, this region reported the implementation of the following interventions: SBIRT through schools and outreach for youth, including through the HAP model; a preventive education programme and two parenting programmes (Utsett! – Delay! and ICDP) with content and structure in line with the Standards.

Finally, in this region, the **innovative** (due to its planned/ ongoing evaluation) intervention iLAG (creating attractive meeting places with interventions for 5th-7th graders to foster togetherness and prevent loneliness and depressive symptoms) was also reported to be implemented.

## 2. Region East

This Region reported the implementation of four **supporting services** (20%, less than the national average of 33%), including three implemented nationally: the provision of day care for children aged 1-5; screening and referral of mental health issues of new parents as mandated in the National guidelines for health promotion and preventive work in the child; and, counselling for children in families with substance use disorders. In addition, an outreach and counselling service for children at risk of harmful sexual abuse was also reported to be implemented.

The three **non-evidence-based** (15%, less than the national average of 25%) and the four (20%, more than the national average of 17%) **weakly-evidence informed** interventions were all also implemented nationally. The former included the utilization of the HAP app, as well as the freely available information films about substances, while the latter included: educational interventions for children and youth based at least partly on personal and social skills, including the core curriculum for primary and secondary education, as well as the UNODC Listen First campaign.

Finally, in addition to the 9 **strongly evidence-informed** (45%, more than the national average of 23%) interventions implemented nationally (tobacco and alcohol policies; SBIRT for pregnant women as mandated in the guidelines for pre-natal care, screening and referral of early onset of mental health disorders in children (as mandated in the National guidelines for health promotion and preventive work in the child) and related services; SBIRT for adolescents in school and through youth centres as provided for in the National guidelines for health promotion and preventive work in the child; the Kjentmann model of supporting school policies on drugs; and the AKAN model), the Region East reported the implementation of FACT Ung.

## 3. Region Oslo

Region Oslo reported the implementation of eight (17%, less than the national average of 33%) **supporting services**. In addition to the three interventions implemented nationally (the provision of day care for children aged 1-5; screening and referral of mental health issues of new parents as mandated in the National guidelines for health promotion and preventive work in the child; and, counselling for children in families with substance use disorders), the region offers counselling and spaces for youth, as well as parent-initiated counselling for parents.

The 13 **non-evidence-based** interventions (27%, more than the national average of 25%) reported to be implemented in this region included those implemented nationally (the utilization of the HAP app, as well as the freely available information films about substances), as well as 6 preventive education interventions for children and youth, mostly in schools, including various combinations of characteristics associated with non-effective programmes in the Standards. An intervention targeting specifically senior citizens and two respondents utilizing the Sisterhood/ Brotherhood model, both non-evidence-based due to their lack of evaluation were also reported.

With regard to the nine **weakly evidence-informed** interventions (19%, more than the national average of 17%), in addition to the four interventions implemented nationally (educational interventions for children and youth based at least partly on personal and social skills, including

the core curriculum for primary and secondary education, as well as the UNODC Listen First campaign), the Region reported the implementation of different preventive education interventions (2), a safe mentor programme, a programme to strengthen school attachment during the first weeks of school, and a parenting programme (Tuning into Teens).

Eighteen (37%, more than the national average of 23%) **strongly evidence-informed** interventions were reported to be implemented in this Region, including those implemented nationally (tobacco and alcohol policies; SBIRT for pregnant women as mandated in the guidelines for pre-natal care, screening and referral of early onset of mental health disorders in children (as mandated in the National guidelines for health promotion and preventive work in the child) and related services; SBIRT for adolescents in school and through youth centres as provided for in the National guidelines for health promotion and preventive work in the child; the Kjentmann model of supporting school policies on drugs; and the AKAN model). In addition, outreach, counselling and follow-up of children and youth strongly based on SBIRT, including based on the HAP model was reported by 7 respondents, as well as the Rusforebyggende' (Drug Prevention) guidelines, the training of staff in entertainment venues, and the provision of mental health services in schools.

### *4. Region North (National)*

As mentioned above, no entries were provided by practitioners in the Region North. However, a specific follow-up was undertaken with regard to the implementation of prevention interventions, particularly among the Sami people, which confirmed the implementation of policies and interventions available nationally. Therefore, for this Region, the description is only based on the nationally implemented interventions. These include three **supporting services** (17%): the provision of day care for children aged 1-5; screening and referral of mental health issues of new parents as mandated in the National guidelines for health promotion and preventive work in the child; and, counselling for children in families with substance use disorders. With regard to the three **non-evidence-based** interventions (17%), these comprise the utilization of the HAP app, as well as freely available information films about substances, while the four **weakly evidence-informed** interventions (22%) refer to educational interventions for children and youth based at least partly on personal and social skills, including the core curriculum for primary and secondary education, as well as the UNODC Listen First campaign. Finally, a number (8) of **strongly evidence-informed** interventions (44%) implemented nationally include: tobacco and alcohol policies; SBIRT for pregnant women as mandated in the guidelines for pre-natal care, screening and referral of early onset of mental health disorders in children (as mandated in the National guidelines for health promotion and preventive work in the child) and related services; SBIRT for adolescents in school and through youth centres as provided for in the National guidelines for health promotion and preventive work in the child; the Kjentmann model of supporting school policies on drugs; and the AKAN model in the workplace.

### *5. Region South*

Only one intervention was reported to be implemented in the Region South in addition to the nationally implemented interventions, which include: three **supporting services** (the provision

of day care for children aged 1-5; screening and referral of mental health issues of new parents as mandated in the National guidelines for health promotion and preventive work in the child; and, counselling for children in families with substance use disorders); three **non-evidence-based** interventions (the utilization of the HAP app, as well as the freely available information films about substances); four **weakly evidence-informed** interventions (educational interventions for children and youth based at least partly on personal and social skills, including the core curriculum for primary and secondary education, as well as the UNODC Listen First campaign) and, eight **strongly evidence-informed** interventions (tobacco and alcohol policies; SBIRT for pregnant women as mandated in the guidelines for pre-natal care, screening and referral of early onset of mental health disorders in children (as mandated in the National guidelines for health promotion and preventive work in the child) and related services; SBIRT for adolescents in school and through youth centres as provided for in the National guidelines for health promotion and preventive work in the child; the Kjentmann model of supporting school policies on drugs; and the AKAN model in the workplace). In addition, this Region reported the local adaptation (with no local evaluation) of an evidence-based programme for parents ("Strengthening Families Programme"), which was thus assessed to be **evidence-based, not locally evaluated**.

### *6. Region Southwest*

Region Southwest reported the implementation of 22 **supporting services** (45%, more than the national average of 33%). These include three nationally implemented interventions: the provision of day care for children aged 1-5; screening and referral of mental health issues of new parents as mandated in the National guidelines for health promotion and preventive work in the child; and, counselling for children in families with substance use disorders. In addition to one intervention creating networks of parents of youth at-risk, 18 interventions provided different kinds of outreach work, counselling, healthy opportunities for leisure, vocational skills/ job opportunities for vulnerable children, including the utilization of the BTI (Better Interdisciplinary Action) model for support of pregnant women, children and youth at risk.

Nine (26%, only slightly more than the national average of 25%) interventions implemented in this Region were assessed to be **non-evidence-based** including those nationally implemented (the HAP app and the freely available information films about substances), as well as preventive education interventions (4) for children and youth or for parents (including various combinations of characteristics associated with non-effective programmes in the Standards) and drug testing.

The seven (21%, more than the national average of 17%) interventions assessed as **weakly evidence-informed** comprised four nationally implemented interventions (educational interventions for children and youth based at least partly on personal and social skills, including the core curriculum for primary and secondary education, as well as the UNODC Listen First campaign), as well as two programmes addressing individual psychological vulnerabilities (FLYT and rePULSE) and a programme for parents (Tuning into Teens).

In addition to the nationally implemented **strongly evidence-informed** interventions (tobacco and alcohol policies; SBIRT for pregnant women as mandated in the guidelines for pre-natal care, screening and referral of early onset of mental health disorders in children (as mandated in the National guidelines for health promotion and preventive work in the child) and related services; SBIRT for adolescents in school and through youth centres as provided for in the National guidelines for health promotion and preventive work in the child; the Kjentmann model of supporting school policies on drugs; and the AKAN model in the workplace), a prevention education intervention in line with the characteristics linked to effectiveness in the Standards and the utilization of HAP were also reported (9 interventions or 26%, more than the national average of 23%).

## *7. Region West*

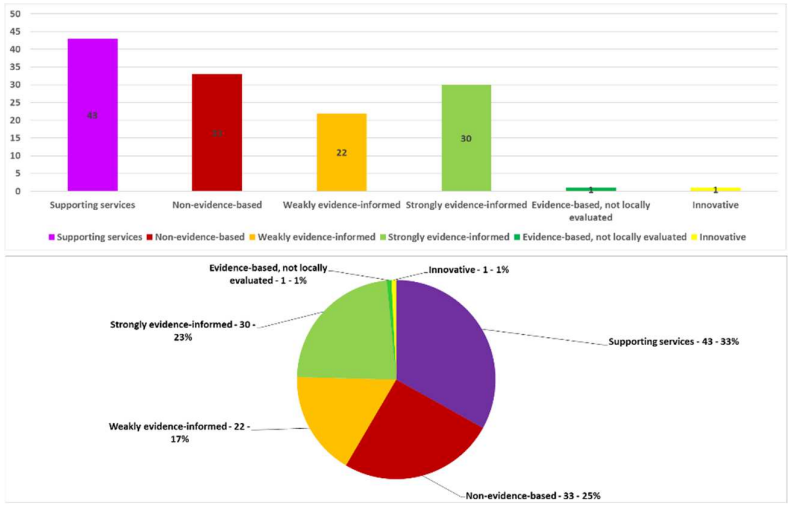
Nine (27%, almost as much as the national average of 33%) **supporting services** were reported to be implemented in this region, including those nationally implemented (the provision of day care for children aged 1-5; screening and referral of mental health issues of new parents as mandated in the National guidelines for health promotion and preventive work in the child; and, counselling for children in families with substance use disorders), as well as 6 interventions providing a range of support and opportunities for youth at risk, such as safe and healthy spaces to spend time, outreach and counselling.

**Non-evidence based** interventions (9 or 26%, only slightly more than the national average of 25%) provided preventive education for students and/or parents (7) that were assessed as such to various combinations of characteristics associated with non-effective programmes, in addition to the nationally implemented interventions (HAP app and freely available information films about substances).

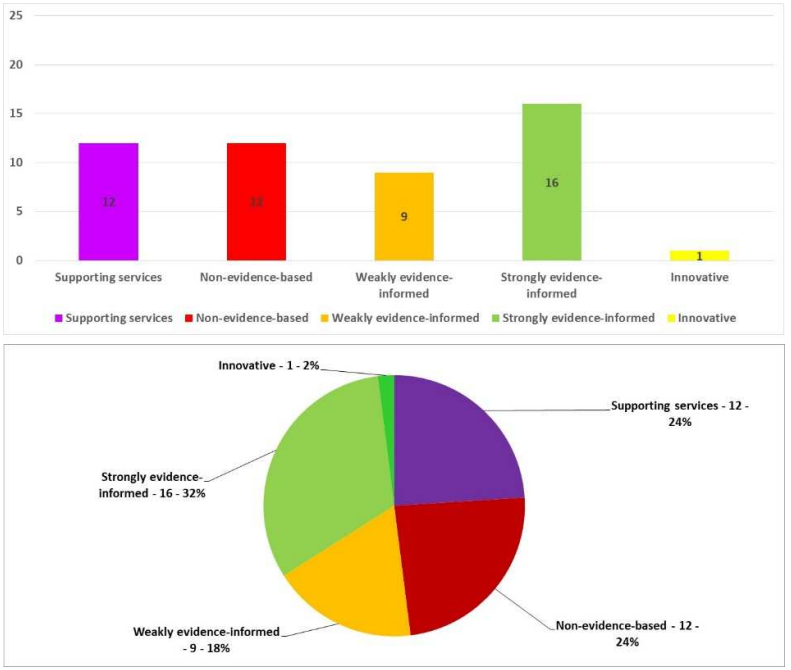
With regard to the seven **weakly evidence-informed** interventions (21%, more than the national average of 17%), in addition to those nationally implemented (educational interventions for children and youth based at least partly on personal and social skills, including the core curriculum for primary and secondary education, as well as the UNODC Listen First campaign), the following were reported in the Region: education connected to the end of schooling celebrations ("Russ"), the provision of drug free events, some support to parents with their parenting skills, including a component of information.

Finally, the nine **strongly evidence-informed** interventions (26%, more than the national average of 23%) included the nationally implemented interventions (tobacco and alcohol policies; SBIRT for pregnant women as mandated in the guidelines for pre-natal care, screening and referral of early onset of mental health disorders in children (as mandated in the National guidelines for health promotion and preventive work in the child) and related services; SBIRT for adolescents in school and through youth centres as provided for in the National guidelines for health promotion and preventive work in the child; the Kjentmann model of supporting school policies on drugs; and the AKAN model in the workplace), as well as the implementation of FACT Ung.

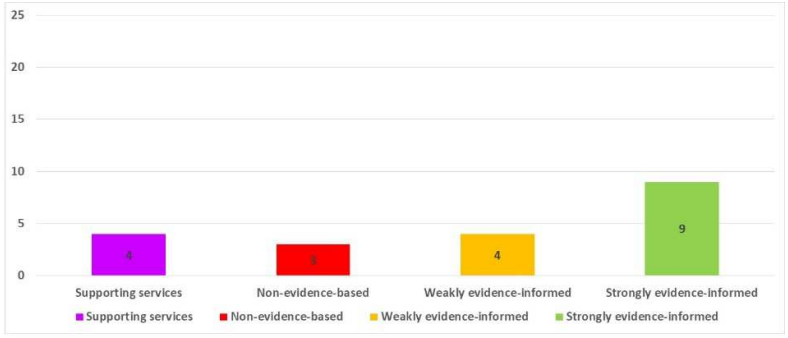
Figures 39. and 40. – Number and percentage of implemented activities by quality – All Norway

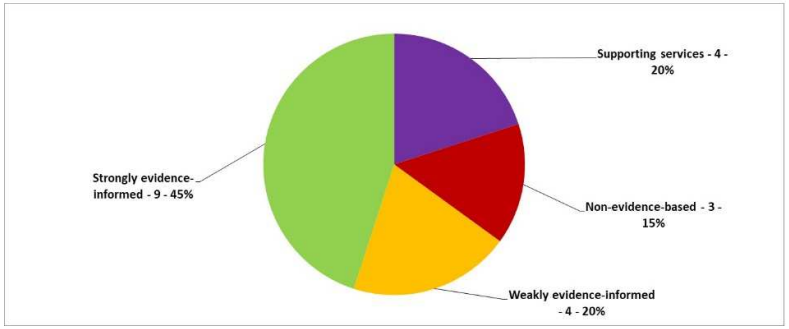



Figures 41. and 42. – Number and percentage of implemented activities by quality – Region Central

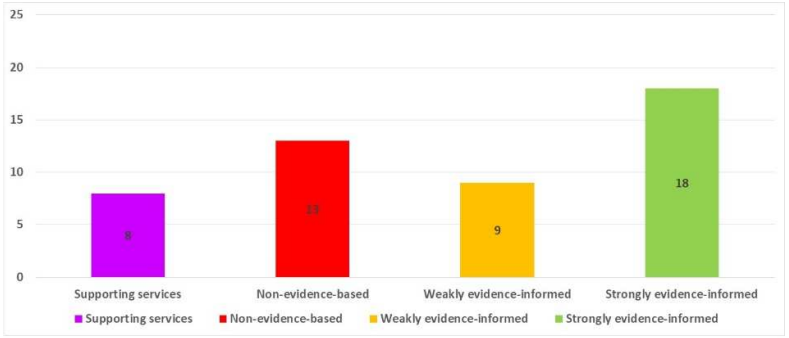


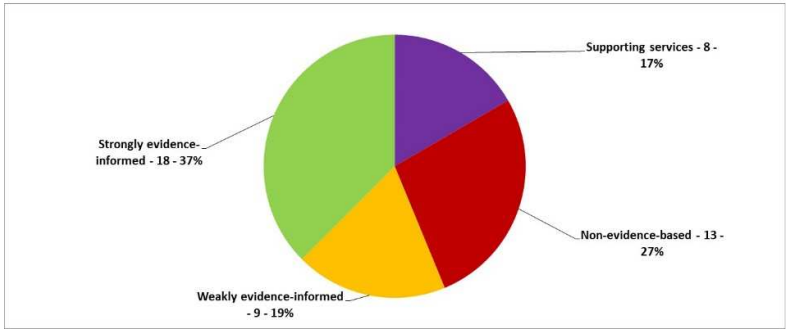
*Figures 43. and 44. – Number and percentage of implemented activities by quality – Region East*



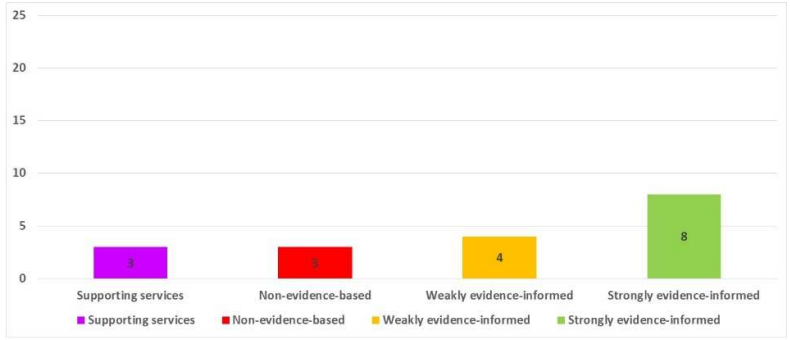



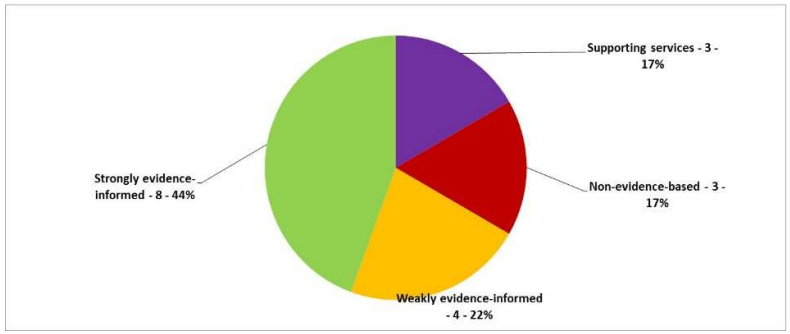

*Figures 45. and 46. – Number and percentage of implemented activities by quality – Region Oslo*



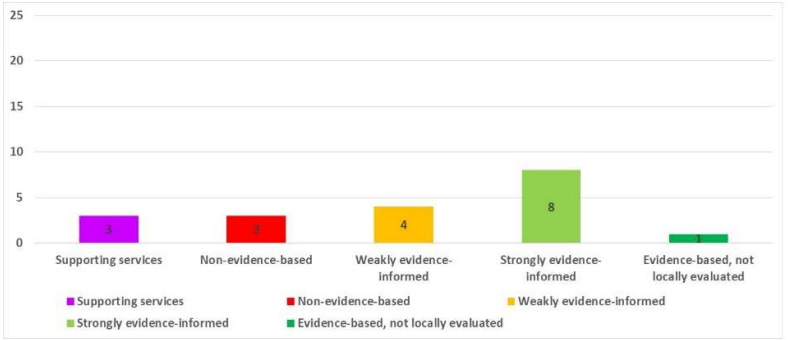



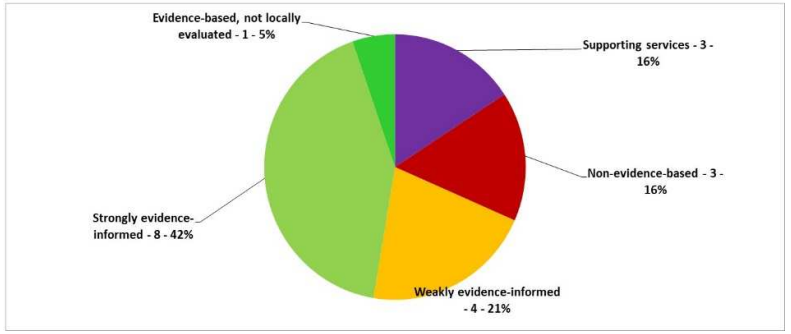
*Figures 47. and 48. – Number and percentage of implemented activities by quality – Region North (National)*



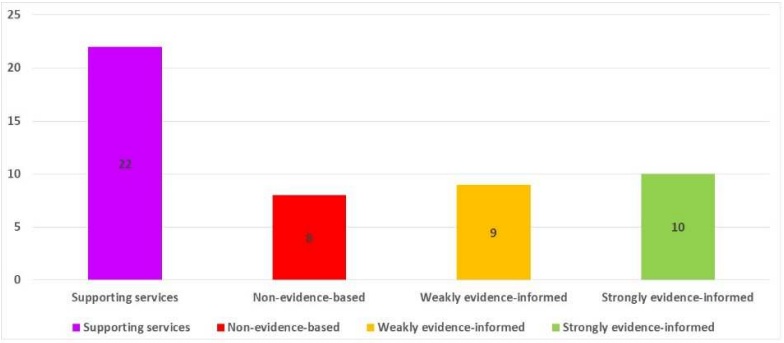



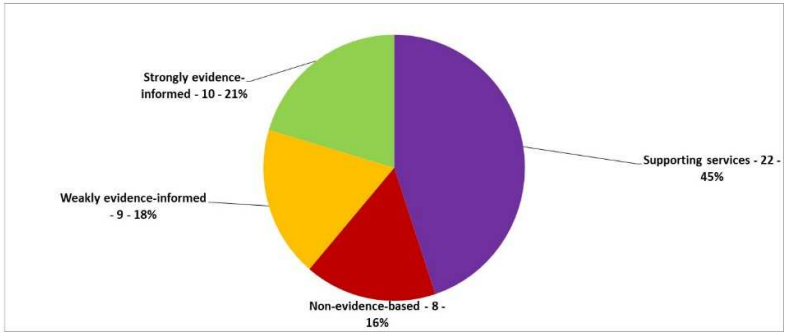

*Figures 49. and 50. – Number and percentage of implemented activities by quality – Region South*



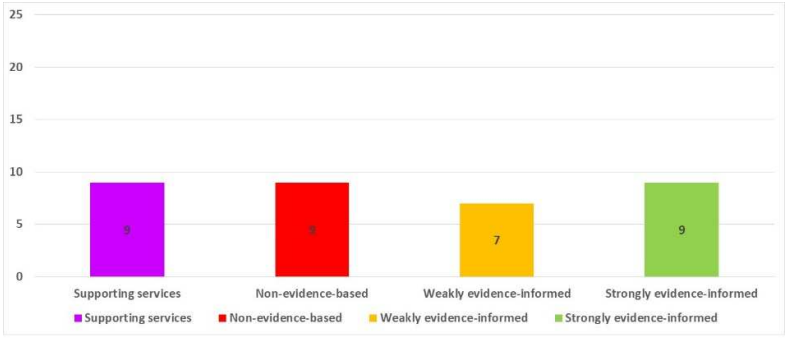



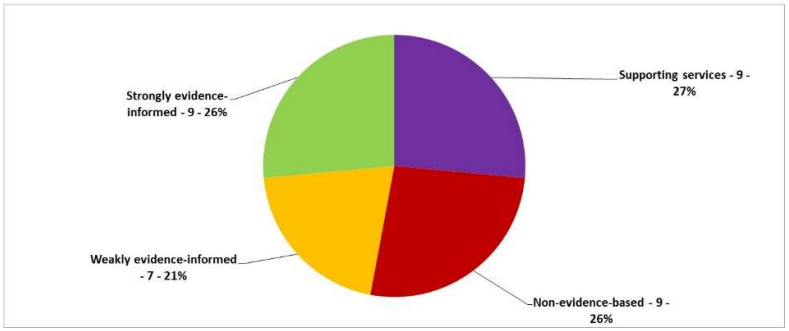
*Figures 51. and 52. – Number and percentage of implemented activities by quality – Region Southwest*




*Figures 53. and 54. – Number and percentage of implemented activities by quality – Region West*



# IV. Quality of the system

This Chapter presents the results of the second component of the Review, as per the data collection and analysis described in Chapter I., discussing whether the system includes all the necessary elements by meeting each of the criteria under each element. Figure 55. summarizes the analysis. Criteria can be met 'fully' (signified by the colour green), partially (signified by the colour yellow) or can be 'not met' (signified by the colour red). Should there be not enough information to arrive at an informed assessment, this will be noted with a 'not enough information' score (signified by the colour blue).

*Figure 55. Summary of results of analysis of the system*

| A. Comprehensive evidence-based interventions | B. Supportive policies and regulations | C. Undertaking and utilization of research |
|---|---|---|
| A.1.The system implements evidence-based interventions targeting all ages | B.1. Funding of prevention interventions is conditional on prevention being evidence- | C.1. A school-based survey of prevalence has been undertaken no more than 3 years ago |
| Met - Evidence-based interventions implemented in each age group | Not met - No system of certification, nor of funding conditionality. | Met - Numerous recent studies, including ESPAD, MyLife, Ungdata, and HBSC. |
| A.2.The system implements evidence-based interventions targeting all levels of risk | B.2. Prevention of drug use is mandatory in educational settings | C.2. The system utilizes the results of school-based surveys and other epidemiological |
| Met - Evidence-based interventions implemented targeting each level of risk | Met - Evidence of mandates relative to the core curriculum and the support to education and services by health centres. | Met - Use of data in past strategy, numerous report of use of data by local stakeholders, HKH. |
| A.3.The system implements evidence-based interventions targeting all settings | B.3. Prevention of drug use is mandatory in workplace settings | C.3. The system supports the evaluation of prevention interventions |
| Met - Evidence-based interventions implemented in each setting | Partially met - No evidence of legislation, but strong structure delivering a strongly evidence-informed model nationally | Partially met - No studies, few EB/ innovative interventions, many interesting interventions warranting evaluation. |
| | | C.4. The system utilizes the evaluation of prevention interventions |
| | | Partially met - Ungsinn, KORUSes and other support structures. However, not possible to be 'met' if C.3. is only 'partially met'. |

| D. Coordination and coherence | E. Competent delivery structure | F. Sustainability |
|---|---|---|
| D.1. There exists a mechanism of coordination of all sectors at national level | E.1.Individuals that deliver prevention interventions need to be trained. | F.1.There exists a prevention policy for the medium term (3-5 years) |
| Partially met - No information reported apart from coordination in the development of the national strategies. | Partially met - No requirement, but in general degree in prevention, health or social science; strong training structures for practitioners. | Met - The most recent policy (2016-2020) is expired, but a process of development of a new one is ongoing. |
| D.2.There exists a mechanism of coordination of all sectors at regional and/or municipal level | E.2.Individuals that decide on prevention interventions are offered training | F.2.The policy is adequately funded |
| Met - SLT/SaLTO, regional coordination of competence centres mandated by the Directorate of Health as part of its funding. | Not enough information | Met - The policy is funded. Percentage of funding for prevention from non-governmental sources is negligible. |
| D.3.There exists a mechanism to ensure policy coherence at all levels | | |
| Met - KORUSes, both through documentation and consistency apparent from the analysis of the interventions. | | |

## A. Comprehensive and evidence-based interventions

### *A.1. The system implements evidence-based interventions targeting all ages*

The results of the first component of the Review described in Chapter III. (see Figure 36.) clearly indicated how interventions were reported to be implemented targeting all ages. Such pattern was observed in all regions. While a preponderance was observed with regard to the number of interventions reported in adolescence, implementation of evidence-based interventions (comprising strongly evidence-informed, evidence-based, not locally evaluated and innovative) was reported in each age group. **MET**

### *A.2. The system implements evidence-based interventions targeting all levels of risk*

The results of the first component of the Review described in Chapter III. (see Figure 37.) clearly indicated how interventions were reported to be implemented targeting all levels of risk, with most interventions at universal, followed by selected and indicated levels. Such pattern was observed in all regions. While a preponderance of non-evidence based interventions was observed among interventions at universal level, as well as a preponderance of supporting services among interventions at selected level, implementation of evidence-based interventions (comprising strongly evidence-informed, evidence-based, not locally evaluated and innovative) was reported in each level of risk. Interesting, the indicated level of risk reported a higher proportion of strongly evidence-informed interventions. **MET**

### *A.3. The system implements evidence-based interventions targeting all settings*

The results of the first component of the Review described in Chapter III. clearly (see Figure 38.) indicated how interventions were reported to be implemented in all settings, with most interventions in community and schools, followed by families and health, with a minority in the workplace and multi-settings. Such pattern was observed in all regions. It should also be underlined that few interventions do not necessarily translate in smaller coverage, as some interventions are national policies that have very high coverage of the target population. The case is particularly clear with regard to workplace, where a single model is implemented nationally. While a preponderance of non-evidence based interventions was observed among interventions in schools, as well as a preponderance of supporting services among interventions in the community and health settings, implementation of evidence-based interventions (comprising strongly evidence-informed, evidence-based, not locally evaluated and innovative) was reported in each setting. **MET**

## B. Supportive policies and regulations

### *B.1. Funding of prevention interventions is conditional on prevention being evidence-based*

There was no evidence of national systems to certify quality of interventions, or organizations, or practitioners in the data collected, nor of system to provide funding conditionally to certification. Together with a limited extent of evaluation, this is possibly at the root of the situation observed in Chapter III., whereby a significant proportion of interventions are still non-evidence based or weakly evidence-informed. It should be noted that decentralization is enshrined in the Constitution, therefore such a national system of conditionality would have no legal basis. **NOT MET**

### *B.2. Prevention of drug use is mandatory in educational settings*

Information was received with regards to the mandate for municipalities to act on tobacco, alcohol and drug use, as well as providing information about prevention of diseases (and, therefore, of substance use disorders). In addition, from the analysis in Chapter III., there emerged clear evidence of the mandatory nature of a number of drug prevention interventions in educational settings, including: the Core curriculum for primary and secondary education of the Ministry of Health; the National guidelines for health promotion and preventive work in the child of the Directorate of Health, mandating health services to support schools in the provision of drug prevention, SBIRT and mental health services for children; and the guidelines "Rusforebyggende" (Drug Prevention) for schools in Oslo. **MET**

### *B.3. Prevention of drug use is mandatory in workplace settings*

The information provided does not refer to a legal mandate or actual legislation. However, from the analysis in Chapter III., there emerged clear evidence of a highly developed system of provision of drug prevention in the workplace nationally as promoted by the Akan Advisory Centre. The Akan Advisory Centre is a non-profit organization, owned and funded by the Norwegian Confederation of Trade Unions (LO), the Confederation of Norwegian Enterprises (NHO) and the Norwegian state, represented by The Ministry of Health and Care Services. The Advisory Centre offers courses, advice, information and digital tools based on the three step Akan-Model where an alcohol & drug policy in the workplace is the most important element. Akan's objective is to enable employers and employees to systematically prevent and handle problematic use of alcohol, drugs, prescription drugs, gambling, gaming and steroids. A number of respondents in the first component of the Review reported on Akan interventions and the model was reviewed and assessed to be strongly evidence-informed. Respondents also reported on a solid structure of delivery including capacity building, mentoring, hotlines and online tools. **PARTIALLY MET**

## C. Undertaking and utilization of research

### *C.1. A school-based survey of prevalence has been undertaken no more than 3 years ago*

Epidemiological and qualitative research was reported to be funded in the last 3 years and information was provided about numerous studies resulting from ongoing and recent data collection on tobacco, alcohol and other drugs, including on patterns and harms, both quantitative and qualitative. In particular, Norway has participated in ESPAD data collection in all the 7 waves since 1995 and has initiated a school-based longitudinal study (MyLife). In addition, municipalities are a very crucial point of reference and analysis: 'Ungdata', a national data collection scheme, conducts youth surveys at the municipal level allowing the inclusion of data on substance and drug use in the municipal Public Health Profiles. Moreover, Norway participates in the Health Behaviour in School-aged Children (HBSC) study, led by the WHO Regional Office for Europe. **MET**

### *C.2. The system utilizes the results of school-based surveys and other epidemiological studies*

Information provided indicated that the national drug prevention strategy 2016-2020 ("Prop. 15 S Opptrappingsplanen for rusfeltet (2016–2020") included epidemiological data. This strategy, which has expired, will be superseded by a White Paper that is under current development, including an analysis of available epidemiological data. In addition, the analysis in Chapter III., provided numerous reports of respondents using the information of from 'Ungdata' or from one of the 'Public Health Profiles' as a basis for planning and/or choosing interventions or during the delivery of their interventions (e.g. in education activities). Moreover, a dedicated model of local planning on the basis of rapid assessments (HKH – Hurtig Kartlegging og Handling), was developed by Korus Bergen, that adapted the WHO Rapid Assessment and Response tool and piloted and evaluated it to work in a Norwegian context. Since 2003 to date, more than 50 individual community assessments in 30 local communities have been conducted using the HKH method in Norway, mostly focusing on adolescents and young adults at risk. **MET**

### *C.3. The system supports the evaluation of prevention interventions*

Information provided indicated that evaluation research has been funded and undertaken. However, the list of studies provided are different kinds of the epidemiological studies, rather than the evaluation research studying the efficacy or effectiveness of interventions. Moreover, the analysis in Chapter III. reported no implemented intervention that was evidence-based intervention (i.e. an intervention the efficacy/ effectiveness of which had been documented by a study with strong methodology in Norway) and only one innovative (i.e. including a planned/ ongoing study of its efficacy/ effectiveness). Some interventions reported evaluations that were either process evaluations or efficacy/ effectiveness studies that had studied intermediate variables, rather than impact on initiation of drug use or transition to drug use disorders, as per the *Standards* in relation to interventions targeting people over 10 years of age. Conversely, a significant number of interventions (49% nationally) were reported to be non-evidence-based.

Finally, a number of models were identified that had been systematically developed and reported to have been implemented repeatedly and that would warrant an evaluation of efficacy/ effectiveness to elevate their status to evidence-based (AKAN, the HAP app, the programme targeting senior citizens, FLYT, Utsett!, Tuning into Teens, BTI, BAPP, FACT Ung, etc).
**PARTIALLY MET**

### *C.4. The system utilizes the evaluation of prevention interventions*

No information was received from the national level. However, analysis in Chapter III. reported on the existence of "Ungsinn", a journal containing systematic reviews of mental health interventions and treatments, including drug use prevention, run by the Regional Centre for Child and Youth Mental Health, North (RKBU North) at UiT, the Arctic University of Norway. As part of the review, each intervention is classified at a level of evidence, following specified criteria to ensure that the interventions are evaluated on the same basis. In addition to this mechanism ensuring that evaluations are systematized for practical use, the analysis in Chapter III., highlighted to strong support mechanisms in the country promoting evidence-based practice, starting from the KORUSes. However, given the lack of evaluation reported in C.3. these mechanisms, which are already , cannot on their own ensure the full utilization of evaluation in the system. **PARTIALLY MET**

## D. Coordination and coherence

### *D.1. There exists a mechanism of coordination of all sectors at national level*

While many ministries were reported to be involved in drug prevention and requested to provide information (Ministry of Health, Ministry of Education, Ministry of Culture and Equality, Ministry of Justice and Public Security, Ministry of Labour and Social Inclusion, Ministry of Local Government and Regional Development, Ministry of Children and Families), only the Ministry of Health and the Ministry of Children and Families did. The development of a Strategy appears to be an opportunity for involvement of many Ministries, as it is clear from "Prop. 15 S Opptrappingsplanen for rusfeltet (2016–2020)" that includes interventions supported by many different Ministries. The Ministry of Health has the leading role to provide data and guidance including the Directorate of Health, the Norwegian Institute of Public Health and a system of seven competence centres (the KORUSes). **PARTIALLY MET**

### *D.2. There exists a mechanism of coordination of all sectors at regional and/or municipal level*

While the questionnaires did not provide conclusive information, the analysis presented in Chapter III. provided strong indication of coordination mechanisms at the local level, specifically the inter-agency model of provision of services for drug and crime prevention among youth: SLT - Samordning av Lokale kriminalitetsforebyggende tiltak (known as SaLTo in Oslo). Seven respondents to the questionnaire on implementation of interventions were in fact local SLT coordinators and a large number of interventions (56) were implemented by

respondents (30) in the context of SLT. As so many respondents identified with this model of interagency coordination, a new 'category' of institutional sector was created in the categorization of responses in Chapter III. An evaluation of the model reported that SLT is firmly rooted in the municipality's plans. In addition, the Directorate of Health requests, as part of its funding agreement, various competence centres to cooperate at regional level with the annual review of a plan of cooperation listing specific activities that will be supported by the centres. As an example, the regional cooperation plan in the East Region coordinates the activities of: RBUP East and South – Regional Centre for Child and Adolescent Mental Health, RVTS East – Regional Resource Centre for Violence, Traumatic Stress, and Suicide Prevention, KORUS East, KORUS Oslo, NAPHA – Norwegian Resource Centre for Community Mental Health, County Governor of Oslo and Viken, and, County Governor of Innlandet. **MET**

### *D.3. There exists a mechanism to ensure policy coherence at all levels*

The information provided to the system from the perspective of the health sector, led by the Ministry of Health and Care Services with its political role and responsibility. The Directorate of Health has the mandate to improve the health of the citizens and the community as a whole through targeted activities across services, sectors and administrative levels, and shall do so by virtue of its role as an executive agency, as a regulatory authority and as an implementing authority in areas of health policy. At next level are seven regional competence centers (the KORUSes) with a primary role to strengthen the field of practice by ensuring the safeguarding, development, and dissemination of drug-related expertise and through this to contribute to government initiatives in the area of drugs. Furthermore, the Norwegian Institute of Public Health (NIPH), responding directly to the Ministry of Health and Care Services, has the mission to produce, summarise and disseminate knowledge to support good public health efforts and healthcare services and thereby contribute to better health, both in Norway and worldwide. The strength of the KORUSes in supporting policy coherence in the country is testified by the analysis in Chapter III, indicating consistency across regions in the number and quality of interventions implemented in different regions, as well as the extent to which evidence-informed models were repeatedly reported to have been implemented. **MET**

### *E.1. Individuals that deliver prevention interventions need to be trained*

The information provided indicated that no such requirement exists, although a minimum level of education is generally required (Bachelor's degree or higher), as well as degrees on prevention science, social sciences including social work, and medicine/ nursing and community health. No information was provided as to the number of practitioners and the training offered. However, the analysis of the interventions highlighted the existence of numerous structures to support the capacity building of practitioners with regard to specific interventions or models, for example: AKAN (see under B.3.) and Kjentmann (see Chapter III). Another example of support is Tidlig Inn, a cooperation between the Directorate of Health and the Directorate for Children, Youth and Family Affairs providing capacity building for municipal (mainly health sector) employees working with pregnant women and their partners, or new parents. It is a six-day training programme, aimed at providing the employees with the courage and competence to ask about

substance use, mental health and violence, and to act appropriately (how to respond, who to involve, etc) on the answers. **PARTIALLY MET**

### *E.2. Individuals that decide on prevention interventions are offered training*

No information was provided on this issue, nor was noted during the analysis of the interventions. **NOT ENOUGH INFORMATION**

### *F.1. There exists a prevention policy for the medium term (3-5 years)*

While the most recent policy, "Prop. 15 S Opptrappingsplanen for rusfeltet (2016–2020), has expired, a process is ongoing to develop a new one, including with a view to utilizing the result of this report. The policy covered controlled and non-controlled substances (e.g. new psychoactive substances, alcohol, doping), but not tobacco. **MET**

### *F.2. The policy is adequately funded*

The information provided indicated that the policy is funded, with the percentage of funding for prevention from non-governmental entities reported to be negligible. This was not only confirmed by the number of prevention interventions reported in the first component of the Review, but also by the fact that only a minority of respondents were non-governmental organizations. **MET**

# Conclusions

This chapter summarizes some of the main points that can be gleaned from the results of the Review presented in the previous chapters with regard to areas of strength in the system, as well as areas that are opportunities for improvement.

- The system is very comprehensive, implementing interventions, including evidence-based interventions targeting all ages, all levels of risk and all settings. Most interventions appear to be targeting adolescence. While this is understandable as this is often the age of initiation, given the developmental nature of the initiation of drug use and progression to drug use disorders, there might be a case to be made for increased attention to early and middle childhood.

- The system is characterized by a significant basis of evidence-based practice, building on a large offer of supporting services, with a significant proportion of interventions that already include at least some characteristics in line with the Standards and could provide an easy basis for enhancement to further align them with the science of the *Standards*.

- However, a fourth of interventions were reported to be non-evidence based and this is an obvious opportunity for improvement. A preponderance of these interventions appeared to be delivered at universal level in adolescence, especially in schools, but also in families and health settings, with interventions of a limited number of sessions privileging the provision of information over the interactive practicing of skills and/or free flowing dialogues over structured

session. Such responses will require an in-depth analysis nationally to be either replaced by more effective interventions or improved to enhance potential of effectiveness.

- A certain number of interventions, including among non-evidence-based interventions, but also among evidence-informed intervention appeared to have been carefully developed, with good theoretical basis and support structure. It would be very important for these interventions to be scientifically evaluated to establish their effectiveness and subsequently promote their dissemination. Some of these interventions do not have an evidence-based equivalent anywhere in the world, for example because they target underserved populations (e.g. children of families with substance use issues or senior citizens) or they are working in a new field (HAP app). A successful evaluation of effectiveness would therefore be of global significance.

- The system is characterized by a high level of consistency across regions. This is remarkable because it happens in spite of the system not meeting some of the criteria about certification/ accreditation of programmes, organizations or practitioners and not practicing conditionality of funding. The consistency is therefore a testimony to the strength of the coordination and delivery structure.

- While coordination at national level appears to be an opportunity for improvement, the coordination at municipal level, supported by the competence of the KORUSes at regional level and the mandated coordination with other regional actors, is flourishing. The number of respondents involved in the SLT/SaLTo interagency mechanism, as well as the number of interventions that they reported are both testimonies to the capacity of the mechanism to be concretely active.

- The system supports (and in many cases responds to and is based on) an impressive amount of epidemiological research, both at national and at local level and the information was clearly reported to be utilized at the local level. Existence of such epidemiological data and long-term monitoring of changing trends will become crucial especially in the context of an evolving prevention system.

- The situation with regard to evaluation of efficacy/ effectiveness of interventions and policies appear to be weaker and is a very important opportunity for improvement. It should be recalled that the *Standards* are based on a methodology requiring interventions to have been found to be effective in preventing drug use in terms of the actual behaviour, with intermediate variable acceptable only in case of interventions targeting children under the age of 10. The first component of the Review did find information about a number of evaluations, but they were mostly process evaluation or studying intermediate variables.

- Nationally provided interventions include the lowest proportion (17%) of non-evidence-based interventions, while it is interventions implemented locally that were disproportionately reported to be non-evidence-based in comparison. In this context, a very important opportunity for improvement will need to be a moment of reflection to collectively identify what might be the most appropriate mechanism to ensure an increase in the adoption of evidence-based

interventions locally. This is particularly the case for the age, setting and level of risk targeted by the majority of interventions and a disproportionate number of non-evidence-based interventions, as described above universal interventions in schools, families and health settings targeting adolescents. Possibilities might lie in requiring or at least forcefully promoting basic training for all practitioners and/or the utilization of interventions that have been found to be effective from some kind of registry. Certainly, training was an area where Review returned a paucity of information, in spite of evidence of many structures of support around specific interventions. The offer of core training to all practitioners might be an untapped opportunity for improvement.

Overall, it should be noted that the Review clearly indicates that the areas of strength of the system are many and surpass those that require attention and improvement. As the RePS has been developed as a tool to support virtuous cycles of improvement, it is natural that the points presented above appear to highlight opportunities for improvement. However, this should be read in the context of an overall picture that is very positive and in the spirit of providing ideas that it is hoped will be useful to enhance the effectiveness of the system in promoting the health and wellbeing of the children, youth, families and communities of Norway.

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