University of Colorado
Anschutz Medical Campus
Department of Pediatrics
Prevention Research Center for Family and Child Health
Mail Stop 8410
13121 East 17th Avenue
Aurora, Colorado 80045

International Nurse-Family Partnership® (NFP)

PHASE THREE ANNUAL REPORT

Phase Three - Randomized Controlled Trial (RCT).
This phase is established to estimate program effects on outcomes of clear public health importance that align with the outcome domains in the original US trials and that address additional goals of that country. This work is designed to determine the added value of the program for the populations and contexts in which it is being delivered. The expected research methodology is a Randomized Clinical Trial (RCT) as this provides the strongest evidence of program impact. In some circumstances, it may not be feasible or appropriate to undertake an RCT (e.g. where the population size is too small to estimate benefits reliably or where there are serious cultural concerns). In these circumstances, consideration will be given to use of quasi-experimental designs. Countries are encouraged to conduct complementary qualitative studies, which can be helpful in understanding results of the RCT. During this phase, the implementing entity may seek approval to continue recruitment of clients in existing pilot and/or RCT sites until analysis and reporting of the RCT data are complete. Countries are expected to continue completing annual reports during this phase.

Purpose of annual report:
As part of the license agreement with the University of Colorado, each country is required to prepare and submit an annual report. Through the annual report, data are reported, analysed and reviewed, to guide discussion of the country's implementation successes and challenges, as well as emergent outcome variations. The annual report forms the basis of the Prevention Research Centre, University of Colorado's (UCD) annual review of NFP implementation and fidelity in licensed partner countries and for discussing quality improvement plans. By using quantitative and qualitative data, the annual report creates an opportunity for each country's leadership team to reflect on progress and develop quality Improvement plans for the following year.

Completing the report:
The country license holder is requested to coordinate the completion of this report, with contributions from the national implementing body, and others, as required.

Please note: If you are unable to complete any items in the report template, please indicate whether this data is not collected in your country or is not able to be analysed at this time. Where terms used in the report template are generic, please specify how items are measured in your country. Where you have adapted your data collection schedule/timings or approach to accommodate local systems, please adapt the document as necessary to take account of this. If you have any questions regarding the content of this document, please do not hesitate to get in touch with your NFP International Consultant.

The report should be sent to Dr David Olds and the country's International Consultant at least three weeks prior to the Annual Review meeting. Further guidance on the conduct of the annual review meeting can be found on the 'International NFP Resources' page of the international website.

PART ONE: PROGRAM OVERVIEW

Name of country: Norway

Dates report covers (reporting period): 01.01.2022 – 02.12.2022

Report completed by: National Office at RBUP (Regional Centre for Children and Youths Psychological Health) and Bufdir (The National Directorate for Children-, Youth- and Family Affairs)

Date submitted: 15.12.2022

The size of our program:

	Number
Fulltime NFP Nurses	30
Part time NFP Nurses	2
Fulltime NFP Supervisors	4
Part time NFP Supervisors	1
Full time NFP Team Coordinators	4
Part time NFP Team Coordinators	1
Total	42

- We have 5 teams (supervisor-led groups of NFP Nurses)
- Average Supervisor to NFP nurse ratio (include Mediator/FPW positions if you have them): 1:7,4 (One team has 8 Family Nurses and 1 Team Coordinator and the other four teams have 6 Family Nurses and 1 Team Coordinator each).

- Current number of implementing agencies/sites delivering NFP: 5
- Number of new sites over the reporting period: 0
- Number of new teams over the reporting period: 0
- Number of sites that have decommissioned NFP over the reporting period: 0
- Successes/challenges with delivery of NFP through our implementing agencies/sites:

Rogaland:
In 2022 the team in South-West (Rogaland) has expanded with two Family Nurses and the team has changed to a more appropriate office place in the host municipality. The process to establish the recordkeeping system has been delayed but is expected to be ready just around new year. A new municipality leader for the team came on board this autumn and RBUP is planning to have regular meetings to help her understand the program etc. Overall, the cooperation with the host municipality is working well.

The team has recruited clients from all seven municipalities included at this site (the four new and the three existing municipalities). The size of the new municipalities is smaller (from 10 000 inhabitants to 20 000). This year, an additional two municipalities have approached the programme with a request to possibly join

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NFP. It is considered that this will improve the possibility for a good recruitment pace, which is particularly important regarding the RCT. It is expected for them to join in early 2023 once necessary agreements and contracts are in place. The host municipality plays an important role in ensuring good cooperation between all the participating municipalities in its' site.

The local advisory board has been expanded with members from the new municipalities. In April we completed a one-day meeting, to ensure thorough introduction of the program and the advisory board to new board members. AFI (The Work Centre at Oslo Metropolitan University) being the contractor for the effect study has visited the site to inform about the RCT which was well received by those attending. An additional meeting with mid-wives in the site is to be scheduled. Since they have a particularly important role in referring to the study.

Oslo:
The team in Oslo was transferred to their host township in January. During February and March, the four new Family Nurses started. The team is the biggest team in the programme with 8 Family Nurses, 1 Supervisor and 1 Team Coordinator. A new municipality leader for the team was settled during spring. She has developed a good understanding of the NFP program. It has been challenging times both for the municipality leader and the team, due to major organisational changes in the municipality/township and the team will have to relocate within one and a half year to a centralized office together with many other services. It is perceived a bit complicated given that the team members must pay attention both to mentioned relocation, as well as processes within their own team to secure a good foundation for the "new" team. Overall, the cooperation with the host township is working well.

The team has recruited clients from the two exciting townships during all of 2022. The three new townships joined during autumn and the team have started recruitment from there as well. All team members participated in the work to inform all the services in the new townships, about NFP and recruitment to the programme.

The local advisory board has been expanded with members from the new townships and three advisory board meetings have been conducted since summer. This includes information about the RCT conducted by AFI in physical meetings. An additional meeting with the midwives covering the site is to take place.

Agder:
The team in Agder is one of the new teams and is located at the host municipality Kristiansand. The site includes 13 municipalities and is the largest site among the 5. While the team has its' main office place in Kristiansand, they also have two office places in Arendal, which are mainly used by two of the Family Nurses during the week, to save transport time. The municipal leader for the team and her superior has a good understanding of the programme and both have been highly engaged and supportive from the very beginning. There are some challenges to secure well-functioning office places, but the supervisor handles it well, so there is little trouble for the team members. The team has recruited clients since the beginning of 2022, and they have recruited from most of the municipalities. There are three small municipalities where there have been no referrals yet (number of inhabitants vary from 1200 to 2500).

The local advisory board has had meetings prior to the establishment of the team. All municipalities have one or more members on the local advisory board and there is a positive engagement.
The team is working well, but unfortunately one of the Family Nurses is expected to be on sick leave for a year. There is another Family Nurse who work part-time due to private circumstances. Also, other Family Nurses have challenges of private character, and it is expected that there will be more sick leave or arrangements of reduced working hours during next year. As we expect it to be busy when the study begins (first quarter of 2023) we have therefore decided to recruit two temporary positions in 80% for one year. This recruitment process will begin towards the very end of 2022.

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AFI has also visited this site to inform about the RCT overall, the study was well received by both the team and the local advisory board.

Vestland:
The team in west is one of the new teams and is hosted in Bergen being the host municipality. The site includes 9 municipalities. The implementation of the programme in Bergen has been a bit fragmented due to several changes among key people representing the leadership at the host municipality. The supervisor was engaged in November 2021. Apparently, she experienced little support from Bergen at the beginning. A new leader for the team came on board during springtime and she developed a good understanding of the NFP program. Bergen and the township who host the team are going through a major organizational change and the team will move to a centralized new office together with many other services in January 2023. This has taken its toll both on the municipal leader, the Supervisor, and the team. It is perceived to be a bit complicated given that the team members must pay attention both to mentioned relocation, as well as processes within their own team to secure a good foundation and working environment for the new team.

In addition, the team has had some challenges whereby the team members have not felt sufficiently safe and supported in their team. To address this, we have conducted some meetings between the Clinical lead and the municipal leader, as well as, together with the team and their supervisor. The psychologist that supports the teams on a regular basis has also had a more intensive follow-up of the team. The process has been challenging, but it is believed to go better.

The local advisory board has had three meetings in 2022 and there are representatives from all the included municipalities.

The team has recruited from all municipalities except from one bigger municipality (number of inhabitants: 25 213, Bjørnafjorden). The Supervisor has taken steps to get the recruitment started. Apparently there has been a shortage of midwives at the municipality, along with possible a misunderstanding that NFP might be seen as a competitive program when compared to another program offered by the municipality.

Trøndelag:
The team in Trøndelag is also new and is located at one of the townships of Trondheim being the host municipality. The township has a high level of vulnerable families. The site counts three municipalities, and they hope to have an additional municipality joining at the beginning of 2023. The team office is at the Public Health Center. The team has premises that work well. The supervisor has had some challenges with the former project leader about common understanding about roles and responsibilities. She has worked systematically to resolve these issues and it is now working much better. The supervisor liaises closely with her municipal leader to secure his strategic support.

The local advisory board has had 4 meetings this year, and at most of the meetings there have been members from all townships and municipalities. There is a positive and good engagement in the advisory board.

The team has recruited people from all municipalities, mostly from the townships in Trondheim and slightly less from the other two municipalities.

The team is working very well, and it seems that all team-members are feeling safe and supported in their team. However, it appears that they can improve their contact with the municipalities/townships included beyond Trondheim. It can be considered normal that the teams in the beginning are investing more energy

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in the host-municipality/host-township to ensure a good understanding and cooperation, but it is now time to invest more in similar cooperation with the two other municipalities.

AFI has visited both the team and the local advisory board to inform about the study, which overall was well received.

Description of our national/ implementation / leadership team capacity and functions

License holder name: The Directorate for Children, Youth and Family Affairs (Bufdir)
Role and Organisation: The National Directorate is reporting to the Ministry of Children, Youth and Family Affairs. The Directorate is in charge of the up-bringing sector and to facilitate a safe up-bringing for children, as well as leading the child protection services at national level and providing certain specialized services for local authorities targeted at vulnerable children and their families. The Directorate is the license holder and is responsible vis a vis the Ministry of Children, Youth and Family Affairs for the assignment to test NFP in Norway. The Directorate is also responsible vis a vis UCD to ensure that the license requirements and core elements of the program is complied with, as well as following the phases of the program. The program is funded by the Government.

Description of our National implementing capacity and roles:

1. Clinical Leadership:

Norway's Clinical Lead draws on her clinical background as a midwife from different municipalities when planning clinical adaptations, implementation support to sites and training of the NFP teams. During many years she contributed to the training of midwives at the Institute of Nursing at Oslo Metropolitan University. She has a master's degree in Health and Empowerment with a master's thesis focused on women's experience of home visits by midwives in early maternity. She also has a history of engagement in the Midwives' Association.

The Senior Advisor has her clinical background from child welfare and has ample experience from work with vulnerable pregnant women, children, and families. Her skills and knowledge about dyadic assessment and tools, especially about Emotional Availability Scales (EAS) and video feedback of Infant-Parent Interaction, has been particularly beneficial in the process of developing DANCE (Dyadic Assessment of Naturalistic Caregiver child Experiences) "substitute."

The other Senior Advisor has her clinical background in Public Health working as a public health nurse and as a family therapist. She has broad clinical and theoretical knowledge, in infant and toddler development, parent and child interaction and mental health. She has in-depth knowledge of the various municipal services and interdisciplinary collaboration. The Senior Advisor has been Supervisor for the NFP team in Oslo since the beginning of 2016 and joined the National Office in January 2021.

We have expanded the National Office with one person, she is a Development Coordinator. She has a bachelor's degree in psychology from the University of Tromsø, and a master's degree in Work and Organizational Psychology from the University of Oslo. She has previously worked in the health sector and has experience in organizational change and development.

The Network of Infant and Toddler Mental Health at RBUP, offers technical and clinical support to the Clinical Lead and Senior Advisor, and facilitates expert discussions and guidance throughout the country on relevant topics.

2. Data analysis, reporting and evaluation:

As from 2022 we have two research coordinators. One has a master's degree in health and social psychology and a bachelor's degree in psychology from the University of Oslo. She also has a one-year study program in

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Economics and Management from Oslo and Akershus University College. She was back from maternity leave in January.

The other research coordinator has a bachelor's degree in social work with intercultural specialization from NTNU, experience in social work from NAV, substance abuse care and prison care, and a master's degree in interdisciplinary health research from the University of Oslo.

As a Research coordinator, one works full time and is responsible for overseeing the data collection and data input process, analyzing the data, and making the data reports. This year, there has been a high focus on the development of a new digital data collection system in collaboration with the research team. The research coordinator at RBUP manages the data system and develops monthly data reports.
While one of the Research Coordinators has mainly been responsible for the data collection and the reports, the other Research Coordinator has among other tasks mainly been responsible for the website.

3. Service development/site support:

The experience from this year is that the five sites, and the host municipalities/host townships are unique in their approach to NFP at this stage. They are different in many ways, for example in size, organization, and current challenges. They have different ways of handling similar tasks. At some host municipalities the process of securing necessary agreements on data handling has been quite demanding. Nevertheless, we have learned a lot and acknowledge the importance of taking the time for these processes to secure ownership locally. Furthermore, there have been some changes in local leaders/persons with responsibilities linked to NFP. This requires specific attention per area to ensure a good basic understanding of NFP and what it requires among all stakeholders at the individual sites. Due to these very different processes at each host municipality, it has not been found appropriate to arrange gatherings for the local leaders yet. However, this will take place in 2023.

During 2022 it has mainly been the Clinical lead who have worked together with the local leaders and with the local advisory boards. In general, there are many skilled and engaged leaders at the sites and there is in general a very positive support towards NFP and phase three. The cooperation, need for support and conversations has differed a lot, from discussions about offices, parking places for the team, to administrative follow-up of the team, as well as, and general support of the team and the Supervisor. The experience from the two sites with existing teams, who have expanded and have been transferred to local engagement, are quite similar. There is still a lot of details to handle in order to get everything work well at the host township in Oslo. There have been regular meetings with the local leaders, Supervisors and Clinical lead. Some of these meetings have been without the Supervisor because of the administrative focus. These matters also differ from site to site.

In addition, the Senior Advisor with experience as Supervisor in phase 2, has supported the Supervisors in their role and has also supported the teams in familiarizing with the RCT. Next year, she will continue to support the teams to get ready to contribute to the recruitment of the RCT.

4. Quality improvement:

A short list of what we have established to ensure quality improvement:

- As we prepared for the new teams to join the NFP training, we undertook a comprehensive quality improvement and adaptation of the NFP material to the Norwegian context, this work has continued through 2022.
- Completed training for all team-members in line with the NFP education plan.
- Developed system for Video Guidance to the Family Nurses and Supervisors
- Systematic digital data collection up and running
- New website up and running, one part is open for the public and another part is internal

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- Developed a report-system for the sites to report to the National Office. First report delivered in November.
- Conducted almost weekly meetings between Clinical Lead and Political Lead in Bufdir
- Delivered regularly status reports from RBUP to Bufdir to be used towards the Ministry of Children, Youth and Families.
- Conducted weekly meetings between National Office and Supervisors at the 5 sites.
- Conducted regular physical gatherings for Supervisors
- Started to use a new secure platform for storing and analyzing sensitive data called Services for sensitive data (TSD).

5. NFP Educators:

Based on their respective areas of competence everyone at the National Office has contributed greatly to the development and education of the new teams and during the physical gatherings. Also, we have an agreement with a psychologist who is a specialist in Motivational Interviewing and who provides additional support to the teams.

6. Other (please describe)

Description of our local and national NFP funding arrangements:

The program is fully funded by the national government, with some minor contributions by the local authorities in implementing sites. However, we foresee some budgetary challenges from 2023 and forward since the funding level is slightly below the effective needs in the program. This is partly since the program was expanded to three new sites and not two as originally planned for.

Current policy/government support for NFP:

The Directorate is pleased that it was stated in the national budget in October 2021 that the program is to be funded for the period of 2021-2027. The program was also mentioned in the National budget for 2023 which is securing earmarked funding. The current Minister does not have the same ownership of the program as previous Ministers. However, the program continues to be referred to in several new strategic government papers and action plans which is considered as positive.

The program is also considered highly relevant to the child protection reform in Norway and the stronger emphasis on preventive child protection measures at the municipal level.

Organisation responsible for NFP education:

Not applicable

Description of any partner agencies and their role in support of the NFP program:

Some work has been invested in bringing the health sector at national level on board in the program implementation. Their collaboration is needed especially about the following two issues; 1) Where and how to organize the program beyond phase 3 (health sector versus child protection services or in collaboration between the sectors) and 2) Health sectors interest in the NFP- effect evaluation. Unfortunately, it is still challenging to get the Health Directorate and its Ministry of Health on board.

Other relevant/important information regarding our NFP program:

Also 2022 has been an intense year for the National office overseeing the implementation of the program on the ground. The national office has spent time developing its role for phase 3, which is quite different when overseeing the implementation of five and not two sites. It is a balancing act to on one hand develop

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relations with the new sites and meet their individual needs and concerns, and on the other hand to streamline the follow-up of the sites and secure that one develops effective communication and reporting structures across the sites. Another milestone has been the new programme website with up-dated programme material, as well as the conducted training of all new team members in various roles. The latter has impressed the Directorate.

At the level of the Directorate RCT has been a key focus for 2022. A new announcement was made at the beginning of the year and the agreement with the contractor, AFI, was signed in May. The Directorate is very pleased with the skilled research team of AFI and the way they have presented the RCT to all the sites both at the level of the Teams, and to the Local Advisory boards. The RCT is slightly delayed and is awaiting approval from the Regional Ethical Committee. Hopefully it will be approved just before Christmas and can then start by the first quarter of 2023.
There continue to be legal issues around the handling of personal data. This has demanded the Directorates attention and dialogue with the Ministry, as well as the National Office for handling personal information and the National archive office. There have also been budgetary constraints both for the current year, as well as forward which has demanded the Directorates attention.

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PART TWO: PROGRAM IMPLEMENTATION

Clients

of NFP clients participating in the program at any point over the last year: 272

- Current clients: Pregnancy phase (n/%): 75 (35 %) by November 29th, 2022
- Current clients: Infancy phase (n/%): 95 (44 %) by November 29th, 2022
- Current clients: Toddler phase (n/%): 44 (21 %) by November 29th, 2022

Nursing Workforce

- **Average nurse caseload:** 7 (for all Family Nurses)
  - Family Nurses who started working in 2022, had an average caseload of 5 clients by November 21st, 2022.
  - Family Nurses who have been working since before 2022, had an average caseload of 10 clients by November 21st, 2022.

	Nurses	SVs	Other	Total
# of staff at start of reporting year:	32	5	5	42
# of staff who left during reporting period	0	0	0	0
% annual turnover	0 %	0 %	0 %	0 %
# of replacement staff hired during reporting period	0	0	0	0
# of staff at end of reporting period:	32	5	5	42
# of vacant positions	0	0	0	0

- **Reflections on NFP nurse/supervisor turnover/retention during reporting year:**
  There has not been anyone who has left their job in NFP this year. One Supervisor has worked in 80% engagement for half a year. Two Family Nurses have got special arrangement for reduced working hours due to private reasons.

- **Successes/challenges with NFP nurse/supervisor recruitment:**
  Due to long-term sick leave and special arrangement of reduced working hours there will be engaged two Family Nurses in 80% in temporary engagement at one of the sites. There were 22 applicants in the advertisement. The Family Nurses in temporary engagement is expected to start on 1st mars 2023 and will have an engagement for one year.

- **Any plans to address workforce issues:**
  We have focused on developing teams where the team members can feel safe and supported, both in education and in the supervisor group. Experience from this year is that it is important to work closely with the local leaders and to cooperate to provide a good working environment for the teams. The local leaders are very busy having NFP as only one of their responsibilities, but we try to arrange for regular meetings.

NFP education

- **Briefly describe your NFP education curricula**

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For all nurses and supervisors:
NFP training modules:

- 5 days Infancy training in September 2022 for the new teams and Family Nurses. The training included the transition from pregnancy to parenthood, video guidance, ASQ and PIPE. It also included training in TSD (our digital platform to ensure privacy, storage of videos). The training was provided by the National Office.
- Newborn Behavioral Observation training (NBO). The training over 5 days was carried out during the period from March to September 2022 and was provided by certified trainers at RBUP.
- Video guidance (VIS). In addition to the days of introduction about how to use video in NFP during the infancy training, Senior Advisor from National Office visits each team for supervision every five/six week. In addition to these visits the nurses can also get individual supervision through Teams, mainly on Tuesdays and Thursdays, or by appointment.
- Motivational Interviewing (MI). 2 days MI training in October. This training is provided by our external expert and consultant in MI.
- Intimate Partner Violence (IPV). 2 days IPV training in June. Provided by the National Office. Each team will work further with deepening the IPV learning. The supervisors are responsible for pursuing this. They report that they have had 2 full days this autumn.

Experience gatherings:

- In March, we carried out 2 days of training in digital data collection
- In June we launched our open website
- In October we carried out one day where all the nurses had an introduction and training to use our internal website “Kompasset” that contains all the material in the program. For more information, please refer to part 4.
- In November we carried out 2 days focusing on client engagement and team resilience. This was carried out in collaboration with Ann Rowe.

For supervisors:

- We have conducted 8 one-day meetings for the supervisor over the year. The content of these days is deepening of selected theoretical and practical parts of the program.
- In addition, we have a two-hour digital meeting every week with the supervisors.

Team Coordinators:
The Team Coordinators have received specific training throughout the year in our trainings

- In March we carried out three days of training, two days with an overall focus on NFP, to give them a better understanding of the program, and one day training in digital data collection
- In June we carried out one day training focusing on communication and relations
- After the launch of “Kompasset” in October, we carried out one extra day with more in-depth information, and conducted user tests, is order for them to be able to support and teach the Family Nurses.
- In November we carried out one day with a primary focus on their role and work tasks.

- **Changes to NFP education since the last report**

No changes

- **Successes/challenges with delivery of core NFP nurse/supervisor education:**

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In the infancy training we invited the experienced nurses and supervisors to come and work with the new nurses and supervisors. Their contribution to groupwork and discussions was very useful. Bringing the experienced nurses together with the new nurses at all the gatherings we have had has been very successful, since the new nurses report that this is particularity useful when learning the program.

The NBO training includes 4 days with physical meetings and 1 day which is digital. In parallel, the nurses and supervisors must carry out 10 observations which must be logged, submitted, and approved. The nurses and supervisors have reported that this has been a lot to consume at once, given that they were in the process of learning and understanding the content of the NFP program.

The supervisors are responsible for arranging extended team conferences to deepen selected theoretical topics. The plan for which topics and when this is to be carried out is made together with the National Office. Both the nurses and supervisors report this to be very useful. Some nurses report that they experience that the joint training and our gatherings can be overwhelming in terms of content and scope. Therefore, it is important that they have sufficient time with their respective teams to collect and reflect on what they have learned.

Motivational interview (MI):
The program collaborates with the same psychologist specialist, Tom Barth, as we have done since the start of 2016. He has given notice that he plans to retire. We are in the initial phase of planning how to take care of the training and maintenance of MI for NFP Norway in the future. We think that we want to identify one or two people (in Norway or Scandinavia) that the national office can connect with. Furthermore, we have thoughts about whether it would be advisable to identify a Family Nurse/Supervisor in each team who will be further educated in MI. We believe that it is important that each team is increasingly strengthened to take care of the maintenance of MI locally. The overall basic MI education and training will be provided by the National Office in collaboration with selected specialists.

- **Successes/challenges with ongoing (integration) NFP nurse/supervisor education:**
  The 5 supervisors report that the monthly gatherings are very important to them. The National Office prepares and plans the theme for the day in advance of each meeting. The focus is to bring them together in a common understanding of how the program is to be delivered. And to help them understand the complex role of being a supervisor. They all have different personal work backgrounds and experiences, and the 5 sites also have different municipal practices.

  It has been especially important to spend time on reflective supervision and how to execute this. In addition to deepen a more concrete understanding and use of all program material.

- **Successes/challenges with delivery of NFP induction/ introduction, education and CPD for associated team members (Family Partnership Worker/Mediator)**
  There is only one Team Coordinator in each team, thus they are alone in their role. The training and gatherings have therefore been important for the Team Coordinators to gain a shared and good understanding of the program and their role.

  During phase 2, their role and work mainly consisted of plotting data from paper forms. Due to the digitalization of the data collection, their work tasks and role has changed, and is still in development. Due to municipal differences, different work background and experiences, their

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role varies from team to team, which can be challenging. Nevertheless, we experience that they find good support in each other and from the National Office.

Reflective Supervision

- Successes/challenges with NFP nurse reflective supervision:
  The supervisors report that reflective supervision is going well. They find the material and documents useful. The 3 new supervisors are still in a learning phase, and they report that they together with the nurses are exploring how to understand and use the supervision documents. They report that this is a very positive thing to do together, and that they all learn a lot from it.

  We focus on the use of motivational interviewing. MI is included in the weekly supervision with supervisors, to help them focus on MI in their own supervision with nurses in the teams.

- Successes/challenges with reflective supervision to our supervisors:
  The National Office continues to be in close contact with supervisors in meetings once a week. There is a lot for the new supervisors to learn and integrate, in addition to getting to know the new municipalities, relevant leaders, host municipality and the sites. The National Office needs to strike the balance between providing them with a good understanding of the program and at the same time to help them overcome local challenges or obstacles. This is more challenging in some of the implementing sites than for others. We have experienced that when the National Office offers a low thresh hold to contact us for any questions it makes the everyday work easier for the supervisors.

- Successes/challenges with delivery of reflective supervision to our associated team members (Family Partnership Worker/Mediator)
  The National Office offers follow-up and support, with meetings every second week with two from the National Office. The Team Coordinators report that they are satisfied with the follow-up and that they appreciate having a place where they can share experiences and ask questions.

NFP Information System

- High level description of our NFP information system, including how data are entered:
  We have a digital data collection system called “NFP-portalen”. The Family Nurses use their personal iPad or their computer to fill out the data forms. The supervisor and the Team Coordinator fill out the data forms about supervision and team meetings.
  In the data portal, the nurses can choose a client, and see which data forms are completed and which data forms need to be completed.

  Our data is stored in the digital data collection system. When we analyze the data, we extract the data we want to look at in more detail to a platform called Services for sensitive data (TSD). We have started using this secure platform for storing and analyzing sensitive data this year. TSD is developed and operated by the University of Oslo. We also store our videos used for video guidance in TSD.

- Commentary on data completeness and/ or accuracy:
  The data seems to be more accurate now than before we digitized the data collection. We have developed a logic in the questionnaires, to avoid errors. The proportion of time spent on

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the various program areas cannot, for example, exceed 100%. It is not possible to give a "wrong" answer to a lot of the questions.

We have many new Family Nurses this year and it is important to pay close attention to the data collection. Misunderstandings may arise regarding how the forms should be filled in and differences may occur between the teams. The research coordinator will have extra focus on this at the beginning of 2023.

- Reports that are generated, how often, and for whom:
  In the data portal, the Family Nurses have access to automatic reports for each of their clients. The reports are based on GAD-7, PHQ-9, Home Visit Encounter Form and Client Intake Form (Control and Mastery and Feelings).

  The supervisor and the Team Coordinator have access to an automatic report based on Home Visit Encounter Form and Alternative Home Visit Encounter Form for the entire team.

  The supervisor and the Team Coordinator also have access to automatic reports based on the different supervision- and team meetings data forms. They can see how many weekly supervisions each Family Nurse has gotten and what they have talked about.

  The Team Coordinator also makes several reports when necessary, including to Bufdir.

- Our reflections on our information system - what we need to do to improve its functionality, usefulness and quality:
  The data portal works well, but there are several things that could be improved. We want to further develop the automatic reports and make them more user-friendly. The teams also need follow-up on how they can use the information in the data reports in clinical practice.

  In connection with the work with the data for the annual report, we have discovered some challenges related to the extraction of the data. There was some data that was not included in the extract and other data that was missing a date etc. We are working to find good solutions and routines for this.

Continuous Quality Improvement (CQI) Program

- Brief description of CQI processes:
  - Regular meetings between Bufdir and the National Office and follow-up of joint results framework and key activities for the year, as well as risk analysis and management.
  - The National Office delivers mainly oral updates, but also some written reports to Bufdir and has discussions based on them. The content of the written reports is mainly used to update the Ministry on the progress and challenges in the program implementation.
  - National Office has developed a report template for the half-yearly report from the 5 sites. The content of the report is used for the annual report to UCD and as background for collaboration around needed adjustments. Furthermore, the plan is to prepare a report per area, that can be used in the annual meeting with local managers to ensure good grounding in municipal management.
  - Delivers tables and diagrams from the data collection to the Supervisor for presentation at local advisory board meetings. It gives board members the opportunity to discuss successes and challenges based on collected program data.
  - Sends out evaluations after training sessions

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- How we use qualitative and quantitative information as part of our CQI program:
    - Data collection is used to present data in table and diagram form, for Supervisors to use in individual and team supervision, for local advisory boards and on demand from the directorate etc.
    - Half-year status reports from the sites which are used for reflection and follow-up.

- Successes/challenges with our CQI approach:
    - The experience is that the teams find it motivating when they see data described in table and diagram form
    - The Local Advisory Boards appreciate to see data in numbers, tables and diagrams
    - There is still a way to go regarding regular use of data directly in individual supervision
    - We are still in the process of establishing good reporting routines from and to the sites

For more details on CQI please refer to part four.

Any other relevant information:

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PART TWO: PROGRAM IMPLEMENTATION - NFP CORE MODEL ELEMENTS (CMEs)

Please complete the table below to identify how the CMEs are being monitored/assured, progress against benchmarks, and actions planned or undertaken to address any challenges. Where there is a need to add more content than space allows, please add appendices as necessary. Please explain any missing data or analyses.

NB: Where any temporary variances to the CMEs have been agreed, please indicate these in the text box below as well as completing Appendix 2 of this document

Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
1. Client participates voluntarily in the Nurse-Family Partnership (NFP) program.	100% voluntary participation Monitored /assured by: (e.g. by signed informed consent) Family Nurses	100 % voluntary participation	
2. Client is a first-time mother	100% first time mothers enrolled Monitored/assured by: Family Nurses	100 % first time mothers	In one team a client was included who had experienced SIDS with her first child. In another team, a client had experienced a still birth with her first child.
3. Client meets socioeconomic disadvantage criteria at intake	The eligibility criteria for inclusion in the program in our country are: 1. Perceived neglect, physical/mental, violence/abuse or bullying 2. Contact with child welfare in own upbringing 3. Little social support from family	100 % clients enrolled who meet the country's eligibility criteria	

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Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
	and network 4. Persistent or serious conflicts in relationship with partner or others 5. Difficulties in utilizing relevant services being offered 6. Not working or in education, and a low level of education 7. Persistent low income/difficult economy 8. Mental challenges 9. Drug problems 10. Young age There must be two or more criteria present for inclusion This includes the socio-economic criteria of: Application of these criteria are assured and monitored by: Supervisors and Family Nurses in collaboration with the National Office		
4. Client is enrolled in the program early in her pregnancy and receives her first home visit no later than the 28th week of pregnancy.	a) 100% of NFP clients receive their first home visit no later than the 28th week of pregnancy. b) 75% of eligible referrals who are intended to be recruited to NFP are enrolled in the program.	100 % of NFP clients receive their first home visit no later than the 28th week of pregnancy 81 % of eligible referrals who are intended to be recruited to NFP are enrolled in the program	

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Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
	c) 60% of pregnant women are enrolled by 16 weeks' gestation or earlier	13 % of pregnant women are enrolled by 16 weeks' gestation or earlier	Due to the transition to digital data collection, the data on inclusion week is somewhat uncertain. Sometimes it takes some days/weeks before a new participant is registered in the data collection solution. We are working to establish better routines for this and doing some changes in the data form.
5. Each client is assigned an identified NFP nurse who establishes a therapeutic relationship through individual NFP home visits.	100% of clients are assigned a single NFP nurse.	100 % clients are assigned a single NFP nurse	Some clients have changed Family Nurse this year. • Due to a long sick leave, four clients in one team have transferred to another Family Nurse. • One client moved from one NFP-area (Vestland) to another (Rogaland) and got a new Family Nurse in the new area. • One client transferred to another Family Nurse because the Family Nurse reported concerns to Child Welfare Services.
6. Client is visited face-to-face in the home, or occasionally in another	National benchmark set is: ____% visits take place in the home	81 % visits take place in the home % breakdown of where visits are being	After several years of covid-19 and fewer physical home-visits, we are now back to normal levels again.

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Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
setting (mutually determined by the NFP nurse and client), when this is not possible.	We have not developed benchmarks on this.	conducted other than in the client's home: Family/Friend's Home: 2 % Public Health Office: 0 % NFP-Office: 6 % Doctor/Clinic: 1 % Telehealth (phone): 2 % Telehealth (video): 1 % Café: 2 % Other: 5 %	
7. Client is visited throughout her pregnancy and the first two years of her child's life in accordance with the current standard NFP visit schedule or an alternative visit schedule agreed upon between the client and nurse.	a) Length of visits by phase country benchmarks are: • Pregnancy phase: • Infancy phase: • Toddler phase:	• _____% of clients being visited on standard visit schedule • Average number of visits by program phase for clients on standard visit schedule is _____ • _____% of clients being visited on alternate visit schedule • Average number of visits by program phase for clients on alternate visit schedule is_____ Average number of completed visits for clients who have completed each phase: • Pregnancy: 8. Range: 1 – 26. • Infancy: 20. Range: 8 – 37. • Toddlerhood: 14. Range: 2 – 35. • Length of visits by phase (average and range):	We do not collect data on how many clients are visited on standard or alternative visit schedule. Due to the transition to digital data collection, the data on average number of completed visits are not completely updated. Hence, we will take a closer look at the data before the annual meeting.

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Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
	b) Client attrition by program phase country benchmarks are: _____% attrition in Pregnancy phase _____% attrition in Infancy phase _____% attrition in Toddler phase	• Pregnancy phase: Average: 85 minutes. Range: 15 – 199 minutes. • Infancy phase: Average: 84 minutes. Range: 15 – 420 minutes. • Toddler phase: Average: 79 minutes. Range: 20 – 180 minutes. Client attrition by phase and reasons: 3 % attrition in Pregnancy phase (of the 272 clients active this year) 9 clients left the program in pregnancy phase in 2022. • 1 client was dissatisfied with the program • 3 clients perceived that they had sufficient knowledge or support • 1 client was lost to follow-up • 1 client moved to an area where NFP is not available • 1 client had a miscarriage • 2 clients left the program for other reasons 7 % attrition in Infancy phase (of the 272 clients active this year) 18 clients left the program in infancy phase in 2022: • 1 client was dissatisfied with the program	

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Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
		• 1 client left because she didn't have time for visits • 5 clients perceived that they had sufficient knowledge or support • 2 clients refused NFP following report to Child Welfare Services • 4 clients left the program because the babies are no longer in mothers' custody • 1 client was lost to follow-up • 2 clients moved to an area where NFP is not available • 1 client perceived that she had received what she needed from the program • 1 client left the program for other reasons 1 % attrition in Toddler phase (of the 272 clients active this year) 2 clients left the program in toddler phase in 2022: • 1 client was lost to follow-up • 1 client left the program for other reasons	
8. NFP nurses and supervisors are registered nurses or registered nurse-midwives with a	100% of NFP nurses are registered nurses or registered midwives with a minimum of a baccalaureate /bachelor's degree. Monitored/assured by (eg standardized	100 % NFP nurses are registered nurses or registered midwives with a minimum of a baccalaureate /bachelor's degree	

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Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
minimum of a baccalaureate /bachelor's degree.	job description); Countries may also want to analyze other nurse variables such as age, years within profession, specialist qualifications etc.		
9. NFP nurses and nurse supervisors develop the core NFP competencies by completing the required NFP educational curricula and participating in on-going learning activities	100% of NFP nurses and supervisors complete the required NFP educational curricula _____% of NFP team meetings, case conferences and team education sessions are completed (against expected for time period)	______% of NFP nurses and supervisors complete the required NFP educational curricula and participate in on-going learning activities 95 % completion of team meetings, 91 % completion of case conference and 97 % completion of education sessions	100% completed Foundation training 100% New and experienced Family Nurses and Supervisors completed IPV training (face to face) 96% completed Infancy training (one Family Nurse on long-term sick leave) 83% completed training days (team resilience and client engagement) It is a challenge with team members who have booked private travels up front. We have planned all training for 2023. We aim to make individual follow up for those on sick leave.
10. NFP nurses, using professional knowledge, judgment and skill, utilize the Visit-to-Visit Guidelines; individualizing them to the strengths & risks of each family, and	Please complete the section at the end of this table*.	Please complete the section at the end of this table*.	Please complete the section at the end of this table*.

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Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
apportioning time appropriately across the five program domains.			
11. NFP nurses and supervisors apply the theoretical framework that underpins the program (self-efficacy, human ecology, and attachment theories) to guide their clinical work and achievement of the three NFP goals.	100% of 4-monthly Accompanied Home Visits completed (against expected).	______% of 4-monthly Accompanied Home Visits completed	
12. Each NFP team has an assigned NFP Supervisor who leads and manages the team and provides nurses with regular clinical and reflective supervision	100% of NFP teams have an assigned NFP Supervisor 100% of reflective supervision sessions conducted against expected (calculated by time – working weeks- and number of nurses).	100 % of NFP teams have an assigned NFP Supervisor 61 % of reflective supervision sessions conducted	
13. NFP teams, implementing agencies, and national units collect/and utilize data to: guide program implementation, inform continuous quality improvement,	No benchmark. Monitored/assured by:	Progress:	

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Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
demonstrate program fidelity, assess indicative client outcomes, and guide clinical practice/reflective supervision.			
14. High quality NFP implementation is developed and sustained through national and local organized support	_____% of Advisory Boards or equivalents held in relation to expected _____% attendance at Advisory Boards held in relation to expected Monitored/assured by (including other measures used to assure high quality implementation):	_____% of Advisory Boards or equivalents _____% attendance at Advisory Boards	4 Local Advisory Board meeting is planned pr year. There have been between 3-5 meetings at each site. It has not been completely determined who will be the members in the local AB. We have started to secure relevant members who want to get involved. The numbers of board members vary from place to place and is between 12 to 18 members.

Domain coverage*

Please complete with your country benchmarks and average (for proportion of time spent within each domain during visits)

Domain	Pregnancy Benchmark (%)	Pregnancy actual (%)	Infancy benchmark (%)	Infancy actual (%)	Toddler benchmark (%)	Toddler actual (%)
Personal Health (My Health)	35 – 40 %	30 %	14 – 20 %	20 %	10 – 15 %	21 %
Maternal Role (My Child and Me)	23 – 25 %	30 %	45 – 50 %	49 %	40 – 45 %	41 %
Environmental Health (My Home)	15 – 22 %	24 %	17 – 25 %	18 %	17 – 25 %	21 %

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My Family & Friends (Family & Friends)						
Life Course Development (My Life)	10 – 15 %	17 %	10 – 15 %	12 %	18 – 20 %	17 %

Commentary: (please identify any successes and challenges highlighted for CME 10 and any suggested actions to address these here):

When we look at the benchmarks and average (proportion of time spent within each domain during visits) we see that our Family Nurses spend more time on the maternal role during pregnancy than benchmarks from the US show. In Norway, we have a strong focus on motherhood, and the attachment that starts in pregnancy. It forms the basis for attachment to the child when it is born, and we see the value of bringing the unborn child into the conversations during pregnancy. We find that the window in pregnancy in relation to their new life provides a golden opportunity to create emotional availability from the mother, just as David Olds has pointed out from the very beginning.

In Norway, we are above the average benchmark from the US when it comes to the program area personal health in the toddler phase. The average from the US is 10-15%, while in Norway we spend 21% of the time during home visits in the Toddler phase focusing on Personal Health. We are not sure why but assume it may be related to an increased focus on mental health in society, and that good mental health is important to experience coping capacity, satisfaction, belonging, development and growth, autonomy, meaning full and positive relationships. Good mental health is a prerequisite for learning and coping with life.

As in 2021 we notice that in the pregnancy phase, the personal health-average is below the benchmark. This may be because the clients get pregnancy follow-up from the universal services, where personal health in pregnancy is an important focus. There is also an increased emphasize on mental health challenges in the public health services and in the society more in general.

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PART THREE: PROGRAM IMPACTS

Countries report on data indicative of program outcomes to demonstrate continuing achievement of the three NFP program goals:

1. Improve pregnancy outcomes 2. Improve child health and development 3. Improve parents' economic self-sufficiency

Please complete the tables below and/or add any additional text or diagrams in Appendix 1. Where terms used in the report template are generic, please specify how items are measured as necessary. Please explain any missing data or analyses.

Characteristics of our clients at enrolment		
Health, Social and economic Conditions at enrolment	**Previous year(s) (n/%)** (2016 – 2021)	**Current Period (n/%)** (2022)
Age (range and mean)	Range: 16 – 44 Mean: 27	Range: 16 – 44 Mean: 28
Race/ethnicity distribution	65 % (N= 185) of clients are Norwegian/Scandinavian. 35 % (N= 99) of clients have another ethnicity than Norwegian/Scandinavian.	79 % (N= 84) of clients are Norwegian/Scandinavian. 21 % (N= 22) of clients have another ethnicity than Norwegian/Scandinavian. See table 2 for more details.
Home visits where father/partner is present	27 % (N=2269)	26 % (N=594)
Home visits where other family members are present:	2 % (N=193)	4 % (N=85)
Income (please state how this is defined) The annual median salary in Norway in 2021 was around 550 000 NOK (USD 53,000).	80 % (N=216) of clients had an annual income of less than USD 53,000. In addition, 12 % (N= 31) of clients didn't want to/couldn't answer this question.	81 % (N=85) of clients had an annual income of less than USD 53,000. In addition, 10 % (N= 11) of clients didn't want to/couldn't answer this question.
Inadequate Housing (please define) • Staying with friend(s) temporarily • Residential care (treatment center, maternity home) (Residential care can be both inadequate and adequate	Staying with friend(s) temporarily: 2 % (N= 5) Residential care (treatment center, maternity home): 2 % (N= 5)	Residential care (treatment center, maternity home): 3 % (N=3) Other arrangement: 3 % (N= 3)

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housing. Housing for the homeless is e.g. inadequate, but a client that currently lives at a treatment center, can normally have an adequate housing alternative) • Other arrangement	Other arrangement: 2 % (N= 6)	
Educational Achievement	Primary school: 28 % (N= 79) High school: 29 % (N= 81) Vocational school: 1 % (N= 4) One-year program at university or college: 5 % (N= 15) Bachelors' degree: 21 % (N= 58) Masters' degree: 13 % (N= 36) PHD: 1 % (N= 3) Other: 1 % (N=4)	Primary school: 23 % (N= 24) High school: 31 % (N= 33) Vocational school: 10 % (N= 10) One-year program at university or college: 1 % (N= 1) Bachelors' degree: 18 % (N= 19) Masters' degree: 13 % (N= 15) PHD: % (N= 3) Unknown or no completed education: 1 % (N= 1) Other: 2 % (N=2)
Employment	52 % (N= 141) of clients were in employment.	63 % (N= 66) of clients were in employment.
Food Insecurity (please define)	Not Applicable	Not Applicable
Ever In the care of the State (as a child or currently)	Foster Parents: 8 % (N= 22) Residential Care: 10 % (N= 29) (as a child)	Foster Parents: 8 % (N= 8) Residential Care: 10 % (N= 10) (as a child)
Obesity (BMI of 30 or more)	10 % (N=26)	15 % (N=16)
Severe Obesity (BMI of 40 or more)	1 % (N=2)	6 % (N=6)
Underweight (BMI of 18.5 or less)	10 % (N=27)	8 % (N=8)
Heart Disease	4 % (N=11)	4 % (N=4)
Hypertension	1 % (N=4)	2 % (N=2)
Diabetes – T1	1 % (N=3)	0 % (N=0)
Diabetes – T2	1 % (N=4)	1 % (N=1)
Kidney disease	1 % (N=3)	2 % (N=2)
Epilepsy	2 % (N=2)	3 % (N=3)
Sickle cell Disease	0 % (N=1)	0 % (N=0)
Chronic Gastrointestinal disease	7 % (N=19)	6 % (N=6)

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Asthma/other chronic pulmonary disease	13 % (N=36)	17 % (N=18)
Chronic Urinary Tract Infections	9 % (N=24)	7 % (N=7)
Chronic Vaginal Infections (e.g., yeast infections)	7 % (N=19)	6 % (N=6)
Sexually Transmitted Infections	19 % (N=54)	9 % (N=9)
Substance Use Disorder	11 % (N=32)	12 % (N=13)
Mental Illness: Anxiety	46 % (N=128)	59 % (N=62)
Mental Illness: Depression	47 % (N=133)	62 % (N=65)
Eating Disorder	17 % (N=48)	21 % (N=22)
ADHD (ADHD was added to the list in 2020, so we do not have data from the years before this)	4 % (N=10)	15 % (N=16)
Learning difficulties	9 % (N=26)	17 % (N=18)
Behavioural problems	7 % (N=21)	10 % (N=10)
Other (please define)		

Please comment below on the vulnerability of your client population, including analysis of STAR (or equivalent) data and reviewing trends over time.

We do not collect data based on STAR. Recruitment and the inclusion process that we have in Norway imply that we meet a more selected and vulnerable group. Compared with previous years, we see that the client group consists of families with even more vulnerabilities. Clients with Anxiety and Depression illness have increased by 13-15% from previous years. They may not receive help from other health services when they are included in the program, but we have an important intention to help clients to utilize and cooperate with the health services in the municipality. It is striking that the proportion who have difficulties in making use of relevant services is much higher in Oslo than at other sites. In Trøndelag, no one has difficulties with this, while in Oslo it is reported that 33% have such difficulties. In the remaining three areas, the figures are between 7 and 15%.
Clients with learning difficulties have increased by 8% in 2022 (from 9 to 17%), and behavioral problems have also increased from previous years. We also see an increase in clients with ADHD, from 4% in 2021 to 15% in 2022.

Compared to earlier years, there are in total fewer clients in 2022 with another ethnicity than Norwegian/Scandinavian (35% previous years and 21% in 2022). See table 2. But there is a decisive difference between the sites. In Oslo there is 62% clients with another ethnicity than Norwegian/Scandinavian this year. This has increased from 55% in 2021. Oslo is the capital and biggest city in Norway, and many immigrants and refugees seek to Oslo. They often have relatives and network here. 2 of the districts which have NFP have a large proportion of immigrant residents.

It is interesting to study the figures of inclusion criteria in the various sites and reflect on what the differences might mean (see table 1). In Oslo, for example, fewer clients have experienced neglect, physical/psychological violence/assault or serious bullying than in the other sites. In Agder, there are

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twice as many who have this criterion for inclusion than in Oslo (42% in Oslo and 85% in Agder). In Oslo, there are also fewer clients who have reported mental health problems than in the other areas. In Rogaland and Trøndelag, over 90% of the clients have mental difficulties, while in Oslo the figure is 71%.

When it comes to lack of perceived social support from family and friends, the figure is much higher in Oslo than in the other sites, with 71% in Oslo, and between 38-54% in the other sites. The high number in Oslo can be seen in the context of the number of clients who did not grow up in Norway. Oslo is the main capital in Norway, and the lack of perceived support may be explained by Oslo as a city not being too transparent, so you can live close to each other without really knowing your neighbors at all.

Age (range and mean) have not differed from previous years (see table 3). Not unexpectedly, the average age of clients is highest in Oslo, at 33 years. In the south of the country, in Agder, the average age of participants is 25 years old, which is the lowest mean. We have seen this trend in previous years, but it is even more significant this year, where the southernmost areas (Agder and Vestland) have 27-30% young mothers, while the figure in Oslo is 4%.

Alterable Maternal Behavior/ program impacts for clients (please complete for all the time periods where the data is collected)					
	Intake	**36 Weeks of Pregnancy**	**Postpartum**	**12 months**	**18 months**
Anxiety (n, % moderate + clinical range) Generalized Anxiety Disorder 7 (GAD-7)	N = 327 20 % moderate anxiety 12 % severe anxiety	N = 183 17 % moderate anxiety 3 % severe anxiety	N = 276 17 % moderate anxiety 6 % severe anxiety	N = 115 7 % moderate anxiety 8 % severe anxiety	N = 98 18 % moderate anxiety 5 % severe anxiety
Depression, (n, % moderate + clinical range) Patient Health Questionnaire-9 (PHQ-9)	N = 329 26 % moderate depression 13 % moderately severe depression 5 % severe depression	N = 183 26 % moderate depression 8 % moderately severe depression 1 % severe depression	N = 273 20 % moderate depression 7 % moderately severe depression 2 % severe depression	N = 113 19 % moderate depression 8 % moderately severe depression 2 % severe depression	N = 98 14 % moderate depression 5 % moderately severe depression 5 % severe depression
Cigarette Smoking, (n, % 1+ during pregnancy, mean number /48 hours)	23 % (N=89) of clients have been smoking in the	9 % (N=15) of clients have been		23 % (N=31) of clients have been smoking since	

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We changed the questions about smoking and drug use in June 2020. We have added the question “Do you smoke now/at the moment”? It will be interesting to see how these numbers change/develop when more data forms are filled out. This data form is now being filled out four times during the program: pregnancy intake, 36 weeks of pregnancy, 12 months and 18 months.	pregnancy, including before they found out that they were pregnant. 2 % (N=4) of clients smoke daily. 2 % (N=4) of clients smoke sometimes. 96 % (N=175) of clients are not currently smoking.	smoking in their pregnancy. 2 % (N=2) of clients smoke daily. 0 % (N=0) of clients smoke sometimes. 98 % (N=95) of clients are not currently smoking.		their baby was born. 7 % (N=4) of clients smoke daily. 7 % (N=4) of clients smoke sometimes. 85 % (N=46) of clients are not currently smoking.	3 % (N=1) of clients smoke daily. 5 % (N=2) of clients smoke sometimes. 92 % (N=35) of clients are not currently smoking.
Snus use (A popular tobacco product in Norway)	28 % (N=108) of clients have been using snus in pregnancy, including before they found out that they were pregnant. 10 % (N=18) of clients use snus daily.	16 % (N=25) of clients have been using snus in pregnancy. 7 % (N=7) of clients use snus daily.		22 % (N=12) of clients use snus daily.	22 % (N=8) of clients are using snus daily.

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	4 % (N=7) of clients use snus sometimes. 86 % (N=158) of clients are not currently using snus.	2 % (N=2) of clients are using snus sometimes. 91 % (N=87) of clients are not currently using snus.		2 % (N=1) of clients use snus sometimes. 76 % (N=41) of clients are not currently using snus.	0 % (N=0) of clients use snus sometimes. 78 % (N=29) of clients are not currently using snus.
Alcohol, (n, % during pregnancy, units/last 14 days) Same changes in the data form as mentioned above.	41 % (N=160) of clients have been drinking during the pregnancy, including before they found out that they were pregnant. 1 % (N=1) of clients are currently drinking sometimes. 99 % (N=181) of clients are not currently drinking alcohol.	100 % (N=97) of clients are not currently drinking alcohol.		54 % (N=33) of clients are currently drinking sometimes. 46 % (N=28) of clients are not currently drinking alcohol.	59 % (N=23) of clients are currently drinking sometimes. 41 % (N=16) of clients are not currently drinking alcohol.
Marijuana, (n, % used in pregnancy, days used last 14 days) Same changes in the data form as mentioned above.	6 % (N=19) of clients have been using marijuana during the pregnancy, including before they found out			2 % (N=1) are using marijuana	3 % (N=1) are using marijuana once a

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	that they were pregnant. 100 % (N=181) of clients are not currently using marijuana.	100 % (N=99) of clients are not currently using marijuana.		once a month or less frequently 98 % (N=57) of clients are not currently using marijuana.	month or less frequently 97 % (N=35) of clients are not currently using marijuana.
Cocaine, (n, % used in pregnancy, days used last 14 days) Same changes in the data form as mentioned above.	1 % (N=4) of clients have been using cocaine during the pregnancy, including before they found out that they were pregnant. 100 % (N=178) of clients are not currently using cocaine.	100 % (N=95) of clients are not currently using cocaine.		100 % (N=54) of clients are not currently using cocaine.	100 % (N=32) of clients are not currently using cocaine.
Other street drugs, (n, % used in pregnancy, days used last 14 days) Same changes in the data form as mentioned above.	1 % (N=5) of clients have been using other street drugs during the pregnancy, including before they found out that they were pregnant. 100 % (N=178) of clients are not	100 % (N=96) of clients are not		100 % (N=60) of clients are not	100 % (N=33) of clients are not

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	currently using any other street drugs.	currently using any other street drugs.		currently using any other street drugs.	currently using any other street drugs.
Excessive Weight Gain from baseline BMI - Pregnancy, (n, %)	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Other: Physical activity How often are you so physically active that you become short of breath or sweaty?	Never: 17 % (N=31) Less than once per week: 20 % (N=37) 1 time per week: 11 % (N=21) 2 times per week: 22 % (N=41) 3-4 times per week: 17 % (N=31) 5 times per week or more: 13 % (N=25)	Never: 18 % (N=18) Less than once per week: 14 % (N=14) 1 time per week: 12 % (N=12) 2 times per week: 17 % (N=17) 3-4 times per week: 17 % (N=17) 5 times per week or more: 21 % (N=21)		Never: 19 % (N=13) Less than once per week: 13 % (N=9) 1 time per week: 9 % (N=6) 2 times per week: 10 % (N=7) 3-4 times per week: 28 % (N=19) 5 times per week or more: 19 % (N=13)	Never: 16 % (N=7) Less than once per week: 14 % (N=6) 1 time per week: 14 % (N=6) 2 times per week: 25 % (N=11) 3-4 times per week: 20 % (N=9) 5 times per week or more: 11 % (N=5)
Mastery, (n, mean) Low Mastery = 19 or under. Not Low Mastery = 20 or more.	Intake: N = 365 Mean = 21.6 Low mastery: 28 % (N= 101)	6 months: N = 179 Mean = 22.5 Low mastery: 18 % (N= 33)	12 months: N = 153 Mean = 22.2 Low mastery: 20 % (N= 31)	18 months: N = 107 Mean = 22.3 Low mastery: 19 % (N= 20)	24 months: N = 84 Mean = 22.3 Low mastery: 23 % (N= 19)
IPV disclosure, (n, %)	Pregnancy: 19 % (N= 28)	Infancy: 19 % (N=22)	Toddler: 13 % (N=8)		

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	6 Months	12 Months	18 months	24 Months	
Reliable Birth Control use, (n, %) Condoms, birth control pills, patch, quarterly birth control injection, hormonal implant, IUD Hormonal and IUD Non-Hormonal	46 % (N=88)	58 % (N=93)	57 % (N=65)	56 % (N=51)	
Subsequent pregnancies, (n, %)	3 % (N=5)	12 % (N=18)	18 % (N=20)	26 % (N=23)	
Breast Feeding, (n, %) We changed the question “Have you been breastfeeding the baby exclusively since the birth?” to “Have you breastfed your baby?” in June 2020. The results from both questions are presented here. We also added a question “How are you currently feeding your baby?”	**First postpartum visit:** Exclusive breastfeeding: 57 % (N=98) of clients had breastfed their baby exclusively. Breastfeeding: 92 % (N=122) have breastfeed their baby. Currently feeding their baby: 62 % (N=83) are exclusively breastfeeding. 27 % (N=36) of clients are breastfeeding non-exclusively.	**6 months:** 20 % (N=39) of clients are exclusively breastfeeding. 43 % (N=86) of clients are breastfeeding non-exclusively. 38 % (N=75) of clients are not breastfeeding.	**12 months:** 45 % (N=60) of clients breastfeed non-exclusively. 55 % (N=73) of clients are not breastfeeding.	**18 months:** 32 % (N=27) of clients are breastfeeding non-exclusively. 68 % (N=57) of clients are not breastfeeding.	**24 months:** 15 % (N=9) of clients breastfeed non-exclusively. 85 % (N=53) of clients are not breastfeeding.

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	11 % (N=15) of clients are not breastfeeding.				
Involvement in Education, (n, %)	23 % (N= 44)	24 % (N=36)	22 % (N=24)	35 % (N=31)	
Employed, (n, %)	52 % (N= 74)	53 % (N=73)	65 % (N=62)	54 % (N=45)	
Housing needs, (n, %)	Not Applicable	Not Applicable	Not Applicable	Not Applicable	
DANCE (or equivalent), (mean - 2, 9, 15, 22 mos.)	Not Applicable	Not Applicable	Not Applicable	Not Applicable	
Father's involvement in care of child, (n, %) During the past three months, how often did the baby's biological father spend time taking care of and/or playing with the baby?	He does most/all of the care: 2 % (N= 4) Every day: 58 % (N= 110) 3-6 times a week: 11 % (N= 20) Once or twice a week: 7 % (N =13) 1-3 times a month: 3 % (N= 5) Less than once a month: 4 % (N= 7) He has not spent time caring for or	He does most/all of the care: 4 % (N= 6) Every day: 57 % (N= 90) 3-6 times a week: 6 % (N= 10) Once or twice a week: 8 % (N =12) 1-3 times a month: 3 % (N= 5) Less than once a month: 6 % (N= 9) He has not spent time caring for or	He does most/all of the care: 2 % (N= 2) Every day: 58 % (N= 65) 3-6 times a week: 12 % (N= 14) Once or twice a week: 7 % (N =8) 1-3 times a month: 2 % (N= 2) Less than once a month: 6 % (N= 7) He has not spent time caring for or	He does most/all of the care: 3 % (N= 3) Every day: 47 % (N= 41) 3-6 times a week: 11 % (N= 10) Once or twice a week: 9 % (N =8) 1-3 times a month: 7 % (N= 6) Less than once a month: 7 % (N= 6) He has not spent time caring for or	

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	interacting with the baby: 16 % (N= 31)	interacting with the baby: 17 % (N= 27)	interacting with the baby: 13 % (N= 15)	interacting with the baby: 15 % (N= 13)	
Other (please define)					

Please comment below on the program impacts for clients, as indicated by the data provided (include comparisons where possible e.g. to previous years, to equivalent populations etc.)**:**

Mental health is an important area. The percentage of clients with severe anxiety decreases from 9 % to 4 % from intake to 18 months. But at the same time, the percentage of clients with moderate anxiety increases from 17 % to 20 % during the same time frame. When it comes to depression, moderately severe or severe depression decreases from 16 % to 11 % from intake to 18 months. Here, moderate depression also decreases from 24 % to 17 %. But the numbers are still quite high. It is important to remember that mental difficulties are one of the most common eligibility criteria for our clients. 80 % of the clients recruited in 2021, had mental difficulties as one of their eligibility criteria.

The tobacco product called "snus" is used more frequently than cigarette smoking. It's common to quit cigarette smoking and use "snus" instead in Norway, as you still get nicotine, and the product is more «socially accepted». Existing research tends to show that "snus" might be less dangerous than cigarettes, but still has negative health impacts on both mother and child.

In which areas is the program having greatest impact on maternal behaviors?

It is challenging to pinpoint exactly which areas of the program that have the greatest impact on maternal behavior, but the most important impact is maybe to have the same Family Nurse to follow up the family over time. This relationship, which develops over time, helps Family Nurses to get in a position where they can discuss topics that may be more challenging for other health services, which do not have as frequent and long-term follow-up as the Family Nurses. The Family Nurse can adapt to the client's pace because they follow the family over two and a half years. The trust clients gain in Family Nurses, and the relationship they develop, is priceless. The Family Nurse is considered a reliable professional who can provide important input and perspectives and support to the family in making good choices for the child and family. The Family Nurse's continues emphasis on a family strength is perceived as positive by the clients, as well as the focus on the client's competence and level of mastery. The clients experience that they are believed in, and that small changes have ripple effects, which benefits the child and the family.

The expansion from two to five teams has forced us to put the assessment with Emotional Availability Scales (EAS) on hold, for practical reasons. We do not have enough certified coders to carry out assessments in all teams. In anticipation of a new assessment tool for interaction between parents and children, which is being developed at RBUP, we have therefore emphasized regular follow-up in each team when it comes to assessment and guidance of the

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mother's role. Senior adviser at the National Office regularly visits the teams and offers guidance in individual cases and more general topics related to child development and motherhood. The Senior Advisor takes part in home visits when the Family Nurse wants a second opinion of the family in the home environment. The experience of this so far is good. The Family Nurses are positive about bringing an external person to home visits when needed, and find it useful.

Which are the areas of challenge?

It will always be a challenge that we do not know whether the clients know how to answer the questionnaires. Mother's assessment of her own functioning and satisfaction does not always seem to be a reliable source for assessing central factors such as emotional availability, sensitivity, and responsiveness in interaction with the infant. There may be agreement, mothers may assess themselves as both better or worse functioning than what is expressed in the interaction with the infant.

Birth data		
	Number	**% of total births for year**
Extremely preterm (less than 28 weeks' gestation)	0	0 %
Very preterm (28-32 weeks' gestation)	2	1 %
Moderate to late preterm (32-37 weeks' gestation)[1]	16	5 %
Low birthweight (please define for your context) Low birthweight: below 2500 g	17	6 %
Large for Gestational Age (LGA) (please define for your context)		
Other (please define)		

Please comment below on your birth data: Generally, there is a good follow up of preterm births in Norway. The numbers in NFP are close to the national numbers regarding preterm births. When it comes to low birthweight our numbers (6.0%) are higher than the Norwegian average (4,2%).

[1] https://www.who.int/news-room/fact-sheets/detail/preterm-birth

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Child Health/Development				
	6 months (% of total)	**12 months (% of total)**	**18 months (% of total)**	**24 months (% of total)**
Immunizations Up to Date	Up to date: 98 % (N=198) Not up to date: 1 % (N=3) Does not want to vaccinate the child: 1 % (N=2)	Up to date: 98 % (N=154) Not up to date: 1 % (N=1) Does not want to vaccinate the child: 1 % (N=2)	Up to date: 98 % (N=111) Not up to date: 0 % (N=0) Does not want to vaccinate the child: 2 % (N=2)	Up to date: 99 % (N=91) Not up to date: 1 % (N=1) Does not want to vaccinate the child: 0 % (N=0)
Hospitalization for Injuries	0 % (N=0)	1 % (N=1)	1 % (N=1)	3 % (N=1)
ASQ scores requiring monitoring (grey zone)	Communication: 1 % (N=2) Gross Motor: 1 % (N=2) Fine Motor: 5 % (N=10) Problem Solving: 3 % (N=6) Personal Social: 1 % (N=3)	Communication: 1 % (N=1) Gross Motor: 3 % (N=4) Fine Motor: 2 % (N=3) Problem Solving: 4 % (N=5) Personal Social: 1 % (N=1)	Communication: 5 % (N=5) Gross Motor: 1 % (N=1) Fine Motor: 3 % (N=3) Problem Solving: 4 % (N=4) Personal Social: 4 % (N=4)	Communication: 9 % (N=7) Gross Motor: 6 % (N=5) Fine Motor: 5 % (N=4) Problem Solving: 7 % (N=6) Personal Social: 5 % (N=4)
ASQ scores requiring further assessment/referral				
ASQ-SE scores requiring monitoring (grey zone)	Social Emotional: 3 % (N=5)	Social Emotional: 1 % (N=1)	Social Emotional: 2 % (N=2)	Social Emotional: 3 % (N=2)
ASQ-SE scores requiring further assessment/referral				
Child Protection (please define for your context) Do you know if anyone has/have you reported concerns to the Child Welfare Services in the last 6 months regarding suspected abuse or neglect?	9 % (N=18) of clients had been referred to the Child Welfare Services by other than the Family Nurse. 3 % (N=6) of clients were referred to the Child Welfare Services by the Family Nurse.	5 % (N=8) of clients had been referred to the Child Welfare Services by other than the Family Nurse. 1 % (N=2) of clients were referred to the Child Welfare Services by the Family Nurse.	11 % (N=11) of clients had been referred to the Child Welfare Services by other than the Family Nurse. 2 % (N=2) of clients had been referred to the Child Welfare Services by the Family Nurse.	5 % (N=4) of clients had been referred to the Child Welfare Services by other than the Family Nurse. 3 % (N=3) of clients had been referred to the Child Welfare Services by the Family Nurse.

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Child Protection (please define for your context) Do you know if anyone has/have you recommended that the Child Welfare Service implement voluntary support services for the family in the last 6 months?	8 % (N=15) of clients were referred to the Child Welfare Services by other than the Family Nurse. 5 % (N=9) of clients were referred to the Child Welfare Services by the Family Nurse.	8 % (N=13) of clients were referred to the Child Welfare Services by other than the Family Nurse. 4 % (N=6) of clients had been referred to the Child Welfare Services by the Family Nurse.	10 % (N=10) of clients were referred to the Child Welfare Services by other than the Family Nurse. 4 % (N=4) of clients were referred to the Child Welfare Services by the Family Nurse.	5 % (N=4) of clients had been referred to the Child Welfare Services by other than the Family Nurse. 3 % (N=3) of clients had been referred to the Child Welfare Services by the Family Nurse.
Other (please define) Where/by whom is the child looked after during the day?	Kindergarten: 0 % (N=0) Family kindergarten: 0 % (N=0) Childminder: 0 % (N=0) At home with parent(s): 98 % (N=85) At home with other family members: 2 % (N=2) If kindergarten, full-time or part-time: Full-time: N/A Part-time: N/A	Kindergarten: 35 % (N=26) Family kindergarten: 0 % (N=0) Childminder: 1 % (N=1) At home with parent(s): 54 % (N=40) At home with other family members: 9 % (N=7) If kindergarten, full-time or part-time: Full-time: 100 % (N=26) Part-time: 0 % (N=0)	Kindergarten: 77 % (N=36) Family kindergarten: 0 % (N=0) Childminder: 0 % (N=0) At home with parent(s): 23 % (N=11) At home with other family members: 0 % (N=0) If kindergarten, full-time or part-time: Full-time: 94 % (N=34) Part-time: 6 % (N=2)	Kindergarten: 91 % (N=40) Family kindergarten: 0 % (N=0) Childminder: 0 % (N=0) At home with parent(s): 7 % (N=3) At home with other family members: 2 % (N=1) If kindergarten, full-time or part-time: Full-time: 100 % (N=37) Part-time: 0 % (N=0)

Please comment below on your child health/development data

In Norway, kindergarten coverage is very high. The quality of the kindergartens is good, and it is a goal in Norway that parents should be able to return to work after maternity leave. The number of children attending kindergarten at 24 months in NFP is in line with the rest of the population (91%). We find this very pleasing because good quality in the kindergarten seems to prevent the development of language and behavioral difficulties over time, especially in vulnerable children.

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Regarding ASQ, we find very little difference when comparing with 2021. Like last year, there are more children in the grey zone (requiring monitoring) at 24 months than at 6 months, except from Fine Motor skills, where the % is the same at 6 and 24 months. We are curious about the reference goals in ASQ, and we are looking forward to see if the results from RCT will show differences from our group to the control group, concerning children's development.

The number of Referrals to Child Welfare Services – Voluntary support services by other than the Family Nurse at 24 months is halved from previous years. We are not sure why, but maybe the local welfare services rely more on the quality of NFP, our Family Nurses get more and more skilled, and the clients manage on their own, after 2 ½ years of with NFP? We are curious about potential differences between the established and new sites when it comes to the number of referrals to the Child Welfare Services.

Additional analyses
Please insert here any additional analyses undertaken to further explore program impacts
Client experiences
Please insert here any materials you would like to present regarding client experiences of the program. This can include collated client feedback, a case study or by clients providing video evidence etc. When we created content for our new website, we conducted three interviews with three different clients. One who was pregnant, one with a 1,5-year-old boy and one who finished the program a year ago. A colleague, working in RBUPs communication department and not directly working with the program, conducted the interviews. Below are some citations from the interviews: "I didn't have any faith in myself at all or the faith that it would all go well; it has helped that someone has been there and sees me" "The fact that I have had a lot of insecurity and challenges in my own childhood meant that I needed a little extra support" “If I have a difficult period, I think: What would Tone (Family Nurse) say or what would Tone do now? In a way, I have managed to rewire my brain to look at things more positively. Although I may experience that things are negative, I manage to think that I am a good mother to my son anyway. It's quite a difference from how things were for me before. I can look at him and think that I have done a good job and could do this again, says client.” "I thought it was going to be a lot harder to be a mother, but it's been so positive. I feel that this child kind of turned my life around"

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"I want to take care of my child and to do that I need a job. Which means I need an education. This is something I think about and try to figure out with my Family Nurse"

"I suddenly didn't feel lonely anymore, I knew she (Family Nurse) would support me throughout the process and also after the baby was born"

The nurses experience feedback from their clients especially in connection with graduation. The nurses often share this with the National office. We would like to share one of these feedbacks with you.

Background: The client had multiple challenges; she is a single mom, socioeconomic disadvantage, little social support, not ethnic Norwegian, did not speak Norwegian and did not write any language. Analphabetic. Through the program they worked among other things, with integration into Norwegian society. She wrote a card to the Family Nurse when the child was 2 years old, and she graduated. She wrote the card in Norwegian, saying:
"Thank you! For everything you taught me, seeing my potential when I didn't. Everything has been with love. You have made me a better person, a mature woman and mother. I am forever grateful".

Sentinel / Significant events that deserve review:

Event	Number	What was the learning?
Child death	0	
Maternal death	0	
Other	0	

Any other relevant information or other events to report:
No

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PART FOUR: PROGRAM IMPROVEMENT & EVALUATION

Continuous Quality Improvement (CQI) program

- Briefly describe your system for monitoring implementation quality:

Our digital data collection system helps us monitoring implementation quality, and we regularly have meetings with the five teams to calibrate and ensure that we collect the data we want to focus on. We value feedback from the Family Nurses because they know the clients well and can help ensure that the data forms focus on relevant topics.

In NFP in Norway, we have used EAS - Emotional Availability Scales (Biringen 2008) to assess mother-child interaction from 2016-2021. When using EA Scales, we had regular consensus meetings with the five coders, to collaborate findings and analyze together. This ensured high quality in assessments, and it appeared as quality assurance for the NFP program to have coders discussing dyads together.

Due to the expansion from 2 to 5 teams, EA Scoring is too extensive and complex to offer all our families. We do not have enough coders, and the certification itself is extensive and demanding. Therefore, we have been investigating several observational instruments for the past years, to find a suitable instrument that can match our needs. It has been challenging to find a suitable replacement for EAS, and we have had to ensure the quality of the mother-child interaction in other ways. We have arranged for frequent guidance, both individually and in teams. Marte Meo Supervisor from the National Office visits each team every five/six week. Analysis of video clips and suggestions for feedback on the videos are given in the group/team. In addition, the Family Nurses get individual supervision (In vivo or over Teams) twice a week. The Family Nurses need guidance regularly to ensure the quality of the mother-child interaction, and in the supervision in video interaction analysis, we strive to ensure the quality. The selection of clips is done together with the Marte Meo Supervisor, and how to give feedback on the video clips are also practiced in this supervision.

To ensure the quality of the supervision, our supervisor in Marte Meo will have regular collaboration with a Licensed Supervisor in Marte Meo. This will ensure the quality of interaction analyzes in NFP.

We use two main themes to focus on in the video guidance, and experiences from the Family Nurses to this “light” version of Marte Meo, is promising. Instead of 6/7 elements, we focus on two main elements:

1. Following the child - Child-initiated

At three months of age, infants' interest is related to faces and human contact, preferably caregivers. Therefore, the first theme will be about the infant's contact initiative. Parents' most important task in this phase is to wait for the child, and then respond to the infant by imitating / mirroring the infant's expression and condition.

2. Leading the child - Parent-initiated

Focus on the child's capacity to follow another's leadership. Parents who prepare, both themselves and the child, for what is to happen and put into words what is going on here and now, are predictable parents.

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We repeat these two themes when the child grows older, approximately when the child turns one and again at one and a half. The Family Nurses may use video as a tool at other times during the follow-up as well, supervised by the national Office.
We have developed a guide/booklet for the Family Nurses, and a booklet for the parents, where the intervention is described. The booklet for the families is being translated into English.

We repeat these two themes when the child grows older, approximately when the child turns one and again at one and a half. The Family Nurses may use video as a tool at other times during the follow-up as well, supervised by the National Office.

- Goals and Objectives for CQI program during the reporting period:

Because of the lack of a better observational instrument in Norway, RBUP, in cooperation with other regional centers of expertise within child welfare, wanted to develop a new observational instrument. Here are our main reasons for developing:

- Many instruments are intended to be used for research and are not adapted to Norwegian conditions.
- Copyright makes existing instruments expensive to use, in addition to the fact that only a few people can contribute with the certification of professionals.
- Certification has become even more complicated because it is currently very difficult to share sensitive material with the United States (general data protection regulation), where several of the developers of today's methods are located.

The new observational instrument will measure level of quality in parent-child interaction among families with children aged 0-6 years. The purpose of developing a new instrument is to be able to adapt it to Norwegian needs at child health clinics, BUP (specialist healthcare service for children) and the Child Welfare Service. NFP in Norway will be the first program to test the new observational instrument, planned startup during 2024.

- Outcomes of CQI program for the reporting period

We have adjusted the materials in NFP to the Norwegian context. This applies to both the facilitators and the information documents. This is now placed on our internal website. The Family Nurses believe that the website will make their work easier, more efficient and of higher quality.

Regular supervision of video analysis, both individually and as a team, has been useful and ensured the quality of interaction analyzes in families in NFP. Family Nurses learn from each other, when they watch each other's video clips and participate in guidance from the Supervisor. The opportunity for individual guidance twice a week is also a success, to ensure continuity in video follow-up in the families. The Family Nurses can get supervision when they need it, without having to wait for the next team supervision.

- Lessons learned from CQI initiatives and how these will be applied in future:

We have learned how valuable feedback is, both from each Family Nurse, and from experience gatherings with all the Family Nurses, where we ask for specific feedback on various topics. We find it important to have routines for feedback and input from the Family Nurses.

- Goals for CQI in next year:
  - Further development of our internal website
  - Development of education curricula, both overall and individual.

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- Development of material for preparation before gatherings and training.

Program innovations tested and/or implemented this year (this includes both international and local innovations)

- Program innovations tested[2]:

In October 2021 we launched our new digital data collection system called "NFP-portalen" and all teams have started to use the system. During the year, we have continued to develop the data collection system. For example, we have made some of the forms more user-friendly, developed more automatic reports and created tables that give an overview of the number of participants. The data collection works well, but there are still things that can be improved and changed.

- Program innovations implemented:

In June we launched our new name, website and visual profile.

New name

We changed the name of our program from "Familie for første gang" to "Sammen på vei". Our new name has two different meanings:

1. "Sammen på vei" can be directly translated to "together on the way". The second part, "på vei", builds on the Norwegian expression "å ha noe på vei" (directly translated "to have something on the way/in the process of"). It is an expression used in relation to pregnancy, referring to someone being "on their way" to becoming a mother. The first part, "sammen", which means "together", adds to the name the meaning that you are on your way to motherhood together with someone.
2. We all walk on a path through life. Some people carry heavier "baggage" than others and some walk a lot on their own. We hope that our new name can symbolize the support and encouragement that the Family Nurses provide to the clients - cheering, helping, building their confidence, and walking with them on their path, with their baby "on the way".

New website

[2] Please attach the materials used for the innovations.

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Our website consists of an open site (https://sammenpavei.no/) which, everyone has access, and an intranet/internal website ("Kompasset", in English "the Compass") for employees in the program. On the open site you find information about the program, where the program is offered, and how you can get in touch with the team in your area. On the internal site you can search and filter among the program's facilitators and documents, as well as get information and updates from the National Office. The content (facilitators and documents) has been revised, adapted, and implemented digitally in pdf-format. The facilitators can easily be printed from "Kompasset", or the Family Nurses can access the facilitators digitally on their iPad during home visits.

Kompasset Biblioteket Logg ut

På vei til å bli mor?

Sammen på vei er et frivillig oppfølgingsprogram for kvinner med sammensatte utfordringer som skal bli mor for første gang

Visual profile

Together with the design agency Dinamo, we have developed a new visual profile for the program. The work included new color palette, illustrations, and pictures, as well as appearance on our website. We chose to use a lot of illustrations because it can be easier to express diversity and mixed/complex feelings. Illustrations are also more "time neutral" than pictures (See appendix 4).

- Findings and next steps:

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We have received positive feedback regarding the new facilitators.

The launch of "Kompasset" at the end of October was successful. The Family Nurses believe that "Kompasset" will make their work easier, more efficient and of higher quality. In 2023 we will continue to improve and develop the website and "Kompasset". We will adjust and develop new facilitators, develop informative/education videos, and modules. By the end of 2022, we will send out an evaluation survey. The results of this survey will give us information about what we should improve and prioritize next year to further develop.

We receive continuous feedback from the teams about improvements and suggestions about what we could improve further.

Temporary Variances to CMEs

For each variance agreed please attach a report of the variance evaluation methods and findings to date in Appendix 2 to this document

Additional Approved Model Elements (AAMEs)

Please attach a summary of findings in relation to any Additional Approved Model Elements in Appendix 3 to this document

RCT or equivalent commissioned Research

Research team and their institutions:
AFI as contractor is linked to OsloMet. AFI is a social science institute performing multidisciplinary, action-oriented research. Anne Grete Tøge and Eirin Pedersen are project managers of the multi-disciplinary research team consisting of researchers from subject areas like social politics, nursing and health inequalities, RCT, welfare politics and social economics. The researchers come from various research and competence institutions which are highly relevant to the planned research. Pedersen was part of the team conducting the evaluation in phase 2, which the Directorate considers to be a strength. It has also been well received by RBUP. The Norwegian research team also have a reference group of international experts with representatives who have been involved in RCTs in other NFP countries.

For information about the content of the RCT and for primary and secondary outcomes for the RCT reference is made to the study protocol being sent to UCD as an attachment to the annual report.

Please note that the study protocol cannot be shared beyond UCD which is strictly limited to David Olds and Ann Rowe. It implies that the study protocol cannot be posted on the international NFP website before it has been approved by the Regional Committee for Medical and Health Research Ethics (REK).

Brief outline of research methodology:

Reference is made to mentioned Study protocol.

Details of progress to date:
In Norway all medical and health research projects must be pre-approved by the Regional Committee for Medical and Health Research Ethics (REK). Approval must be obtained before the study can start. AFI is awaiting a response from REK between the 18-21 of December. AFI is using the current time to inform the sites about the study as well as developing the database, the questionnaires and different strategies to optimize the recruitment process once the study starts.

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The department in charge of overseeing the effect study in Bufdir will either give a brief update to UCD in written or in the annual meeting.
Expected reporting period and consultation with UCD prior to publication: Not applicable now.

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PART FIVE: ACTION PLAN

LAST YEAR:

Our planned objectives for last year:

RBUP:

• Carry out the Infancy training in week 36 (September 2022) as planned in the curricula.
• Carry out the IPV training in June 2022
• Carry out the New-born Behavioral Observation training which start in March 2022
• Facilitate the establishment of Local Advisory Boards in all sites and enable them to function well
• Conduct information/education gatherings for local leaders at the implementing sites, especially the new ones
• Develop a good reporting system for the Local Advisory Boards
• Translate the new material and documents into English and some of it into the most used languages at the implementing sites
• Develop and carry out education for the Team Coordinators

Linked to changes in the overall program structure and the adaption of the material to the Norwegian context, we plan to arrange experience conference with the teams. The intention is to develop and meet the needs of the nurses, exchange of knowledge, perceptions, and experiences in using the new material will be important. This will also be important to ensure that the new teams and Family Nurses gain a broader understanding of the content and delivery of the program as intended.

Hopefully during spring 2022 our new visual profile will be launched, as well as our new website. The launch is pending a decision from the Ministry whether they are accepting the proposed name change or not. We will continue to develop, in cooperation with the design agency, the profile of our licensed material and the content on our website. During 2022 we hope to have time to start writing articles based on our data reports and to publish them, alongside Norwegian Nurse-Family Partnership news, on our new website.

Bufdir:

Solve the two assignments that we have received from our Ministry regarding NFP:

- 1) To develop a legal regulation for the handling of personal information in the program 2) to explore if there will be a need to develop a law or regulation which covers NFP as a service.
- Continue to work on the collaboration with the health sector at the government level
- Identify an agency which can undertake the effect evaluation and start the RCT in 2022.
- Continue to deliver regular updates to our Ministry about the progress and status in the program implementation

RBUP: Progress against those objectives

The National Office as a team has worked well with progress to this year's objectives. We have achieved most of our plans.

- The education, Infancy training, IPV and NBO all have been carried out and it has worked well. We have learned about and reflected on possible enhancement for the future.
- The Local Advisory Boards in all sites are up and running and the experience is good according to members who join the board meetings.

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- As described earlier in the report, there are very dissimilar processes at each host municipality, and we have assessed that it hasn't been appropriate to arrange meetings/gatherings for the local leaders yet. This is expected to be arranged during 2023.
- We have only just begun with the reporting system for the sites/Local Advisory Boards so this work will be continued in 2023.
- We have sent parts of the new updated material for translation. Especially in Oslo, which have a high proportion of non – ethnically Norwegian clients this is a need. We start with the most important material to see how it works and if we need to translate more. We will initially translate into English. Eventually, in collaboration with the Family Nurses, we will assess the need for translation into other languages as well.
- The training of Team Coordinators is going well and is still in the development process. As we have improved the access to the materials and digitized the data collection it has become clear that the Team Coordinators position in 100% engagement most likely are too big for the size of team in this phase. Therefore, we work together with the Team Coordinators to define their tasks and role and work together with the local leader to assure their engagement by adding some local tasks if possible.
- In June we launched our new name, visual profile and our new website, and in October we launched "Kompasset" being the internal part of the website. It was successful, and the Family Nurses were very pleased.

Bufdir: progress against objectives

- The two legal assignments have been solved and delivered by the Department of Child Law and Child Protection Law.
- Little progress has been achieved on improving the collaboration with the health sector, this is partly due to changes at the level of Director for Bufdir and partly awaiting REKs approval of the effect study. The new Director started in August and is in the process of being familiarized with the various responsibilities of the Directorate, as well as different interventions like NFP. A meeting with her has been scheduled for the 5th of January.
- A contract with AFI was signed in May 2022. Both Bufdir and RBUP is very satisfied with the selected contractor and the way they are planning the study.
- Quarterly reports have been sent to the Ministry.

Reflections on our progress:

RBUP: We are proud to have achieved a major part of our goals. Having the teams employed locally is new to us and we have learned a lot about how different municipalities and townships can be. To strike the balance between providing the teams and sites with a good understanding of the program for the best program delivery, and at the same time support them to find good solutions to local challenges and obstacles is a challenge. There were still challenges posed by The Covid-19 at the beginning of the year. Despite challenges, the National Office has been functioning well and everyone has worked very hard to achieve our plans and goals.

Bufdir: We are in general satisfied with our own progress measured against set objectives, as well as the progress made by RBUP. We consider the close collaboration and dialogue between our two agencies to be one of the key success factors in securing a good framework for the implementation of the program and the expansion now in phase 3. There has been and continue to be many issues and questions arising which requires joint reflections and ability to find solutions which is not evident since the programme still is in a phase of testing it out in a Norwegian context. It is important that the program blends in with the other services at the level of the municipality while at the same time ensuring the required quality of the programme.

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The challenges we are facing to get our counterparts in the health sector on board are slightly demanding. But we are hopeful that we in dialogue with our new Director will find some entry points to secure some involvement from their side.

NEXT YEAR:

Our planned objectives for next year:

RBUP:

- Carry out the Toddlerhood training in week 36 (September 2023) as planned in the curricula
- Change the Danger assessment tool (for use in IPV intervention) to a tool that is used by other services in Norway and are more relevant in the Norwegian context.
- Gatherings for all teams as planned in the annual plan, to share experiences and continue education and development
- Have a routine of the reporting system for the sites
- Have meeting/ gathering for local leaders in the host municipalities to enhance the understanding of the program and the balance between the demands from the program and the National Office and the local organization and system in a given site.
- Develop a plan for how to take care of the training and maintenance of MI for NFP Norway in the future.
- Develop a plan for our MI specialist retirement
- Further develop the digital data collection system and automatic reports
- In 2023 we will continue to improve and develop “Kompasset”. We will adjust and develop new facilitators, develop informative/education videos, and modules.
- RBUP; continuing developing a new observational instrument of parent-child interaction for families with children aged 0-6 years that is suitable for Norwegian/Nordic conditions.

Bufdir:

- Bufdir will follow closely the effect study and have regular meetings with AFI. Bufdir will continue to encourage a good information flow between AFI and National Office, NFP Teams and key actors at the level of the municipality as local Advisory Boards.
- Continue to secure the best possible use of available funding while the needs of the programme are increasing beyond available funding.
- Continue to follow-up with the National Archive Office how Bufdir best can safeguard that its collection of personal data in the programme is in line with the Archive Law and on the other side the participants right/possibilities to have information about themselves removed from registered files and journals if in line with other existing laws like health law and law on child protection. As well as safeguarding a child's right as a youth or adult to have access to relevant information from the time their mother was enrolled in the programme in, for instance, a case of complaint.
- Continue to explore the opportunity to improve the collaboration with the Directorate of Health and a closer collaboration with the Ministry.

Measures planned for evaluating our success:

RBUP:

- Toddlerhood training conducted as planned
- Experience conferences have been conducted according to plan
- The Danger assessment tool has been changed and implemented
- The local leaders have had meetings and developed a plan for meetings (2 or more times a year)
- Local AB reporting system is developed and working well

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- We have a plan for the training and maintenance of MI for NFP Norway in the future - The digital data collection has been further developed and is documented - A new observational instrument of parent-child interaction has been developed - We have developed new education videos and modules Bufdir: - Record of conducted meetings with AFI. Feedback from the National Office on how communication with AFI has been in course of the year. - Secured a continued good dialogue with Bufdirs' Finance Department, as well as continued close dialogue with the National office on budgeting and economic reporting in course of 2023. - Reached an agreement in course of 2023 to solve the issues raised above under objectives for 2023. - Improved collaboration between Bufdir and the Health Directorate and their Ministry, as well as closer collaboration with our own Ministry around the complexities of the programme, but also its relevance in view if the on-going Child Protection reform.
Any plans/requests for program expansion? N/A
FEEDBACK FOR UCD INTERNATIONAL TEAM:
The most helpful things we have received from the international team over the last year have been: RBUP: The regular meetings with the international consultant to the Clinical Lead and others from the National Office is found very useful. We appreciate the availability and support we get from Ann whenever we need. At the National Office we attend the regular meetings of the Clinical Advisory Group (CAG), the Forum for NFP international Analytical and Research leads, and of the International Education Group. We find these meetings very helpful. We also find the international website useful. The visit from Ann during a gathering in November was highly appreciated. Both her presentation with the International NFP perspective, as well as her participation in the training on Team resilience and Client engagement and her participation in the Supervisor gathering was key. Bufdir: The regular meeting with Ann seems to be of reciprocal value as an update for UCD and to get insight in the programme implementation in Norway and the various challenges which must be solved in parallel at various levels. From Bufdirs perspective it is useful to get access to experiences from other countries via national consultant or be put in contact with relevant resource persons. It is also of value to get international consultants' views on specific challenges. The establishment of the Strategic Leads meetings on a quarterly basis to share experiences bears promising developments but is still to find its form. Its relevance and effectiveness will also depend much on to which extent the different NFP countries will priorities attending the meetings.
Our suggestions for how NFP could be developed and improved internationally are: - Ref. Last comment above - UCD could communicate more clearly about the strategic and financial plan for UCDs continued support and follow-up vis-a-vis existing NFP countries and how to expand NFP to new countries.

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This what we would like from UCD through our Support Services Agreement for next year: Reference is made to the Scope of Work for 2023.

Please note with permission, all completed annual reports are uploaded to the restricted pages of the international website so that every implementing country can mutually benefit in sharing their progress and achievements.

Please indicate your country's willingness to share this report in this way by checking one of the boxes below:

I agree to this report being uploaded onto the restricted pages of the international website ☑ v

I do not agree to this report being uploaded onto the international website ☐

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PART SIX: ANNUAL REPORT FROM UCD

(To be completed by UCD following annual review meeting)

Brief summary of services/support provided by UCD over the last year:

- Information and support to Clinical lead and others in the National Office, including support for adapting the approach to dyadic assessments.
- In-person visit to support nurse and supervisor education and meetings with the National Office and Bufdir with the research team
- Commentary on the research tender contents.
- Responses to ad hoc questions and requests for information, clarification, documents etc
- Updating and maintaining the international NFP website, including creating opportunities for accessing international program resources, educational materials, and NFP news updates.
- Provision of a range of international themed meetings including the international Clinical Leads' Advisory Group, the data analytic and research-leads forum, the PIPE education group (now the education group) and the strategic leads group.
- Sharing new program innovations developed and researched by PRC and all implementing countries
- Facilitating the sharing of good practice among countries on particular topics.
- Sharing new NFP international research outputs from all countries via the website and through the international research seminars.

Identified strengths of program:

- The extent of the achievements in 2022, enabling progression to Phase three of the program within a strong and supportive context.
- The quality of the leadership of the program, both in policy and implementation, and the extent of positive collaboration between the two agencies
- The range and quality of the specialists within the National Office team, enabling high quality education and support to the NFP teams and sites.
- The robustness of the research procurement process, enabling a very thorough framework to be presented to the research community
- The collaborative nature of the research process, now that the research team are in place, which will ensure that the challenges of recruitment to the study, and lessons learned are shared in a timely way.
- The learning approach taken to working with expanded and new sites, made up of multiple stakeholders and the efforts made to ensure that LABs are functioning and supporting local implementation
- The quality of the FNP workforce, whose work is highlighted by the findings presented in this report and the commitment to their continued development through the ongoing 'gatherings' of the clinical teams in Norway
- The impressive quality of program data analysis and the quality of program delivery, as evidenced by the implementation data analysis findings of this report
- The collaborative approach being taken to quality improvement and plans for this to expand in 2023

Areas for further work:

- It was agreed during the annual review meeting that some further analysis would be undertaken of the population of participants who have experienced higher education. This will review the eligibility factors that this group present with.

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Agreed upon priorities for country to focus on during the coming year: • As per Part Five above.
Any approved Core Model Element Variances: NA
Agreed upon activities that UCD will provide through Support Services Agreement: As per the agreed Scope of Work

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Appendix 1: Additional data analyses and /or graphic representations of the data

Table 1: Inclusion criteria for all clients enrolled in 2022 by team and total. % of all clients enrolled with this criterion

	Rogaland	Oslo	Agder	Trøndelag	Vestland	Total
Perceived neglect, violence/abuse or bullying	62 %	42 %	85 %	73 %	65 %	66 %
Contact with child welfare in your own upbringing	41 %	17 %	50 %	23 %	35 %	34 %
Little social support in family and network	38 %	71 %	54 %	42 %	39 %	48 %
Persistent or serious conflicts with partner or others	41 %	54 %	46 %	42 %	30 %	43 %
Difficulties in utilizing relevant services being offered	7 %	33 %	15 %	0 %	9 %	13 %
Not in work, education, and a low level of education	24 %	38 %	54 %	31 %	48 %	38 %
Persistent low income/difficult economy	31 %	46 %	58 %	27 %	22 %	37 %
Mental difficulties	90 %	71 %	85 %	92 %	83 %	84 %
Drug problems	24 %	0 %	15 %	27 %	17 %	17 %
Young of age	17 %	4 %	27 %	19 %	30 %	20 %

Table 2: Ethnicity for clients enrolled in 2022 by team and total

	Rogaland	Oslo	Agder	Trøndelag	Vestland	Total
Norwegian	86 %	38 %	95 %	95 %	82 %	79 %
Other	14 %	62 %	5 %	5 %	18 %	21 %

Table 3: Age (mean and range) for clients enrolled in 2022 by team and total

	Rogaland	Oslo	Agder	Trøndelag	Vestland	Total
Mean	27	33	25	28	26	28
Range	19 - 44	19 - 42	16 - 35	18 - 40	18 - 37	16 - 44

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Appendix 2: Evaluation of temporary CME variances

Please complete the table below for each variance agreed for your country.

CME #:
Temporary Variance to CME agreed:
Brief description of approach taken to testing the variance:
Methods for evaluating impact of variance:
Findings of evaluation to date:

CME #:
Temporary Variance to CME agreed:
Brief description of approach taken to testing the variance:
Methods for evaluating impact of variance:
Findings of evaluation to date:

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Appendix 3: Additional Approved Model Element (AAME)

AAME agreed:
Reflections and findings in relation to use of the AAME

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Appendix 4

Screenshots from "Kompasset".

- **Facilitator "hvordan legge merke til god oppførsel" ("how to notice good behavior")**

Hvordan legge merke til god oppførsel

Barnet og foreldrerollen → Emosjonell omsorg → Regulering og grenser → **Hvordan legge merke til god oppførsel** Side 2

Gi barnet valgmuligheter når du kan. Valgmuligheter gir barnet innflytelse over eget liv. Valgmuligheter lærer barnet å ta beslutninger.
Tilby bare valgmuligheter som du også vil være fornøyd med.

«Nå er det leggetid. Vil du ha en eller to godnatt-fortellinger?»

«Nå må vi gå til bilen. Vil du gå med kjempeskritt eller med museskritt?»

Lag noen regler, og vær konsekvent

- Regler eller grenser gir barnet en følelse av trygghet
- Lag noen regler som du kan hjelpe barnet å følge

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Hvordan legge merke til god oppførsel

Barnet og foreldrerollen → Emosjonell omsorg → Regulering og grenser → **Hvordan legge merke til god oppførsel** Side 1

Legg merke til og kommenter god oppførsel

Hvis du gjør det, er det lettere for barnet å vite hvordan du ønsker at barnet skal oppføre seg.

Si:
«Så fint at du delte maten med vennen din.»
«Takk for at du ryddet bort lekene.»
«Så flott at du kledde på deg helt selv.»

Det fungerer bedre å fortelle barnet hva du vil det skal gjøre, enn å fortelle det hva du IKKE vil det skal gjøre.

I stedet for: «Ikke slå katten.»
Si: «Vær forsiktig med katten.»

I stedet for: «Slutt å sparke i bordet.»
Si: «Hold føttene på gulvet.»

Gi barnet av tiden din. Barnet ditt trenger tid med deg hver dag. Dere kan snakke, leke, synge, lese eller bare kose.

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Sammen på vei

Velkommen til Kompasset!

Her finner dere alt av lisensiert materiale i Sammen på vei, i tillegg til brukerveiledninger og faglig påfyll

Søk i biblioteket

Ansatte ↓ Årshjul ↓ Mor i Norge-studien ↓ Booke videoveiledning ↓ Spørsmål ↓

Temaark → Programinnhold → Informasjonsmateriell →

Vi i Sammen på vei

Her finner man en oversikt over alle ansatte i hvert team og på

Biblioteket

Søk i biblioteket

Søk i programmets materiale. Bruk filtreringsfunksjonen for å innsnevre søket.

Bokmerkede sider

Filter

Typer +

Programområder –

- Familie og nettverk ↓
- Barnet og foreldrerollen ↓
- Personlig helse ↓
- Livssituasjon ↓
- Tverrfaglig samarbeid ↓

Egenskap –

- Temaark ☐
- Video ☐
- Andre språk ☐
- Overordnede dokumenter ☐

Motiverende intervju

Registrering av ukentlig veiledning (dataskjema)

Registrering av ukentlig veiledning

Registrering av teammøter, saksdrøfting og felles veiledning (dataskjema)

Registrering av teammøter, saksdrøfting og felles veiledning

Registrering av felles hjemmebesøk (dataskjema)

Registrering av felles hjemmebesøk

Registrering av ekstra veiledning (dataskjema)

Registrering av ekstra veiledning

6. Intervensjoner tilpasset deltakerens behov

6. Intervensjoner tilpasset deltakerens behov

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