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Nurse-Family Partnership® (NFP) International

Phase Two Annual Report

Phase Two: Feasibility and Acceptability through Pilot Testing and Evaluation
Conduct a pilot test of the adapted Nurse-Family Partnership (NFP) program to inform what additional adaptations may be needed to ensure the feasibility and acceptability of the adapted NFP program.

- Some information may not be applicable in which case note it as N/A
- If you don't have the requested information, you may leave the section blank

PART ONE: PROGRAM OVERVIEW

Name of country: Norway

Dates report covers: 2019

Report completed by: Tine Aaserud, Kristin Lund, Marte Dalane-Hval from Regional Center for Child and Adolescent Mental Health (RBUP), and Benedicte Petersen from the Norwegian Directorate for Children-, Youth- and Family Affairs (Bufdir)

The size of our program:

	# Who work exclusively in NFP	# Who have additional assignments	**Total**
Fulltime NFP Nurses	**8**		**8**
Part time NFP Nurses			
Fulltime NFP Supervisors	**2**		**2**
Part time NFP Supervisors			
Total	**10**		

- We have _____2_____ teams (supervisor-led groups of NFP Nurses)
- Average Supervisor to NFP nurse (+ other staff) ratio: _____1:5_____
- We have enrolled 200 NFP clients since starting Phase Two

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

Clinical leadership, support and guidance: Norway's Clinical Lead draws on her clinical background as a Midwife from two different municipalities when planning clinical adaptations, implementation support to sites and training of the NFP teams. She contributes through many years, to the training of Midwives at the Institute of Nursing at Oslo Metropolitan University. She also has a history of engagement in the Midwives Association. The Senior Advisor has her clinical background in 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 (VIPI), is particularly beneficial in the process of developing the DANCE "substitute".

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.

Description of our National implementing capacity and roles (how these functions are organized):

- Service / implementing agency development:

Implementation partner RBUP has plentiful experience in piloting new programs and methodology and offers implementation research support as part of the testing of new interventions. The Clinical Lead and Senior Advisor at the National NFP Office at RBUP offer daily support to the sites. Clinical Lead is staff manager for both NFP teams.

- Information system and data analysis and reporting: We have one research coordinator who works part time and is responsible for overseeing the data collection and data input process and analyzing the data and making the data reports.

  The administrators/team secretaries in both sites are trained on data input and data quality, and reports are being run evenly. The family nurses collect data on paper forms, and the administrators handle the data system input/plotting into SPSS. The research coordinator at RBUP manage the data system and develop monthly data reports. The research coordinator has regular Skype meetings with each supervisor to hand over data reports and discuss data findings.

License holder: The license holder for the testing of NFP in Norway is the Norwegian Directorate for Children, Youth and Family Affairs (Bufdir). The Directorate is the technical subsidiary body to the Norwegian Ministry of Children and Equality, and heads the national Office for Children, Youth and Family Affairs. Policy support is strong within both institutions, with senior management and political power behind all efforts.

Other (please describe): The national leadership and implementation team is made up by dedicated staff at the licensee, The Norwegian Directorate for Children, Youth and Family Affairs (Bufdir), and a dedicated NFP unit within the National Network on Infant and Child Mental Health at the Regional Centre for Child and Youth Mental Health of Eastern and Southern Norway (RBUP). Externally it has been necessary to distinguish more clearly between the role of the Directorate as the license holder and the role of RBUP. The Directorate has as license holder the

overall responsibilities for the NFP programme, policy support, framework and budgeting and authority liaison. While the role of RBUP is to be in charge of the programme implementation consisting of clinical adaptations, implementation support to local sites, data collection and management, as well as the training programme for staff.
This said, the collaboration agreement between the Directorate and RBUP regarding implementation cooperation was written up specifically to fit a very close joint effort, and the ethos of the programme has in a profound way impacted on the relationship. All decisions are discussed, reflected upon and finally concluded in dialogue, and the regular collaboration is much closer than the norm for a relationship between a commissioning and a service providing institution.

National Board of Experts to be replaced by a Reference Group:
In course of 2018 it become increasingly apparent that the National Board of Experts had not been working optimally and its dedicated members had been declining. After an evaluation last autumn, the Directorate decided to terminate the National Board of Experts and have it replaced by a reference group. The intention is that the reference group will have representation from professional organisations and user representatives who have interests in the NFP-programme. The reference group and its mandate will be set up once it is clear what the Ministry decides to do as next step now as the feasibility and acceptability evaluation by AFI (the Work Research Institute of the Oslo and Akershus University College) has been finalised. It will also be important to secure a closer collaboration with the Norwegian Directorate of Health (Hdir), also at management level.

Description of our local and national NFP funding arrangements, including plans for funding for a randomized controlled trial:
During the current phase 2 (feasibility and acceptability), funds for local staff positions and all activity costs (car costs, training costs, equipment etc) are covered by central government allocations. Local governments (municipalities and townships) contribute some funds towards office rent and contribute staff time in the daily management of the local implementation (heading the local NFP boards). All costs related to national level administration of the programme (license holder's costs and national implementation team) are fully covered by central government allocations. Governmental budgets are annual and dependent on Parliamentary approval, hence funding for the programme testing in Norway is the same. However, the commitment to fund the testing of the programme in Norway is as strong as such our budgetary system allows, with multiple references to the programme in various policy documents and national action plans.

The evaluation which is documenting the feasibility and piloting phase has been undertaken by the Work Research Institute of the Oslo and Akershus University College (AFI) and is funded by the government. An investment proposal for 2021 regarding phase 3 and the importance of expanding the program in order to prepare for some type of research to be able to measure the effects of the program has been submitted to the Norwegian Ministry of Children and Equality in November. A meeting with the Ministry is scheduled for November 18th where we hope to get better clarity about the next steps in testing NFP in the Norwegian context, including the framework for undertaking more research.

Description of our research team and capacity to conduct quantitative and qualitative evaluation (feasibility and acceptability study):

The evaluation team (of phase 2) has been headed by social scientists from the Work Research Institute of the Oslo and Akershus University College (AFI), with participation from the Institute of Nursing at the Oslo and Akershus University College, the Institute of Psychology at the University of Oslo, the Norwegian Institute of Public Health as well as international participation from the University of Melbourne and the Monash University in Melbourne. Evaluation Lead has been Eirin Pedersen, senior researcher at the Work Research Institute. She holds a PhD in Sociology on the interrelations between welfare systems, socio economic status and fertility choices. Wendy Nilsen has been contributing senior researcher from the Work Research Institute, with a PhD in developmental psychology.

RBUP has been making quantitative data reports (gathered by nurses) available to the evaluation team for their quantitative analysis of progress of participating families within key areas. Sharing of data has been governed by specialized contracts, building on templates from the Norwegian Data Protection Agency. This summer we had to revise the data handling contracts due to the new GDPR regulations.

AFI submitted the final report by the end of October having followed the programme for 4 years. The quality of the report is good and we are pleased to share it with the UCD in an English translation, as well as with our international colleagues in the NFP community through the International NFP website. The final report is now with our Ministry for Children and Youth Affairs for assessment and to decide the next steps for the program in Norway.

For more information please be referred to part 4.

Current policy/government support for NFP: (Including plans for responding to challenges and opportunities in government policy, funding constraints, professional changes):
As previously reported the piloting of the Nurse Family Partnership in Norway has been mandated as a measure in several central Government policy documents like: “A good childhood lasts a lifetime”. “Plan of Measures to combat violence and sexual abuse of children and youth (2014-2017)”, “Children living in poverty. Government Strategy (2015-2017)”, ”Escalation Plan on Substance Abuse (2016-2020)” and in the “Escalation Plan against Violence and Abuse (2017-20201)”. Lastly it was also included in the Governments’ new “Strategy on parent support (2018-2021)”. In the latter it is being stated under measure 9 that one will consider extending and expanding the NFP programme if the programme can demonstrate good results. The final evaluation report from AFI has recently been submitted to the Ministry for their assessment and decision about next steps for the NFP programme.

As mentioned in previous annual reports the initiative to test NFP for use in Norway has grown out of the Government’s concern that vulnerable families, and in particular their children, do not benefit fully from the universal services offered, and that socioeconomic disadvantage is inherited across generations, despite efforts to curb and counteract social inequalities in the population. The commitment to the program still appears to be strong when looking at how the programme is being referred to in many key policy documents regarding prevention of violence and early identification of children at risk. Since last reporting there has yet been a new change of Minister, with Kjetil Inge Ropstad heading the post.

Please also be referred to part 4.

Description of our implementing agencies/sites:

High level description of our implementing agencies/sites: Oslo municipality (of which two townships function as a joint site) adopted its municipality strategy “Smart, Safe, Green. Oslo

towards 2030" in 2015, with its introduction chapter focusing on child and youth participation. Target area 2 under "Safe" deals with high quality services and target area 3 deals with equal rights to a beneficial and active life. Early intervention towards families in need is mentioned.

Sandnes municipality, the host municipality within the three municipalities joint site in the South West, has its own municipal child and youth council. Its municipality strategy "Sandnes - front and centre of the future" was developed with the participation of children and youth and contains a section on public health specifically mentioning prevention of persisting social inequalities in health. Two out of the three municipalities in the south western site have received central government seed funding to develop more coordinated efforts of early identification and intervention aimed at parents to children 0-6 suffering from mental illness or substance abuse (including in pregnancy) and see NFP fitting in very well with capacities and outreach strengthened through these focused efforts.

- Current number of implementing agencies/sites delivering NFP: 2 sites

How we select and develop new sites: No new sites have been selected since starting the piloting. However, as we now move forward and in few of further research it will be important to expand the program in order to secure a necessary research sample. Several municipalities have showed interest in the programme. When expanding we plan to invite municipalities to send letter of interest to join the programme. The municipalities will then be selected based on a set of criteria which needs to be further developed.

- Successes/challenges with delivery of NFP through our implementing agencies/sites:

We still receive much positive feedback from participants, collaborators and NFP nurses. There are more referrals coming to the team in the Oslo site now and it seems that the referred families are a better fit for the program. It is obvious that the cooperation with the midwives have become better. There have been changes of 1 family nurse in the team in South West and there is one more family nurse who will be leaving in February 2020. The referral pace has been slowing down a bit perhaps due to exchange of personnel, but it has also been explained that some of the services had understood that the project was supposed to end. We are addressing this misinterpretation.

There was a meeting with a highly influential local politician from Oslo in January with the team, member from the local advisory board (AB) and some of our clients. The background for the meeting was that there is a universal home visiting program in Oslo which is building on the NFP programme initiated by the aforementioned politician called "New families". The problem is that the New families programme is being presented to be equal to NFP which is not the case in terms of target group, quality and structure. This was clearly described in the meeting, from the members of the local advisory board and our clients. The leader in the local AB and the clinical leader have tried to arrange a follow-up meeting with the local politician and her team to discuss how the two interventions can cooperate rather than competing but without success so far.

There has been solid engagement from the leader of the AB and the leader from the other township, in Oslo. The focus in the Oslo site has mostly been on meetings between RBUP and administrative and political leaders to arrange for the transition of the teams to become locally employed. The leaders in Oslo site are positive to the transition. Nevertheless, the AB in Oslo has not been working as well as whished and there has been more apologises resulting in fewer meetings. We believe that lack of predictability and the wish for knowing whether there will be a

future for the program has influenced this. Another point is that the leader of the AB is very busy, and there has been limited planning for the meetings with e.g. focus on the experiences and program content. We plan to discuss this with the leaders in a working group meeting on January 10th where we amongst other things will prepare for the AB meeting on January 16th . The focus in the AB meeting will be on evaluation and debate about the role of the AB and the particular needs for the future phase. It seems as a good time to do this and the same agenda will be brought up in 2020 in South West even though their AB are better working. There are now two clients in the AB in South West and we experience it as very beneficial for the meetings. The cooperation with different services, but especially the child welfare is increasingly good, and we notice the importance of the continuity of contact.

Both NFP teams are still employed by RBUP, but as mentioned above the process of transfer is moving forward and the plan is to have both teams transferred by the end of 2020. There have been different challenges for the local sites to prepare for the transition and they are particularly pre-occupied by the financial aspects and financing and predictability about the programmes continued political focus by the national government. The perspective of secure budgets at the national level for only a year at the time seem difficult for them to handle/accept, even if their attention is drawn to the fact that there is a longer-term political commitment to the programme.

It is also challenging, not to have any experiences or guidelines on how to organise the programme a local level and how to best integrate it with existing services. The transition of the nurses to be employed at local level will be therefore be an important experience.

Other relevant/important information regarding our NFP program:

N/A

PART TWO: NFP CORE MODEL ELEMENTS (CMEs)

Core Model Element	Successes (including progress against benchmarks)	Challenges and suggested actions to address these
1. Client participates voluntarily in the Nurse-Family Partnership (NFP) program.	100 % of our clients have signed informed consent and participate voluntarily in the program.	The family nurses have by now experienced the importance of having one or more thorough exploring conversations. We work focusing on both the client's challenges, needs and wishes and the program content and structure according to fidelity.
2. Client is a first-time mother	100 % of our clients are first-time mothers.	Still there are questions about the possibility for multiparas
3. Client meets socioeconomic disadvantage criteria at intake	Our socioeconomic disadvantage criteria: Most clients are in a position of socioeconomic disadvantage, with the majority (92.2 %) being below the average national gross income. Overall at intake, 33.9 % (N=63) of clients were not in education or employment (NEET) and 66.1 % (N=123) of client were in education or employment (EET). 62.5 % (N=115) of clients have not completed education above the high school level.	We have realized in course of the year that we need to further refine the criteria for inclusion/exclusion of the programme. This will be pursued for 2019 ref. part 5.
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.	41.0 % (N=16) of the clients recruited so far in 2019 were recruited by week 16 gestation.	We are working to increase this. By now, the nurses have experienced how important it is to get started early in the pregnancy and has learned that it is

	100 % (N=39) of the clients were recruited by week 28 gestation. The mean gestational age at enrolment was 18.4 and the range was from week 10 to week 27.	beneficial to share experiences even more with other services and the AB. There has been a strengthened staffing in the basic midwifery service in the Oslo area which might have had the effect that the referrals are increased.
5. Each client is assigned an identified NFP nurse who establishes a therapeutic relationship through individual NFP home visits.	Yes. 31 clients have been transferred to another family nurse, mostly because the family nurse got another job. 10 clients have dropped out of the program because they refuse a new family nurse.	The challenges with turnover among family nurses is that it clearly impacts on the number of dropouts among families in the programme. The nurses therefore talk more with their clients about the team-family nurse set up and how it is beneficial the team members can help one another out during holidays, if a nurse gets ill etc. The increased practice in accompanied home visits has also been a help to raise this awareness and acceptance among families.
6. Client is visited face-to-face in the home, or occasionally in another setting (mutually determined by the NFP nurse and client), when this is not possible.	The clients are mostly visited in their home. Of the 1513 home visits so far in 2019, 1203 (79.9 %) of them were in the clients' home. 76 (5.0 %) of the visits were in a family member or friends' home, 14 (0.9 %) of the visits were at a public health center and 212 (14.1 %) of the visits were at another place. Around half of the visits in the "Other"-category takes place at the NFP-office.	
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.	All clients are visited according to an agreed upon schedule.	As we now begin to learn about the toddler phase, we see that there might be a challenge with the mothers who go back to school or work. It can be

		challenging for the client to find time for the visits. Also, the fact that the child can be in the kindergarten during daytime can affect this matter. We are monitoring the development in delivery.
8. NFP nurses and supervisors are registered nurses or registered nurse-midwives with a minimum of a baccalaureate /bachelor's degree.	In Norway all NFP-nurses are registered nurses with additional training and recognition as public health nurses or midwives.	
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	The eight nurses and two supervisors have completed the NFP educational curricula. The last two nurses got their NFP Diploma in November 2019. We have excellent cooperation with Scotland, who offers foundation training to our new nurses. We have on-going learning activities/refreshment meetings for supervisors and nurses, separate and together, every month.	There is a challenge with few nurses, and to cope with training of the new nurses in teams. There were two nurses in the Toddler training last month. They were both satisfied, but we see that in bigger groups, there are more opportunities of learning from each other, and these dynamics in a group must not be undervalued.
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 apportioning time appropriately across the five program domains.	For information about the mean percentage of time the nurses have spent on each domain during their home visits, please be referred to the Annual Data Report.	At the start of the piloting the nurses needed to learn about the program and the material. By now as we have experienced and understand the program from a to z it is easier to individualize the program while at the same safeguarding program fidelity. Also, we notice the importance of focusing regularly on the balance between fixed and flexed.
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	The teams use their knowledge of theoretical framework to guide their clinical work. The supervisors also aim, during supervision, to connect the theories	

three NFP goals.	to the clinical work. The attachment theories are very relevant when it comes to the supervision in NBO, PIPE and Video feedback interaction from the Senior advisor. The three theoretical framework that underpins the program is the basis of all the nurses work in the home visits. See more about the use of attachment theories later in the report.	
12. Each NFP team has an assigned NFP Supervisor who leads and manages the team and provides nurses with regular clinical and reflective supervision	Yes, we have one supervisor in each team, who provides clinical and reflective supervision individually and in teams evenly/every week.	Keeping up the consistency of weekly reflective supervision, especially individual supervision, is challenging in a practice but is less challenging now than a year ago. The nurses and supervisors high light the supervision as important, both for professional updates and self-development. The supervisors (SV) have worked with the clinical lead to develop the content of the reflective supervision in line with the work and process of the international reflective supervision working group. The understanding of reflective supervision in NFP has increased during this year. The regular meetings with the Supervisors in Scotland are useful and supportive in the developmental process.
13. NFP teams, implementing agencies, and national units collect/and utilize data to: guide program implementation, inform continuous quality improvement, demonstrate program fidelity, assess	The administrators/team secretaries are plotting collected data into the data platform. The research coordinator develops reports to be used to guide	

indicative client outcomes, and guide clinical practice/reflective supervision.	program implementation, inform continuous quality improvement, demonstrate program fidelity, assess indicative client outcomes, and guide clinical practice/reflective supervision. The research coordinator has monthly meetings with each of the supervisors, where data reports are discussed. The supervisors also use data reports in the individual supervision. Our experience is that it is very useful to use data reports in supervision, in team meetings and in meetings with other services and especially in the AB. The nurses videotape 20-minute interactional sequences of mother and child in a naturalistic, non-stressful context. These recordings are being scored by coders who are trained and certified by Biringen in the Emotional Availability Scales (EAS). The results of coding often bring up relevant themes that the nurses find expedient to bring in during feedback to the families. The EAS facilitates observation of changes in the quality of interaction, which can help guide the focus of support and intervention by nurses to strengthen dyadic development.	

14. High quality NFP implementation is developed and sustained through national and local organized support	We work closely with the leadership in the sites and use the engagement of the local advisory boards to ensure that local implementation will be sustained.	The challenges with transferring the nurses to local employment contracts is an impediment to gain experience about the programmes implementation and integration with existing services. We hope to do a solid job in securing the employment transition in course of 2020. We will lean on the NFP management manual and job description etc. to guide us in this process.

Any requested CME variance(s): ☐ No ☐ Yes (please attach completed variance request form)
Where CME variances have previously been granted, please add date of review of the evaluation of these here:
Any Additional Approved Model Elements (AAMEs) : ☐ No ☐ Yes
Where AAMEs have been granted please attach completed document and comment on progress with these below:

PART THREE: PROGRAM IMPLEMENTATION

Reflections on clients, family members, and the community

- # of NFP clients participating in the program over the last year: 39 enrolled, 97 currently active.

- % of those eligible clients offered the program who have enrolled over the last year: 84.8 % (N=39) of eligible clients were enrolled in the program.

- Our initial reflections regarding the characteristics of our NFP clients:
  We find that many of our clients struggle with poor mental health, and neglect in their childhood. 59.4 % of our clients have mental problems at intake and 62.9 % of our clients have had challenges in their early life. We see that the nurses often need to use more time and all their good knowledge and clinical experience to help these families. We have very few "light weight" clients, more often we see that they have multiple and complex problems.

- Client engagement in the program (including client retention): Our retention rate is currently at 63.0 % (97 remaining out of the 154 included who have not graduated the program) for the full program period (i.e. 2016-2019).
  On average the clients have a 4.5 score on involvement, 4.4 score on understanding the material and 4.5 score on acceptance of material in the home visits completed in 2019.

- Engagement of fathers: In 2019, fathers were present and participating at 25.2 % (N=382) of the home visits. In addition, fathers were present and not participating at 3.6 % (N=55) of the home visits. On average the father has a 4.1 score on involvement, 4.3 score on understanding the material and 4.3 score on acceptance of material in the home visits.
  Our experience is that many fathers are interested in the program and are eager to learn and participate.

- Engagement of other family members: Family members (client's mother or father, foster parent(s) and other family members) were present and participated at 2.2 % (N=34) of the home visits in 2019 and were present, but did not participate at 4.5 % (N=68) of the home visits.

- Engagement of community, in particular primary care providers and child welfare agencies:
  We experience that engagement and cooperation with other services is important to keep continually in focus. The teams meet with the midwives and the public health nurses on regular basis. The AB meetings are also helpful in this work. Useful agreements have been developed between the services and NFP teams and the nurses have mostly very good cooperation with the child welfare agencies/consultants and other care providers.

- Success/challenges with receiving referrals
  The referrals are more targeted and relevant for the program. Over the piloting years it seems as if there has been developed a better understanding of who the program is for. The high turnover in the team in South West is affecting the capacity for the team to take in new clients. In Oslo there has been a more sustained period when it comes to turnover among nurses and the referrals are coming in a more regularly pace. According to the Feasibility and Acceptability Study from AFI, around 5 % of the first-time mothers each year in the two districts in Oslo have been included in the program. In South West, around 2.5 % of the first-

time mothers have been included. These numbers are higher than expected and might indicate that the potential client group is larger than expected.

Program Implementation

- Any adaptations, changes, enhancements made to: Visit-to-Visit Guidelines, Nursing Assessment/Data Collection Forms etc.:
  Only minor adjustments to Norwegian context has been undertaken.

- Brief description of our nursing education program:

Our nurse education program consists of three training modules, including program content as well as program delivery during the three phases of pregnancy, infancy and toddlerhood. The clinic lead and the senior advisor have held the infancy and toddlerhood training this year, while the pregnancy training was in Scotland as NFP Scotland has been so helpful and let us send our new nurses to their trainings. We find it to be very useful that the foundation week is held with a bigger NFP community than we can offer here in Norway. In addition, our nurses have been trained and certified in New-born Behavioural Observation (NBO), trained in Motivational Interviewing (MI), this training is regularly followed up and boosted and Marte Meo (Video feedback of Infant-Parent Interaction, VIPI). They have also received training on how to use ASQ and ASQ:SE. PIPE education was received in the infancy training, and we aim to have regularly training in how to use the PIPE material the way it is intended to be used. The new nurses received training in IPV in January 2019.

- Any enhancements we have made to the program:

We use Emotional Availability (EA) Scales to measure the affect and behavior of both the child and mother. There are four caregiver components (sensitivity, structuring, non-intrusiveness, and non-hostility) and two child components (child's responsiveness to the caregiver and the child's involvement of the caregiver). This is a replacement for the DANCE observation. The nurses provide video recording in naturalistic settings with mother and child, and we use external coders to do the assessments. The senior advisor is the head of this and provides supervision to the nurses based on the measurements. The nurses find it useful to discuss challenges regarding to the interaction between mother and child.

Video Interaction Feedback: After the visit of David Olds in March, and helpful discussions with him, we agreed to let the nurses start with Video Interaction Feedback earlier than before, because the nurses found it useful in some of the families. So now the nurses may offer Video Interaction after NBO intervention, from the baby is three months of age. The nurses find the use of Video feedback expedient. We have been asked by some of the fathers if they may participate in the video filming as well, and we will very much like to give them an opportunity for that. Since they are not registered as clients in the program, we are not sure if we can do that because of privacy considerations.

Program Fidelity

- Our assessment of program dosage patterns and length of visits in relation to client strengths and risks to date:
  This is a topic that we are currently working on. Now that clients are starting to complete the program, we are exploring the data on how many visits they get and how this is in relation to client strengths and risks. We see from the data that the number of visits and length of visits varies quite a lot. We are planning to make a summary note after each phase to document the

reasons why a client gets fewer or more visits than the "normal", and pin down the reflections made around this decision. We will address this issue more in 2020.

- Our assessment of program content delivered to date (domains):
  Pregnancy: based on data from 2016 to 2019, we see that none of the five program content domains are within the visit content goals. The biggest difference is in personal health (see Annual Data Report) where our nurses use less time than the visit content goal. This might be because the mothers also receive follow-up from their midwife and doctor during pregnancy.

  Infancy: based on data from 2016 to 2019, we see that four of the five program content domains are within the visit content goals. The family and friends-domain is just above range (15.7 %).

  Toddlerhood: based on data from 2016 to 2019, we see that one (maternal role) of the five program content domains are within the visit content goals. The other four domains are either just above or just below range.

- Our assessment of any other program fidelity benchmarks:
  We still need to focus on earlier inclusion to achieve the benchmark of recruiting 60% or more clients before gestation week 16.

- Our reflections on the issues revealed and actions we are taking /planning in response to these: We are planning to make a summary note after each phase to document the reasons why a client gets fewer or more visits than the "normal", and pin down the reflections made around this decision. We will address this issue more in 2020.

Client and Child Program Impacts

Please provide a summary of your annual program client and child outcome indicators, collected through your NFP information system or attach a copy of your annual data report (guidance can be found in the document 'Producing data for the annual report', which can be downloaded from the International NFP website).

Please be referred to the Annual Data report.

- Our reflections and key learning from our data regarding program impact:

Pleased be referred to the Feasibility and Acceptability Study from AFI, as well as part 4.

- Our reflections on what we could do in addition to enhance program impacts for clients:

The fact that we only by now during the last months, have learned from all the three phases and that we have graduated more than 40 clients make us believe that the adjustments we can do now will be more appropriate being based on firsthand experience with the program cycle.

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.

Our data suggests that the mothers are very pleased with Video feedback interaction (Marte Meo) and have learned a lot about their babies and the interactions between the parent and the child. Between 70 % and 94 % (depending on the question) of the mothers responds that they have

learned a lot or quite a lot about what their baby can do, how the baby can communicate with their parents, how they can respond to their baby, how they can help their baby when he/she is crying and how they can make eye contact and interact with their baby.
The mothers also report that they feel more confident as a parent after the video feedback interaction with the family nurse (58 % answered a lot more confident and 35 % answered quite a lot more confident). When asked about how they feel in general that the video feedback interaction has been regarding getting knowledge about their baby, 48 % answered "Very good", 21 % answered "Good", 24 % answered "Fair" and 7 % answered "Poor".
Some clients comment that is was fun to use Video feedback interaction and that they became more aware of their interaction with their baby.

Upon request, we may describe one or two Video interaction Processes, to show how we implement this tool in practice.

NFP program innovations

- We are using/plan to use the following program innovations/enhancements (e.g. STAR Framework, DANCE, IPV, Mental Health, other):

Our nurse education program consists of the three training modules (pregnancy, infancy and toddlerhood), including delivery of NFP program content. We use STAR Framework and IPV as recommended. We have replaced DANCE, as recommended by the international team, with assessments that are common to use in Norway. Our nurses have been trained and certified in Newborn Behavioral Observation (NBO), they have been trained in Motivational Interviewing (MI), Marte Meo (Video feedback of Infant-Parent Interaction, VIPI) and they receive ongoing practice in ASQ, ASQ:SE and PIPE.

- Assessment of our successes/challenges in implementing/adapting these program innovations:

Successes: Our four new nurses have attended a Foundation week in Scotland, and they call it a perfect way to tune in to the NFP work. Clinical lead and Senior adviser at National office in Norway delivered the Infancy module in 2018 and Toddler module in November 2019 for the new nurses, and the feedback on this is good as well. Clinical lead and Senior adviser at National office in Norway delivered the Infancy module in 2018 and Toddler module in November 2019 for the new nurses, and the feedback of this is also good.
NBO is quite common in Norway, so many of the nurses got the certification before they started as NFP-nurses. For those who do not have the NBO education from the start, they find it very useful to get the training, delivered by colleagues at RBUP.

Challenges: We see that training that give the nurses time to concentrate on the learning material over a few days, is better than to divide it into pieces. Our challenge is that the nurses cannot have days and days with training, because of the visit plans for the families. Especially the PIPE curricula, is difficult to integrate well enough. There are many reasons for this, firstly, there is not enough time to practice the sessions. Secondly, the nurses find it unnatural to have a teaching role vis-a-vis the parents. The first two steps are good to do, but to have the mothers demonstrate with their baby, can be unnatural for the nurses. We agreed to try out a more relaxed way of step three, with the nurses and mothers trying out the tasks together/simultaneous, mother with the baby and nurse with the doll. We see that all the topics are theoretically sound, but the nurses want to be good in both theory and practice. We agreed to have extra focus on five of the lessons, and that the nurses feel free to use other lessons if they want. We also agreed in having PIPE practicing in team meetings more often.

We have planned for a zoom meeting and cooperation regarding Interaction tools with Nancy Donelan-McCall, PhD, Associate Professor, University of Colorado Denver on December 17th. We are looking forward to sharing our experiences, and to discuss challenges in using PIPE the proper way, and how to face the challenges.

Any alternate tools we will use/are using and why:
We use NBO the first three months of life, and video feedback interaction (Marte Meo) after that. After discussions with David Olds in March 2019, during his visit in Norway, we agreed to try out video interaction from the infants turn three months of age, for those who wants it. So, we are not using an alternative tool, but offering it at a different point of age than we did before.

- Reflections on use of these alternate tools to date:

We find our dyadic assessment tool (DANCE replacement) combining NBO and Video Interaction Feedback methodology, and the measuring with EA Scales to be an enhancement of the program. The use of EA Scales, both for research and clinical use, is also successful. It is even better than last year, because the coders are more trained, and the nurses find the feedback reports useful in clinical practice. There is, though, a challenge with the EA coding, asthere are few certified EA coders in Norway. We have ongoing dialogue with the founder of EA Scales, Zeynep Biringen, from Colorado for refreshing, and to make suggestions for adaptations to fit NFP. We find the cooperation very useful. Together with her team, Biringen is developing an EA measurement to be used in pregnancy (PreEA). This may be of interest for our clients, to look at their mentalization of the coming child.

To use video feedback in the families is a success. Today, the nurses do the filming, and pass it over to the senior advisor for analysis and finding the right clips. It is doable with the small teams we have today, but in the long run, we need to get the nurses skilled enough to do the analysis more on their own. We have agreed to offer the nurses to be certified as Marte Meo therapists. The training is mostly what they already do, to practice the method in at least ten families, and it ends with an exam where the nurses show the process from the beginning till the end, and how they use the theory from Marte Meo (attachment theory) and sensitization of the parents to the child. They need to film themselves giving feedback to the parents while they are watching the videoclips of the dyad. This is about one year of education, including 100 hours of supervision of a Marte Meo supervisor (the senior advisor in NFP).

Our information system and analytical capacity:

- How we are currently collecting, analyzing and using NFP program data (information system, data quality, how it is used at NFP nurse, supervisor, team/site, national levels etc.):
  The nurses collect the data on paper data forms and the administrators/team secretaries plot the data into the SPSS data program, developed for NFP data management by our research team. The research team have monthly data-report meetings with the supervisors, focusing on different data forms and various subjects. The supervisors use the data in individual supervision and in team meetings. We also have data-report meetings with the teams, where we discuss findings and how they can be useful in their clinical practice.

  In 2019 the supervisors have started to use the data reports more in individual supervision and have worked together with the research coordinator at the national office to improve the reports and make them as useful as possible.

  Since the data forms are filled out on paper and then manually plotted into SPSS, we do experience some mistakes and missing data forms. The research coordinator does a lot of quality assurance to improve the data quality.

- Our reflections on our information system and what we need to do to improve its functionality, usefulness and quality:
  We have worked a lot this year to adjust the data forms. Our experience is that they don't always fit to our context and our clients. The research coordinator has analyzed the data we have so far, and the teams have shared their experiences using the data forms. We hope that our updated data forms will be finished early 2020.

  We also plan to start working on a digital data collection system soon.

- Our plans to develop a Continuous Quality Improvement process:
  We have joint gatherings five times a year were the clinical issues and the nurse's experiences are brought forward. We highlight the experiences from the work of the nurses. Now that several of the nurses have followed families through the whole program, and the nurses have become more confident in program delivery, it is easier to be more flexible and offer tailor-made follow-up within the NFP framework. The nurses do, to a greater extent, as expected during the home visits and manage to focus on the areas that the families need most, so that the program delivery should be optimal for each family.
  Clients highlight the relationship with the nurse as unique. We see that among the clients who drop out, the reason most often is when there is a change of nurse and the client needs to have a new nurse. This means that the relationship is important, but it also means that we will strive for developing an approach of confidence so that clients want to continue in NFP despite the change of a nurse.

  We have several experiences where the father expresses that he wishes to be more involved in the program, even when it comes to video guidance. It is a challenge for us, as he is not a part of the program, and we do not have consent directly related to Dad's participation. Although Dad's role is important, especially in Norway, where it is required by law for father to stay at home several weeks with the baby, and if he does not stay at home for these weeks, these weeks cannot be transferred to the mother. So, the father has an active role towards the child, and we would like to involve him even more in the program delivery.

  We plan to make a curriculum for the Norwegian NFP-education both to have a structure for handling it more efficiently in future plans and to be able to show how thorough and complex the education and program is. The gatherings for exchanging experiences we have had during these first years will probably be developed and enhanced to be more focused on refreshing and developing relevant knowledge. Experience gatherings, training in NBO, Marte Meo, IPV and more, will appear in the annual year wheel. This will help us anticipate and plan meetings and training for both new nurses and those already employed in NFP.

Nursing Workforce

- Reflections on NFP nurse/supervisor turnover/retention during reporting year:
  It is still a challenge to handle turnover in the small teams. Lack of clear cut sustainability for the program future at national and local level, has an impact on the nurses turnover/retention. Reference is made to what has been said on this issue earlier in this report. It could be added that the local leaders in Oslo have always pointed out that they want the family nurses in their townships, while the leaders in the 3 municipalities have not been as clear at their level. However, the fact that the family nurses are very skilled and educated makes them attractive for other services.

- Successes/challenges with NFP nurse/supervisor recruitment:
  We experience that even if there is a lack of public health nurses and midwives in general in Norway we always get applicants for the announced engagements. However, we experience that it takes some time from the advertisement before applications are received. It is helpful to inform open posts through various channels. During the interview phase applicants often want to join the NFP team even more.

- Successes/challenges with delivery of core NFP nurse/supervisor education: As it is still small teams where it is possible to have the overview. It is not a problem to educate few at a time, but it is expensive. The challenge, amongst other things, is that there are few nurses for developing discussions/ opportunities of learning from each other, and the dynamics in a group is in many ways missing.

- Successes/challenges with ongoing (integration phase) NFP nurse/supervisor education: We experience that there are both positive and challenging experiences by being small. We can quite easy recognize if there is challenges in understanding or using some part of the program and we can relatively quickly plan for increasing focus on an area. We get close being a small team and perhaps the opportunities for learning from one another is smaller then.

- Successes/challenges with delivery of NFP nurse reflective supervision: The reflective supervision is working better now. The theory behind and the structure is better understood now than earlier and the nurses and SV experiences of the benefits of using STAR in supervision has been helpful in this.

- Successes/challenges with delivery of reflective supervision to our supervisors: The Clinical Lead have Skype meetings with both Supervisors, every week. When needed they also have one to one meetings. In addition, they also have two days working meeting, approximately every 6 weeks. The attention on reflective supervision has been mostly when working on how to increase the focus in the supervision with the nurses. The supervision is related to either challenges with nurse staff/individual nurses or various challenges in the everyday life in the program.
- Any plans to address nursing workforce issues: Looking forward we hope to be able to expand the existing teams and for the future to have bigger teams. We do believe that bigger teams will be more sustainable.

Summary

- What have we achieved this year: We would like to high light some other issues which is not being boxed above, but which has been important for the program implementation. Firstly, we had a successful and inspirational Conference in Mars including a very useful and nice visit by David Olds and Ann Rowe. Moreover, we have had important meetings and contacts with local politicians and two meetings with the Minister of Children and Family Affairs. The Minister has also met some of our clients. Several clients have wanted to tell about their experiences about joining the program and they have been interviewed in meetings with cooperating services at municipal level. We have completed toddlerhood training with two new nurses and IPV training for three nurses. During gatherings with both teams five times through the year we have focused on experiences and development and have found the gatherings very useful. There has been recruitment as expected and there are now approximately 45 clients who have graduated from NFP. We have had graduation gatherings for clients and their families. The evaluation report covering phase two was finalized by the end of November and was positive to the pilot phase and support a transition to phase 3.

When the evaluation report was launched there was a very good media coverage on the national radio including interview with a client, a nurse and the Director of Bufdir.

- What challenges do we face? It will be important to prepare and facilitate a good transfer process for the teams to be employed by local authorities. Since the process has prolonged, we experience that there is a lack of knowledge about the programme among the local leaders who haven't been responsible for the teams yet. The unpredictability about the future is challenging because there is much to prepare for an expansion. It will be a big job to adjust both data forms and material according to our experiences and the Norwegian context. We see that we need to find a solution to give clients partners the opportunity to participate to a greater extent due to for instance Norwegian leave regulations etc.

- Anything else:

Any other relevant information:

PART FOUR: ASSESSMENT OF PROGRAM TESTING AND EVALUATION

Our feasibility & acceptability study:

Goals: Norwegian pilot phase evaluation consists of two main components; a "traditional" feasibility and acceptability study/process evaluation (qualitative) and a pre- and post-intervention outcome evaluation (quantitative). Goals of the evaluation were to:

• explore the feasibility and acceptability of the programme in the Norwegian context
• document adaptations of the programme from international standards to Norwegian realities
• discuss overlap/conflict with existing welfare services in a high-service societal context
• document experiences from families and nurses with a focus on feasibility, acceptability and usefulness in the Norwegian context
• document the criteria and process for inclusion and recruitment of participants
• explore success indicators/tendencies of effect/improvement for participating families

The evaluation has been undertaken by AFI.

Methods: For the process evaluation (qualitative acceptability and feasibility study), the focus has been on exploring the mechanisms at work in the implementation of NFP and their relevant outcomes. Regarding recruitment of participants, the focus has been on criteria and practical working methods and preventing drop out. Data sources for this part of the study include qualitative interviews with implementers, local NFP board members, NFP nurses and participants, as well as other stakeholders. Written questionnaires and document studies, including analysis of public reporting data (local to central government reporting system KOSTRA) was to supplement interview data.

For the outcome evaluation (quantitative study) which was finalized by the end of October 2019, the hope was to identify some success indicators/tendencies of effect/improvement for participating families. The data used for the analysis consists of various mappings, scoring and data gathering already integral to the NFP information system. For targets with more than one point of data input, for instance regarding the mental health of the mother, pre- and post-analysis or development analysis (for example growth curves) was used to track indications of positive developments. For targets with only one point of data input, such as birth outcomes (birth weight, Apgar score etc.), the aim was to compare data to available national figures for similar

populations, available figures from NFP evaluations in other countries, or available data from other studies/programmes in Norway. Given the fact that final report was finalized in October 2019 and therefore not capturing the whole cycle of phase two of the programme which is running till mid-2021, we are probably limiting the possibility to identify some of the success indicators/improvements for the participating families.

Sample: In accordance with the license agreement, 150 families are the sample size for quantitative analysis in the outcome evaluation. This said NFP Norway has renegotiated a license agreement of 240 families.

In the final report from AFI at total of 81 interviews were undertaken between 2016 and 2019 for the quantitative data. This is a mix of interviews composed by participating families, family nurses, collaborating services and representatives from the municipalities.

As for the qualitative data collected for the final report it covers 185 families, by September 35 families had finalized the program and there were relatively few families in the toodler phase. Frequencies and analysis in the final report is therefore based on participating families in the pregnancy or infant phase.

- Progress to-date: Final report by AFI was submitted to Bufdir by the end of October 2019 and shared with the Ministry for assessment and way forward.

Findings from feasibility & acceptability study to date:

- Key findings from our study:
- 1. The program is well implemented and of a high quality
- 2. The program targets a vulnerable group which is normally not easy to reach
- 3. The intervention improves the families mental health challenges, their housing og parent skills.
- 4. The program fits into the Norwegian context and existing services – being an important supplement. Moreover, the families in the program seems to improve their ability to benefit from other existing services through the building of trust in their experience with the family nurse.
- 5. The program has limitations in terms of geographical coverage and cannot be rolled out nationally due to its structure and target group.

Moreover, the report conclude that it is likely that the program is preventing transfer of child custody from parents to public institutions. The latter is of great importance in the Norwegian context.
The most important effect mechanism in the program is considered to be the strong relationship between the nurses and the families.

- Reflections on our findings/results: The findings in the report are overall positive and offers a good basis for taking the program forward, depending on what the Ministry decides to do. We know from the data collected that many of the families have experience/linkages to the child protection services. As many as over 2/3 of the participants have themselves been taken away from their parents more than three months before the age of 18. This is significant in terms of who the program is targeting. It would be of great importance in further research if one can prove that the NFP program prevents transfer of child custody from parents to public authorities. There is a strong component of strengthening the parenting skills in the NFP program in Norway. If one manages to break the negative generation cycle of multiple risk

factors in the early years of a child through the NFP program this is of great value both at an individual level, as well as at community level.

- Any actions planned based on results: Based on the final report from AFI, Bufdir has recommended to the Ministry that the NFP program is being continued and expanded, and that some type of research is being undertaken in order to measure the effect of the program in a Norwegian context.

Anything else that would be helpful for UCD to know?

PART FIVE: ACTION PLANNING FOR NEXT YEAR

Our planned program priorities for next year:

1. RBUP plan to transfer the teams from RBUP to employment at the level of the municipality. This imply preparatory work and sound agreements between RBUP and local authorities.
2. Refine and develop the data forms and other materials to fit better to the Norwegian context.
3. Develop the educational curriculum for the Norwegian context. Develop dyadic tools to secure better sustainability.
4. Prepare for expansion for 2021 by strengthening the national office (provided that the Ministry is pursuing the programme). Here under developing a digital data collection system. Send invitation to municipalities to send letter of interest to join the programme.
5. Work on refining the inclusion/exclusion criteria for the program when recruiting participants.

Any plans/requests to UCD for program expansion/adaptation? Bufdir has currently a license agreement with UCD of 240 families. Currently 200 families have been enrolled in the programme. Depending on the next steps and the Ministry's decision for 2020 there might be a need for expanding the license agreement already in 2020. If need be, Bufdir will revert to UCD on this issue in course of the year.

This is what we think we need to be doing next year to adapt and improve the quality of our NFP program in the coming year: Continue to develop as written above and to continue to work in close collaboration with the nurses to be sure to develop the program in accordance to their experiences, while keeping up fidelity to the program.

Our research/program evaluation priorities for next year:
Bufdir will enter into a dialogue with the Ministry to identify what the Ministry is expecting/willing to fund and what research design one is to pursue to be able to measure effects of the program in a Norwegian context. The outcome measures have to be selected accordingly.

How we will know if we have been successful in meeting our objectives?

1. Teams has been transferred to the local authorities and functional contracts are in place.
2. Refined and new data forms and other materials have been developed. Dyadic tools have been sustained.
3. Developed the educational curricula for the Norwegian context, as well as sustainable dyadic tools.

4. National office has been strengthened and necessary preparations for an expansion has been undertaken. A digital data collection system has been outlined and developed.
5. Refinement of the inclusion/exclusion criteria has been undertaken.

This is what we would like from UCD through our Support Services Agreement for next year:
Support in developing the above-mentioned planned activities. To put us in contact with persons in NFP who might know something extra around specific themes.

Our suggestions for how NFP could be developed and improved internationally are:
Continue the regular zoom meetings for clinical leaders with focus on development which is of outmost importance. Continue the website for international questions, discussions etc. Take initiative to work on setting up a joint NFP conference across countries? If possible, to develop some high-level guidance on how to integrate/structure the NFP program along local services?

PART SIX: ANNUAL REPORT FROM UCD

(To be completed by UCD following meeting to review annual report)

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

- Mentoring and guidance to Clinical Lead
- Strategic consultation for license holders
- Advice and guidance on program expansion for phase three
- Guidance re potential research design and outcome measures for phase three
- Contributions to National Conference, Oslo.
- Responses to ad hoc questions and requests for documents etc
- Access to NFP International website and resources, Clinical Advisory Group and other International collaboration.

Identified strengths of program:

- The expertise and commitment of the License holders to ensure that the program is well supported at Government level
- The outstanding clinical leadership provided to the teams and supporting agencies
- The thoughtful, insightful and respectful way that adaptations to the program have been made and evaluated.
- The commitment, talents and experience of the NFP nurses and supervisors
- The support and commitment provided to local leaders of the program to ensure integration of the program with existing services.
- The emerging use of data reports to guide quality improvements and the high-quality national data report produced for the annual review
- The strategic plans in place to enable progression to phase three
- The willingness of all involved to continue to learn, adapt and improve the program in Norway

Areas for further work:

- To gain full commitment to expansion and sustainability strategic plans
- To continue the progression of nurses to local employment
- To make further adaptations for context, based on the learning from phase 2
- To review and adapt the methods for assessments of caregivers and dyadic interactions to create a sustainable model for the future
- Further refinement of the inclusion and exclusion criteria for the program in Norway
- Develop educational curricula and content for NFP in Norway
- Continue to expand the range of data reports available for sites and teams during 2020.
- Development of a research design/methodology proposal for phase 3

Agreed upon priorities for country to focus on during the coming year:

- As per part 5 with addition of development of a proposed research design/methodology for phase 3

Any approved Core Model Element Variances: No

Agreed upon activities that UCD will provide through Support Services Agreement:

- Continued mentoring and guidance for Clinical Lead
- Monitoring of license, oversight of fidelity and agreement of quality improvement plans
- Guidance regarding research design for phase 3
- Consultation on further adaptations and quality improvements
- Visit to Norway; September 2020.

