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Abstract

Engaging fathers has the potential to benefit the entire family through 1. promoting fathers' wellbeing directly, 2. building on fathers' vital capacity to support mothers' psychological wellbeing, 3. maternal health behaviours, and 4. promoting children's mental health and development. Benefits to a child's development include positive impacts on cognitive development, educational attainment, social competence, positive self-esteem and reduced incidence of emotional and behavioural problems. However, the barriers to father-inclusive practice are real and numerous and include personal, organisational, strategic and societal factors. This article reviews the need to work more closely and fruitfully with fathers, and acknowledges some of the barriers.

Introduction

Fathers make an indelible contribution to the lives of their children, and health visitors are well placed to ensure that this is a positive legacy. Engaging fathers has the potential to benefit the entire family through 1. promoting fathers' wellbeing directly, 2. building on fathers' vital capacity to support mothers' psychological wellbeing, 3. maternal health behaviours, and 4. promoting children's mental health and development. Benefits to a child's development include positive impacts on cognitive development, educational attainment, social competence, positive self-esteem and reduced incidence of emotional and behavioural problems. To realise the benefits of dads and partners being more involved in children's care and lives, health visitors need to engage fathers as key collaborators in the physical and psychological wellbeing of the family. However, the barriers to father-inclusive practice are real and numerous and include personal, organisational, strategic and societal factors. Progress requires change at each of these levels.

The changing social context of fatherhood

In the UK, it is increasingly expected and observed that fathers will be actively involved throughout pregnancy, birth, the postnatal period and parenting (Royal College of Midwives, 2011). One example of fathers' greater involvement is attendance at birth. In the 1960s, about one in ten UK men were present at the birth of their child (King, 2012) , whereas in 2003 it was around 86% (Kiernan and Smith, 2003). Fathers now spend more time with their children than they did in the 1970s (Asmussen and Weizel, 2009) but a substantial proportion (46%) still wish they could be doing more (Parker and Livingston, 2016) . Alongside greater physical presence, the nature of their role is changing, with fathers increasingly expected to be more involved in nurture and greater sharing of caring responsibilities (McBride et al, 2005, Gregory and Milner, 2011). Despite fathers welcoming these changes, evidence shows that many men are ill-prepared for the impact of parenthood on their lives and require more tailored information and support, especially where there may have been a lack of role modelling if their own father was less involved (Condon et al, 2004).

Policy context

The changing landscape of fatherhood is also evident within the policy context; for example, the recent introduction of shared parental leave (although it is yet to be seen how this will be adopted in practice). The need for health professionals to support fathers' involvement throughout pregnancy, childbirth, and during the transition to parenthood is clear in several UK policies (NICE 2006, 2008, Department of Health 2007, Department for Children, Schools and Families 2010). Of key relevance for health visitors is the position taken in the government's *Healthy Child* Programme (Department of Health, 2009), emphasising the need to support and engage fathers.

Box 1: Healthy Child Programme (2009: p10)

"A major emphasis on parenting support

- Supporting mothers and fathers to provide sensitive and attuned parenting, in particular during the first months and years of life.
- Supporting strong couple relationships and stable positive relationships within families, in accordance with The Children's Plan (Department for Children, Schools and Families, 2007).
- Ensuring that contact with the family routinely involves and supports fathers, including non-resident fathers.
- Supporting the transition to parenthood, especially for first-time mothers and fathers."

What are the benefits of being more inclusive of fathers?

Fathers have the potential to contribute to family wellbeing in a number of ways, and there is a wealth of good quality research evidence that illustrates the critical role they play in family mental health, maternal health behaviours such as breastfeeding, smoking and nutrition, and the social, academic, emotional and behavioural outcomes of their children. Some of these associations are observable from pregnancy; thus there is a clear rationale for adopting father-inclusive practice from before a child is born.

Child development

Most of the research undertaken on the impact on fathering has concentrated on the implications for child and adolescent mental health with persuasive evidence to indicate that fathering has an important protective and constructive influence on the mental health of children across various ages. Sarkadi et al's (2008) systemic review of 18 studies found that father involvement influences

psychological, behavioural, social and cognitive outcomes in children. More father involvement is associated with better cognitive and social competence, improved capacity for social responsibility and empathy, positive self-esteem, better relationships with siblings and better educational outcomes. Goodwin and Styron (2012) demonstrate that fathers who display positive engagement with their children, such as accessibility and responsibility to participate positively, impact on improved psychological and emotional regulation, social maturity and life skills in the child as well as a more constructive child/adolescent-father relationship. Remaining warm and supportive, concerned, occupied and engaged with the child are among fathering characteristics that have been shown to constructively impact on a child's mental health (Flouri and Buchanan, 2003, Sarkadi et al, 2008, Reeb and Conger, 2011).

Fathers' positive involvement impacts on child development in several ways - directly through father-child interactions, indirectly through reduced inter-parent conflict and indirectly by acting as a 'buffer' for their young children against the potentially negative effects of mother's postnatal depression (Chang et al., 2007) . Supporting fathers therefore has the potential to benefit the entire family in both the short-term and long-term.

There is also evidence indicating effects that continue into adolescence and adulthood. Martin et al (2010) and Welsh et al (2004) report that positive fathering has a noteworthy influence on school preparedness, academic performance and educational outcomes. Similarly, Wilson and Prior's (2011) literature review found that constructive fathering facilitated and promoted: fewer school adjustment difficulties, improved academic advancement, increased access to higher and further education with subsequent enhanced occupational attainments in adulthood.

Parental mental health and psychological wellbeing

The psychological wellbeing of fathers can have a direct impact on maternal mental health, both positively and negatively. Having a supportive partner is a protective factor against developing

mental health problems (Lancaster et al, 2010). Services often struggle to meet mothers' mental health needs (Bauer et al, 2014, Darwin et al 2015) and partners are a critical source of support. The mental health of mothers and fathers is modestly correlated (Paulson and Bazemore 2010) and early paternal depressive symptoms predict worsening or continuing or maternal depressive symptoms (Paulson et al, 2016). Thus paternal mental health also warrants consideration and it should be noted that approximately 5-10% of fathers experience perinatal depression (Paulson and Bazemore, 2010) and approximately 5-15% experience perinatal anxiety (Leach et al, 2016).

Maternal health behaviours / Public health messaging

Alongside the contribution of fathers to the emotional wellbeing of the family, fathers can also benefit the physical health of the family through supporting positive health behaviours. Pregnancy and the perinatal period is often described as a window of opportunity for health behaviour change (Phelan, 2010) and it equally may offer a time of high motivation where engagement with fathers can have a direct, positive impact on their pregnant partner's health behaviours.

Smoking and Alcohol Consumption

Two Fatherhood Institute reviews (2007, 2015) reported that the strongest predictor of maternal smoking during pregnancy was the partner's smoking status (Penn and Owen, 2002) and that a partner's heavy alcohol consumption is associated with an impaired mother-infant relationship (Eiden and Leonard, 1996).

Breastfeeding

Mothers with a partner who supports their decision to breastfeed are more likely to be breastfeeding on discharge from hospital (Scott et al, 2001) and to breastfeed for a longer duration (Brown and Lee, 2011). Father-inclusive breast feeding education and support was shown to reduce postnatal anxiety (Tohotoa et al, 2011) leaving fathers better able to support their female partner. Brown and Davies (2014) provide a review of how to maximise the benefits of partner support in breastfeeding promotion.

Childhood Obesity

Fathers have the potential to influence the likelihood of developing childhood obesity through their involvement with various health behaviours. For example, breastfeeding reduces the risk of childhood obesity (e.g. Monasta et al, 2010) whereas maternal smoking has a dose-dependent relationship with childhood obesity: the more a woman smokes during pregnancy the more likely her child is to be obese at age 5-7 years (von Kries et al, 2002). Fathers are an important extra ally when it comes to public health messaging across a range of behaviours but this opportunity has yet to be realised.

<u>Fathers continue to be overlooked and underserved</u>

Despite this wealth of good quality research evidence highlighting the central role that fathers play in a range of wide-reaching family outcomes, there appears to be something pervasive and immutable about our difficulties in engaging fathers. For instance, in a 2014 review of over fifty peer-reviewed articles about engaging fathers in family services, Burgess et al (2014: 5) concluded "the needs of fathers with young children are not being met, nor are they clearly understood". Fathers continue to feel overlooked by maternity and family services (StGeorge and Fletcher, 2011)

and "*invisible and insulted"* (Salzmann-Erikson and Eriksson, 2013: 385) around the birth of their baby and during the postnatal period, which can often create feelings of helplessness (Backstrom and Hertfelt Wahn, 2011) and isolation (Deave et al, 2008).Fathers continue to be underused as a source of support for their children (Fisher, 2007) despite the observation that "*healthcare professionals, especially midwives and health visitors, are well placed to support expectant and new fathers"* (Deave and Johnson, 2008: 632). The Healthy Child Programme (DoH, 2009) adds "The contribution that fathers make to their children's development, health and wellbeing is important, but services do not do enough to recognise or support them. Research consistently finds that men are not provided with the educative and social supports to assume their fathering role. (Burck and Speed, 1995, Kraemer, 2000, Featherstone et al, 2007, 2010, Laming, 2009).

The barriers to involving fathers

The barriers to father-inclusive practice are numerous and include personal, organisational, strategic and societal factors. Addressing each barrier in turn can lead to a step forward but sustained, speedier progress requires change at all of these levels. The barriers potentially include the preponderance of female early years professionals, societal attitudes and biases around fatherhood, a lack of specialist training or personal reflective space on fatherhood for early years professionals, workload capacity of early years professionals, and a reluctance of some mothers to include their partner. We will now go on to discuss these in turn within the specific context of health visiting.

Gender of health visitors

As of September 2010, 99% of health visitors and 99.6% of midwives in England were female (Department of Health, 2012). Male health visitors totalled 101. Page et al (2008) found that the predominantly female workforce might be acting as a barrier to engaging fathers, partially because both genders make assumptions about the female-centric nature of care. For example, one of the key barriers to father engagement reported in the literature is fathers feeling that they would not

find 'traditional' perinatal support helpful and useful as they perceive that it is developed for, and aimed at, mothers (Lee et al, 2011). Men in this study reported that they would be more interested in engaging in support that had been designed specifically for fathers.

Attitudes and stereotypes

Men face various stereotypes related to their gender and masculinity, which are further compacted by additional stereotypes specifically about fatherhood. For example fathers are often unhelpfully represented in the media and wider society as disinterested, feckless, absent, irresponsible or dangerous (Lloyd, 2001). The view that men are less competent parents and in need of female supervision when caring for children appears pervasive in British society, to be internalised by men themselves and be a view held equally by both men and women (Lamb, 2004).

Men may be reluctant to get involved in childcare, inadvertently reinforcing the stereotype or indeed having internalised it. Mothers and health visitors, sensing men's reluctance, may consciously or unconsciously facilitate men to take a back seat, for a range of reasons including the stereotype that women are just more suited than men to childcare.

Perceived disinterest of fathers

Another widely held stereotype relating to fathers is around their perceived disinterest and lack of engagement/motivation. The Fatherhood Institute recently evaluated a programme of one-day fatherhood training funded by the Department for Children, Society and Families (Burgess et al, 2014). Prior to attending the training day, fathers' behaviour was interpreted by frontline professionals as reluctance or unwillingness to be involved during home visits. One participant had said "*The dads kind of leave the room and leave the mums to it or go and walk the dog or smoke in the garden or something".* Post-training evaluation found improved participant knowledge and

attitudes, and a positive impact on practice. Follow-up telephone interviews found the majority of participants felt the training had raised their awareness of the importance of engaging with fathers.

There is a critical need for training and reflective supervision to address these attitudes and stereotypes.

A lack of fatherhood training and reflective supervision

When exploring what perpetuates stereotypes about fathers, a lack of professional education and/or reflective supervision is often identified (Page et al, 2008). This suggests that there may be a systemic bias in which fatherhood issues are not prioritised in clinical training or practice.

Safety and risk

A barrier which potentially undermines father-inclusive practice concerns perceived threats to personal safety around men. Lloyd (2001) notes the common assertion among health and social care professionals that "men are dangerous". Swann (2015) found that the fear of assault, including sexual assault, is a widely held but unspoken worry for female social workers. It follows that if one holds the view that men might be dangerous to women and children, this might act as a covert barrier to assertive engagement of fathers, especially amongst a predominantly female workforce.

Father-inclusive practice does not mean having to tolerate abuse or violence from men or encourage women to put up with these behaviours in the interests of protecting the father-child relationship (Swann, 2015). The vast majority of dads are not risky, and it is also important to remind ourselves that perpetrators of sexual abuse, emotional or physical abuse, or child neglect can also be women (Radford et al, 2011). As with many of the barriers, the first step in overcoming this issue is to talk about these concerns either in supervision or as a team, so that the feelings of worry and fear can be aired. In the minority of cases where parents are known to be risky, the risks must be articulated and

addressed in advance of the work. Some fathers do have a harmful impact on their partner and/or children, and the benefits of working with these fathers may be even greater. For example, the NSPCC Caring Dads: Safer Children programme for fathers who have previously perpetrated domestic abuse found that this group of "risky" fathers can be helped to reduce incidents of domestic violence and improve relationships with their children (McConnell et al, 2016)

Box 2: Reflective Practice

Dads matter and our views about dads matter. We each hold an emotional and mental representation of fathers based on our early life experiences, and this is true whether he was present or absent, loving or abusive, alive or dead. Take a minute to think about your own father. What was he like, what did your experiences of him tell you about a man's role in the family? In what way do you think of the fathers on your caseload as the same or different? Whatever your dad is or was like, even if you never met him, the probability is that he will have shaped you, your life and your practice in some way.

Workload capacity

Lack of training and supervision are not the only barriers faced by health visitors. As we enter our eighth consecutive year of austerity, it continues to be a challenge to maintain a universal service for mothers and children. Health Visitors may fear that including fathers in their practice will increase their workload and detract from the needs of women.

It may well be true that engaging fathers at the outset of the health visiting relationship will lead to some extra work, but this has not been tested. However, there are proven benefits that including fathers can improve the physical and emotional wellbeing of all family members – and increase the

capacity to support mothers from within the family unit, and thus potentially more efficient in the long-term. For example, a mother experiencing postnatal depression is more likely to recover more quickly if she has a supportive partner (Pilkington et al, 2015).

As noted previously, fathers are a potential ally for public health messaging. They are an untapped resource within the family system which can act to complement and supplement professional intervention and support healthy family functioning. Hence, we need to start seeing fathers less like another demand on our time, and more like an incredibly valuable and important on-site resource.

Box 3: Quote from our interview with a male Dads worker

"If midwives actively seek out dads to engage with, they [the dads] can become a key tool to ensuring the appropriate support is present for mum during pregnancy. Instead of midwives exhausting themselves with responding to the problems mum presents with, and managing all the support for that, they can tackle the causes with the whole family to offer real sustainable change."

<u>Having the time and tools to assess and support perinatal mental health</u>

A significant concern reported by health visitors and midwives is that they are already struggling to meet the needs of new mums, so finding the time to screen, detect and support paternal wellbeing issues raises obvious concerns about workload capacity. However, there is some evidence that not doing so may lead to greater family support needs later down the road. For example, a mother is more likely to be depressed if her partner is also depressed (Paulson and Bazemore, 2010) hence, seeking timely specialist support for either parent would be helpful for the family as a whole.

There are several challenges however concerning the assessment of fathers. Firstly, as for women, pursuit of improved identification needs to be accompanied by appropriate referral and

management (Darwin et al, 2015) and, secondly, validated tools are required. There is some evidence that tools may need to be adapted in terms of the language used to describe symptoms (Madsen and Juhl, 2007) and in terms of the thresholds used (Matthey et al, 2001).

Maternal reluctance

One barrier to including partners might be maternal reluctance to involve the father and/or for the health visitor to have direct contact with him. For example, there may be a suggestion from mum that there are already relationship difficulties between them, or mum may have heavily invested in her identity as "the main carer" as a way of processing anxiety about her role change and potential loss of career. It is understandable that health visitors might resist engaging dad into the work where he or she knows that this could be unwelcome for mum. There will likely be additional reluctance where there are concerns that dad may be harmful or have a negative impact on the family. However, these may be the men with whom our work might be most fruitful, and the benefits of appropriate father-inclusive practice to all family members, especially to the child's life long outcomes, make this decision one which needs very careful consideration. Thinking about whether a reluctant mother can or should legitimately act as gate-keeper to a piece of necessary work with a father again emphasises the need for reflective supervision. Broader discussion of mothers' role in gate-keeping contact between dads and helping professions is overdue .

Overcoming mum's reluctance to her partner's involvement in our work may be extremely beneficial for the children. Children benefit from a positive parental couple or co-parenting relationship (Harold et al, 2016). Higher father involvement with the children correlates with a more positive couple relationship (Pleck and Masciadrelli, 2004). Jones (2010) found evidence that marital conflict negatively affects parenting behaviour which in turn negatively affects children. Therefore, whatever can be done to support the inter-parent relationship – be that as a couple or as individuals

- is likely to have a positive impact upon child wellbeing and this may mean persuading mum to include dad more in her contacts with child health professionals.

Box 4: Excerpt from our interview with a health visitor talking about the value of working with fathers

"Jodie was a young mum and had a history of postnatal depression so I wasn't surprised when she was diagnosed with it again after her third child. She'd always complained about her partner not supporting her enough and I knew their relationship was under stress. One day she told me that he had really shouted at the baby whilst bathing her and that he refused to do any of the nappies or feeding. I was starting to become quite concerned and asked to see them both together. Jodie's partner felt quite got at by "us women" and I had to do a lot of listening to him, look mainly at him, and direct my questions to him by name before I felt the rapport develop. It turned out he'd been diagnosed with Asperger's Syndrome as a boy and basically he just couldn't decipher the baby. This led to him getting really stressed and shouting. I saw them together several times to help him decipher baby cues and baby states, and referred him to a course about understanding your child. When I see Jodie at baby clinic now, she tells me her partner is still using his visual prompt cards about baby cues, and occasionally he'll ring me directly to check something out with me. That piece of work built capacity within the family that exceeds any external referral".

Conclusions

There is a wealth of evidence to show that fathers' positive involvement during the perinatal period and beyond can lead to a number of benefits for family psychological wellbeing, maternal health behaviours and a child's emotional wellbeing and development. Despite national policy advocating for health professionals to promote engagement with fathers this is not yet consistently evident in practice. For this to change, we need to identify and acknowledge what it is that makes father-inclusive practice difficult to achieve. As illustrated here, the barriers to father-inclusive practice are

numerous and include personal, organisational, strategic and societal factors, requiring approaches that span these levels. A collective approach will be required, and wider changes in organisational and social culture are still necessary, but small changes by individual health visitors, teams and service leads could lead to big impacts. We need to work towards men perceiving our health visiting service to be not only for their partners and children, but also for them as parents and partners. The arguments for overcoming these barriers are compelling, not least because children benefit so greatly; in addition, there is the potential to ultimately reduce professional workload and strain by building capacity and resilience within the family.

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Further Reading and Useful Information

All Babies Count: the Dad Project. How to support dads during pregnancy and the first year.

www.nspcc.org

A range of useful resources and research reviews are available at www.fatherhoodinstitute.org and www.ihv.org.uk including Local Authority Child Public Health Briefing (7): The Health Visiting contribution to working with fathers