

Evaluation of a Training Programme and Toolkit to Assist Health Visitors and Community Practitioners to Engage with Fathers as Part of the Healthy Child Initiative: A developmental study using action research

A Collaboration Between the Fatherhood Institute and the University of Worcester

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SUMMARY

The growing emphasis in government policy on health professionals engaging more and more effectively with fathers derives from a robust evidence base supporting the positive impact of fathers' early engagement with their children on their emotional, behavioural and educational attainment. Yet there is little evidence that the importance of engaging with fathers is reflected in Health Visitor training or, indeed, that family services are making progress in father-inclusive practice. Assisted by a grant from the Burdett Trust, the Fatherhood Institute has endeavoured to address this deficit by collaborating with the Institute of Health & Society at the University of Worcester to develop and evaluate a training programme and supporting toolkit (manual) for Health Visitors and Community Practitioners delivering the Health Child Programme. The aim of the programme is to enable practitioners to engage better with fathers and father-figures in the families they visit. Using a mixed methods study design, the programme was evaluated by the Research Team at the University of Worcester.. Between 2012 and 2014, 134 Health Visitors and Community Practitioners were recruited from 12 sites across eight NHS Trusts in England to participate in a survey designed to evaluate the impact of the FI training programme on their knowledge, attitudes and practice. The results showed that the training day improved participants' knowledge and attitudes, and positively influenced their practice. These improvements were sustained over the three month study period. Telephone interviews carried out at the end of the study revealed that the majority of participants felt that the training programme had raised their awareness of the importance of engaging with fathers and had offered them some helpful strategies to achieve this in their work. Structural and practical barriers to engagement with fathers were also highlighted. The researchers recommend that health and family services develop a more strategic approach to father inclusive practice, thereby supporting Health Visitors and other family workers in their current efforts to engage with fathers, and their future aspirations.

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APPENDICES

Appendix 1 – Literature Review

Appendix 2 - Fatherhood Institute Training Day

Appendix 3 – Toolkit

Appendix 4 – Questionnaires 1,2,3

Appendix 5 – Semi structured Telephone Interview

Appendix 6 – Role of the Father questionnaire (Palkovitz, 1984)

1. BACKGROUND

In preparing for this study, over fifty papers published in peer-reviewed journals were examined in order to determine whether policy at home and in other English-speaking and European countries has been successful in improving engagement of family services with fathers (Appendix 1). This review concluded that the needs of fathers with young children are not being met, nor are they clearly understood. Common barriers to better engagement with fathers included a predominantly female workforce in family services, lack of training and education for health, social care and family practitioners in how to meet the needs of fathers, a paucity of information specifically aimed at fathers, lack of positive images of men as fathers in health and social care locations, and correspondence from services being directed exclusively at mothers (Page & Whitting, 2008). These barriers persist despite a significant body of evidence testifying to the positive impact of fathers' active involvement on children's educational attainment (e.g. Aldous & Mulligan, 2002) and on reducing the incidence of emotional and behavioural problems children experience (e.g. Ramchandani et al., 2012). In addition, fathers can act as a 'buffer' for their young children against the potentially negative effects of mother's postnatal depression (Chang et al., 2007). Studies also show the need to address fathers' lifestyle behaviours as well as mothers' as two Fatherhood Institute reviews (2008; 2010) revealed that smoking (Penn & Owen, 2002) by a pregnant woman's partner is the most significant predictor of her own smoking, and that a partner's heavy drinking can have a damaging effect on the mother-infant relationship (Eiden & Leonard, 1996).

Yet despite empirical evidence of the positive impact of actively involved fathers on their children's wellbeing, and of the lost opportunity when services neglect to engage with them, there appears to be a limited understanding of what fathers need. Studies frequently report that fathers feel overlooked by maternity and family services (StGeorge & Fletcher, 2011) "*invisible and insulted*" (Salzmann-Erikson & Eriksson, 2013:385) around the birth of their baby and during the postnatal period, resulting in feelings of helplessness (Backstrom & Hertfelt Wahn, 2011) and isolation (Deave et al., 2008). The Fatherhood Institute's report *The Cost and Benefits of Active Fatherhood* (2008) noted that health practitioners often approach father-child relationships at best casually and, at worst, with hostility.

The consensus in the literature is that fathers are underused as a source of support for their children (Fisher, 2007); that "*healthcare professionals, especially midwives and health visitors, are well placed to support expectant and new fathers*" (Deave & Johnson, 2008:632) and that services must develop new ways of reaching out to men (Plantin et al., 2011). Research has clearly established that fathers would like support from health and family care professionals (Garfield & Isacco, 2012). However, professionals need to feel positive and confident about engaging with fathers (Magill-Evans et al., 2006) and this is likely to mean specific education and training to help them address their fear of engaging men and to improve communication with them (Zanoni et al., 2013; National Nursing Research Unit, 2013).

2. RATIONALE

Despite recognition of the benefits of father inclusive health and family services, services are still heavily weighted in favour of mothers, and appear slow to change. A study exploring the impact of education and training to assist Health Visitors and Community Practitioners engage with fathers was considered timely. The aims were to ascertain whether a dedicated, high-quality programme provided by a key third-sector organisation could increase participants' knowledge of the role of fathers, change (if needed) their attitudes towards engaging with fathers, build their confidence and provide them with practical strategies to engage with fathers in their work. In addition, a study was required that would explore health professionals' perceptions and experiences of engaging with fathers and identify obstacles to father-inclusive practices, with a view to addressing these strategically within health and family services.

3. AIM & OBJECTIVES

Aim

To develop and evaluate a training programme and toolkit for Health Visitors and Community Practitioners delivering the Healthy Child Programme (Department of Health, 2009) to enable them to engage better with fathers and father-figures in the families they serve.

Objectives

- To pilot, evaluate and modify a specially designed training programme and supporting toolkit to enable Health Visitors and Community Practitioners to engage better with fathers;
- To roll out the modified training programme and toolkit on five further sites;
- To assess Health Visitors' and Community Practitioners' knowledge of, attitudes towards and current practice in relation to fathers prior to receiving the study-day intervention, using a specially designed questionnaire;
- To assess the immediate impact of the training programme and toolkit on the knowledge, skills and intention to engage with fathers of participants, using a post-intervention questionnaire;
- To assess the longer-term impact on the knowledge, skills and practice behaviour of participants towards fathers, using a second post-intervention questionnaire;
- In addition to modifications made at the pilot stage, to further modify the training programme and toolkit, if required, in response to analysis of the second post-intervention questionnaire;
- To roll out the training programme and toolkit on a further 12 sites in the second year of the project.
- To evaluate the impact on the knowledge, skills and behaviour of Health Visitors and Community Practitioners.

4. THE INTERVENTION

The training day (Appendix 2) was designed by the Fatherhood Institute and facilitated by its own trainers, using Powerpoint slides and a toolkit, *Health Visitors and Fathers: A Good Practice Guide* (Appendix 3) specifically developed for this study.

5. METHODOLOGY

The study used a mixed method, pre-intervention, post-intervention, post-intervention design over a three month period to evaluate the training programme and toolkit. Quantitative data was collected using questionnaires (see Appendix 4) across three time points T1 (start of training day), T2 (end of training day) and T3 (three months later) and qualitative data was collected via open ended questionnaires on the T2 and T3 questionnaires, and semi structured telephone interviews (see Appendix 5) undertaken following completion of the second post-intervention questionnaire. The pilot study and main study were conducted over a 27 month period from April 2012 to June 2014. Completion of the pilot study resulted in:

- Minor amendments to the content of the toolkit.
- Two adjustments to the study Consent Form (see *Ethical Considerations:p8*).
- An alteration to the data collection method for the third questionnaire, from postal to online using Survey Monkey.

No further changes were made to the training day or toolkit in the course of the study. During Year 1 of the study, a further amendment was made to the protocol to extend data collection to practising student Health Visitors and Community Practitioners such as Family Nurse Practitioners and Community Nursery Nurses.

Procedure

The Fatherhood Institute (FI) identified and approached NHS Trusts throughout England to carry out the training day. The University of Worcester (UoW) developed the evaluation tools and approached local Research & Development Officers at participating Trusts to obtain ethics permission for the study. Initially, six NHS sites expressed interest in participating in the study; one later withdrew and another was excluded as the majority of participants would have been inexperienced student Health Visitors, with no opportunity to test their learning in a practice setting. A further 25 sites were approached by the FI to take part and an e-shot was sent out to 8,000 practitioners from the FI database at the start of Year 2. Eleven sites were finally involved in the study in addition to the pilot site.

Local collaborators at each site disseminated information about the training day to Health Visitors and Community Practitioners via emails, meetings and notice boards and recruited participants to the training day. Once recruitment was complete (maximum 20 people per site) the local collaborator emailed an Information Sheet about the study to each participant one week before the training day.

The training was facilitated by a professional trainer from the FI. Information about the study was given at the start of the day by one of the two members of the research team (HH or MN) who also received the written informed consent of participants. Questionnaires T1 and T2 were administered at the start and end of the training day respectively. Fifteen minutes were set aside for each questionnaire to be completed.

Three months' after the training day, the third questionnaire, T3, was emailed to the study participants via Survey Monkey, using the email addresses provided on the Consent Form (with the exception of the pilot study participants who received theirs by post). Non responders were sent two email reminders. Each site was closed to data collection after four weeks.

Once data collection was completed at each site, study participants who showed substantial changes in attitudes (Section 2) and practice behaviour (Section 3) across the three questionnaires were identified and, if they had consented, were contacted by telephone. Twenty-six interviews were carried out.

Sample

For the pilot study and during Year 1 when the training day was delivered at five sites, participants were restricted to qualified Health Visitors. In Year 2, this was extended to include practising student Health Visitors and Community Practitioners (e.g. Family Nurse Practitioners and Community Nursery Nurses) to increase the number of study participants and in recognition of the fact that practitioners other than Health Visitors have contact with families and young babies. In total, 191 people attended training days, with 134 (70%) taking part in the study. This discrepancy was due to people attending the Year 1 training days who did not fulfil the criteria for participation in the study as defined at that time, as well as three people having to leave the training day early.

Measures

a) Questionnaires

The first questionnaire, T1, asked about participants' gender, age and length of time as a Health Visitor/other health or family care practitioner.

All three questionnaires were divided into three sections. Section 1 sought information about participants' knowledge of fathers' level of involvement with young children and impact on family life. Section 2 explored their attitudes towards fathers, and Section 3 investigated their actual or intended practice in relation to engaging with fathers.

Section 1 – Knowledge Questions

This section was designed by the research team to gain a broad overview of participants' knowledge of the impact of fathers on their children's and partners' health and wellbeing. Questions drew on work completed by the Fatherhood Institute (2008; 2010) detailing the impact of fathers on families, and on findings from the literature review. Some questions had several correct answers, and some had one only.

- Maximum score for Section 1: 19

Section 2 – Attitude Questions

This section explored participants' attitudes towards fathers using the *Role of the Father Questionnaire* (ROFQ) (Palkovitz, 1980, 1984) (Appendix 6). The validity of this questionnaire has previously been established with parent populations, either mothers and/or fathers. However, it was felt that the questionnaire could appropriately be used in the present study to measure health professionals' perceptions of the father's role in caring for their young babies/children. The ROFQ contains 15 statements, and participants were asked to indicate their level of agreement or disagreement with each item on a 5 point Likert scale. Total scores on the ROFQ range from 15 to 75, with higher scores reflecting attitudes that fathers are capable, sensitive to their children and should be involved with them.

- Maximum score (indicating very positive attitudes) for Section 2: 75

Section 3 – Behaviour in Practice Questions

This section was designed by the research team to ascertain the extent to which study participants engage with fathers of families that they visit. Questions at T1 explored their current level of engagement with fathers; questions at T2 explored their intended level of engagement at the end of the training day, and at T3, explored their actual level of engagement during the three months following the training day. There were 13 statements in this section and participants were asked to respond either *yes*, *no* or *uncertain* to each statement.

- Maximum score (indicating high level of actual or intended engagement) for Section 3: 26

b) Training Day Evaluation

Three questions at the end of T2 and T3 invited participants to respond to statements about the usefulness of the training day on a 5 point Likert scale, ranging from *strongly agree* to *strongly disagree*.

c) Telephone Interview:

A semi-structured telephone interview schedule was devised by the research team to drill down further into participants' responses on the questionnaires and to explore in greater depth their experiences of engaging with fathers in practice, as well as their evaluation of the usefulness of the training day and toolkit.

Ethical Considerations

Initial ethical approval to carry out the study was obtained from the University of Worcester's Institute of Health & Society Ethics Committee and research governance approval was obtained from the Research & Development (R&D) department of each of the participating NHS Trusts. Two amendments to the study consent form, and one to the protocol (inclusion of non Health Visitors as participants) were subsequently submitted to the University Ethics committee and the relevant NHS Trust R&D departments for approval.

Before administering the questionnaires at each training day, a member of the research team reassured participants that the information they provided would be kept confidential. Participants were informed that they could withdraw from the study at any time without offering an explanation. At the start of each telephone interview, HH asked permission to record the interview and consent was recorded once the digital recorder had been turned on.

Analysis

SPSS, Version 21 for windows was used for analysis of quantitative data.

Non parametric analysis using the Friedman test was carried out for the pilot and main study phases combined, to identify any change in participants' questionnaire scores across the three time periods. Where statistically significant differences were identified, the Wilcoxon Signed Rank Test was used to measure any change in pre-test knowledge, attitudes and behaviour in practice in the short term (i.e. by the end of the study day) and longer term (i.e. 3 months' later).

Potential telephone interview participants were identified using a line graph to observe directionality of change in responses across the three questionnaires, based on scores for Sections 2 and 3 (attitudes and practice behaviour). Participants were invited to be interviewed if they demonstrated a substantial change in attitudes and/or practice during the study period. The interviews were transcribed verbatim and analysed according to frequency of themes identified.

6. RESULTS

Analysis: quantitative data

The socio-demographic characteristics of participants are presented in Table 1.

Table 1 : Participants' socio-demographic characteristics

N=134		Total Sample N (%)
Gender :	Male	3 (2.2)
	Female	131 (97.8)
Age Range :	20-29	11 (8.2)
	30-39	30 (22.4)
	40-49	49 (36.6)
	50-59	40 (29.9)
	60-69	4 (3.0)
Job Title :	Health Visitor	110 (82.1)
	Practising Student Health Visitor	14 (10.4)
	Community Nursery Nurse	5 (3.7)
	Family Nurse Practitioner	3 (2.2)
	Staff Nurse	2 (1.5)
Time working with families:	Mean (range) SD 115.96	8yrs 4 mths (1 month – 37 yrs)
	Median	4 months
	Less than 1 yr	46 (34.3)
	1-5 yrs	26 (19.4)
	6-10 yrs	19 (14.2)
	11 + yrs	43 (32.1)

The largest proportion of study participants were within the 40-49 years (36.6%) age range and female (97.8%). The majority were qualified Health Visitors (82.1%). The length of time that participants had worked with families in the community ranged from 1 month to 37 years, with a mean of 8 years and 4 months and median of 4 months. These figures are likely to have been affected by the inclusion of practising student Health Visitors and other Community Practitioners in Year 2 of the study.

Response rates for each questionnaire are reported, per site, in Table 2.

Table 2: Response rates to the questionnaires (by site)

Site	Responses received T1 N=134	Responses received T2 N=134	Responses received T3 N=87
Pilot Study :			
Bath, Somerset	9	9	8
Year 1 :			
Glastonbury, Somerset	10	10	4
Dereham, Norfolk	14	14	10
Leeds	10	10	6
Bexhill, East Sussex	8	8	5
Year 2 :			
Wells, Somerset	7	7	5
Bridgwater, Somerset	1	1	1
Surbiton, Surrey	7	7	6
South Tyneside	15	15	12 *
Bexhill, East Sussex	15	15	8
Shrewsbury, Shropshire	18	18	12 *
Torbay, Devon	20	20	10 *

* One participant from each of these sites stated their intent not to complete the third questionnaire (as opposed to not returning it).

Completion rates for the two questionnaires administered during the training day were high, as anticipated, and 87 participants (65%) responded to the third and final questionnaire administered 3 months' later.

The median scores per section of each questionnaire, at each of the three time points, are reported in Table 3.

Table 3: Median scores per section of each questionnaire at T1, T2 and T3

	Median knowledge score (max score 19)	Median attitudes score (max score 75)	Median behaviour in practice score (max score 26)
T1	15	65	19
T2	17	68	26
T3	16	67	22

The Friedman test indicated that there was a statistically significant difference in knowledge scores across T1, T2 and T3 ($\chi^2 (2, n=80) = 52.993, p < .001$); in attitude scores $\chi^2 (2, n=83) = 34.995, p < .001$) and behaviour in practice scores $\chi^2 (2, n=80) = 91.684, p < .001$).

Post hoc analysis using the Wilcoxon Signed Ranks test was carried out to determine where the specific differences lay. A Bonferroni correction was applied to the initial $\alpha=.05$ for the post hoc analyses, resulting in an adjusted significance level of .017 to account for the increased risk of a Type I error.

In summary, the analyses showed statistically significant improvements in knowledge, more positive attitudes towards fathers and heightened intention to engage with fathers in practice between T1 and T2, with moderate to strong effect sizes. However, scores consistently decreased across these three areas between T2 and T3, and this was statistically significant for knowledge (with a small effect size $r=.23$) and behaviour in practice (with a moderate to strong effect size $r=.43$) but not significant for attitudes (with a small effect size of $r=.14$). Overall, the results showed that the initial improvement observed during the training day (T1 to T2), was also statistically significant between T1 and T3, with small to moderate effect sizes, indicating that learning was sustained over the three month study period.

At the end of the training day (T2), participants were asked to rate the usefulness of the day on a five point Likert scale. Of the 134 participants, 132 (98.5 %) completed these questions (Table 4).

Table 4 : Participant evaluation of the training day at T2

N=132	Strongly Disagree N (%)	Disagree N (%)	Neither Agree or Disagree N (%)	Agree N (%)	Strongly Agree N (%)
Found the training and toolkit useful in helping me understand more about the importance of engaging with fathers on home visits	1 (0.8%)	4 (3%)	11 (8.3%)	31 (23.5%)	85 (64.4%)
The training day and toolkit provided me with at least 3 new strategies for engaging with fathers	1 (0.8%)	4 (3%)	17 (12.9%)	32 (24.2%)	78 (59.1%)
The training day and toolkit provided me with practical ideas for engaging better with fathers when they are present on home visits	1 (0.8%)	5 (3.8%)	15 (11.4%)	33 (25%)	78 (59.1%)

Overall, the majority of participants strongly agreed with the three statements, indicating a positive response to the content of the training day.

Analysis: qualitative dataEvaluation of training day:-

The third questionnaire, administered three months after the training day, invited participants to respond to two open-ended questions Q37 & Q38) about the day.

Q37: How would you assess the usefulness of the training day and toolkit in retrospect? What has been most useful and what has been least useful?

Eighty-three (95.4%) participants responded. Most comments fell into five main categories.

- a) Comments on the usefulness of the training day in raising awareness of the importance of engaging with fathers;
- b) Comments on the helpfulness of research evidence provided during the training day in relation to the impact on children of actively involved fathers;
- c) Comments on the usefulness of learning practical strategies to increase engagement with fathers of young babies;
- d) Comments on the opportunity to share knowledge and experiences with other community health professionals;
- e) Comments on how services do or do not demonstrate father-inclusive practice.

a) Usefulness of the training day in raising awareness of the importance of engaging with fathers

The majority of study participants reported that they had found the training day useful:

It helped to raise my awareness of the importance of engaging with Fathers and supporting and encouraging them to be involved in their child's physical and emotional care.

Increased awareness of how invisible father can be made to feel at times.

Some reported how this increased awareness had led to making changes to their practice during the three months since the training day:

I have been made aware that it is SO important to include fathers in the initial new birth contact and the antenatal contact. I like to make sure I include them when they are at the visits.

A minority of participants felt that the training day had not meet their expectations, and reported that they had learned nothing of value as engaging fathers was already part of their practice:

I did not learn anything I did not already know about the importance of engaging fathers. The statistics were not useful to me in everyday practice.

A lot of the content was not new to us and as practitioners, we are convinced of the necessity to engage fathers.

b) Helpfulness of research evidence provided during the training day in relation to the impact on children of actively involved fathers

Many participants felt confirmed and supported in the work they were already doing with fathers, or aspired to do, as a result of the discussion of fatherhood research during the training day:

It (the research) has shone a light on what I see in my role; that on the whole Dads want, need and can play an active and irreplaceable role in their children's lives to the benefit of the whole family unit.

c) Usefulness of learning practical strategies to increase engagement with fathers of young babies

Many of the participants welcomed tips on how to get in touch with and engage with fathers of young babies:

How to include fathers using names on appointment cards. Asking for both parents to be present at visits.

How to engage with fathers more, to include them and speak to them more on visits, rather than aiming everything at the mother, which I was probably doing before the training.

Some participants had been inspired to introduce creative new strategies into their practice, with a positive response from fathers:

Following the study day, we started a nature walking group which was aimed at both Fathers and whole families. Initial attendance of fathers has been good.

d) Opportunity to share knowledge and experiences with other community health professionals

A number of participants commented on how they had appreciated talking to other community practitioners and sharing their knowledge and experiences. For some, this was a rare and therefore, especially valuable opportunity:

It was good to network with other professionals and listen to others' views on the subject.

e) How services do or do not demonstrate father inclusive practice.

Some participants expressed their frustration at not being able to engage fathers in the way they would like due to restrictions imposed by the service they worked in:

All staff in all multidisciplinary teams should access training in this area. Despite utilising tools suggested to engage fathers, we are still not effective. More work needs to be done on why this is and men still feel alienated and excluded in the upbringing of their children – staff need to be more flexible towards fathers i.e. offering later appointments/preparation for parenthood classes in the evenings and not just sticking to the traditional health visiting hours of 9 to 5.

The training has highlighted that there needs to be more services and groups made accessible to fathers ... as this is a gap in our area.

What we need is the strategic interventions that will support us to achieve change in the way things are decided at an organisational level.

Q38: Do you feel you need any further training to help you engage more effectively with fathers? If yes, please specify

Fifty-four participants (64.3%) responded *No* and 30 (35.7%) responded *Yes* to the first part of this question. Of these, 33 (39.2%) added further comments.

The majority of participants agreed that ongoing and/or further training was needed:

Regular updates of new, innovative ways to engage fathers would be beneficial. Annual updates suggested.

Some participants felt that further training should adopt a more didactic approach:

Would be useful to look at what actually works – more skills based rather than why we should engage fathers.

Others made helpful suggestions about future training agendas:

Would be good to speak to a group of dads to hear what they want from HVs.

Working with teenage fathers would be helpful.

It would be beneficial to have a collaborative approach to involving fathers so invites to Children's Centres and midwives would be beneficial.

Training on fathers with more complex issues would be useful, i.e. substance misuse, anger management issues. Sadly, these are the fathers we work with a lot.

Telephone Interviews:-

Of the 87 participants who completed the T3 questionnaire, four stated that they did not wish to undertake a telephone interview. Fifty-four (65.1%) of the remaining 83 were contacted, of whom 26 (48.1%) agreed to be interviewed.

The interviews confirmed findings from the open ended questions at T3, namely that the training day had increased participants' awareness of the importance of engaging with fathers, that it had been valuable to learn about the research underpinning practice and to be told about practical strategies for improving father inclusive services, and that it had been supportive to share ideas and concerns with peers.

Three further themes emerged from the telephone interviews:

- a) Perceptions of fathers' willingness to engage with services
- b) Difficulties in accessing fathers
- c) Obstacles to father inclusive practice at a strategic level.

a) Perceptions of fathers' willingness to engage with services

Several participants commented that fathers often seemed unwilling to engage with them and appeared disinterested when they made home visits or ran parenting sessions:

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.

I think it's down to the fathers themselves not particularly want(ing) to attend sessions.

I've noticed how they hang back and they don't really push themselves forward and engage in the same way as the mothers do.

Prior to the training day, some participants had interpreted this as fathers not wanting to be involved but had changed their attitude subsequently:

I'd made an assumption that they weren't that bothered about being included whereas now I don't feel that way.

Another participant divided fathers into those who were interested and those who declined to engage:

If the dads present for the visit, it's usually because they want to be ... if they're not interested they tend to make themselves scarce.

For a minority, father inclusiveness seemed an uphill task:

They're not even visiting their babies even though they know they're born.

Post training, however, several health practitioners reflected on the fact that services still consider that their clients are mothers and so fathers may feel pushed out:

Some of the fathers have said they don't feel comfortable in the clinic.

They now felt that it was up to them to encourage fathers to get involved:

It's just a matter of providing them with the opportunity.

Keeping lines of communication open to fathers was mentioned as important and explaining to them what the service was offering them:

Having the ability to be approachable.

Letting dads know that if they have any concerns, they're more than welcome to ring us.

Some participants reflected on the problems for both fathers and professionals posed by health visiting being a predominantly female profession:

Maybe they would be different if it was a male trying to talk to them, so maybe it's their preconceived ideas about who can help them and who can't.

Having conversations with fathers is quite different to having conversations with mothers. I mean traditionally, we've been maternal and child health services. We're very used to talking with women. Most of us are women so we relate woman to woman in a very different way and that's an interesting scenario.

Everyone interviewed mentioned the practice tips that they had picked up from the training day. There was universal surprise at how some simple strategies to increase engagement with fathers such as including the father's name on letters and engaging them in direct conversation, *giving a lot of good eye contact*, were having a positive effect on the number of fathers attending appointments:

Most fathers do want to engage and they look absolutely delighted when you do. Really it's quite shameful because you're just treating them the same as the mothers and it's quite shameful when you do look back at your practice and you see the difference that it has made but it's about making progress over the years.

b) Difficulties accessing fathers

Many participants commented on fathers' unavailability. By the time of their first visit, most dads had already gone back to work. Some services have begun to address this:

We are just in the process of looking at alternative working practices which would include later evening visits and weekends and Saturday visits as well.

However, some participants anticipated that there would be reluctance around flexible working hours:

I think a lot of people possibly choose this job because they quite like the hours.

Then there are financial costs, there are issues around premises, there are issues around safety.

A few considered that one means of tackling the difficulty of accessing fathers who were back at work was to offer a better explanation of what the health visiting service can offer them:

Maybe promoting ourselves to dads more and making them realise it's a family thing, not just a mum thing, and then they might be able to be there more often if work would allow it.

c) Obstacles to father inclusive practice

Many participants were concerned that their Trust's system for gathering information failed to acknowledge fathers, resulting in professionals not being able to include them in records:

The electronic record is individually named and they automatically set up the child record when they're born and they link it to its mother's record.

Most participants felt that there was a rhetoric about father-inclusive practice that was not necessarily realised in day-to-day work with families:

There seems to be quite an emphasis about reaching out to dads, but it hasn't quite filtered down into practice.

Some felt there was a lack of support from key stakeholders:

It feels at the moment like we're doing it from the very bottom up .. and that's quite difficult.

I don't think you will see real changes in numbers of fathers who feel fully engaged until we've done more strategic work and that we've got stakeholders who can influence it.

It's more of a Trust level thing than at our level.

Alongside a general recognition of the need for a culture shift was a pragmatic attitude that acknowledged changes in practice were not going to happen immediately:

We've made some small changes as a team which have made a difference, so you just have to keep plugging away at that because it's not something that's going to happen overnight.

7. DISCUSSION

This study set out to evaluate a training programme to assist Health Visitors and Community Practitioners to engage better with fathers of infants. The results suggest that specialist training and education, delivered by skilled and knowledgeable facilitators, has a positive impact on knowledge about the importance of engaging fathers, attitudes towards fathers and behaviour in practice. Of particular relevance is that improvements in these areas occurred not only between the beginning and the end of the training day, but were largely sustained over a three month period with significant improvements in scores between time points 1 and 3, indicating the ongoing effectiveness of the training intervention.

Despite a small decrease in knowledge scores between T2 and T3, statistically significant differences between T1 and T2 and T1 and T3 indicate that new knowledge was largely retained. This suggests that the intervention was effective in conveying to participants new facts about the importance of engaging with fathers of young children. This is borne out by participants who commented in open-ended questions or during interview that the information they had received at the training day had increased their confidence to offer fathers a coherent, evidence based explanation about the importance of their being involved with their children from a very young age.

How and whether Health Visitors and Community Practitioners approach fathers is likely to be influenced by their attitudes towards fathering, and preconceptions about fathers' parenting skills and fathers' ability to respond to babies as effectively as mothers (Gustafsson et al., 2013). Several papers have explored anti-father prejudice in family services, attributing this to a predominantly female workforce whose construction of fathering is out-of-date (Lamour & Letronnier, 2003). This study explored how family healthcare practitioners perceive the role of fathers. Overall, participants scored highly on this section of the three questionnaires, reflecting a positive attitude towards fathers' ability to look after their baby. Scores improved across the training day, and this improvement was sustained during the three month study period. Such positive attitudes are important because health and family practitioners are in a key position to promote the engagement of fathers with their infants with long-term benefits for children's educational attainment and behaviour (Ramchandani et al., 2012; Aldous & Mulligan, 2002).

This study explored the engagement of Health Visitors and Community Practitioners with fathers at the time of attending the training day, their intended engagement at the end of the training day and their behaviour in practice during the next three months. Scores improved significantly between current practice (T1) and intention to engage fathers in practice (T2), and between current practice (T1) and practice three months later (T3) with a good effect size, indicating the effectiveness of the training intervention. However, a statistically significant decrease in scores between T2 and T3, with a moderate to strong effect size, suggests that there are obstacles to enhanced engagement with fathers. This finding is supported by the open-ended questions and telephone interviews which revealed a commonly experienced difficulty in contacting fathers when Health Visitors only work office hours. Taylor and Daniel (2000) advise that Health Visitors should raise this issue at organisational level, so that out of hours' provision can be made to accommodate as many fathers as possible and, indeed, several participants recognised that systemic changes would be required to allow better engagement with fathers.

8. CONCLUSION

Health Visitors are well placed to engage with fathers of young children (Sherriff & Hall, 2011). This study provides strong evidence of the usefulness of training health and family practitioners in father-inclusive practice. The majority of participants responded positively to the Fatherhood Institute training day and reported that it helped raise awareness of the importance of engaging with fathers, and gave them the opportunity of learning new ways to achieve this and of sharing experiences and practice ideas with colleagues. This study also reflects the need for providers of services to reconsider the need for out of hours' services, as well as to assess how fathers' needs and aspirations are acknowledged in leaflets, posters, and group sessions. Participants agree that there is still much work to be done in order to develop truly father-inclusive services.

9. APPENDICES

APPENDIX 1	Literature Review
APPENDIX 2	Fatherhood Institute Training Day Timetable
APPENDIX 3	Toolkit: <i>Health Visitors and Fathers: A Good Practice Guide</i>
APPENDIX 4	Questionnaires T1, T2, T3
APPENDIX 5	Semi Structured Telephone Interview Schedule
APPENDIX 6	Original Role of the Father Questionnaire (Palkovitz, 1984)

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11. ACKNOWLEDGEMENT

The research team would like to thank The Burdett Trust for Nursing for funding this project, and the Fatherhood Institute for the opportunity to collaborate with them. Special thanks also go to the NHS Trusts, the Health Visitors and Community Practitioners who participated in the training and who were so enthusiastic about the study. We would also like to thank Laura Scurlock-Evans from the University of Worcester for her advice concerning statistical measures for the study.